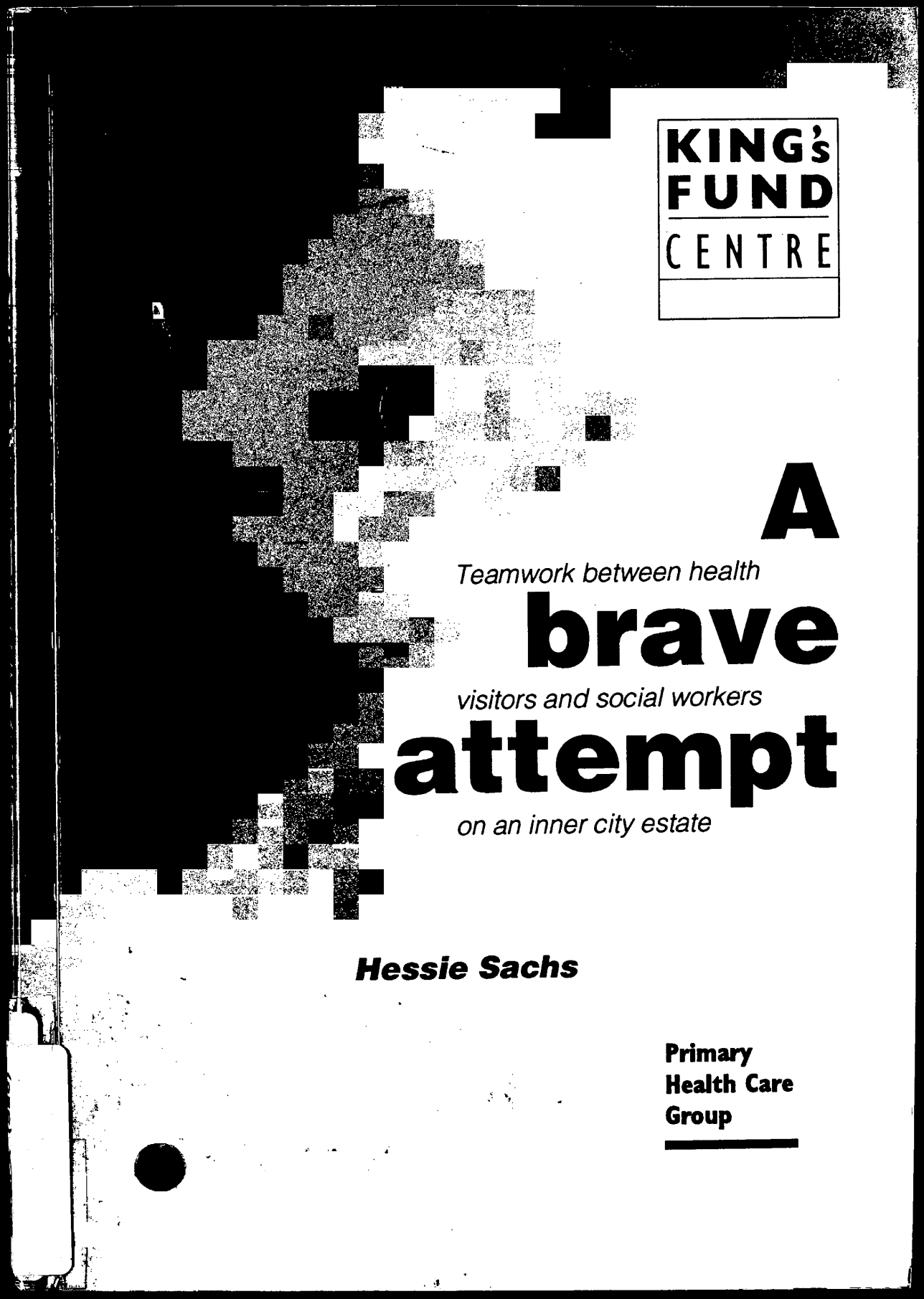

KING's FUND CENTRE

A brave attempt

Teamwork between health visitors and social workers on an inner city estate

Hessie Sachs

Primary Health Care Group

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This one-person study of a multidisciplinary neighbourhood project was initiated by the health visitors working in the project. Their experience had convinced them of the project's worth as a setting for health visiting and that it was important that their experience be documented and publicised. The district authority agreed to sponsor the study and the King's Fund, to fund it. In the event, King's Fund funding turned out to be my credentials. Most participants in the study assumed that I was attached to a university or other recognisable institution. When told I was not, their response, generally, was one of confusion, hesitation and, even, withdrawal. Mention of the King's Fund grant immediately restored my bone fides. To the initiators, the sponsors, the funding and credentialling body and all who participated in the study, my grateful thanks.

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At the end, for disseminating the material, for publishing this report, it is again the King's Fund that I have to thank.

Hessie Sachs

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Preface

During the months that the community nursing review team met, we were presented with persuasive arguments that convinced us that two clear improvements could be made in the way health care was provided in the community. It was suggested, first, that major benefits could be achieved through multidisciplinary working, and second that there was a substantial advantage in focusing on a particular geographical area when planning and delivering services. It was these two criteria that later formed the basis for our proposals on neighbourhood nursing.

It is particularly interesting for me, then, to read about the imaginative initiative which Hessie Sachs describes in her report. While we had to limit ourselves to looking at the benefits of working on a multidisciplinary basis to community nurses only, the project described here was more ambitious. It explored the possible benefits of community nurses — health visitors in particular — getting together and working more closely with social workers. Not only were there limitations of professional differences to cross, staff also had to overcome the constraints imposed by their own agency boundaries.

The experiment was located in a housing estate which suffered high levels of disadvantage. There were many problems facing residents and the professional and voluntary agencies living and working there. The fact that the project was able to focus on a clearly defined area (or neighbourhood as we might describe it) and build up a thorough knowledge of the assets and deficiencies of the place, meant that appropriate responses to need could be developed.

A wealth of voluntary initiatives were fostered with the help or support of project workers. Local residents played an active part in many of them. Health visitors and social workers established good working arrangements with each other; the individuals concerned valued the benefits that joint team working conferred. But the report also demonstrates the sheer hard work involved day-to-day in trying to establish and consolidate a grass-roots project like this one.

Perhaps what it lacked most of all, however, was management vision. A project which is firmly rooted in a local neighbourhood runs the risk of

being overwhelmed by the weight of local problems and the ever-pressing demands made daily on its workers. Positive management support is essential; workers exposed to pressure at ground level need to feel part of a wider network of contacts stretching up into their own organisations. When the going gets hard, managers must be prepared to step in and champion their staff. An experimental project must not be left to flounder. If it is proving successful, management must encourage it to become bedded in and make sure that the lessons learnt are heeded and built into longer term structures. A philosophy of getting close to the consumer is of no use without managerial commitment and managerial structures which are prepared to take it forward.

The project described here provides us with many useful lessons. It stresses the difficulties involved in getting a community-based initiative off the ground and offers us a timely warning that managers must be prepared to offer leadership. But I am delighted that the neighbourhood approach is seen to bear fruit, despite the difficulties, and that multidisciplinary working is both possible and productive. When we wrote our report, we hoped that the approach we recommended for community nurses could be extended to include other professional groups. From the experience reported here, it seems that our hopes were perhaps justified.

Julia Cumberlege
Chairman, Community Nursing Review Team
Member, NHS Policy Board

Chapter I: Introduction

'A slough of despond'

In 1977 a general practitioner working in the vicinity of a housing estate in the London Borough of Brent told his local social services advisory group that he was 'desperate'. The people on the estate lived lives of despair and there was little he could do to meet their needs or alleviate their suffering, so much of which was beyond medicine. He spoke of the anxieties and psychosomatic illnesses of single parents living in tower blocks, of the empty lives of the unemployed and of the disadvantage of even those in employment. He asked the social services to second a social worker to his practice to help meet the needs of the tenants.

His words reflected a growing concern about deteriorating conditions on the large housing estates in the borough and were, it was said, 'the spur to action'. The deterioration, according to a Brent social services officer, was to do with 'demography and Brent Council tenancy policies'. People, many with young families, struggling to cope with their lives were herded together with others in similar circumstances. There were few council services or other resources on the estates and, as seen from officer level, little voluntary activity, or even interaction between neighbours.

The general practitioner's words and corroboration of them by council officers led the council to look for a radical approach to the problems of Kilburn South — the estate in question — and to those of two others, Stonebridge and Chalkhill. It established a working party to determine what resources were needed and how best to provide them.

The Joint Working Party, as it came to be called, asked the managers of the three social services administrative areas in which the estates were located each to prepare a development project proposal. The aim was to co-ordinate council and other services at estate level and make them readily available to residents. They were to ascertain residents' needs and determine how best to meet them. Equally, they were to foster community

development, encouraging residents to involve themselves in estate issues and to participate in planning and running services. In sum, the projects were to deal with existing problems, prevent further deterioration and promote the well-being of residents. They were to be proactive as well as reactive.

The proposals, subsequently approved and implemented, differed for each estate. Those for Stonebridge provided for a team of community workers to be located on the estate. The teams proposed for Kilburn South and Chalkhill were to consist of social workers as well as community workers. In addition, the Chalkhill team was to link up with health services. It was to include health workers and it was to be located in premises adjoining an established health centre accommodating general practitioners and health authority personnel.

The Chalkhill Joint Neighbourhood Project, as it came to be called, was thus the only one of the three planned and developed as a joint local authority and health authority project. It was also, as far as was known, the only one of its kind in England. For the first time health workers would be working with social and community workers in an integrated 'patch' or neighbourhood team.

Originally, the health component was to consist of two district nurses and two health visitors. In the event, only the latter were seconded to the project. In addition to traditional health visiting, they were to participate with other project workers in fostering community development. The purpose of this study was to examine and describe their role in the project.

Background to the study

The initiative for the study came from the project health visitors. They found their work exciting and fulfilling and believed it to be an effective way of working — one that could be extended to other areas of high need. They believed, too, that their experience would make a useful contribution to debates about health visitors undertaking community health and development work in addition to or instead of their traditional work.

For these reasons they wanted a systematic record and independent assessment of their role and made frequent appeals to management for such an appraisal.

For three years management did not respond. Changes in management personnel in the years between the project's conception in 1977 and its inception in early 1980 meant that few of the officers involved in its planning were still in post. Continuity was further disrupted by the second reorganisation of the National Health Service in 1982. In any event, the project health visitors felt that management, having steered them into a new structure and setting, had abandoned them.

> 'Right at the beginning we were hoping that management would do some sort of evaluation or want to write some reports; that they might want to see us or ask us to produce something out of the first or second year's work, but they never did. We didn't even have any organised structure for meeting with them and discussing what we were doing and how and why.'

In 1983 an administrator was appointed to Brent's primary health care unit who had links with academic and research units. When the project health visitors spoke to her about their work she started the process whereby this single-handed study was launched. It was to be sponsored by Brent Health Authority and funded by the King's Fund London Programme.

Study objectives

Initially, the project was seen as an experiment in the location and use of health visiting resources. The primary purpose of the study was to document the experiment and make it known as a possible way of organising and delivering health visiting services. In brief, it might add to existing options of geographically-based or general practice-attached health visiting.

Secondly, it was intended to observe the role of health visitor in different structures. Besides working in the project the two health visitors

were attached to one of three group practices in the Chalkhill Health Centre. Further, as members of the Chalkhill health visiting clinic ('clinic' would seem to be the collective noun for health visitors sharing a common field base and constituting an administrative field unit), each was responsible for a geographical patch.

Once in the field it became apparent that the experiment could be viewed in another way. It could be seen as an experiment in the allocation of resources of a health visitor clinic responsible for the care of defined populations, including that of a large local authority estate. The Chalkhill clinic had a complement of six health visitors, including the project health visitors. It was decided that while the main focus of the study would be the project health visitors, information would also be sought on the work and attitudes of their colleagues.

From the start it was emphasised that the study would not be evaluative in the sense of measuring outcomes such as effects of health visiting on the health, behaviour or morale of clients. Such measures are notoriously difficult and expensive to devise and apply and could not be attempted in a study on this scale. Nor did the study set out to measure, in quantifiable terms, the extent to which the project's organisational goals were met. Instead it sought health visitors' perceptions of their functions and structures. Data were to be collected to help answer questions such as:

- What do health visitors think they should be doing — what are their professional objectives? What, in fact, do they do? What is the nature of their relationships with their clients and with other members of the communities they serve?
- How do organisational structures and physical settings affect the role? How does the work of a health visitor in a multidisciplinary neighbourhood or 'patch' project differ from her work in a primary care team or as a traditional geographical worker?

- What do other workers working in teams with health visitors feel about their presence? What effect do they think they have on their work and on relationships in the teams?
- Last, what is the nature of the relationship between authorities sponsoring a multidisciplinary neighbourhood project? To what extent do they have common objectives and to what extent do their objectives differ?

Besides these questions specific to the health visiting role in the units studied, it was intended that the data collected would be relevant to a number of debates influencing the social and occupational climate in which care providers operate. Foremost among these were debates about the nature of health and social services and the extent to which they should be proactive or reactive. Given that the goal of most community and personal services is to help people towards greater autonomy and control of their lives, to what extent should workers seek to locate and identify people at risk, in need or in trouble? Or should they leave the responsibility for asking for help to the people themselves or lay networks (Baldock 1983[1])?

Other debates concerned definitions of community work and who should be doing it. For example, should the functions of established health and welfare professionals be extended to include promotion and support of community initiatives or should community work be a separate and distinct occupation? (National Institute for Social Work 1982[2], Thomas 1983[3])

Yet another debate centred on inter- and intra-service relationships and the primary care team versus 'patch'. In general, interdisciplinary teamwork was favoured, less so the interdisciplinary primary care team based in general practice. Disappointed by the failure of most primary care teams to develop truly egalitarian structures, leaders of non-medical occupations were seeking other ways of maintaining multidisciplinary teamwork and comprehensive care in the community. A solution gaining support rapidly was collaboration between different 'patch' or single-occupation neighbourhood teams (Clare and Corney 1982[4]; Health Visitors' Association 1985[5]; DHSS 1986[6]).

In short, the study was not designed to test well worked out hypotheses but to provide new insights into health visiting and to highlight matters and themes important to health visitors and others in health and welfare fields.

Data collection

Data collection started at the beginning of October 1984 and the researcher spent the first three months in the company of one or both project health visitors. She attended their clinics and their health education talks, sat beside them while they completed their records, answered correspondence or dealt with telephone queries or consultations. She read through a one in two sample of their child and family records and scanned their monthly returns to the Department of Health. She listened while they sought advice from project or health centre colleagues or were consulted by them about client or estate problems. She accompanied them to meetings of the project, of their primary health care team, of the health centre management committee, of various units and working parties in the Brent nursing hierarchy. She attended two case reviews, a case conference and meetings with members of external agencies.

The information obtained from observation and discussion in the first three months of the study was used to prepare checklists for the interviews conducted in the next stage. Six health visitors, their seniors in the Brent Health Authority nursing hierarchy and representatives of all the occupational groups in the project and of most in the health centre were interviewed. Also interviewed were representatives of other services on the estate — housing and education, and of two Brent services serving the estate — a child and family guidance unit and the court office. Last but not least were interviews with eleven Chalkhill residents — seven in their capacities as representatives of estate organisations, two as child-minders and two as mothers of children who were minded.

In all, 41 interviews were conducted. Some, with the project health visitors and a senior nurse, involved several sessions, each lasting two to three hours, but most were completed in single one to three hour sessions.

Throughout the interview period the researcher continued, when possible, to attend meetings with the project health visitors and also spent time with other Chalkhill health visitors. During this period she went to meetings of Brent Health Authority and of the Chalkhill Estate Management Board. In May, she attended sessions in Brent Town Hall of an inquiry into the non-accidental death of a child.

In the pages that follow some of the material obtained in the course of the study is presented. There are, of course, many gaps unfilled and questions unanswered. Deficiencies stem, in part, from the study's limitations in terms of time and personnel, in part from the complexities of the structures and networks studied and in part from the number of 'events' which occurred during the study period. Besides the distress and concern associated with the inquiry into the non-accidental death of the child, there was a major change in the personnel of the project and a threat to reduce its staff complement. There were conflicts about the use of space in both the project and the health centre and, for the health visitors, about the introduction of functions not previously undertaken by health visitors in Brent — routine developmental assessments of infants and children and regular visits to elderly people.

The next chapter deals briefly with the history of the Chalkhill Estate, its population, the management of the estate and life on it. Chapter III looks at the conception and development of the project and Chapter IV at the role of the health visitor in it. Chapter V deals with some of the project's achievements and Chapter VI with assessments of the project as a whole. Chapter VII gives a summary of findings and draws some conclusions.

Chapter II: The Chalkhill Estate

'There is a mythical component to the image of Chalkhill which makes it out to be worse than anywhere else.' This was the view of many of those interviewed. The history of the estate suggested that, in part, the myth of its awfulness — as opposed to the real difficulties and drawbacks of life on it — stemmed from the violent antagonism of residents in the adjoining areas towards its development and was rekindled by the bitterness of some of the original tenants towards those who came later. Its history was thus one of conflict followed by apathy and despair which reached its nadir just about the time the general practitioner was expressing his despair about Kilburn South.

Its history also reflects shifts in housing and welfare policies accompanying changes in local and central government over the past two and a half decades and the extent to which these shifts determined the fate of the estate. It reflects, too, the influence of external events such as the riots in Toxteth, Bristol and Brixton and at least one internal event, the violent death of a young girl on the estate.

Depending on one's viewpoint the estate, and others like it, can be seen as: a fact of social life; social Darwinism and the outcome of natural selection; the sorry result of well intentioned social policies— selection by need; a casualty of party-politicking; or a mixture of all of these.

This chapter begins with an outline of the history of the estate, followed by a brief description of its layout and accommodation. Next, the characteristics of its population are listed. The third section deals with the management of the estate, the fourth with organisations on the estate, and the last with life on the estate.

History

In a period when many London working class areas were undergoing 'gentrification' or 'colonisation by the middle classes', a reverse process was occuring on the Chalkhill Estate (Glass 1964[7]; Hannett and Williams 1979[8]). The estate, which today accommodates 5,000 people on

59 acres of ground, is set in a predominantly middle class area of Brent. Begun as private speculative development in the early 1960s in what was then the Borough of Wembley, it too was intended for middle class owner-occupation. In 1965, however, the properties were acquired by the newly formed London Borough of Brent.

Established by the London Government Act (1963), the London Borough of Brent was an amalgam of predominantly middle class Wembley and predominantly working class Willesden. The new borough's council was Labour controlled and, according to a council officer, began immediately to look for sites on which to build to alleviate Willesden's acute housing problems.

> 'They saw this enormous expanse of land with only about 100 houses on it as an ideal place for development. It was also right in the heart of a very salubrious part of Wembley and from day one, there was a very high level of animosity towards it.'

The decision to purchase the site was resisted strongly by councillors for the old Wembley constituencies and their constituents remained extremely hostile towards its development. A Chalkhill 'original', one of the estate's earliest residents, said:

> 'I know because I attended their meetings, not as a council tenant but just to see. Building had just started and the hostility — you would have thought you were back in the Reichstag — there was a terrible amount of hatred and bitterness and it was directed towards the people who were coming to live on the estate, people who just wanted a place to live. They hadn't committed any crime.'

By 1969, when the first houses were ready for occupation, control of the council had passed to the Conservative Party, among whose supporters were opponents of the development. It was likely, a council officer surmised, that the council did not want an invasion of the area by several thousand tenants who could be expected to vote Labour. However, short

of selling public housing stock, a procedure unheard of at the time, the council had to begin to receive tenants, for economic as well as social reasons. It did so but excluded the estate from rent or rate rebate schemes, thereby restricting it to tenants who could afford economic rents.

In this way, according to the officer, the council sought to maintain the ambience of the area, protect private property values and prevent dilution of support for the Conservative Party. Finally, as the council intended that the tenants would come from other designated areas in Brent, it anticipated that their removal to Chalkhill would promote more rapid development of these other areas to house tenants who could not afford economic rents.

A Chalkhill 'original' who was interviewed confirmed that the council, in the early days, was 'very selective' and asked for three references including a financial one which, he said, automatically excluded most people from redevelopment areas — 'a very peculiar situation in local authority housing'.

Despite the attraction of a modern building, lifts to all floors, twenty minutes from London's West End, there was difficulty in filling the flats with people from Brent because 'Chalkhill was still a block of council flats'. Next the council advertised nationally and attracted people whose housing needs were not particularly great. Many were home owners who sold their houses to raise money for business ventures and so on. The council's policy thus failed to reduce its own housing problems.

In 1972 when about three quarters of the housing on the estate was let, Labour regained control of the council. On the principle that council housing must be allocated on the basis of need, the incoming council extended rent and rebate schemes to Chalkhill Estate. A Chalkhill resident said:

> 'They stood the whole thing on its head and many of the original tenants cried: "Not fair, we were promised a high class residential area and now we are getting the roughs from all over the borough." In truth, the newcomers were on a different economic level and, as always, there

> was friction between the families who had and those who had not. Many of the 'originals' left and the underlying current of hostility persisted for many years.'

While agreeing that much of the tension at that time was in the nature of 'class conflict', another resident thought it had also to do with numbers: the size of the estate's population and, once the tenancy policy was changed, the speed with which people from 'slum' areas (areas designated for urgent redevelopment) were moved on to it. In particular, it was the problems of rubbish disposal and collection which, she felt, made the place look, smell and feel so unpleasant and led to apathy and low morale.

> 'It was luxury accommodation in the beginning and one of its features was the Garchey system: bottles, cans, almost everything except big cardboard boxes go down the sink. In the early days, as tenants moved in, its use was explained and demonstrated and anything that went wrong was quickly repaired. But the rent rebate people weren't taught so well — there were so many of them moving in one after another and there wasn't the personnel to demonstrate its use, deal with mechanical breakdowns or clear the rubbish which rapidly accumulated.'

It may be, she said, that if the council had made more staff available conditions and morale would not have deteriorated so. For the first wave of newcomers, the move to Chalkhill Estate was an achievement. It was only as the problems multiplied (families with young children in top floor flats, lifts not working, the endless accumulation of rubbish) and earlier residents began to move out, that the downturn occurred and it became one of the least desirable housing options. Families from bed and breakfast hotels accepted accommodation on it, hoping it would be a halfway house to better accommodation. An officer of the council summed up what had happened:

> 'The majority of people who were socially mobile, who had some control over their affairs moved off leaving space

> for people with high need — those with the necessary points, mostly homeless families. So, in effect, the Labour council's tenancy policy resulted in the concentration on the estate of socially immobile people — people who didn't have control over their affairs — and a downward spiral of dependency.'

He estimated that by 1977 only 20% of Chalkhill tenants were not in receipt of rent subsidies of one kind or another.

Layout and accommodation on the estate

By 1977 when the estate was declared a 'priority area', house building had been completed and the estate then, as now, contained approximately 1,750 dwelling units. Thirty-eight percent of the units were bedsits or had one bedroom, 30% had two bedrooms, 22% had three bedrooms and 9% had four bedrooms. Nearly three-quarters of the units were one storey or duplex flats accommodated in 30 concrete blocks. The blocks were long rather than tall, the highest having eight storeys. Grouped in 'claws', they were linked by decks at every third floor with lifts and staircases in the links and surrounded by six acres of open space. Besides flats, the blocks contained a housing branch office, eight shops, a tenants' hall and two multi-storey car parks, sections of which were recently converted into community facilities. There was a community centre in one and a leisure complex in the other.

The remaining accommodation — low-rise terraced housing and flats— was on the perimeter of the estate, as were a day nursery, a primary school and a health centre, the last located in one of the few concrete blocks reaching to the estate's boundary.

In designing the layout the Borough Architect apparently had the safety and happiness of children in mind. In an internal council memo he wrote:

> 'The road system is limited to the minimum necessary to serve the site, bearing in mind the continuous decks within the blocks and an independent system of pedestrian paths on the ground linking all

> the major features of the scheme. Each 'claw' has an equipped play area which in one case includes a paddling pool, but the general spaciousness of the site permits informal play almost anywhere.'

It was ironic that by 1977, life for many children on the estate was neither safe nor happy. According to an internal council memo, proportionately more children on the estate than elsewhere in Brent were subject to care orders.

It would seem too that many of the design features which provided comfort and amenity for one class of resident added to the difficulties and discomfort of another. For example, by providing decks on every third floor only, space in the flats and maisonettes on the floors between was maximised. It meant, however, that rooms, frequently bedrooms, were located beneath the decks. As the population turned over there was a considerable increase in the number of children and teenagers on the estate and so also in the volume of noisy traffic on the decks, especially late at night.

More seriously, because the decks were planned as public walkways they, as well as the lifts and the stairs, were open to all and in due course became venues for 'street' crime, muggings and, eventually, a murder. In 1982 a young Asian woman returning from work was assaulted in a stairwell. She dragged herself to the first floor landing and died upon reaching it. Her killer and the motive for killing were never discovered.

Similarly, the open spaces planned for pedestrian traffic and leisure enjoyment were dangerous after dark, making homecoming difficult for many. Not infrequently late home-comers hired taxis to drive them the few hundred yards from the station or bus stop to the nearest point of access to their flats and it was not always possible to find a cab prepared to enter the estate. To coin a phrase, one person's park had become another's jungle.

Who lives on Chalkhill?

In attributing the rapid deterioration of life on the estate after 1972 to 'demography and housing policies', the Brent social services officer perceived the former as, largely, a consequence of the latter. The 1981 census and a survey by Brent Housing Department in the same year both found that the Chalkhill estate had a population with higher than average proportions of young people, one-parent families, members of ethnic minority groups, previously homeless families and unemployed people.

Approximately 5,000 people lived on the estate. Of this number, 11% were under five years old and 34% under 17 years old. People over 60 years old accounted for 12% of the population but, because of their vulnerability to mugging and burglary, the council was no longer encouraging older people to move to Chalkhill.

The population lived in 1,747 households, half of which were family households with at least one child. Forty percent of families were one-parent families, compared with 21% in Brent borough as a whole.

Sixty-two percent of the population were New Commonwealth immigrants or their descendants (compared with 33% in Brent) of whom half were of Afro-Caribbean origin and half of Asian origin. The Chalkhill population was thus made up of three roughly equally-sized ethnic groups: indigenous white, Afro-Caribbean and Asian.

At least one third of the households were 'homeless' at the time that they accepted accommodation on the estate. Finally, the rate of unemployment on the estate was estimated at 17% compared with 10% in Brent as a whole.

How the estate was managed

> 'Planning and the determination of policy, the allocation of resources and the formation of programmes designed to change the lives of people is a business which is limited to the

> ruling class and is a matter in which the majority of people have no way of becoming involved or knowing anything about. The people constitute little more than a mass target, mute and inert, toward which national plans and programmes are directed.'

This quote is from Poston (1963[9]) and refers to the 'newly developing' countries of Africa, America and Asia in which government was a highly centralised institution and there were no institutions of local government or voluntary civic organisation through which people could engage in organised efforts to control or improve their physical and social environments. The lack of civic organisation in village, town or city neighbourhood, resulted in a great void between 'government and people, between planners of change and those whose lives [were] to be changed'. In consequence, he concluded, programmes and expenditure of vast sums of money resulted in very little improvement because there was 'virtually no channel of communication between the givers and the receivers'. Poston's description, according to many living or working on Chalkhill, might aptly be applied to Chalkhill.

The population of Chalkhill was 5,000, equal to that of a village or small town. Residents had the same rights of parliamentary and civic enfranchisement as residents anywhere else. To what extent, however, were they able to exercise control over their immediate environment? Chalkhill Estate, like other council estates, was managed by a housing office on behalf of the Brent Council housing committee: 'Managed by a bureaucracy', according to a Chalkhill resident. To 'leaven the control from above — but not too much', as another put it, the council established the Chalkhill Board of Management. Its role was to advise the council on estate affairs but not to run the estate.

The following section deals briefly with the mechanisms for 'managing' the estate: maintaining and improving its physical structure and controlling and regulating tenancies. The next concentrates on its local voluntary organisations or structures with the potential to mediate

between government and governed.

The district housing office

The Chalkhill Housing Office was one of three district housing offices in Brent, each responsible for roughly a third of the borough's housing stock. It was located on the estate and, in addition to the estate's housing, it managed 5,000 properties off the estate, a total of approximately 7,200 in all.

While accounting for only one quarter of the properties managed by the Chalkhill office, the estate, according to a housing officer, accounted for at least half its work. Further, its location on the estate made for extra work in other ways too. Tenants living elsewhere were reluctant to call in person. 'So,' said the officer, 'we get a lot more mail than we should, a lot more telephone calls and almost permanently congested switchboards and officers having to spend a lot of time going out to see people rather than people coming here.'

The office performed four main functions. It was responsible for the physical structures on the estate: the major capital works as well as the day-to-day repairs. Second, it kept Brent Central Housing Office informed of vacancies on the estate and saw to the housing of new tenants allocated to them. The allocations were on the basis of priority — the point system — and family size. 'We wouldn't try social engineering in terms of ethnic or other mixes,' a housing officer said, 'there are dangers in that from which we all shy.'

The office's third function was rent collection and the recovery of rent arrears. It made all recovery decisions short of eviction, which were made by a sub-committee of the housing committee. Once these were made, however, the district office served the notices to quit and initiated any necessary court action. In mid-1985 Chalkhill rent arrears were running at £1,500,000 and the housing office had been instructed to take a more aggressive line which, the officer said, was not easy. 'It's difficult to talk about arrears to families suffering all sorts of problems and who, in the first place, did not choose to live here.' Like many London housing

authorities, Brent's housing supply fell far short of demand and, frequently, all that was on offer to a homeless family was a flat on a 'problem estate or an estate with problems' — one of the three priority estates.

In theory, he explained, applicants had choice and were told to state their area of choice. In practice, they were made two offers and both might be on Chalkhill Estate. If they refused them and, 'on review', at least one was found to be 'reasonable' — within travelling distance of employment, education, etc. — bed and breakfast payments were withdrawn and a family could face bills of between £200 and £400 per week.

The office's fourth major function was 'processing and prioritising' applications for 'transfers off' the estate, which not infrequently involved housing staff in investigating claims of racial harassment, disputes between neighbours, family breakdown and marital difficulties. Again, although the district office was the 'tenant's point of contact — the place where application was made' — transfer decisions, like eviction decisions, were made centrally, not locally, a distinction which, the housing officer thought, most applicants failed to grasp. So, for the people of Chalkhill, the housing office, like the social services and the police, had a dual character: on the one hand, protecting and promoting tenant welfare; on the other, applying sanctions or preventing release from a way of life which many felt to be intolerable.

The Chalkhill Management Board

Although 'managed by a bureaucracy', the estate had a management board of elected residents established by Brent Council 'to involve residents ...in the general management of the estate'. All matters relating to its management were to be considered first by the management board and the board's recommendations passed to the council. Its role was thus advisory.

Besides elected residents (30 in all) voting members on the board included the ward councillors and two other councillors. Elected members chose the board's officers and appointed its subcommittees — a general

purpose and an environmental subcommittee. The district housing office serviced the board but neither its officers nor other co-opted members — representatives of schools, the joint neighbourhood project and other agencies serving the estate — had voting rights.

The Chalkhill Management Board was unique in Brent: no other estate had one. It came into being in the early seventies mainly, according to several informants, as a result of a campaign by the Chalkhill Tenants' Association for a better and happier estate. The association, a pressure group formed by the 'originals' in the early days of the estate, envisaged the management board as the equivalent of a parish council. 'After all,' it argued, 'we are the size of a small town.' Opinions on the success and effectiveness of the board varied. A resident who thought it successful claimed:

> 'It works exactly like a parish council — through its two committees. It meets monthly. It has an AGM. Business is discussed at its monthly meetings very much as at a council meeting and if any member wants a report from, say, the Borough Engineer he can ask for it and ask the Borough Engineer to explain it. Similarly, he can ask the Borough Architect to explain his designs. So the board can call on any member of council staff to attend its meetings.'
>
> 'It's true we don't have much money — peanuts — barely enough to produce leaflets for public meetings.'

As examples of the board's initiative he cited improved lighting on the estate and the enclosure of the walkways. Both improvements made the estate a safer place. The latter by providing amenity areas exclusive to the twelve or so households sharing a deck gave them defensible space, small enough for residents to identify with, and made the estate a far pleasanter place on which to live. He added bitterly that it had, however, taken

a murder to get the council to agree to the innovations. The management board had pressed for them for a long time but it was only after the mugging and death on the walkway that the council acted.

Another resident thought the influence of the board was waning; it had been more influential in the days when Labour had a definite majority on the council. (In 1982 a Labour member crossed the floor, since when the council was a hung one.) Contrasting the board's position in the past with the present, she said:

> 'We used always to be involved in the appointment of estate officers, but not now. We used to have a voting representative on the Brent housing management subcommittee: that has stopped. Whereas the Labour council encouraged our participation, the Conservative councillors, frequently backed by the Liberals, have stopped it.'

Nevertheless, she too, maintained that the board had a number of achievements to its credit, including the community centre then nearing completion and, in her view, long overdue. 'It's a disgrace,' she said, 'that an estate the size of Chalkhill was without a social centre for so long: how they could build an estate like this and not have a community centre beggars belief.' She explained that except for the tenants' hall and the 'community suite' in the primary school, both able to accommodate limited numbers only, and a building converted to serve, unsatisfactorily, as a youth club, there was no accommodation on the estate for social gatherings and activities. The board, and before it the tenants' association, had never ceased campaigning for a community centre and now, at last, the estate was to have one.

While acknowledging the board's initiative and persistence, a third resident pointed out that the community centre campaign succeeded only after the inner city riots of the early eighties. Just as a murder preceded improved lighting and the walkway enclosures, Toxteth, Bristol and

A brave attempt

Brixton loosened government purse strings and made money available for a community centre and much else besides.

> 'The government was seized with fear that these things might repeat themselves in other places where there were large ethnic minorities. It spent money hoping to stave off any simmering hostility that might exist. It's been done before. It's nothing new. And so certain monies — Urban Aid — were directed to places like Chalkhill where the ethnic population was growing.'

Two residents thought the board made little impact on the state of the estate. 'It is managed by the council through the district housing office — that's where the power is.' This was a view shared by a social worker, who said, 'It's a classic community group controlled by a few people in their own interests. Most people on the board are white and the majority on the estate is black and that is where the problem is. In any event it's just a talking shop.'

A housing officer, however, saw the board as relatively effective in two ways. While it was not involved in day-to-day management of the estate, such as repairs, transfers, rent arrears, supervision of the caretaker services, which were all concerns of the district office, it was a group to which officers could talk about these things and obtain feedback. Second, the board had the right of referral to council committees making it different from a tenants' association or other local organisations. 'As an officer you can listen to or consult members of local organisations and then, if you want to, ignore them. The management board you can listen to, consult and advise but if its members want something taken to the council, it must be done.'

Neither officers nor residents saw the role of the board progressing to the point where it would take over the running of the estate in the foreseeable future. 'Too many council members would not want that'. 'Instead,' said a board member, 'we have the project, the money dispenser for the

council.' As he saw it, the staff in the joint neighbourhood project provided expertise in community organisation and did things which residents on their own, much as they would like to, could not do. They had neither the time nor the experience to make applications, whether on behalf of individuals or groups, nor could they understand 'all the nuances involved in doing so'. The project members were paid to do it — that was their job. 'But,' he concluded, 'they haven't the compassion we have. They have some, but not to the extent we have it.'

This was one view of the project. Others are reported in Chapter VI.

Estate organisations

> 'Social organisation is important for one reason alone: to enable a social unit to take action as a unit to meet a collective need.' (Coleman 1971[10])

> 'People band together to study, to learn, to plan, to work and to take action to improve their environment.' (Poston 1963[9])

A major purpose of the three 'priority estate' projects in Brent was to enable and encourage the development of local organisations and it would seem that on Chalkhill at any rate, progress in this direction was made.

As quoted earlier, a council officer maintained that, 'viewed from officer level', there were, in 1977 when the plans for the Chalkhill Joint Neighbourhood Project were formulated, virtually no local voluntary organisations on the estate. He was wrong in that at least one — the Chalkhill Tenants' Association — was in existence and had been for more than seven years.

In 1985 there were 41 organisations on Chalkhill of which 22 were attributed to the initiative or encouragement and support of members of staff of the Chalkhill project. These are shown on the organisational chart (Table 1). Most of the organisations, it was said, catered for limited interests and had few members. Some were likely to be short-lived.

Most people acknowledged, however, that each was important, helping to raise the self-esteem of its members, especially of its office-holders, and contributing to levels of interaction on the estate. It was pointed out, too, that a short life was not necessarily a failed one. It might indicate the opposite: mission achieved and the end of an organisation's raison d'etre. Even the failures left residues of collaboration or conflict which, in turn, generated or contributed to further activity.

Table 1
Chalkhill Organisational Chart

SECTION	NAME OF GROUP	CONVENERS/CONTACTS
1. SPORT		
	Chalkhill Sport	Community worker
	Brent Judo Club	Resident
	X and Y Judo Club	Resident
	Chalkhill Rangers (Netball)	Resident and community worker
	Chalkhill Football Club	Resident
2. KEEP FIT AND DANCE		
	Modern Dance and Ballet	Volunteer (non-resident)
	Popmobility	Community worker and resident
	Keep fit and relaxation class	Health visitor and social worker
3. CREATIVE		
	Needlework class	Community worker
	Sparetime Club (arts and crafts for 9-11 year olds, offshoot of Nutshell)	Residents and community worker
	Photography	Resident
4. EDUCATION		
	Black Parents' Advisory Group	Social worker and community worker
	Saturday School	Teacher (Brent Education Dept.)
	Black Studies	Social worker and community worker
	English Classes	Teacher (Brent Education Dept.)
	Adult Literacy	Teacher (Brent Education Dept.)

	Gujarati	Teacher (Brent EducationDept.)
5. UNDER FIVES/PARENTS		
	Mothers and Toddlers	Family aides
	Toy Library	Family aides
	Pre-school playgroup	Resident
6. YOUNG PEOPLE		
	Silhouette (Girls project, offshoot of Nutshell)	Resident and community worker
	After School Club (South Junior School sport and creative)	Resident
	Latchkey Club (North Junior School games/sport/educational)	Community worker and resident
	Youth Club	Community worker and resident
	Junior Action (games/sport/outings)	Resident
	Youth Advisory Service	Health visitors
7. SOCIAL AND RECREATIONAL		
	Senior Citizens Lunch Club	WRVS
	Asian Forum Lunch Club	Resident
	Homegrowers (Table games and refereshment)	Resident
8. INTEREST AND PRESSURE GROUPS		
	Tenant's Association	Resident
	Asian Forum	Resident
	Nutshell (black mothers)	Resident and community worker
	Unity (for unemployed youths)	Community worker
	Tuesday Club (for isolated mentally ill people)	Social worker and community worker
	Community Shop (advice and information centre)	Community worker
	Women's Group	Resident
	Day Nursery Campaign	Resident and community worker
	'Save our Subsidy' (childminding)	Resident and childminding dev. officer
	Mini Bus (for use of groups)	Community worker
	Link (umbrella organisation for Estate groups)	Community worker

Four organisations nominated by most respondents as 'effectual', 'having clout' or 'an impact on life on the estate' were, in order of longevity, the tenants' association, Asian Forum, Nutshell and Unity. There was also Link, intended as an 'umbrella' for all Chalkhill organisations. The origins and aims of each are examined briefly, beginning with the tenants' association.

Chalkhill Tenants' Association

The Tenants' Association, a founding member claimed, was in many ways the forerunner of the Chalkhill Management Board. Like most tenants' associations, it began as a pressure group formed to fight a rise in rents imposed virtually as the first tenants moved in. Membership of the association was open to all and as the estate grew so did the association. As conditions on the estate deteriorated, more and more of the association's energy was taken up pressing for building repairs and improvements and, without success, a seven-day rubbish collection.

The association's base was the tenants' hall built in 1969 as part of the main development. It belonged to the council, but the association was the leaseholder: 'We hold the deeds and, unlike most tenants associations, pay rent.' In turn, the assocation let the hall to other groups on the estate, generally without charge.

In its early days the association was represented on various council committees and, a member claimed, it was due to the association's initiative and persistence that the youth club premises were acquired for the estate. The association's next major effort was the management board which, in the first few years of its existence, was run mainly by the association's honorary officer. In due course the association's role as a pressure group passed to the board and the association concerned itself mainly, but not exclusively, with the welfare of senior citizens. 'We feel there are sufficient agencies — social workers and health visitors — for the young, for single parents and for children, so we concentrate on the old folk.'

The association prided itself on its independence: 'We are jealous of it and won't take a penny from anyone.' It raised money from jumble sales and other events to pay the rent and insurance of the hall (about £1,500 per annum) and to finance the activities it organised: outings, teas, bingo and an annual dinner for between 150 and 200 old people on the estate. It produced a bi-monthly journal — also at its own expense — and distributed it to every household on the estate. Although, by and large, it had become a benevolent association, it still retained some of its clout. Comparing it with the management board, a founder member said, 'Through its ties with the council the board can do things we can't but it is restricted in ways that we aren't. For example, because we are independent of the council we can discuss rents which the board can't.'

This view of the association's strengths was shared by other estate residents and officers. A project worker said: 'The Tenants' Association is probably more political than the management board, although there is considerable overlap in personnel. Also, although dominated by the older white members of the community, it's actually got its politics sorted out as far as the estate and racial issues are concerned.' With 1,800 members on its books, it was by far the largest organisation on the estate and its membership cut across all sections of the population. 'We have always maintained that there is a bottom line and that line is that we are all council tenants. If we concentrate on what we hold in common and don't bother about the things that divide us, we can be that much stronger.'

Other Chalkhill organisations

The other three organisations regarded as effectual were all based on racial origin and two of them, on gender and age. All three had been helped by the joint neighbourhood project to obtain premises and funds from the council and other sources. Asian Forum was a grassroots development, the initiative coming from Asians on the estate. The existence of the other two, Nutshell and Unity, was generally credited to the Chalkhill project.

Asian Forum, the largest and oldest of the three, was open to Asian people of all religions and countries of origin both on the estate (300 families) and in its immediate vicinity (100 families). Its aims were: to get members of the Asian community to work together for a better life for themselves; to deal with housing, immigration, social security and other problems or difficulties experienced by members; and to provide interpreters and translators.

Nutshell, an association of single parent young mothers was exclusively Afro-Caribbean. 'Black mums get together to organise things for other black mums and their children on the estate who, we find, are the ones always left out,' said a representative of the association. 'So many black mothers just wake up and stay in, just sit in their houses all day. They have such a negative attitude to life — don't want to go anywhere or do anything — and it is this apathy that Nutshell is trying to overcome.' She defended Nutshell's separatist philosophy: 'Blacks have to establish themselves in the community and make the community aware that they want things done — once they have got their own group going they can move out and contribute on a wider sphere.'

The project community worker associated with the group, supported this view. She, a white person, believed black people had to organise themselves; they could not be part of a multiracial group led by white members. In such groups their needs were always overlooked.

It was acknowledged generally that Nutshell was initiated by the project but the worker concerned maintained she had got it off the ground to the point only where needs were identified and articulated.

> 'I invited some girls I met at the youth club to have a chat with me about things they might like to set up. Three came and, in due course, brought their friends. All were single black mothers and they decided to form a committee to organise things for people like themselves — "single black mums" — and gave it the name "Nutshell".'

She said that was how decisions to launch initiatives were generally made. Decisions to provide resources to develop or sustain initiatives were more complex processes. A campaign for premises for Nutshell was unsuccessful at first, but after the death on the walkway, Nutshell was given a flat on the estate by the council.

Campaigning for premises, as a group activity, helped the group to gel and to attract new members: 'It is part of the group development process.' Another campaign with similar consequences was the one for a community day nursery. Members wanted a day nursery because the only one on the estate was always full. Also, they wanted one run on different lines: by parents, who would be trained on the job and at college, with the help of one or two professionals.

Offshoots of Nutshell were the Sparetime Club, a club for children aged nine to eleven, which met one evening a week for supervised art — drawing and sewing — and Silhouette, a club for teenage girls. Nutshell's membership numbered between 30 and 40 mothers and five to ten children attended meetings of each club.

Unity was the newest of the 'effectual' organisations. It 'emerged' in 1984 to 'tackle the estate's most intractable problem' — unemployed, mainly black, youth on the estate. Residents and workers held that the youngsters were doing themselves no good 'roaming about not knowing what to do, smoking heavily and taking drugs', and were doing the estate a great deal of harm — 'muggings, vandalism, theft, burglary and God knows what else'.

Getting Unity going, according to a project worker, was, as with Nutshell, the direct result of straightforward 'street work': making contact with young black men on the walkways, talking to them about their needs and making arrangements for a place for them to meet. It involved, too, enlisting the help of older residents to lead the youngsters in more meaningful directions. Four middle-aged black men were engaged as 'leaders-in-charge'. All four, working voluntarily to promote Fun Day, a council sponsored festival held the previous summer, had demonstrated a capacity for organisation and keeping things in hand. Their brief as

leaders-in-charge was to do something about the youngsters congregating on the walkways and disturbing residents late at night. The project helped them obtain temporary accommodation in which to provide a seven-day service while a purpose-designed centre was prepared for them in the new leisure complex.

In its first report, Unity defined its aims as the provision of 'sanctuary, tranquillity and support...'. It hoped to build relationships with the young people which would help them become more accountable for themselves to their peers and the community in which they lived. It operated a 'job hunting programme' and its facilities included a pool table, 'space invaders', small table games and dominoes. Its premises were open from 9.30am to midnight weekdays and 1pm to 7pm Saturdays and Sundays. An extension to 3am had been recommended as the early hours were the crucial ones. 'It is then that the young people are inclined to congregate on the estate instead of returning home.'

Opinions varied as to the success or even the potential of Unity. One view was that all it had done was 'move the problem from A to B'. The youths continued to behave as always, pursuing delinquent activities and plotting crime. Another was that the move itself was an achievement: 'At least they are off the walkways'. Others were more sanguine. They believed that attempts at rapid, radical change would be counter-productive, that gradual containment had to be the way forward. 'They are not youngsters at boarding school: you've got to work slowly and patiently to get their attention and that is beginning to happen.'

Link was intended to link all the Chalkhill organisations. Established by the project in 1983, it worked well for about a year and a half then split on issues of resource allocation. A witness to its dissolution described the break-up as 'horrific — so much bitterness and scrabbling for resources — the community was riven'. Because, in the project's view, it was essential to have a forum in which all estate interests were represented, which would help the project to identify community needs and serve as a sounding board for development plans, Link was reconvened in 1985: 'Too often,' said a community worker, 'ideas are asked for and then lost.

We have to make sure that doesn't happen.'

The resident who associated the funding of the Chalkhill Community Centre with the aftermath of the 1981/2 urban disturbances also perceived Link as part of government strategy for preventing trouble. Monies allocated for developmental purposes to places like Chalkhill could not be handed over to the community. 'You can't just say to the estate, "well here's a few hundred thousand pounds". You have to put officers in charge. So Link is the bridge between the community and authority and decides how to distribute the money.'

There were conflicting reports about its progress. Some thought its meetings were poorly attended, but a resident who was a member gave this optimistic report: 'We've got an input from about twelve different groups which is really quite good and we all get on pretty well.'

A community worker hoped that, long-term, Link would play a major part in co-ordinating community activities, in allocating funds and, eventually, in partnership with councillors and council officers, in the provision and management of estate resources, functions which yet others hoped the management board would, in due course, fulfil.

Life on Chalkhill

In 1977 the social services manager for the area in which Chalkhill is located listed the estate's problems as marital, housing, financial and child care; all of which he considered were increasing in volume and severity. In the introduction to his proposals for a Chalkhill project he wrote:

> 'There appears to be a concentration of families with children on the estate who experience multiple problems in the levels of psycho-social functioning.....Preventative work being undertaken to treat or support one parent or multiproblem families is greater than elsewhere in the area.'

Yet, he concluded, despite these efforts, proportionately more children

were received into care from Chalkhill than from elsewhere in the area or any other part of the borough.

In the years between 1977 and 1984/85 the number of estate children in care was reduced from 40 to 13, a dramatic reduction by any standard. (A Brent court officer cautioned that part of the reduction might be due to 'cleaning up of the register' — removing names which should have been removed years before, names of children now grown up and married). People interviewed for the study were divided almost equally between those who thought the quality of life on the estate had improved in recent years and those who saw no diminution in its problems. All agreed there were massive problems on the estate but disagreed about what was cause and what was effect.

Factors most frequently associated with distress on the estate were its scale and design, transience (real or in the mind), sectionalism, lack of adequate community facilities, laxity in rule and in law enforcement and the estate's reputation. The data concerning these factors are looked at in turn.

Estate size and layout

It was generally held that 'no estate should be as large as this'. Because of its size Chalkhill was unmanageable, unencompassable, a concrete jungle with all the worst features of urbanism — loneliness, apathy, crime, vandalism and the ever-present plastic litter. 'The main problem is loneliness,' said a Chalkhill 'original'. 'The way the estate is built does a lot of harm. The structure is such that you don't often see people about.' An Asian resident agreed. The flats were good internally but the estate's layout was confusing — people often lost their way — and the endless corridors were heaven-sent for criminal activity. In his view, the environment, coupled with youth unemployment and frustration — 'they have no present and no future'— lay at the root of much misery on the estate. 'People are frightened: they are forced to confine themselves to their homes for fear of being mugged or harrassed or insulted, spat upon.

So isolation, especially among the elderly, is a real problem.'

A sense of transience

Others insisted that size and design were not the start of the trouble. 'Physically,' a psychiatric social worker commented, 'the place is not bad. The flats themselves are nice and there are lawns and green trees outside.' As she saw it, the difficulties began with the fact that so many people were on the estate against their will, forced to live on it. 'They hate living here — how can they like it. If they do, they won't be moved, so they are there as if in a refugee camp and in order to keep reminding those in power that they don't want to stay, they have to spoil it.'

At the time of the 1981 council's demographic survey of the estate, 25% of households (28% in the concrete blocks) had applied to be 'transferred off' the estate. Many thought this figure was not a true reflection of the number wanting to leave but an indication of the extent to which people had come to accept the futility of applying for transfers. They knew they would not get a house in their area of choice. The realisation did not, however, change their view of Chalkhill. For many it remained a 'half-way house', a view which, in turn, contributed to a depressed quality of life. 'Because of it,' a resident said, 'most people do not make the effort to make this their home — mentally, their real place of living is somewhere else.'

The sense of transience was referred to again and again. 'People see Chalkhill as a stepping stone, a transit camp, anything but a long-term family home.' For this reason, said a housing officer, community associations on Chalkhill, such as the parent-teacher association, were weak: people did not want a ten-year commitment to a Chalkhill school.

Sectionalism

Chalkhill's 'originals' and some professionals listed sectionalism as a factor contributing to lack of commitment to the estate. It was acknowledged generally that divisions on the estate tended to be along

racial, not class, lines and that in recent years the divisions had sharpened. Not only did sectionalism, in the view of some older residents, weaken the collective effort, but competing and conflicting sectional interests increased community disorganisation. And, some residents thought, the project had strengthened sectionalism:

> 'I lay a lot of blame on the project for taking it on itself to develop Asian or West Indian groups as entities in themselves. Now the Asians feel they have been put upon by the West Indians and the West Indians consider that a non-runner. At the end it only causes divisiveness.'

A counter claim was that the multiracialists were generally white residents who directed and dominated community proceedings and who experienced sectionalism as a challenge to their power. 'It's an issue,' said a project worker, 'on which no one can win.'

Lack of adequate community facilities

One outcome of lack of commitment was, it was held, the endless vandalisation of the estate. A teacher compared the housing office's efforts to keep abreast with repairs with 'the labours of Sisyphus'. Although the acts of vandalism were committed by a few people only, the majority did not see it as their problem — it was the council's.

The inadequacy of estate services and facilities compounded the problems. The list of omissions included a seven-day rubbish collection — 'essential for so large and concentrated a population'— and sufficient day care facilities for children. 'Young mums can't go out to earn. They get into debt. They start getting depressed and taking it out on their children and things literally collapse round their ears.'

Laxity in rule and law enforcement

Then there were complaints about the council's unwillingness or inability to enforce its own rules. One rule was that animals were not to be kept on

the estate and it was a sore point with many residents that this rule was defied so frequently: it wasn't fair to the animals and they fouled the estate. Friction was generated, too, by children playing and roller-skating on the walkways. Parents defended their children saying that if they played outside they would be mugged or their skates would be stolen. 'And there's no way,' a council officer explained, 'that the council is going to start evicting people because a five year old roller-skated on a walkway.'

A very difficult matter was the balance of policing on the estate. There was, it was said, a great deal of known crime and a tremendous amount of unknown crime and patterns of peaks and troughs. 'Take mugging, for example,' said another officer, 'there would be a lot of it and the police would make two or three arrests and it would go down only to start up again a few weeks later in a different part of the estate.' There was a lot of burglary, too, and would have been more if people went out more at night. Many chose to live indoors, securing everything with padlocks. Drugs posed a grave problem. If the police clamped down the consequence could be the kind of riot which, the officer felt, had been narrowly averted over successive summers. And there was the problem of parties: 'Once there is a party with two or three hundred people there is no way that we can stop it, so we let it go ahead and resign ourselves to the complaints that come the next day.'

There were vast differences in attitudes towards the police within the community. One officer said: 'As a generalisation Asian members of the community would like a policewoman outside each of their homes and to walk them back and forward across the estate, whereas young West Indians would like not to see another policeman as long as they lived and say they are far better at policing themselves.' He regretted that, as he saw it, there was as yet no influence in the community that could deal with these problems and channel energies constructively.

Reputation

Finally, there was the estate's reputation, which was referred to at the start of this chapter. While acknowledging the estate's many problems and

drawbacks, everyone participating in the study resented the never-ending negative publicity the estate received. The local press had referred to Chalkhill as a 'robber den' and a speaker at a Conservative Party Conference had spoken of it as 'the most lawless area in Northern Europe'. In fact, according to residents and officers alike, things were no worse on Chalkhill than on other large council estates and its bad name had unfortunate practical consequences for residents: 'For instance,' said one, 'it affects your interview when you apply for a job.'

A senior social worker summed up all the factors associated with the distress on the estate when he said bitterly:

> 'Besides strictly functional difficulties of living here — lifts not working, rubbish and excrement on the stairs, unsafe car parking, vandalism, burglaries, arson and that sort of thing — there is the gut-level fear. Lots of people, women, the elderly in particular, are afraid most of their lives here. There is a high incidence of "street" crime — mugging — and a good deal of racial harassment. Couple this with Chalkhill's media and local image as a focus of crime, violence, deprivation and you have a powerful feeling of oppression, isolation, a general sense of being undervalued as a human being. This is very corrosive and hard for professionals to understand or change.'

Solutions?

What solutions were there to the problems of Chalkhill? For many social and health workers Chalkhill presented a moral dilemma: 'Do we actually work to make people like what they must have without attacking the central problem, which is not to do with the physical environment but with

getting a balanced group of people living here?'

According to at least half the informants, the only real solution was not to have places like Chalkhill — but to give people the homes they wanted in the areas they liked. 'I'm all for demolishing the estate, knocking it down — if you could find the money.' And there was the rub. The council would not finish paying for Chalkhill for another 45 years. Where would it find the money to build another 1,700 homes? In any event, where would 1,700 families live in the meantime? Brent had no vacancies. In fact, while the number of homeless families increased, its housing stock decreased. The council was selling off homes and not building new ones. Seven hundred properties had been sold in the Chalkhill district (only one on Chalkhill). Most were the desirable properties, accommodation of the kind to which many Chalkhill residents aspired and their sale diminished tenants' hopes of an upward housing career.

So energy and effort had to be invested in making Chalkhill a better place to live: the closure of the walkways, the development of community and leisure centres were seen as the most recent and, for many, the most valuable improvements and additions to the estate. Suggestions for other physical improvements were demolition of some blocks or removal of upper storeys to let in more light.

Another solution was to get more people to accept Chalkhill as home. A resident said, 'If we could just somehow get to them and say: "Look, this is where its at and this is where you're going to be for a long time. Why not work at it?"'

While acknowledging the bleak and frightening catalogue of Chalkhill's problems, nine of the ten Chalkhill residents interviewed claimed to be doing just that. Said a Chalkhill 'original', 'I always thought this was my home and a home for my children. And when you meet others who feel like that you feel there is a community.'

A young Afro-Caribbean mother, stressing that although, in general, morale was bad on the estate, said she did not find living on it a handicap. 'Its a question of getting yourself together and working to bring about the kind of changes you want.' A young white single mother found life on the

estate 'generally bearable' and much better since the opening of the sports centre — she enjoyed the amenities. An Asian registered child-minder was even enthusiastic about Chalkhill: 'It's a nice life — I enjoy it. Inside the flats are lovely. I sometimes feel frightened outside, but I have my friends here.'

It should be remembered that the residents interviewed were representatives of estate groups or associations or registered child-minders. And it may be that involvement of this kind compensated for much else. This was certainly the case for one Afro-Caribbbean man, a Unity 'leader-in-charge'. 'I have been here 15 years and for much of that time life was barren. Since I have become part of the organisation, someone with an identity, someone who is known, its like the dropping of a barrier, the opening of a gate.'

Two professionals made the point that no-one really knew whether most people on Chalkhill wanted to be elsewhere. While lots of people wanted to leave, there seemed to be as many who were strongly in favour of living on the estate and who 'get very cross at talk about how bad it is and the publicity and so on about the estate.'

Chapter III: The Chalkhill project

The Chalkhill project was planned as a joint neighbourhood project. Joint, it was said, implied working together at a number of different levels. It signified co-ordination of the projects for the three estates; interdepartmental co-operation within projects and, in the case of Chalkhill, collaboration between the health and local authorities. Yet the history of the Chalkhill project, like that of the Chalkhill Estate, was one of considerable conflict.

Neighbourhood project meant a decentralised or locally-based community service. It was left to the individual social services area managers to determine the extent to which each would be a predominantly social service or a community development project. Later, the council questioned the balance between social and community work in the projects and made changes to their structures. Hence, according to a council officer, as a demonstration model for a multidisciplinary neighbourhood project, the Chalkhill project was slightly flawed — 'the structure was tinkered with.'

The council launched the projects amid high hopes and great expectations but then, for about two and a half years, appeared to forget them, and 'to lose momentum for doing something about the priority estates'. During this time, the Chalkhill team was assembled and members recollect it as a period of 'depression within and hostility without'. They were aware of the expectations of them: they were to work in ways different from any before — 'a phrase which reared up like a cobra and struck several times', for no-one had tried to operationalise goals or indicate what the different ways were to be. 'There was a vacuum — wherever the impetus came from — there was a vacuum about what it meant in reality and considerable anxiety about how we would ultimately work.'

The sense of vacuum was prolonged by repeated delays in moving on site: it was to be nearly two years before the move was made. During these years, team members were located at the social services area office for

met with considerable resentment in each.

Resentment extended to other agencies in the area. For example, members of the Brent Child and Family Centre recalled that they were upset when they were not asked to participate in planning the project nor given the opportunity to make known what they could offer. Their exclusion at that stage left a residue of hurt which alienated the centre from the project for several years.

Moving on site did not, for some time, enable team members 'to get down to the 'real' work of observing the area, its problems and needs, and of formulating strategies for meeting them'. Initially, a great deal of energy was consumed by logistics and practical difficulties — getting phones and furniture, etc. Initially, too, the personal service workers were inundated with casework, including child abuse and neglect and families in all kinds of distress to which workers could respond with traditional casework only. The goal of developing new initiatives was 'kind of frozen'.

A year later the council, returning its gaze to the projects, began to ask questions about rates of progress, and soon after separated the community workers from the service delivery workers in the project.

Difficulties of translating 'different ways of working' into concrete propositions; of moving on site; of meeting the demands for statutory and casework; and finally, the restructuring of the team, led to 'much painful flailing about and quite alot of blaming'. The objects of blame were, frequently, team members' hierarchies. A senior social worker said:

> 'The project was thought a good idea initially and then we were left to get on with it. Not only were we not given any direction or support but we were having to fight for every resource. Not only were we being asked to do a difficult job but we were expected to produce results, change things, quickly. And people were making decisions about us without really knowing what was going on here.'

The sense of beleaguerment had a positive aspect; it accelerated team cohesion. A senior officer suggested that, at the time, direction from above would very likely have been experienced as interference and constraint. The team had to 'wing it' and did eventually find a direction and one which, he believed, made sense for Chalkhill.

The account which follows is an overview of the project's development. The health visitors' role in the project is the subject of Chapter IV.

A brief for Chalkhill

The aim of establishing the three projects, as interpreted by participants in the study, was to halt the breakdown of social and family life on the priority estates, improve the quality of life on them and, in the wake of the 1976 inner city disturbances, reduce the risk of anarchy and riots.

The projects were initiated by Brent Council and, although the Chalkhill project was jointly sponsored and staffed by the Borough of Brent and Brent Health Authority, the local authority's contribution was considered to be the crucial one. A council officer described the project as a social service sub-office with health worker attachment and pointed out that were health authority support withdrawn, the character of the project would very likely change, but that local authority withdrawal would spell its demise.

The brief given to the area social service managers by Brent Council was to commit staff and resources to the estates for purposes of:-

- delivering council services locally and disseminating information about them and other services;
- co-ordinating the services; and involving estate residents in all issues concerning them.

Thus the projects were to operate on 'patch', team and community development principles.

The purpose of this chapter is to recount how the objectives were put into operation in the Chalkhill project. The concepts of 'patch', team and community development are discussed briefly, first in the context of social work and health visiting in general, then in terms of their influence on the Chalkhill proposals. The proposals for the Chalkhill project are then described in detail. The chapter ends with participants' accounts of how the proposals were implemented.

Underlying concepts

'Patch' and community development are closely related concepts, as are 'patch' and the idea of a neighbourhood team. The concept of community development preceded and, in considerable degree, was responsible for the emergence of the patch model for service delivery.

Community development

Concern about a void between government and the people is not new. More than 150 years ago, Baron de Tocqueville, the celebrated French visitor to America, identified the void as a likely concomitant of democracy. The problem, in de Tocqueville's view, derived from increased personal freedom and individuation on the one hand and, on the other, powerful forms of government, remote from, albeit elected by, the people (de Tocqueville 1936[11]). Others attributed individuation and the void to the 'urban condition', a condition which, for many in inner cities and on large housing estates, is perhaps closer to anomie than individuation (Wirth 1940[12]).

A generally agreed prescription for dealing with the void is to make connections between people and between people and government and so create intermediary structures as channels for communication. By this means the mass of the population can participate intelligently and effectively in changing and improving local conditions (Poston 1963[9]).

Sociologists have described many and various forms of social organisation (Durkheim 1966[13]; Gerth and Mills 1948[14]; Mayo 1933[15];

among others), but the form most often identified as effective has been the neighbourhood — community or networks of relationships based on residence. While its relevance to 20th century western society has been questioned, its supporters argue that neighbourhoods are important and likely to be more so in the future because, as Thomas (1983[16]) maintained:

> 'Unemployment, early retirement, shorter working hours....financial and energy restraints on travel, increase in the population of the elderly....will all mean that there will be more people spending more time at the point of residence and neighbourhood.'

Which leads to two questions: 'How, when communities break down, are communities recreated?' and 'who recreates them?'. The answer frequently given is 'community work done by community workers'.

Community work

The Younghusband report (Ministry of Health 1959[17]) defined community work as 'primarily aimed at helping people within a local community to identify social needs, to consider the most effective ways of meeting these and to set about doing so in so far as their available resources permit.' Thomas (1983[16]) subsequently defined it as 'intervention into processes within neighbourhoods and agencies for purposes of initiating and sustaining social networks and creating a climate of confidence and legitimacy for asserting felt needs, and modelling how collective action might be undertaken'.

The Younghusband report identified community work as a method of social work. A decade later the Seebohm committee confirmed community work as integral to the role of the area office social work team (Committee on Local Authority and Allied Personal Services 1968[18]). Despite these pronouncements there was, throughout the sixties and seventies, little evidence of community work by social workers in social

work posts. Instead, the nettle was grasped by a new breed of worker, the community worker who, since the early sixties, on housing estates and in decaying inner city areas, has sought to encourage community initiative and promote community cohesion (Thomas 1983[16]).

The Barclay report, published in 1982, acknowledged that social and community work were not co-extensive (National Institute for Social Work 1982[2]). Social work included counselling and social care planning which community work did not, and community work involved tasks which lay well outside the direct concern of the social worker and the personal social services. Nevertheless, there was, the report acknowledged, considerable overlap between the two occupations, for both worked with and encouraged formation of community groups and organisations.

About the time the Barclay committee confirmed that social work was in part community work, the Royal College of Nursing endorsed community work as an appropriate health visiting method and, in some circumstances, a more effective one than work on a one-to-one basis. It defined community work in health visiting as monitoring and meeting the health needs of the community as a whole, encouraging the community to participate in primary health care and in mobilising resources for it. It regretted that the method was given so little support in policy documents and was so little used by field health visitors (Royal College of Nursing 1983[19]).

Two years later, the Health Visitors' Association (HVA) stressed that the health visitor, by virtue of her long term relationships with individuals, families and neighbourhoods, was both a highly effective resource for community work undertaken by others and in a strong position to promote and support action taken by clients so that they could become active participants rather than passive recipients in planning, delivery and evaluation of services (Health Visitors' Association 1985[5]). There was evidence, too, of increasing health visitor involvement in community work (Allen and Purkis 1983[20]; Drennan 1984[21]).

The patch system

There has been further elaboration of the notions of community work and its relation to social work, and recently to health visiting, in the concept of 'patch'. Patch, it is claimed, is linked to the principle that 'small is beautiful' (Sinclair and Thomas 1983[22]) and a 'thorough-going community approach' (National Institute for Social Work 1982[2]). As a philosophy and system for the organisation and delivery of community personal services it surfaced first in the field of social work where, according to the Barclay report, it entails 'a greater decentralisation of social services and of control of resources than was contemplated by the legislation following the Seebohm report'.

Social workers, the report continued, would need to have detailed knowledge of the communities they served for their principal task would be encouragement of self-help — motivating and enabling community members to participate in the caring process rather than taking it on themselves. Further, 'they would be accountable, through mechanisms devised at neighbourhood level, to the people they served and only secondarily to any representative organ of government.' (National Institute for Social Work 1982[2]).

By the end of the 1970s, before the publication of the Barclay report, patch-based systems were being developed in area teams around the country (Hadley and McGrath 1980[23]). Supporters of the system pointed out that 'patch' ushered in the 'pedestrianised social worker', accessible and visible to populations of relatively small localities. In contrast to area offices serving populations of 50,000 or more, patch teams worked with populations of 10,000 or less, their members acquiring a knowledge of the neighbourhood and its people to an extent that workers in an area office could not.

Contacts between patch workers and clients were generally less formal and less likely to take place only in the worker's office or the client's home than were contacts between workers and clients in area offices. They were

also less likely to be interviewed because workers saw clients in other roles, for example, leaders or members of community groups. Yet another advantage was that workers got to know members of the community who were not clients. In sum, patch workers, it was claimed, developed a wide variety of relationships, came to know and understand the culture, norms and problems of the community; and, consequently, were able to provide proactive as well as reactive services. There was a 'cost' to workers in developing relationships of this kind. They had to accept some role reversal — assessment by local people of their ability to function 'within the culture and norms of the local community' (Thomas and Shaftoe 1983[3]).

It was claimed, too, that 'patch' facilitated close working relationships between social workers and other agencies serving the neighbourhood with benefit to the quality of inter-agency referrals.

The patch model did not gain universal acceptance in social work circles. Baldock (1983[1]) argued against it on a number of grounds. To go patch nationally would entail doubling existing salaried staff; many people probably would not welcome neighbourly concern or enquiries; and 'returning care to the community' could, in present circumstances, mean pressurising people, especially women, into accepting more responsibility with fewer resources. To this list Pinker (1982[24]) added that community activists were likely to interpret patch as a licence to put community social work to radical political use.

Others have claimed that patch might be appropriate and, in the long run, cost-effective in some areas, including those in which many people were transients with few or no local networks or in which many were low earners or unemployed and few had organisational skills or experience. They argued that if social service resources and effort in these areas were used not only to deal with personal and family problems but also to foster community cohesion, much could be done to reduce levels of disaffection and breakdown and the attendant evils of child abuse, delinquency and other distressing or anti-social behaviour. In short, it could help break what they perceived as the cycle of deprivation.

Health visiting and patch

While social workers have debated the merits of 'patch' since at least the beginning of the 1980s, health visitors have begun only recently to regard the 'patch' principle as applicable to health visiting. Until the 1960s, nearly all health visitors worked geographically, each responsible for the population of a defined geographical area, but resemblance to 'patch' stopped there. The sixties saw the growing popularity of general practice attachment schemes and of the primary care team concept as devices for integrating community based services in ways which would benefit patients and increase the job satisfaction of workers. By 1980, most health visitors (89%) were in attachment schemes of one kind or other, constructing their caseloads from general practice patient lists (Dunnell and Dobbs 1982[25]). By that time, too, there was growing disillusionment with attachment, mainly because most doctors, it was held, failed to understand the function of health visiting and the nature of their relationship with health visitors (Health Visitors' Association 1975[26]; 1980[27]).

A further reason for rejecting attachment was, in the HVA's words, that it impeded the adoption of community work as a health visiting method. The wide geographical spread of general practice patients (especially in inner city areas with high proportions of single-handed practitioners) and, hence, of health visitor clients, meant that health visitors could not get to know and be known by socially coherent neighbourhoods and help develop local initiatives (Health Visitors' Association 1985[5]).

The HVA did not suggest a return to the earlier individualistic geographical system but proposed one closely resembling patch in social work. It recommended groupings of five to ten health visitors serving 'natural communities' or neighbourhoods of 20,000 - 30,000 people. The report of the Community Nursing Review Team also favoured the idea of a neighbourhood service and proposed a community nursing team in which district nurses, health visitors and school nurses, grouped together,

would respond to the needs of defined localities (DHSS 1986[6]).

The team approach

Local authority social work, at least since Seebohm, has been organised on the team principle— intake teams, long-term teams — with built-in allocation, support and supervision systems. In contrast, health visiting, traditionally, is individual effort. Health visitors are responsible for constructing their own caseloads, organising their programmes and for decisions and action on behalf of clients. The HVA (1985[5]) argued that, working in teams, health visitors would provide a better service for clients and, for each other: 'The opportunity for much needed professional and emotional mutual support in what can for most [health visitors] be a highly stressful occupation at times.'

The concept of 'team' relates equally to multidisciplinary groupings, egalitarian units for interdisciplinary collaboration. In the main, multidisciplinary units of which health visitors and social workers have had experience are primary care teams based in general practice. In 1985 the HVA acknowledged that when general practice attachment worked well, the primary health care team was the best setting for interprofessional teamwork, but maintained that it rarely did. The primary care team was 'a team in name only in the vast majority of cases'.

Compared with health visiting, social worker attachment to general practice has been relatively rare. Nevertheless, social workers too concluded that attachment does not necessarily make for teamwork or for egalitarian relationships between doctors and social workers. Like health visitors, their enthusiasm for the multidisciplinary team in general practice is on the wane (Clare and Corney 1982[4]).

However, in 1977 when the Chard social service managers were asked for proposals for projects for the estates, the body of health visiting and social work opinion had not yet swung against the primary care team in general practice. General practice was still regarded as a promising setting for the promotion of interdisciplinary collaboration and for

co-ordination of primary care services at the local level.

The Chalkhill proposals

The proposals for Chalkhill, according to the manager for the area in which Chalkhill is located, were written by him and the Brent Health Authority divisional nursing officer. At the time of the study the nursing officer was no longer in post. While records of correspondence and discussions and the testimony of those who knew her showed her enthusiasm for the project and determination that health workers would participate in it, they revealed little about the thinking behind the proposals. For this information, the study is indebted to the area manager.

The area manager said he had welcomed the opportunity to provide a patch service for Chalkhill. He believed it was the right service for Chalkhill and similar estates. Because of the extent to which the War and post-War redevelopment had destroyed traditional housing and social environments, and with them networks of trust, care and support, many of those moving to new housing estates had only professionals to depend on. This was especially so, he said, among people living on high rise estates. The new structures might be more comfortable physically but they were a disaster socially — people could not make relationships to enable them to survive at a level they found comfortable. Finally, he maintained, although social workers might deal only symptomatically with many of the problems on these estates, they could do so far better working together locally than individually from remote offices.

The patch principle appealed to him for other reasons, too. It facilitated a community development approach. He believed that as well as repairing and supporting, personal social services should be preventive and enabling. In addition to serving individual families, they should promote self-help activities and groups, thus encouraging residents to meet their own needs as far as was 'possible and desirable.' (He stressed he used these terms advisedly). To this end he envisaged professionals working with 'organised and unorganised voluntary effort in

the area'.

Finally, the area manager saw the brief for a neighbourhood project as the opportunity to develop an integrated multidisciplinary approach to work on the estate. 'The more perspectives and the more resources there are, the more people of different disciplines discuss problems and their resolution and possible improvements to the estate, the better.' He wanted both social and community workers in the Chalkhill team because, as he saw it, they complemented one another. 'Social workers concentrate essentially on individual casework: community workers maintain the broader perspective, identifying actual and potential self-help and special interest groups and group activity generally and helping to build a viable community.' But the split between the two professions was not, as he put it, 'that clean'. Social workers, too, did group work and there wasn't always that much difference between therapeutic and community development groups.

Social workers were to be in the majority. This was because, well before he was called on to produce proposals for a neighbourhood project, he had plans to locate a social service 'patch' team on Chalkhill.

The need for a local social services office on the estate had been apparent for a number of years. By the mid-seventies, three quarters of all referrals to his office, the area office which dealt with Chalkhill, were from Chalkhill and four-fifths of children on the office's 'at risk' register had Chalkhill addresses. Yet Chalkhill was two and a half miles and two bus rides away from the office. Two attempts at conducting social work surgeries one or two evenings a week on the estate had failed, mainly, he thought, because of lack of continuity. It seemed therefore, that the answer to the problem was a 'patch' team located permanently on the estate.

He wanted a health input to the project and, especially, to bring into it 'things health visitors normally did'. Especially important was their experience and contact with under-fives, particularly on an estate which generated so much work with children and young people, although he also acknowledged their work with elderly and handicapped people. Finally, he

wanted to establish close working relationships between project workers and the general practitioners and other health personnel in Chalkhill Health Centre. To this end, he opted to locate the project above the health centre.

The proposals for Chalkhill, dated May 1977, were accepted by Chalkhill Management Board, Brent Borough Council, Brent Health Authority and the Chalkhill Health Centre general practitioners. There was much informal discussion and many formal meetings to settle details but, at this stage, progress was rapid. At the beginning of January 1978 local authority and health authority personnel and general practitioners from the health centre met to finalise site and staffing arrangements. The area manager confirmed that, as no office accommodation was available anywhere on the estate, three flats above the health centre were to be converted to accommodate the project.

Local authority staff would consist of: nine social workers including a home care worker; five community workers; and four to five clerical workers. One of the social workers would be project leader and two would be attached to the general practices in the health centre. All would be employees of Brent social services and responsible to the area manager through the project leader. Brent Health Authority's contribution to the project was to be part-time secondment of two health visitors (who would also be in attachment to a health centre general practice) and two district nurses, and joint funding with Brent social services of the two general practice attached social workers' salaries.

Hence, as envisaged and agreed at this point, the agencies directly involved in the project were to be Brent Social Services Department and the community nursing division of Brent Health Authority. The service delivery disciplines represented in the team were to be social work, community work, health visiting and district nursing. General practice would be connected by social worker and health visitor attachment.

So ended the period of initial exploration, discussion and planning. According to those involved, it was a period of great enthusiasm, idealism and commitment. Participants believed they were about to launch

'something different, something that would revitalise the estate'.

Building the team

The Chalkhill project proposals, like those for the other two priority estates, were accepted in early 1978. Two years later the team which had been assembled moved on site. The delay was attributed to the slow rate of conversion into offices of the flats above the health centre. A year after the move the project was divided or 'split' into two units: one of social workers and health visitors, the other of community workers. There were thus three phases in the evolution of the project into the structure in which it was studied: before the move or the waiting period; after the move; and after the 'split'.

The waiting period

Two major amendments to the initial proposals were made during this period. The first was a decision not to send a home care worker to Chalkhill; the second, that in addition to social services, other local authority departments would participate in the project.

Shortly after the proposals were accepted, Brent Social Services Department decided that rather than include a home care worker in the project team, care in the community of elderly and physically handicapped people on Chalkhill, as in the rest of the area, would be administered by a specialist home care team based at area office. In turn, Brent Health Authority decided to second health visitors only, not district nurses, to the project.

As a result of the decision the scope of the project was reduced and the Brent Health Authority contingent halved. The team which moved on site was geared essentially to dealing with families and children. 'This meant,' explained a project worker, 'that if a hale seventeen year old and a disabled seventy year old came into the office, I could say to the former "we'll see you," but to the latter "I'm sorry, you've got to go to the area office".'

The decision meant, too, that Brent Health Authority involvement in the project in this period was minimal. One of the health centre health visitors was invited and agreed to take one of the project health visitor posts. It was decided not to fill the other post until the project moved on site.

The council's decision to allow other departments to participate in the project determined the composition of the project's community worker contingent and, more crucially, of the management of the project as a whole. A social services officer described the process as 'an invasion by other council departments of what had been planned as an exclusively social services initiative'. He acknowledged that his department had been having difficulty finding suitably qualified workers for the community worker posts and that only one had been filled when Brent Housing Department and Brent Education Department each bid successfully for one of the others.

Subsequently, yet other departments became involved in the project. Although sharing a preventive stance, the different parent bodies had different philosophies and expectations of their workers. Consequently, he maintained, becoming a team and working together was more difficult than it might otherwise have been.

Delay in moving on site contributed to difficulties in assembling the social work team. The area office was chronically short of space and lack of it meant not all posts could be filled. Overcrowding also served to exacerbate friction between social workers enrolled for the project — the 'Chalkhill designates' — and those who were to remain in the area office. The former were made responsible for all work on the estate and, according to an administrative worker, were 'self-consciously elitist'. They had elected to break new ground, adopt a new approach and move to a difficult and, as some perceived it, dangerous environment. Seeking to establish a team identity, they drew apart, alienating themselves from the others.

Finally, there was friction between the two social workers apppointed to the health centre attached posts and the health centre staff. Partly because it was thought a good idea and partly because of the space problem, the attached social workers accepted an offer of accommodation in a general

practice suite in the health centre. From day one, according to all accounts, relations between them and the doctors were 'explosive'. A year later the doctors who had made the offer decided they could no longer spare the room and, to a considerable extent, it was the 'homelessness' of the attached social workers that precipitated the team's occupation of the then still unfinished Chalkhill project premises.

The year after the move

The team moved on site in March 1979. It consisted of eight social workers (including the two health centre attached social workers), a social work clerk, three community workers, an administrator and one health visitor. It was joined soon after by a receptionist, two family aides and a second health visitor. Subsequently two more social workers were transferred to it from area office and, in 1984, a child-minding development officer was appointed to the project. At the time of the study the two unfilled community work posts were still unfilled. The composition of the project's staff at the start of the study in September 1984 is shown in Table 2 opposite.

Workers' objectives

All the workers said they joined the project because they were enthusiastic about its blueprint and agreed with its philosophy and principles. They liked the idea of working in a small locality 'where you can listen and hear what people are saying' and with colleagues of different disciplines. They liked the idea of a holistic approach, of helping people to look at things in different ways and, if useful and desirable, to change not only their attitudes and behaviour, but also their environment. For example, said a health visitor, ensuring that there was adequate heating on the estate could be a more effective way of preventing hypothermia than assessments and applications on behalf of individual clients. Helping people change their environment meant helping them to acquire organisational skills, to learn how to deal with the council and its committees

TABLE 2
CHALKHILL NEIGHBOURHOOD PROJECT
COMPOSITION AND EMPLOYERS OF STAFF: OCTOBER 1984

Service Delivery Unit

Health visitors		2	Brent Health Authority
Social workers		10	London Borough of Brent Social Services Department
seniors		2	
statutory workers		6	
health centre attached		2	
Child-minding development officer	1		
Family aides	2		
Social work clerks	2		
Receptionist*	1		
Administrative assistant	1		Law and Administration

Community Development Unit

Project leader		1	Chief Executive's office
Neighbourhood workers	3		
		1	Social Services Department
		1	Education Department
		1	Housing Department
Secretary	1		Chief Executive's office

** Administrative assistant and receptionist served both units*

and other political and funding bodies and to gain greater personal and communal autonomy — in sum, helping to empower them.

Early difficulties

Despite agreement about the goals of the project and commitment to them, most workers recalled that a sense of gloom, of bewilderment, permeated the early days. 'There was,' said one, 'enormous enthusiasm for the ideas but at our very first meeting a profound depression settled on us and stayed around for quite a while.'

One reason for the depression was the unfinished state of the offices and the energy absorbed in obtaining basic office equipment. In due course the offices were furnished, but they were never adequate. Space, chronically in short supply, was to be a bone of contention between social workers and clerical and adminstrative staff. Lack of space also hampered group activity. The stairwell and deck constituting the approach to the offices were, in the words of a worker, 'grim, dank, dirty and off-putting'.

Another reason was the size and nature of the health visitor and social worker caseloads. Each health visitor had a caseload of approximately 400 families, mostly Chalkhill residents, many requiring considerable support and attention. For the social workers, arrival on site 'opened floodgates'. People who, apparently, had been unwilling or unable to travel to the area office or to do so as often as they wished, presented themselves at the project office. 'It was to do with "patch" rather than the project,' one social worker explained. 'You had to be quite determined to get to the area office — buses were few and far between. When on their doorstep people who wouldn't have bothered were using us and some who were already our clients were using us more.'

It was also, they recognised, the phenomenon of a new local office with a rapidly growing reputation for willingness to help. 'We were absolutely shattered; things kept coming in, the NAI [non-accidental injury] stuff, it was horrific.' Another recalled 'wanting people to come in and then having to shut the door'.

The social workers found they had neither time nor energy to develop 'new ways of working'. They considered themselves in need of assistance, so much so, that to meet their need and because there were no funds for additional staff, the area manager found himself forced to transfer two more social workers from his office to the project. In turn, inability to make a start on a developmental programme was a further source of frustration.

Yet another factor to which they attributed their depression was difficulty in welding workers of the different disciplines represented in the project into a cohesive team.

The project structure

To begin with, while in the area office, the workers assembled for the Chalkhill project were very much part of the area office team, although 'picking up' all the work for the Chalkhill. Then they began to separate from the area team and a Chalkhill team emerged. The core of the team was the social workers carrying the Chalkhill statutory load. Attached to this core but not of it were the two health centre attached social workers.

It was agreed that the latter should be free to deal with work generated in the health centre, not 'bogged down' with statutory work, an agreement which, at times, was a source of strain between the two sets of social workers. It was especially so when, immediately after the move, 'core' social workers felt they were 'drowning in a morass of horrendous cases', while it seemed to them that the attached workers were dealing with more interesting and far less stressful work. There was a counterbalance, however, said a 'core' worker, 'the attached workers' struggle to reach a modus vivendi with health centre general practitioners'.

Two of the community workers attached themselves to the core. They were the workers seconded by the housing and the education departments. The third community worker, the social services appointment, found she had little in common with the social workers for, she maintained, community work, unlike social work, was not problem-oriented. She

felt 'irrelevant' in a team which, it seemed to her, was concerned almost solely with people's minds and not with the conditions in which they lived.

She detached herself from the 'core', spending her time in the community on the grounds that a community worker's role wasn't helped by being seen alongside social workers and that a community worker had to go to people rather than wait for them to come to her. She felt, too, that because the social workers 'did not really know what community work was about' and were under pressure, they tended to see community workers as 'doing nothing — hanging around reading the paper'.

In turn, commenting on the relations between social workers and community workers, a 'core' social worker recalled that, from the start, they worked alongside one another — rarely conjointly — sometimes reasonably amiably. He thought the community workers were almost always unhappy with what they were doing. In any event, they brought a lot of frustration to meetings which he and other social workers were never quite sure what to do with, because, he explained, 'we had a fair amount of our own — trying to find a sense of direction which we eventually did, but I'm not sure they did.'

Despite the tensions and frictions between them, the social workers and the community workers saw their own and each other's roles as relevant and important but not so, initially, that of the health visitors. They understood vaguely that they were to be joined by health visitors but tended to regard the health visitor role as, almost, a 'non-role'. 'I saw them as incidental and weightless,' said one social worker. Another said, 'I had very little idea of what they did but whatever it was I didn't think their input would be very important.' And for quite a while, according to the social workers, the health visitors were more remote from the core than the community workers.

In turn, the health visitors found that they had constantly to remind the social workers that they were there, that they were likely to know the Chalkhill children and families referred to social workers and that a collaborative approach was more beneficial than two unilateral ones.

Team building tactics

Various efforts were made to meld the strands of individual disciplines into a team. It was decided early on that the team would operate as a participative democracy, all members taking part in discussion and decision-making. Two regular weekly meetings were set up: one, attended by all, dealing with organisational matters; the other, attended by social workers and social work clerks, for case discussion and allocation of new cases. The function of the former, said a social worker, was 'team building through interaction — content was less important — but the time was also used to learn about each other's functions and objectives'. She maintained that care was taken to ensure that everyone had 'space' and was encouraged to express their views. A clerical worker agreed that the meetings worked quite well but, nonetheless, were dominated by the social workers who had the 'advantage of numbers, delegated power and the power of words and knowledge', and that, not infrequently, interests of others were overlooked.

Nevertheless, most project members considered that progress toward becoming a unified team had been made and that the collective depression was beginning to lift when, at the end of the first year, the 'split' occurred.

The split and after

The reason for the 'split', according to Brent Council records, was concern about the direction, rate of progress and management of all three projects. At its meeting in September 1980, the Joint Neighbourhood Projects' Working Party (the working party established by Brent Council in 1977 to deal with conditions on the 'priority' estates) expressed the view that the projects had become 'too social services oriented', that they had not succeeded in co-ordinating services locally and had made insufficient progress in sponsoring and encouraging community development. In March 1981, the working party submitted recommendations for restructuring the projects to Brent Council.

To redress the imbalance between the provision of services and community development it made two recommendations. First, the separation of community workers from social workers, dividing the projects into two units. Second, that staffing and administrative costs be shared by social services, housing and education, the three departments represented in the projects, and not, as hitherto, borne almost entirely by social services. To co-ordinate services further the working party recommended the establishment of middle and senior management groups representing the departments serving the estates and the office of the council's chief executive officer. The groups were to ensure inter-departmental liaison and to oversee the work of the projects. Finally, it recommended its own dissolution and the submission of all future reports on the projects to the council's policy and resources committee.

The restructuring or split of the Chalkhill project was resisted by nearly all its workers. A social worker gave the following description of the climate at the time:

> 'Having left the projects to make their way as best they could, Brent councillors began to ask questions about the money and resources poured into them. It had become highly contentious. People wanted quick outcomes to the problems on Chalkhill which was unrealistic. Councillors wandered through the project offices asking questions and there was anger on all sides.'

Project members, especially the social workers, felt under attack and unjustly so. They maintained that their rate of progress had, in considerable degree, been determined by factors outside their control — delay in converting the premises and, when the project offices opened, the demand, beyond all expectations, for statutory and casework.

Two informants suggested that the changes introduced were not so much a response to real or assumed rates of progress by the projects but a move to demonstrate that the council was innovative and to make political capital out of it. 'That's when people, including departmental heads,

began to see the political significance of controlling neighbourhood work in a different way. There was the PR aspect of showing that council could carry out its policies of caring for people with different controls: via the town clerk's department, not via social services.'

One project worker, however, the social services neighbourhood worker, saw the situation differently. 'Back in 1979/80,' she said, 'there wasn't full understanding among social workers of the meaning and philosophy of community work. Their emphasis was on case and crisis work — and there was a great deal of that for them to do. Community work was the slow maturation of pre-crisis situations and the difference in the two approaches made for confusion — crisis work cutting across preventive work.'

The 'split' was effected by transferring the community workers and a newly appointed project leader out of the social services hierarchy and into that of the chief executive. They remained, however, in offices adjoining those of the social workers and health visitors, and the administrator and the receptionist continued to serve both units. The receptionist remained part of the social services department but the administrator was transferred to yet another department, that of law and administration. The project leader had no managerial jurisdiction over the personal service workers, but the offices and the equipment in them were his responsibility.

Looking back, most project workers conceded that the decision had been the right one and that there was logic behind it. Social workers had statutory responsibilities and, to some extent, identified themselves with the bureaucracy, whereas community workers needed to identify wholly with the community. The social worker's role was a mixed one, trying to promote self-help and working with individual clients — which brought in issues of confidentiality and accountability, constraints from which community workers had to be free in order to be trusted by the community.

In retrospect, too, the social workers and health visitors acknowledged that the 'split' had helped forge them into a close-knit organic team. In fighting it they had come together and developed a high level of mutual trust and, in due course, recognition of the contribution each could make

toward realising the project's objectives.

A regret which remained was that relations between the two sides — service delivery and community development — were not better. Another was that there was little interdepartmental and no interauthority collaboration at management levels.

Management and the team

The different occupational groups in the project were members of different hierarchies. After the 'split' the two hierarchies represented in the personal services unit were Brent local authority social services and Brent Health Authority community nursing services. The former exercised more control and provided more support for its frontline workers in the course of their work with individual clients and families than the latter. Social workers and family aides were supervised by, in the first instance, the project's senior social workers (a second senior was appointed after the 'split'). Their caseloads were constructed at allocation meetings where new referrals were discussed and assigned. In turn, the senior workers were answerable to the area manager. The health visitors, traditionally independent practitioners, were responsible for constructing their own caseloads and work programmes and for decisions taken on behalf of clients. In developing 'new ways of working' both groups of workers were very much on their own. Neither the social services nor the nursing hierarchy sought to direct or influence their developmental activities.

Co-ordinating services for Chalkhill

At the same time as the project was restructured, the management committees recommended by the working party were established — a middle management group for each estate and one at senior level for all three. The Chalkhill middle management group, which met monthly, was chaired by the project leader. Its members included the social service area manager and a Chalkhill senior social worker, the district housing officer, and representatives of the council's planning and architects' departments

and of its youth and community and leisure services which, independent of the project, had presences on Chalkhill. The education services were represented by the principals of the primary and secondary schools serving Chalkhill; and Brent Health Authority was represented by a senior nurse. Its brief was to co-ordinate and integrate services for the estate.

The senior management group was concerned with the welfare of all three priority estates. Its remit was to coordinate the work of the three projects while recognising and planning for different needs in the communities served by each. There was provision on it for a Brent Health Authority representative.

Informants thought the management groups served useful functions but most considered that, despite their usefulness, the goal of an integrated service for the estate was not met. 'We work fragmentedly because we haven't got the structure right and the structure won't come right because of the politics.' The speaker, an administrative worker, maintained that because of internal and local politics the various local authority services were not even administered with the consistency of a true bureaucracy. 'What we have is a highly politicised structure and because of the composition of Brent Council, support for its various endeavours is dicey. People change sides and do all sorts of unplanned things whenever there is a public outcry about, say, a kid found wandering on the estate or an old person mugged.' He believed there should be a 'single on-site manager to control all on-site resources'.

A community worker stressed the extent to which interdepartmental rivalry was the stumbling block. 'It's a question of a lot of departments and insufficient co-operation between them because each is very protective of doing its own thing. The number of professional workers on the estate is actually very high, but I doubt if all the services add up to value for money.'

A housing officer agreed that, as presently structured, the project was fragmented: there were too many departments or sections within

departments dealing with estate issues, each following a departmental perspective. He, too, saw the ideal as an estate with all the different disciplines located in one building and responsible to one manager who, in turn, would be responsible direct to the council. 'I suppose it's area management, to give it its posh title, actually managing an area rather than, as at present, having different departments injecting bits into it and hoping that it works.' He acknowledged that a monolithic hierarchy could be tyrannical and that an effective residents' forum would be an essential safeguard.

If there was ambivalence or equivocation about the effectiveness of joint management of council services on the estate at middle and senior management levels, there was none about the lack of liaison between Brent Council and Brent Health Authority. The health authority's representative on the Chalkhill middle management group, the project health visitors' senior nurse, rarely attended meetings. In any event, she had considerably less power in allocating resources than other members of that group. Whereas, for example, a difference between housing and social services concerning the elderly could be resolved at a middle management meeting, the senior nurse had to refer such matters to the next tier in the health authority's hierarchy.

As for Brent Health Authority's representative on the senior management group, it was so long since a representative had attended that it was no longer known who that representative was.

The next chapter explores the health authority's contribution to the project at ground level — the health visitors and their work on the estate.

Chapter IV: The health visitors in the project

In 1978, when the proposals for the Chalkhill project were accepted, the Chalkhill health visiting unit consisted of three health visitors based in a room in the Chalkhill Health Centre. Each worked geographically, that is, provided a health visiting service to residents in a defined geographical area. Each, too, was attached to a general practice in the health centre and offered services to people registered with the practice. One health visitor was attached to two of the general practices.

At the time there were four practices in the health centre, each with two principals. The health visitor who was to join the project was attached to practice A, a second to practice B and the third to practices C and D. A year later the practice D doctors retired. Their patient lists were taken over by practice A, almost doubling the lists of that practice and the caseload of its health visitor. For nine months — from the time of the merger until she was joined by a second health visitor in the practice and in the project — the practice A health visitor worked with a caseload of over 700 families. Even when sharing the load the two health visitors found that they were unable to participate in the life of the project as fully as they deemed necessary and a third health visitor was appointed in a part-time capacity to practice A. An additional part-time appointment was also made to practice B. Thus by the time of the study the Chalkhill complement had increased to six health visitors, four full-time and two part-time. Four had their desks in the health centre health visitors' room, the other two, the project health visitors, in the project office (see Table 3 overleaf).

At the time of the study there were nine general practitioners in the health centre, each practice having acquired a third principal. Also accommodated in it were health authority dental, school health, speech therapy and district nursing services.

The two attached social workers were appointed in 1979, one each to practices A and B, the other to C and D. With the transfer of practice D's lists to practice A, its social work attachment was transferred too. Thus both

Table 3
Disposition and size of caseloads of Chalkhill Health Visitors

Health visitor	Full or part-time	Base	Practice to which attached	Caseload: (no. of households)
HVa	Full time	Project	Practice A	197
HVb	Full time	Project	Practice A	199
HVc	Parttime	H. Centre	Practice A	260
HVd	Full time	H. Centre	Practice B	274
HVe	Part time	H. Centre	Practice B	247
HVf	Full time	H. Centre	Practice C	290

social workers were in attachment to practice A. As related earlier, they were, to begin with, accommodated in one of the health centre general practice suites. A year later they were asked to vacate it and they and the practice A health visitor moved their desks to the project offices above the health centre.

Table 4
Composition of the practices in Chalkhill Health Centre

Personnel	Practice A	Practice B	Practice C
General practitioners	3	3	3
GP trainees	1	1	1
Health visitors	3	2	1
Social workers*	2	1	1
District nurse	1	1	1

** Both social workers (g.and h.)were attached to practice A and each to one of the others: SW g. to Practice B and SW h. to Practice C*

The composition of the general practices to which health visitors and social workers were attached is shown in Table 4. Attached workers outnumbered doctors only in practice A, to which all four project/health

centre workers were attached. It was also the only practice to hold regular meetings of all its workers and which had come to regard itself as a multidisciplinary team. Finally, the power of numbers affected not only relationships in the practice but in the health centre as a whole and had consequences for the management and use of the centre.

Joining the project

The two health visitors who joined the project were attracted by the project's philosophy and aims. Experience had taught them that the needs of many clients could be met only by a multidisciplinary approach. They had concluded, too, that much individual and family distress was associated with factors which could be dealt with at community level only. Whereas, initially, they had seen health visiting as the process of visiting people and ladling out advice to them, they had become aware of other ways of working which, in some circumstances, could be more effective. 'When I had seen 50 people with the same problem,' said one, 'I realised that the problem could only be tackled as a social or political issue and that it was rightly part of my job to try to do so.'

The project seemed to offer opportunities for developing their ideas and putting them into practice. To begin with, however, they had to establish their identity as health visitors in the project.

The first health visitor to join the project recalled wavering at the point of doing so. When the idea of it was first mooted, she, her colleagues, the doctors and other workers in the health centre were enthusiastic. Later some of the enthusiasm turned to anxiety. Minutes of a meeting early in 1978 to discuss the project reveal concern lest the new development upset relationships between general practitioners and health visitors which, in the words of a general practitioner, had taken virtually since the formation of the health centre to build. In the event, the hostility between the social workers and the doctors served, to begin with, to strengthen the relationships between doctors and health visitors.

The hostility between doctors and social workers was attributed to differences in perception of the work of an attached social worker and of her relationship with doctors. The social workers believed that the reason they were asked to vacate the room in the health centre was not so much because, as the doctors made out, the space was needed, but because they were not doing what the doctors wanted them to.

Initially, the health visitors aligned themselves with the doctors and, the social workers recalled, 'gave us a hard time'. The first project health visitor admitted doing so and feeling threatened by them. 'Until then our only contact with a social worker had been at the end of a phone and here they were walking unannounced and uninvited into our room whenever there was anything they wanted to talk about, the room we had always regarded as secure for health visiting talk.'

The social workers stirred things up in ways which the health visitors found disturbing but which, in retrospect, they recognised as the impetus for many progressive changes in the health centre. They confronted the doctors, 'it was clear they were not to be handmaidens', and pressed for innovations such as regular practice and centre meetings.

The health visitor who was to join the project began to be apprehensive about working in a team composed mainly of social workers and possibly having to share an office with them. Supported by her colleagues, she petitioned the nursing hierarchy against the move. The divisional nursing officer argued that 'it would be sad if an opportunity to work in such a project were lost just because the health visitors wanted the security of their own offices.' The move was made but, to begin with, some of the health visitor's fears were confirmed. For the first year she and her colleague had repeatedly to make their presence known.

Five years later, when the study was undertaken, both were 'very enthusiastic about working with social workers'. They attributed successful collaboration with them to, in the main, their own perseverance in insisting on joint discussion of families with whom they were involved and to the contribution they were able to make to the project's community initiatives. External factors, principally the forced

separation of personal services and community workers and, as they experienced it, neglect by their hierarchy, helped to forge a coalition between them and the social workers.

Establishing their presence

The project health visitors spent much of their first year in the project reminding others they were there.

> 'We just got forgotten, not intentionally, perhaps, but because there were so many "others": nine social workers, three community workers and two administrative workers — all local authority staff — and just the two of us. We were not so much excluded as lumped in with the others, not acknowledged as different.'

There were regular meetings of all project staff, devoted in the main to logistics — 'desks and telephones'. The health visitors used the meetings to convey to the social workers the importance of checking with them every time they received a referral of a family with an under-five. They pointed out that the family was likely to be known to them and that their knowledge could be of considerable help to social workers; and it was important to avoid crossed lines and the risk of a social worker, ignorant of the health visitor's involvement, undermining her work or confusing the client.

The social workers, accepting the arguments, agreed to check but repeatedly forgot to do so. 'They weren't used to doing that sort of thing. It isn't practice in area offices.' So time and again the health visitors overheard discussion of families known to them, but without reference to them and had to say 'Excuse me, could we talk about that?'

They discovered that the social workers had little idea of their role, their knowledge and skills. It seemed to them, too, that social workers had a limited range of solutions and tended, not infrequently, to overreact to situations, to adopt heroic solutions when simple ones would do. Once they started talking to one another, the social workers, the health visitors

believed, began to appreciate their knowledge of the estate and of many families living on it, and to learn from them about other options for dealing with problems.

> 'When a parent said "I've had enough", the social workers used to reach for a care order in the same way as a doctor would reach for his prescription pad. We argued for less drastic measures — a child-minder, a nursery, etc. — thereby defining the situation as less extraordinary, more normal.'

In turn, the health visitors were impressed with the social workers' analytic skills and ability to help people work through deep-seated personal and social difficulties.

Working together in shared offices made it possible to keep each other informed of even small developments in families in shared care and to consult before taking action. In some instances a health visitor and a social worker worked conjointly, and visited the family together. Mostly, for economy of time and, not infrequently, respect for a client's need to 'compartmentalise different elements of her life', they visited separately. Mostly, too, they maintained a division of labour. 'I focus on health and baby care and things like that, the social worker on relations in the family and the mother's feelings about them.'

Sometimes a consultation with a social worker enabled a health visitor to help a family resolve its problems without social work intervention. They came to appreciate that social workers could not take on all cases referred to them and, to use their time effectively, had to be selective. From social workers, they also learnt about self-criticism and self-care, 'awareness of oneself as the instrument of care', and believed that as a result they were better workers.

Understanding one another's perspectives, and respect for each other's expertise, increased rapidly when project members embarked on group and community work. The health visitors were able to recruit and involve residents with whom social workers and even the community workers

rarely came into contact — residents who had much to contribute to community programmes — and thus enable the project to tap grass-roots energies.

Helping the project find direction

As related in Chapter III, when the social workers moved on site they were 'inundated with work, much of it statutory'. The demand for their services and the problems of settling into ill-equipped offices left little time or energy for considering new ways of dealing with problems. The health visitors, although at the time also working with extremely heavy caseloads, nevertheless pressed for experimentation with new approaches. 'We spent a lot of time beavering away at the whole preventive philosophy. We weren't saying "forget the statutory work", but suggesting that the social workers could take a few risks, that there were ways to approach the work differently and so prevent a lot of the statutory work.'

The health visitors initiated the project's first break with tradition. They objected to the practice of 'clientising' callers no matter what their business. The social workers had introduced the procedure, apparently standard practice in the area office, of completing a 'blue form' and opening a file for every caller. The form was, in effect, a device for measuring workload. The health visitors, joined by the community workers, insisted that callers wanting information or advice about, say, welfare rights, should not be 'turned into statistics', that entering the calls in the daybook could satisfy record-keeping. The social workers agreed to modify the procedure, a modification which, later, in the face of 'the cuts', was to rebound on them.

The next innovation was setting aside time for members of the different disciplines to inform the others of their backgrounds, work experience, what they thought could be achieved by the project and how they envisaged joint work.

Joint work started with a health visitor and a community worker visiting new arrivals on the estate to inform them of available services and

facilities and 'leave them a packet of gen'. Other initiatives followed. These are described in Chapter V. Here the health visitors' account of the history of the project and their part in it is continued.

Responding to the restructuring

The reason given by the council for dividing the project into service delivery and community development units was that the project's predominantly casework orientation held back the community workers and community work. Although initially appalled and distressed by the decision, the health visitors, like other project members, subsequently agreed that the division made sense because the disciplines had different ways of building bridges into the community. Community workers did so by seeking out community activists and helping them consolidate their activities and initiate new ones. Strategies eventually evolved by the health visitors and social workers were, in the main, linked to needs encountered in casework or based on networks established by the health visitors, the child-minding development officer and, to a lesser extent, the social workers.

For the health visitors, the immediate effect of the split was to put them 'in limbo'. The social workers, under local authority social services management, constituted one team, the community workers, now responsible to the chief executive, another. And the health visitors were 'strung between'. When it was eventually decided that they belonged to the former and a senior social worker said to them: 'Come on, you're part of our team', they felt, at last, that they were wanted. 'And,' said one, 'that was good for us.'

An early decision of the re-constituted service delivery team was to press for additional staff. Members argued successfully that if they were to undertake true preventive and community development work, caseloads had to be reduced. It was then that two additional social workers were appointed to the project and the health visitors secured the attachment of a third health visitor to practice A.

An integrated and beleaguered team

A direct result of the 'split' was consolidation of the 'service delivery rump into an integrated team'. According to a health visitor, 'it was after the split that the "family quality" grew: intense relationships and great concern for everyone within the team and a good skin around us establishing our boundaries.'

In the team, as well as the health visitors and social workers, were the family aides and, in time, a child-minding development officer. Beyond their boundaries, they sensed an essentially uncaring, if not hostile, world. They were, they maintained, progressively abandoned by management, resented by their colleagues in the smaller health centre practices and, for many health centre doctors, a 'thorn in the flesh'.

The divisional nursing officer who helped plan the project left soon after the proposals were accepted. Her successor, 'a keen believer in helping communities prove their worth', was equally enthusiastic about the project, seeing it as 'a fantastic opportunity to contribute to community development'. Her actual participation in it, however, was minimal. She would say: 'If you find it too much, give me a ring. That's what I'm here for.' Nor could their overworked line management make good the deficiency.

The health visitors concluded that health authority participation in the project began and ended with their appointment — 'making field workers available' — when what they felt was needed, was management involvement on the ground. 'We were a small group in a large group and much in need of support and nurturing by our own kind. If it had been forthcoming, we would gradually have weaned ourselves.'

Matters changed for the worse when the divisional nursing officer, who had been retitled director of community nursing, was replaced by a director with a different style of management. According to the health visitors, she viewed their participation in the project as an extravagance. She came to believe too, that, through the health

visitors, the project exerted a subversive influence on Brent health visitors as a body. Given the opportunity, they maintained, she would not have hesitated to withdraw them from the project.

For a time, too, the project health visitors perceived a rift between them and their colleagues in the health centre. Before the advent of the project, relationships in the small Chalkhill health visiting unit were close. The disappearance 'upstairs' of one of their number and her absorption into the project was experienced by the others, the project health visitors surmised, as a 'betrayal'. She was still around but no longer part of their world. They suffered, too, from 'exclusion — fascinated by what was going on but not part of it'. Relationships improved again when the health centre health visitors supported the project health visitors and the attached social workers in confrontations with the doctors on issues such as the use of health centre space and the make-up of the health centre management committee.

These confrontations had not endeared the health visitors to the general practitioners. While one or two GPs valued the project as a resource and acknowledged its achievements, most, the health visitors thought, saw it as more trouble than it was worth. The health visitors believed that the GPs attributed a number of developments to their machinations and those of the attached social workers. These were: erosion of the doctors' control of management of the health centre and of the use to which the building was put; challenges to their work, such as a campaign for a well-women clinic which the doctors averted and a project youth advisory service which they did not.

Project social workers were turning inwards, too, away from their social work hierarchy and the council beyond it. The process, begun at the time of the 'split', which the social workers regarded as 'a slight and an unfair judgment on their performance', gathered momentum when, four years later, their productivity and, in turn, staffing levels were challenged. The council maintained that the project's workload, as reflected in statistical returns, was too low to warrant its social worker establishment. The social workers argued that their work consisted not only of the casework

reflected in the returns, but of group and community work not reflected in them, and that the two sets of activities had contributed to a marked reduction in numbers of Chalkhill children 'in care' or 'at risk'. They won the argument and retained their staffing levels but regarded the challenge as further evidence of how little their work was understood or appreciated by their management. 'Initially,' they said, 'we were accused of too much casework and too little community work. Next, the accusation was reversed. So much of our energy has had to go toward ensuring the survival of the project.' But they acknowledged, too, that beleaguerment was an additional spur to achievement.

The health visitors assess outcomes

'This is where I belong philosophically and where I can do the most effective work.' The project health visitor who made that statement stressed that her ideas and philosophy predated joining the project. The project had given her the opportunity to put them into practice. Discussing what working in the project meant to them, the health visitors referred to outcomes at a number of levels. They spoke of changes in themselves and in their work with individual clients. They dealt with their experiences in group and community development work. They assessed their influence on other members of the team and their contribution to project initatives and they recounted the project's achievements. Their comments on each are related below.

What they gained

At the personal level, working in the project was, they said, 'a strengthening experience', one of 'personal growth and development'. Besides close contact with field social workers, the senior social workers had provided them with supervision and nurturing of the kind routinely provided to social workers. Watching the former and guided by the latter they had learnt to look after themselves: to set limits in their relationships with clients and colleagues.

At a professional level, it had increased their understanding of the dynamics of interpersonal relations and their ability to 'hear' what clients were saying; they became more skilled as counsellors. They learnt group work techniques — even project meetings were exercises in group relations — and one health visitor went on a social services group training course.

Working alongside the social workers had made the health visitors more political, readier to act against retrograde measures. They submitted evidence to commissions, sat on working parties, spoke up at public meetings and lobbied local councils. Working in the project had given them new strengths and skills which, they believed, helped them to provide a better service to clients.

Working in the project improved their service to clients in other ways too. Knowing the skills and expertise of other workers, they referred clients to the one best suited to deal with their problems. 'It makes a difference to take-up rates.' They had direct access to a wide range of resources within the team, 'virtually to those of an area team'. 'If I worked anywhere else I could send someone down the road to, say, welfare rights. Here I can introduce the client to one or other of the two project workers who have established and now run the welfare rights office for Chalkhill.'

They valued especially easy access to the project's family aides and child-minding development officer, workers who, in their view, provided outstanding services to Chalkhill residents. The principal function of family aides, as defined by the health visitors, was 'going into homes to look after children when parents were ill, hospitalised or just not coping'. They provided non-threatening practical support and guidance in parenting and home-management to inexperienced or depressed mothers, spending as much time with them as necessary including, on occasions, staying the night. 'They are befrienders and models of mothering to mothers.' The child-minding development officer ensured the best possible fit between mother, child and minder and helped mothers in need obtain subsidies to help pay child-minding fees. She monitored the children's progress and supported and guided the minders.

The health visitors in the project

Groups and facilities established by the project constituted yet further resources to draw on (see Chapter V). There was, for example, the mothers' and toddlers' group to lessen a mother's isolation and give her child the opportunity to play with other children, and the toy library to help her stimulate her child at home.

Working in the project also gave them access to a wide range of external resources. Each project worker was, in effect, 'gatekeeper to a different network of outside agencies'. With help from each, they were able to mobilise more services and to do so more speedily than working elsewhere. The cumulative effect was access to more resources than were available even to health visitors in successful primary health teams and to a store of knowledge which facilitated 'lateral thinking, novel suggestions to clients', whether for 'ordinary living' or dealing with problems. 'All in all,' said one of the health visitors, 'I can't think of another job where, as a health visitor, you can enhance people's power as you can here.'

What they put into the project

Besides gaining a great deal, personally and professionally, from working in the project, they had, they believed, made important contributions to it. They were an 'on-site' source of health information on which the social workers, when making 'whole person assessments', frequently drew. 'We can answer a lot of their questions and, in joint work, contribute the expertise about women's and children's health.' They were the project's main link with doctors, especially the health centre doctors. Doctors would readily discuss with the health visitors medical problems that they were unlikely to discuss with social workers.

Their major contribution, however, was countering the emanation of pathology associated with social work. Even though the social workers had decided that the project was not to be just another social service agency, 'a small-sized area team with appendages', their contacts with the Chalkhill community were mainly with people with problems and it was left to the health visitors to introduce an 'atmosphere of normality'. It was

their clients — just by coming in through the door — and the health visiting perspective which brought normality to the project. They believed, too, that over time, they had helped the social workers focus on 'positives' — to adopt a truly preventive approach — and that as a result the project social workers were doing more creative casework and participating in more joint work than social workers in area offices.

Other workers' perceptions of health visitors

How did the other project workers view the health visitors in the project? Without exception, very positively. All but two claimed to have had little knowledge of health visiting before coming to the project. They knew health visitors visited mothers with new babies to see they were all right and to offer advice, but tended to regard their work as 'routine, perfunctory and superficial'. Even those who were mothers and had been visited by health visitors had not, they said, appreciated the kind of assessments made by health visitors. An exception was a clerical worker, an immigrant whose first baby was born soon after her arrival in England. For her, the health visitor had been a 'lifeline' and had helped her 'to grasp motherhood'.

The social workers had not taken the multidisciplinary concept very seriously. What attracted them to the project was 'working patch'. A senior social worker said: 'Even at the point of moving to Chalkhill I knew little and expected little of health visitors. Health services, as I understood them, were provided by doctors and our goal of working multidisciplinarily was to be met by the attachment of the two social workers to the health centre practices.'

For quite some time he and his social work colleagues took little account of the health visitors in the project. The two health visitors quietly and persistently made their presence felt at project meetings and in discussions of families known to them and revealed a core of hard knowledge about under-fives and their development, about pregnancies and terminations, about health measures in general — a whole body of knowledge to which social workers rarely have access. The next step

was orchestration of care which, a social worker claimed, was now a reality.

> 'If it's a new referral I always check out whether it's known to a health visitor. If it's a child-related problem I talk to them before taking any action. It might be something they can deal with without bringing in another person — me. We compare notes and keep lines clear, keep each other informed of even small changes in a family's situation.'

The social workers confirmed that collaboration took many forms. A health visitor might be the principal worker supported by a social worker or vice versa, or they might work conjointly, but however closely they worked, their roles seldom merged. They complemented one another and, not infrequently, it was work done by a health visitor that brought a family to the point of accepting social work help. In the event of rejection of social work assistance, a health visitor might be the only safeguard against possible child abuse. And when a social worker had to invoke statutory powers the health visitor's knowledge of the family and relationship with it as 'good visitor', in contrast to the social worker's as 'bad', was invaluable.

The family aides spoke equally highly of the health visitors to whom they felt more akin and who, they claimed, made considerably more use of them — referred more clients to them — than social workers. Health visitors, they said, were practical people concerned with meeting immediate needs and meeting them immediately. 'They will ask us to go round at once so that the family knows it's going to be helped.' They were always available for advice or discussion about feeding or other difficulties in a home. The family aides found this approach more useful than that of social workers who, they said, looked for the the 'whys', were more concerned with the mind than with practical aid and rarely accepted that people might need something 'now', not by appointment next week or the one after.

The child-minding development officer, who also owned to little prior knowledge of what health visiting was about, found that her connection

with the health visitors served as an excellent introduction to Chalkhill mothers and minders. To say 'Anne (a project health visitor) sends her good wishes and is pleased the baby's eczema is getting better' was to gain the mother's instant trust. She admired the health visitors' non-judgmental approach and ability to listen to 'trivial' matters without discounting the client's concern or increasing her anxiety. From the health visitors she learnt how to support and encourage people, especially mothers, and help them to make the most of themselves, 'building on their strengths instead of pointing up their weaknesses'.

Because the health visitors viewed children in relation to their families, the community and to all that happened to and around them, it was they who, to a greater extent than social workers, brought a holistic approach to discussions at team meetings and case conferences.

The clerical and administrative workers emphasized the health visitors' 'normalising influence'. Said a social work clerk: 'They come across with a different point of view from that of the social worker, one encompassing that of the family and which throws new light on the situation — makes it less bizarre, more ordinary.' Because, in the public mind, health visitors were associated with motherhood and child development, their presence in the project made the project more acceptable to Chalkhill residents. People who might be reluctant to visit a social work office were happy to call at the project offices and, in due course and if necessary, see a social worker — 'it simplifies the transition'. They were easy to work with — 'available, accessible and reliable'. They were willing to see callers and they were in when they said they would be.

While members of each group emphasised attributes which improved or facilitated their own work, all were as one in praising the health visitors' contribution to project group and community work. A social worker said, 'Having them here has given depth and colour to our understanding of the Chalkhill community, insights into the lives of the ordinary families and has helped us to understand difficulties facing particular groups, for example, Asian women.'

An administrative worker believed that were it not for the health

visitors' contacts and relationships with so many people on the estate, their knowledge of conditions on it and their access to health authority resources, initiatives such as Under-fives Week, the Parents' Group and the drive for the family centre might never have got under way (see Chapter V).

All, too, thought that by any standard the project health visitors were exceptional people — sensitive, insightful and courageous — and that these qualities contributed to the high level of inter-occupational co-operation within the project and, in turn, to its success. They believed, however, that it was the organisational design and physical layout of the project that made contact and collaboration possible. To what extent was this in fact so? How did project health visitors' relationships with the other workers differ from those of health centre health visitors? Before concluding this chapter, differences and similarities between the health visitors in the two settings are examined.

Project and health centre: differences and similarities

The main difference between health visitors in the two settings, according to the study data, was how they viewed and related to social workers. Health centre health visitors, with one exception, were unenthusiastic, if not antagonistic, towards social workers in the health centre, the project, and elsewhere. They considered that social workers, as an occupational group, were arrogant and insular, trained to believe that only they had the answers, and experience of working with them confirmed this view.

Referrals to a social worker, they maintained, seldom resulted in effective action. The social worker had no time to see the client or could only offer an appointment for weeks or months ahead 'by which time the client would have sunk or resolved her difficulties herself', or her difficulties were not those the social worker could do anything about. A practice B health visitor recalled referring to an attached social worker a depressed single mother who was having difficulty caring for her twins. After one session, the social worker reported there was nothing wrong

with the client other than resentment of motherhood and that she would not be seeing her again. 'I thought that a bit much,' the health visitor said, 'a lot of piffle and no help.'

Another had hoped the attached social workers would help clients with practical difficulties, such as financial problems —teach them how to cope and to determine priorities — but they seemed interested only in psycho-sexual counselling. These health visitors concluded that the social workers worked only with clients assessed by them as having potential for change and rejected all others as 'inappropriate referrals'. They had given up referring clients other than, for example, adoptive parents to a social worker.

The exception, the third practice A health visitor, saw herself as part of the social worker-health visitor alliance within that practice's primary care team. She was as well disposed towards the project social workers, not only those attached to the health centre, as the project health visitors. She spoke of turning to them for help for clients and solutions to professional problems and of finding them always co-operative and resourceful.

Project social workers confirmed that relationships between themselves and practice B and C health visitors were not good; they were of the kind most area office social workers had with health visitors. They thought these health visitors did not yet understand the conditions and objectives of social work; the time-consuming statutory duties; the time, thought and energy involved in establishing and maintaining therapeutic relationships; and why social workers could not take all referrals made to them.

There were no marked differences in health visitors' views of other workers or in their accounts of relationships with them. Thus health centre health visitors were as enthusiastic as project health visitors about the family aides and the child-minding development officer and about ease of access to them. In the words of one, the family aides were 'absolutely marvellous' while another described them as 'practical kindly women not easily upset by the filth and squalor they find in some homes. They go quietly ahead trying to get the family on to its feet'. They viewed

collaboration with them as extremely valuable to clients and as a source of 'great comfort' to themselves. They described the child-minding development officer as most helpful, accessible and competent — sensitive and responsive to the needs of children, mothers and child-minders.

There was also little difference in health visitors' relationships with health centre personnel. All claimed to get on well with the school/ clinic nurses and to have little contact with other community nurses. All were ambivalent towards the health centre doctors and attributed their negative feelings to 'the handmaiden syndrome' and the doctors' use of the possessive pronoun — 'my health visitor' — stemming from a mistaken belief that doctors could direct and instruct health visitors.

Not only, the health visitors insisted, were they not the doctors' health visitors but did not, in the first instance, identify themselves with the practices. Project health visitors saw themselves first as project health visitors, then as health centre health visitors and after that as practice A health visitors. 'Health centre health visitor' was what the other health visitors called themselves.

Despite their criticisms of the doctors, all the health visitors favoured attachment. Working in close proximity made for frequent contact, spontaneous useful dialogue and shared knowledge, in contrast to the almost total lack of communication with doctors of geographic clients.

Despite their negative attitudes towards the social workers, the health centre health visitors valued the proximity of the project to the health centre, and access to the groups and facilities it had created, such as the toy library. They acknowledged, too, that it was support from the project that had enabled workers in the health centre to campaign successfully for the conversion of the health centre management committee from one composed almost entirely of doctors to one representative of all occupational groups and to change the use and image of the building from medical centre to community health resource.

In sum it would seem that in terms of relationships with other workers, similarities between the health visitors in the two settings outweighed differences, suggesting that setting or setting alone was not a major determinant of the relationship. It was also apparent that, because of proximity and interconnecting strands, the two settings were quite frequently seen as components of a single health, social and medical complex, each benefiting from resources and facilities in the other. Which left unexplained the difference in relations with social workers. Could the difference be linked to ways in which the health visitors regarded their own role? The data suggested that there was such a link.

Health visitors' views of health visiting

All the health visitors defined health visiting as 'reaching into homes and communities to prevent ill health and promote health'. They defined prevention as early detection of what was wrong — 'deviations from the norm' — and mobilisation of resources and services — making the correct referrals.

Promotion was making people more aware of their ability to make things happen — 'to facilitate, if you like, their own involvement in their health' — and thereby improve the quality of their lives. It involved searching for people's strengths and giving them the kind of re-inforcement which would make them feel they were doing OK, that they were all right in themselves. Said a project health visitor: 'It's really important to boost their egos — particularly in this area. Most of the clients on the estate have rock bottom egos.' A health centre health visitor said, 'The mothers need time, constant encouragement, reinforcement and reassurance that they are doing it right, even if they do seem to be making a muck up here and there. No matter, life is an experiment and you have to let people find their own solutions.'

They agreed about the purpose and function of home visits and clinic work and the place of both in health visiting, but differed in the extent to which they viewed community work as an appropriate health visiting

method. Two health centre health visitors opposed the principle of health visitor involvement in community work, insisting that their role was that of teacher, not catalyst. The other two thought community work appropriate and worthwhile — 'it helps to create group cohesion and a feeling of belonging to the estate' — but neither had a predilection for the work. The project health visitors had joined the project because of their belief in the value of community work and interest in practising it. They found doing so rewarding in many ways, including, it would seem, because they gained a 'dependency advantage' over social workers.

The concept of dependency advantage has been developed and used by sociologists in the study of organisations and interoccupational relationships. In certain circumstances and in varying degree some groups acquire power to make others dependent on them (Davies 1976[28]). The power derives not only from possession of esoteric knowledge valued by society but from a hold over vital material resources.

Dingwall (1982[29]) applied the concept to relationships between health visitors and social workers. He argued that the uneasiness which as a rule pervades these relationships stems in considerable degree from the 'dependency advantage' social workers, as gatekeepers to benefits and resources, have over health visitors. He noted that the relationship was best when, because of access difficulties, social workers were dependent on a health visitor for maintaining contact with a family. Data from the study suggest that multidisciplinary community work is an area in which health visitors can gain dependency advantages. Project social workers and members of other disciplines readily acknowledged the health visitors' unique contribution to project initiatives. The initiatives and the health visitors' contributions to them are examined in the next chapter.

Chapter V: Project initiatives

In Chapter II some Chalkhill organisations were discussed. The discussion dealt, albeit somewhat indirectly, with the work of the project's community workers. This chapter concentrates on group and community work initiated by the project's personal service workers — the health visitors, social workers and family aides. Community workers participated in some of their undertakings.

The two 'sides'

How, in general, did the work of the personal service workers differ from that of the community workers? It differed, mainly, in terms of genesis and degree of universality. Community workers made contact with residents through 'street work' — a community worker talking to people, learning what they wanted to do and helping them to do it. Nutshell was one outcome of such work — Unity, another. Each was a solution community workers proposed to residents to meet the needs of a group perceived to have difficulties and, in the case of the latter, to be a problem for the estate as a whole. They also gave support to existing groups. Asian Forum was a 'grass roots' organisation helped by community workers to obtain premises and staff salaries and in other ways. In contrast, initiatives of the personal service workers 'grew, in the main, out of caseloads'.

Much of the community workers' work was helping ethnic minority groups gain a foothold in the community and deal with needs the groups felt were specific to them. The personal service workers were concerned mainly, not exclusively, with young parents and children of all ethnic groups. A recurring objective of their work was 'better parenting' on the estate as a whole. In pursuing this objective they found themselves, at one time, in competition for funds with the community workers.

Making a start

A senior social worker recalled that he had assumed that the project would 'work scientifically', that its members would 'thrash out philosophies and strategies and arrive on site with well-defined objectives and programmes for action'. He had since revised this view, concluding that the scientific approach to community work, as he then defined it, was a myth and a constraint, incompatible with open-ended exploration and reflexivity.

In the early days, however, inability to adopt a 'scientific approach' was, he thought, one more factor contributing to the depression he and others experienced. Instead of clear-cut objectives the team had only guiding principles of a general kind and, to begin with at least, little time for work other than casework. 'So we never got round to sitting down as a team and planning a programme — deciding that's what needs doing and homing in on it.'

When, about a year later, a breakthrough into group work was made, it was made by individuals, not by the team as a whole. The process, said the senior social worker, was of one or two people becoming aware of a need, checking with colleagues that it was fairly widespread, that others had clients with similar difficulties, and then being able to make plans to do something about it. He too, as senior social worker, found himself responding to workers' awareness of needs with, 'that's very interesting — what are you going to do about it?'

Over time, more and more members undertook group or community work. Usually two or three workers, at most four, were involved in an activity, the rest of the team providing support and duty cover. As workers became more experienced and confident, they involved residents in running a group or event and later in planning and executing it. 'We went through three phases,' a worker said, 'working for groups, working with groups and, most recently, enabling groups to work for themselves.'

The health visitors in group and community work

The health visitors defined group work as assisting a relatively small number of people with like or comparable problems or interests to discuss and find ways of dealing with the problems or promoting the interests. Community work differed from group work in terms of scale: it aimed at involving broad bands of the community if not the community as a whole. The goal in both kinds of work was, ultimately, 'consciousness-raising'.

One or both health visitors initiated or participated in most undertakings of the personal service team and in all those that concerned the welfare of mothers and children. Their work included, in chronological order, a scheme for new arrivals, a parents' group, Under-fives Week, a campaign for a family centre, a youth advisory service and Women's Week. A brief description based on the health visitors' and others' accounts of each follows.

The scheme for new arrivals

The purpose of the scheme was to make moving on to the estate less traumatic. It was initiated by a health visitor who was joined by a community worker. They visited newcomers to Chalkhill and told them about the project and other services and facilities for estate residents. The visits later became an 'estate activity' conducted on a voluntary basis by members of the Chalkhill Link group (see Chapter II).

The Parents' Group

The purpose of the Parents' Group, a weekly group for 'depressed and passive mothers' was 'improved parenting'. One of the first groups established by the project, it was conducted by a health visitor, a social worker and the family aides. On the premise that low morale and self-esteem were at the root of poor mothering, the health visitor and social worker arranged dressmaking, cookery and keep fit classes for the mothers,

while the family aides organised play 'to stimulate and interest their children'. 'It was hard going,' said the health visitor, 'difficult to make any dent in the apathy of the mothers.'

But they kept coming and there were some notable successes. At the end of 16 months, 20 parents had passed through the group and ten had found employment, one as tutor to the keep-fit class started by the health visitor to help people come off tranquillizers. The health visitor and the social worker subsequently withdrew from the group to direct their energies elsewhere. In the words of the health visitor: 'As a parenting group it served the needs of a cohort and died organically.' But the group, run by the family aides as the Mothers' and Toddlers' Group, continued and was still in existence at the time of the study.

Under-fives Week

While one project health visitor was engaged in the new arrivals scheme and the Parents' Group, the other teamed up with a social worker and the family aides to mount Under-fives Week, a programme of talks, informal meetings, displays and opportunities for children's play of all kinds. It was conducted in the health centre and the health visitor mobilised the health authority's publicity and health education resources for it:

> 'There were different demonstrations like a dental therapist showing kids how to clean their teeth properly. At another a nutritionist demonstrated good and bad food and ideas for dealing with toddlers who refused to eat. Kids dressed up as doctors and nurses. There were evening sessions, one for parents of handicapped children, complete with creche.'

Objectives were multiple. One was 'consciousness-raising', making residents and workers alike aware of health and of health resources. Another, 'part of the hidden agenda', was 'improved parenting', helping

parents improve their parenting skills. Focusing on play, the intention was to increase parental insight: 'To let parents know there were different ways of looking at and dealing with children's behaviour.' It was also to bring parents together — those with parenting problems as well as proficient parents — to share experiences and learn from each other as well as from professionals. 'So although on the surface Under-fives Week was child-centred, the real target was the parents'.

Another objective was to change the image of the health centre from a 'medical' to a true 'health' centre — a resource and base not only for health providers but also for the community.

According to study participants, the week was a success. Parents and workers alike were enthusiastic about it. For many social workers, it was their first experience of 'non-problem-oriented health promotion' and of health authority resources and they were impressed. Said one: 'I, personally, got a great deal from working with the health workers. I was made aware of the importance of focussing on everyday topics such as home-safety and nutrition —things which safeguard and improve every-day life.'

Lasting outcomes of the week were a toy library and play sessions for children attending well baby clinics, both conducted by the family aides. Another was the effect on many health centre workers. Project health visitors made every effort to prepare them for the week and to involve them in the programme. 'We kept them informed and warned them that it might mean "kids and chaos".' In the event, it did not and many health centre workers worked side by side with project workers and found the week stimulating and rewarding and, subsequently, a health visitor said, 'were on our side'. Only the general practitioners held apart: 'Not one offered to do a drop-in session or make any contribution to the event'.

For project workers, the success of Under-fives Week — knowing they had 'cracked one thing' — gave them the confidence to embark on other community initiatives and to identify themselves as community workers as well as case and family workers.

The family centre campaign

The health visitors joined with a senior social worker to mount the family centre campaign. They believed that if the impact of efforts such as the Parents' Group and Under-fives Week was to be sustained and immature parenting dealt with, stable and comprehensive provision was needed — a family centre, no less. Their goal was a building in which parents with multiple problems would receive intensive support and learn to care for their children. Instead of a facility, such as a day nursery, for leaving their children in the care of others, the centre would involve parents with their children. To create a climate of normality and provide facilities for the population as a whole, the centre would house a playgroup and a 'drop-in' room in which estate parents could find companionship and pass the time of day. In sum, the centre would be a permanent base for work to prevent family breakdown and its consequences.

The project workers formed a working party of people involved with under fives on the estate, among them the primary school principal, the officer-in-charge of the day nursery and a community worker concerned with the development of playgroups. After months of preparation which included visits to established family centres, meetings with estate residents and lobbying councillors, the plans and estimates for Chalkhill Family Centre were submitted to the local social services committee, accepted by it and placed on the priority funding list. Just then the Government ordered local authority spending cuts and the plans were shelved.

While engaged in the family centre campaign, the project health visitors were drawn into a scheme for a community day nursery initiated by some Chalkhill parents. As the family centre campaign gathered momentum, the health visitors, pressed for time, relinquished their work for the day nursery to the community worker sponsoring Nutshell, the black single mothers' group. The day nursery campaign was incorporated into Nutshell's programme and, for two years, was one of its foremost

rallying activities.

With the cuts that campaign, too, seemed doomed but, early in 1985, the council informed the project that it would support either a family centre or a community day nursery, not both. Project workers were to decide which it was to be. Until then, the two facilities were seen as complementary and as equally important to the welfare of Chalkhill. The final decision was for the community nursery but the rivalry created by the council's directive did not, the health visitors believed, improve relations between them and the community worker. A positive legacy of the campaign was the new knowledge they and some estate residents acquired in the course of it.

A youth advisory service

Concern about the number of teenage mothers on the estate was the impetus for this service. Besides the schoolgirl mothers in the care of the social workers, routine new birth visiting on the estate made the health visitors aware of the need for a teenage counselling and contraceptive service. They learnt that many girls became pregnant, not because they wanted to, or even wanted to have sexual experience, but in the course of 'grappling with problems of autonomy and rebellion'. Consequently, the health visitors concluded, the time for true preventive work was before, not after, conception.

Project health visitors envisaged that, in addition to contraceptive advice, the service would be concerned with general problems of growing up and with practical matters such as career choices. It would be conducted in a 'safe' or 'neutral' place which, for teenagers, they argued, the health centre was not. 'They would be afraid of running into parents or friends waiting to see a general practitioner or, even, of running into the general practitioner who might know their family well.' In contrast, they maintained, the project constituted 'a non-threatening, non-clinical informal setting', one in which teenagers could feel secure from the gaze of family or friends.

The health visitors' proposals were accepted by Brent Health Authority and the service began in September 1981. It consisted of a two-hour evening session conducted weekly by one or other of the health visitors and a community physician. Three years later they reported that the service was uncovering and helping to meet a wide range of teenage needs. Frequently their clients were confused about their problems and needed help to identify and understand them. They found, too, that apparently straightforward requests for contraception could mask things such as traumatic relationships with parents or boyfriends, unmourned abortions or fears of infertility.

The health authority's concern was the level of attendance, which, at an average of five or six clients a week, it thought was too low. The health visitors and community physician argued that it was never their intention to provide merely 'a fast contraceptive and abortion referral service' and that working with small numbers enabled them to give clients the time needed to work through problems. In any event, they maintained, it took time to build a substantial — in terms of numbers — teenage clientele. But the authority remained unconvinced and, in March 1985, moved the service to 'a location more conducive to encouraging young people to attend...'. Project health visitors withdrew from the service and with a social worker were, when the study ended, planning an adolescent group for 'not only caseload kids but a mixture of Chalkhill teenagers'.

Women's Week

Three years after Under-fives Week the health visitor involved and two social workers launched another 'week' — Women's Week. Health was the focus, giving an acceptable opening because it crosses boundaries of class and culture. The week was to highlight women's needs, help them to acknowledge them and find ways to meet them.

Unlike earlier initiatives, residents were to be involved in planning the week from the start. Project workers 'used their networks' to bring women together to talk about the idea. The response was good and a

working party of seven residents, encouraged and supported by the workers, saw the event through from planning to completion — four months in all. The programme consisted of workshops and activities. The workshops, mostly led by outside speakers ('we thought that would be good, especially in groups dealing with fairly painful issues') ended with feedback from participants. The activities were 'fun things', physical things like a football match and dancing and a theatre outing, things which many had never done before.

Like Under-fives Week, Women's Week was judged 'a great success'. Women of all ethnic groups participated and 45 attended the final 'report back' session in the course of which the Women's Group was formed. The group, which met fortnightly to discuss matters of interest to its members, qualified for 'tutor hours', funds dispensed by Brent Education Department, which it used to engage a doctor to attend its meetings and advise on socio-medical issues.

Assessing their group and community work, the health visitors maintained it provided scope for health visiting as it should be done: 'As is laid down in the books — seeking out needs and, in the broadest sense, promoting health.' A senior nurse agreed this was so and believed that the project health visitors kept groups going longer than most.

Other activities

Undertakings in which the health visitors were not directly involved included welfare rights, a surgery conducted weekly by two social workers in the Chalkhill Community Shop, and three groups, the aims and progress of which are described briefly below.

The Tuesday Group

This group, for isolated mentally ill people, began at about the same time as the Parents' Group and was the work of two social workers and a community worker. Four years later when data for the study were collected, a social worker reported that the group was 'going really well'.

All sorts of 'burnt out' cases — emotionally hurt people — attended regularly. Many had been rehabilitated, and were capable now of giving as well as taking. The group's meetings were conducted by its members with only one worker in attendance. Friendships had been formed and members met each other outside meetings and helped one another through crises. The group had applied for its premises — a place of its own where members might meet informally as well as formally. 'It's amazing,' the social worker concluded, 'that people who have been so rejected by society can be so accepting.'

A group for isolated elderly people

In the pipeline, when the study ended, was a plan by the family aides to reduce the loneliness of isolated elderly people on the estate. An earlier attempt by them to conduct a group for elderly people in the health centre had met with only partial success and had foundered when, in the very cold winter of 1984/85, its members had difficulty getting to the centre. In the new plan the group would meet at a nearby home for elderly people which had appropriate facilities and a warden in attendance.

The Black Parents' Advisory Group

This group, the only sectional undertaking of the personal service team, was founded by a social worker of West Indian origin. Its aim, she said, was to confront the educational system's treatment of black children and fill the educational vacuum in which so many of them were caught:

> 'I became aware of the underachievement of black children in schools and the delinquency associated with it. Children were leaving school early without having absorbed any education and so at the end of it, were useless. They had somehow missed out on the first formal stage of education — reading, writing and adding up.'

Many black parents did not understand the educational system and relied on teachers to operate it to their children's advantage. Unfortunately, most teachers had low expectations of black children and treated them accordingly. A fourteen year old girl told her: 'From the time I go to school to the time I come home, I do nothing. So there's no point in going.' It was the same for many others. Backed by her colleagues, the social worker sought to deal with the problem through the parents: 'Children are too vulnerable to fight the fight'.

She asked Chalkhill parents to notify her of expulsions, then averaging three a month, mainly from the secondary schools. She helped them to understand the concept of 'labelling' and its consequences and to make a stand on behalf of their children. They were not to think, because of their pidgin English, that they could not address the teachers. It was the teachers' job to understand them. A mark of the group's success was its recognition by school principals who often, when dealing with 'problem' children, appealed to it for help.

Besides changing teacher attitudes there was a need to make good the children's educational deficiencies. To this end, the group in collaboration with a community worker (education) started the Saturday School. The community worker obtained 'tutor hours' funds to pay a teacher from Brent Education Department. By 1985 the school, with 18 pupils, had reached its limit and the group was planning a Sunday School for the many applicants it turned away. Commenting on the Black Parents' Advisory Group a project health visitor said: 'It is activism, more so than the "weeks". It is directed at impelling a disadvantaged group to acknowledge disadvantagement and adopt measures to rectify it. If the project were closed tomorrow, we would have left this behind.'

These are the initiatives the health visitors saw as milestones in the project's development.

Limits on group and community work

There were limits, the health visitors pointed out, to the way the team, situated and constituted as it was, could operate as a community

development resource. It lacked accommodation for meetings and group activity and the different groups had to make do with what there was on the estate. 'Black Parents' met in the community shop, the Tuesday Group in the Tenants' Hall. The Child-minder's Drop-in Group was conducted in the day nursery and Mothers' and Toddlers' in the premises of the youth club.

At a more fundamental level they were limited because the team was, first and foremost, a service delivery unit with highly confidential files and a reception area which, not infrequently, was occupied by 'really chronic, burnt-out clients waiting to see their social worker'. There were issues of safety, too, more so after attacks by violent clients on workers in the reception area. They had had to give up early ideas of the project office as 'drop-in' centre to which people could come for informal chats.

The personal service team was one component of the Chalkhill project. In the next chapter views on the project as a whole are reported.

Chapter VI: Assessments

As stated in the introduction, the study was not designed to evaluate the project. Its purpose was to examine the role of the health visitors in it. To do so it was necessary to understand how the project came about, the goals it was intended to achieve and how participants set about achieving them.

In the course of collecting the data, views on the project's effectiveness were obtained. These, in the main, were views of project workers and other providers of services; only one quarter of the interview sample, eleven people, were 'beneficiaries' or 'recipients' of the project's activities, that is, estate residents. Unlike the majority of people on the estate, most residents in the sample (seven of the eleven) were active members of Chalkhill organisations — the reason they were selected for interview — and not representative of the population as a whole. Nevertheless, the information obtained in the course of the study may help to provide insights into the complex interactions between programmes of this kind and populations of estates like Chalkhill which they are intended to benefit.

In this chapter the data from the study are set against objectives formulated by Brent Council when, in 1977, it launched the Chalkhill and other 'priority' estate projects. These were: local delivery of council services; co-ordination of these and other services; and involvement of estate residents in issues concerning them. Where appropriate the status of commentators is indicated — whether worker in the project, worker in the health centre or in other agencies serving the estate, estate resident representing estate organisations, child-minder or mother of children being minded.

Patch on Chalkhill in principle and in practice

Two informants were wholly opposed to the project; they opposed it in principle. Three held mixed views about the wisdom of a project for and on Chalkhill. The others favoured the principle. In general, workers other

than project or health centre workers were, with one exception, considerably more likely than project workers or estate residents to view the concept negatively. Elements and aspects of the project selected for comment, positive or negative, also varied with the commentator's relationship to the project.

In the view of the two people wholly opposed to it, the project had two major negative consequences; it accentuated the 'ghetto quality' surrounding and permeating the estate and it deprived neighbouring populations of the benefits of expensive resources. Both commentators worked with children and saw Chalkhill children as 'stigmatised in any case' and more so by the presence of the project. Said one, 'Chalkhill is a ghetto, having its own services isolates it even more.' The other maintained:

> 'Everything should not be confined to the estate: schools, housing, social welfare. The estate has been blacked. If you make it patch you are closing off choices. And you are closing off choices to others too. People off the estate don't even apply for a place in Chalkhill Day Nursery. They believe they have no chance of getting one even though their need may be great.'

The respondents with mixed views agreed that a project on the estate could make it even more of a 'special place'. It increased, too, the likelihood of people's troubles being made public. Nevertheless, not to give an estate the size of Chalkhill its own resources would, they believed, lead to the residents losing out even more. On balance they considered that the advantages outweighed the ghetto effect. A solution suggested by a community worker was siting the project near but not on the estate. 'If people had to walk out for their services, even a couple of blocks, it might give them more self-respect and anonimity.'

Evidence from other sources supported the view that many residents sought to escape confinement to the estate. The child-minding

development officer reported that the majority of mothers applying for child-minding services stipulated an address off the estate. Nutshell planned to locate the community day nursery near the estate but not on it.

The majority, those who approved unequivocally of patch for Chalkhill, maintained that rather than increase its ghetto-like quality, the project created facilities which made the estate less of a 'camp, more of a suburb'. Patch elements of the project selected for commendation were: the workers' knowledge of the community and its networks; accessibility of workers to residents; and frequent opportunities for interaction between them. Many maintained that, at Chalkhill, these elements led to more solid and stable relationships between residents and workers than at an area office and, consequently, a 'better service for residents and more job satisfaction for workers'.

A resident said: 'Having the team on the estate makes it much more approachable and the more contact we have with them, the more we can trust them.' A project social worker commented, 'You get to know the people and their backgrounds and the estate networks in a way you never do in an area office and, in the end, you give a better service. You have to: you feel much more accountable to the people.'

An administrative worker maintained that treatment of callers at the Chalkhill office was different from an area office: 'They aren't just addresses here'. In one respect however — the hours when workers were available — the service was failing residents. To be truly patch, workers should be accessible when residents returned from work and over weekends. 'You can't do preventive work if people can't get to you. Something may not begin as an emergency and warrant missing work to see a worker, but may become one if help is not available when needed. And weekends are fraught times.'

Co-ordination of services

As stated in Chapter III, 'joint' in joint neighbourhood project signified co-ordination and co-operation at different levels, namely, interauthority,

interdepartmental and interdisciplinary. Data from interviews and observation suggested virtually no collaboration in regard to Chalkhill (or the other projects) between Brent local and health authorities at senior level and little more at middle-management level. Relationships between personnel of the different local authority departments working on or for Chalkhill were viewed by most who commented on them as characterised by conflict rather than collaboration. These comments were reported in Chapter III.

The disciplines in or involved with the personal service team were social work (which included the family aides and the child-minding development officer), community work, health visiting and medicine. Although there was collaboration between social workers and community workers, for example in setting up the Tuesday Group and the Black Parents' Advisory Group, relations between them were not as good as members of both groups would have liked.

As related in Chapter IV, members of the project's personal service team were enthusiastic about the level and outcome of collaboration across health and welfare boundaries. For the social workers, collaboration with the health visitors made possible 'early intervention and true preventive work'. Health visitors had contact with a broad spectrum of the community and knowledge of the circumstances of many families which alerted them to incipient problems. Together, too, they were able to promote group and community work which, working on their own, would involve social workers in 'years of liaison and of calling public meetings'.

The health visitors maintained that Chalkhill residents who had difficulty in dealing with problems or coping with everyday life were more likely than residents elsewhere to be in shared care and to benefit from it. Shared care made for more work, but also for better work. 'In effect,' they said, 'team members generate work for one another. It keeps us at full stretch but makes for more effective work and, ultimately, for higher job satisfaction than in most settings.'

A project social work clerk with experience of work in area offices claimed there was greater clarity and less fuss at Chalkhill case

conferences and reviews than at those at area offices. Nor, as she saw it, was there danger of 'collusion instead of collaboration' at the expense of the client. The health visitors and social workers often held different views but respected each others' opinions. A resident perceived the project as an 'office in which workers connect', adding: 'It is so important that the workers connect, that the health visitor recognises a need which only a social worker or a child-minding development officer can meet and tells them about it.'

Despite conflict, levels of collaboration between project workers and health centre general practitioners were, according to representatives of both groups, better than in most settings. A court officer who declared himself 'very pro-project', supported this conclusion. For example, he said, there were social workers in general practice attachment at Brent's two other health centres, but because they were a considerable distance from home base, they were somewhat out on a limb. They were unable, as were the Chalkhill attached social workers, to maintain informal contact with colleagues which, in his view, reduced the need for formal case discussions. Although Chalkhill families still accounted for most of his work from the area, collaboration between workers meant that little escaped their attention, that they were on the ball earlier than in most other places.

These assessments suggest that 'patch' teams of health and social workers situated close to health centres and connected by attachment to group practices in them may, as predicted by others (Clare and Corney 1982[4]), be a recipe for integrated comprehensive primary care.

Involvement of the community

Project workers — personal service and community — listed the groups and organisations which, in one way or other, they had helped to establish. 'Our record of achievement,' said a community worker, 'is progression from three or four to something like 30 organisations in five years, a number of which have their roots in the work of social worker/health

visitor teams.' As further proof of collaboration between project workers and residents they pointed to the community and leisure centres which, as a result of joint effort and pressure on the council by workers and residents, were nearing completion.

Most residents in the sample considered the project had helped them, if not to identify and formulate needs, at any rate to meet them. In the words of a representative of a Chalkhill organisation:

> 'We can't manage without the professionals. Even the process of applying for resources takes time and know-how and those of us in full-time jobs can't give the estate the attention it needs. It is a job for professionals.'

The mothers and child-minders had participated in a successful campaign led by the child-minding development officer against cuts to child-minding subsidies. The campaign, a series of meetings, culminated in minders, mothers and babies crowding the council chamber at a council meeting to voice their protest. These residents spoke not only of their delight at the outcome but also of their enjoyment of the meetings and of the campaign as a whole.

One, however, a resident serving on the committees of several Chalkhill organisations, perceived the project as too often competing, not collaborating, with members of the community. The professionals, she maintained, took the credit for the things the people on Chalkhill had done. She acknowledged, nevertheless, that were it not for the support and encouragement of a community worker she might have given up working for the community centre. 'Whenever my spirits flagged, Sarah (the worker) pushed and pushed me to go on.'

A council officer perceived the project's role in the development of Chalkhill groups and organisations as 'limited, merely enabling'. Most of the groups, she maintained, were grass roots, initiated and sustained by members of the community, the project being merely the gateway to council resources. Another questioned the significance of the groups and

organisations. He considered the list of them 'not very impressive: most were small and functioned for select groups only'. In his view, project workers did not make enough effort to establish needs and to co-operate on an equal basis with residents in meeting them.

Overall impact

All the residents, despite the reservations expressed by some, believed that with the coming of the project, life on the estate had improved. In making their assessments the organisational representatives tended to concentrate on the work of the community workers; child-minders and mothers concentrated on that of the personal service workers. The former were more likely than the latter to express ambivalence towards the project. They were also divided among themselves on what a resident referred to as the project's policy of promoting sectarianism. One resident's negative comments were linked to the personality or behaviour of individual workers bearing out Thomas's (1983[16]) warning that patch workers have to be prepared to be judged as people (Chapter III).

A housing officer who was 'for' the project — both sides of it — and believed it could help an estate with many difficulties deal with them, thought it not as successful as it might have been. He judged its impact by how happy the residents were and most, as he saw it, were very unhappy. A psychiatric social worker asked, 'How much good has the project done? Are people more satisfied? Has it helped to make people proud to live here? I think the answer is to let people progress to a better environment — not keep them here with all the other families with similar problems.' These two commentators, in the course of their work, may have met more unhappy residents than most, such as transfer applicants wanting desperately to leave the estate or families in which members suffered acute personal or interpersonal difficulties.

However, two project workers also had reservations about the project's impact. They doubted if a predominantly white project serving a predominantly black community could really get to grips with its

problems. 'Besides,' said one, 'the past could not just be wiped out: whites have a history of being unfair to blacks and blacks remember it.' The other project workers considered that, in the round, their contribution was worthwhile. As proof, they pointed to the drop in the number of children in care or 'at risk' which, even allowing for adjustment of records, was, they maintained, real. 'And, at the very least,' said a senior social worker, 'the project is an explicit acknowledgement of the existence of Chalkhill and of the pain of those who live on it and an open system for helping residents deal with and lessen the pain.'

Chapter VII: Conclusions

The outcome sought by health visiting, as by all health and social services, is the health and welfare of the community. Since World War I this outcome has been regarded as attainable only by combined effort of workers in the different services (Ministry of Health 1920[30]). For much of this century proposals and measures for the organisation of community services have, to a considerable extent, been directed towards creating structures for the promotion of interdisclipinary collaboration. The establishment of teams and the development of teamwork have been and remain major organisational objectives.

Initially, the favoured device for promoting teamwork was the health centre as proposed by the Dawson report (Ministry of Health 1920[30]). When, in the planning stage of the National Health Service, it became apparent that the tripartite system was to stay, the health centre was viewed as the saving mechanism; it was to integrate community health services at the point of delivery (National Health Service Act 1946, Section 21). For various reasons implementation of health centre programmes was delayed until the late sixties (Hall et al 1975[31]).

Alternative and, as some thought, interim devices for fostering teamwork were schemes whereby local authority health and social workers, but especially the former, would be connected to general practice in attachment, liaison or alignment (Ministry of Health 1954[32]). The schemes, first put into practice in the mid-sixties (Warin 1968[33]), gained favour and by 1980 89% of health visitors were linked in one way or other to general practice (Dunnell and Dobbs 1982[25]). By then, too, evidence had begun to accumulate that neither health centres (Beales 1978[34]) nor attachment (Dunnell and Dobbs 1982[25]) necessarily begot teamwork.

In 1975 the Health Visitors' Association (HVA) reported that health visitors 'entering well-managed [attachment] schemes found them acceptable' and that some health visitors were extremely enthusiastic about them, but that for many, the experience was one of disillusionment

(HVA 1975[26]). Ten years later, it concluded that while primary care teams located in general practice remained the ideal, too many health visitors had been sacrificed to the ideal, for most general practice teams were teams in name only (HVA 1985[5]). There was, the HVA stressed, another major disadvantage to attachment; it impeded community work. As a rule general practice lists, and hence the attached health visitor's clientele, did not relate to 'natural groupings of populations in neighbourhoods or localities', making it difficult for the health visitor to know 'distinct socially coherent neighbourhoods' and identify and develop initiatives to meet local need (HVA 1985[5]).

The HVA proposed an alternative setting for health visiting: the 'neighbourhood team'. Teams of five to ten health visitors and school nurses, accommodated in suitable premises, would be responsible for health promotion in neighbourhoods of 20,000 - 30,000 people. The clientele of each health visitor would relate to and be known by 'a local population ..... identifiable with one or several communities or neighbourhoods'. Health visitors who were members of established effective primary care teams located in general practice would continue in them but restrict their services to clients living within the neighbourhood and liaise with colleagues in other teams in respect of clients living outside.

Unlike their predecessor, the local unit or 'clinic' of five to six health visitors sharing a common base but responsible individually for discrete geographical patches, neighbourhood teams would promote intraoccupational collaboration. The teams would operate as many group general practices do: providing a comprehensive service to the neighbourhood. Clients would have their own health visitors but would be encouraged to get to know the other members of the team and to discuss whatever concerned them with the health visitor most knowledgeable about it.

Neighbourhood teams would also provide opportunities for, in the HVA's words, 'much-needed professional and emotional mutual support in what can for most be a highly stressful occupation at times.' Finally, the

HVA believed, it was as a neighbourhood worker that the health visitor was best able to fulfil her functions as community worker. 'To promote and support action taken by her clients so that they [could] become active participants in, rather than passive recipients of, the planning, delivery and evaluation of the services they wish[ed] to receive.'

In 1986 the Community Nursing Review Team endorsed the concept of the neighbourhood team as an organising principle for health visiting and school nursing services, but extended it to include other community nursing services. It saw 'district nurses, health visitors and school nurses... working together as an integrated team' responsive to the needs of populations in defined areas (DHSS 1986[6]).

In sum, the criteria employed by the HVA and the Community Nursing Review Team to construct an organisational model for health visiting correspond broadly to the objectives for the neighbourhood projects. In this chapter, as in the last, these objectives are used as the organising principle for conclusions about the Chalkhill project as a setting for health visitors.

First, however, it might be useful to recap the elements of the Chalkhill model relevant to health visiting. Its key features were:

- secondment of two health visitors to a social service patch team (despite claims of joint local and health authority sponsorship, that is what the team was);
- project premises located above a health centre accommodating health authority personnel and three general practices each with three principals;
- the project health visitors were members of a health visitor unit of six health visitors based in the health centre;
- the health visitors and two project social workers were attached to the general practices in the health centre and constructed most of their caseloads from the general practitioners' patient lists;
- in addition to proximity, attachment and administrative links, project and health centre were, by 1984/85, connected by project activities conducted in the health centre. The toy library and the

play sessions were run by the project family aides and keepfit and relaxation classes were run by a health visitor and a social worker.

To what extent did the health visitors and their colleagues in this setting meet the objectives of providing a local, coordinated service, involving the community they served?

Patch: local provision of services

The project was designed to serve the people of Chalkhill and, in terms of the brief given to local authority workers, only the people of Chalkhill. For the health visitors, however, the principal factor determining construction of their caseloads was general practice attachment. Over 75% of the clients of the project health visitors, as with those of the health centre health visitors, were registered with doctors in the practice to which they were attached and only 25% were geographical clients. Partly fortuitously and partly by design, considerably more Chalkhill residents were clients of project than of the health centre health visitors. More residents were registered with practice C, the practice to which the project health visitors happened to be attached, than with the others. Once the proposals for the project were adopted, it was agreed that estate 'geographical' clients would be allocated to project health visitors.

Ideally, the project health visitors said, they would have liked to 'work patch' in the way the social workers did but recognised that to do so they would have to relinquish or radically restructure their attachment to general practice. Despite their complaints about the attitudes and behaviour of most of the doctors towards them, project health visitors, and their health centre colleagues, thought attachment better than non-attachment. They acknowledged, too, the value of the other interconnections between project and health centre.

They did not favour any scheme, such as that proposed by the HVA, whereby alignment with a general practice was incomplete. They

considered that solutions of this kind might erode the advantages and effectiveness of attachment. The work of referring clients to other health visitors and maintaining contact with them would be considerable while their participation in the primary care team and standing in it would be undermined.

The data from the study and the arguments of the HVA and other contributors to the literature on health visiting confirm the value of locally based services, especially for estates such as Chalkhill. They suggest, too, that primary care teams which work are worth preserving. As long as locality-based health visitors cannot be aligned fully with limited numbers of doctors, the Chalkhill solution would seem to have much to commend it.

Co-ordination and collaboration

In 1980, as related in Chapter III, the Joint Neighbourhood Projects' Working Party expressed concern about the way in which the projects were developing. Among shortcomings listed was lack of progress in co-ordinating council and other services for the estates. To remedy this it recommended restructuring the projects and their management including the establishment of management groups at middle and senior level. The groups, composed of representatives of council departments serving the estate, the office of the chief executive and the health authority, were to oversee the work of the projects and ensure levels of interdepartmental liaison essential for co-ordination of services.

Council and other workers participating in the study were of the opinion that, despite implementation of these recommendations, services remained poorly co-ordinated. Many explanations for failure were offered but only one remedy was suggested - an alternative management structure. Two respondents suggested that 'area management' or 'a single on-site manager able to control all on-site resources' was the solution. It would ensure co-ordination of the services, reduce the number of professional workers on the estate and make for greater effectiveness.

They acknowledged that a monolithic multi-service structure might appear intimidating, tyrannical even, to recipients of its services and that it would need to be counterbalanced by an effective residents' forum. This solution would seem to be inherently contradictory. Communities able to establish and sustain residents' forums of the kind envisaged are unlikely to require intensive servicing.

Senior and middle management are, in the main, concerned with long-term and intermediate programmes, front-line workers with their day-to-day implementation. What do the data suggest about collaboration at *ground level*? The least effective and satisfactory levels, according to views expressed by informants and the researcher's observations, were between health centre health visitors and project social workers, the most effective between project health visitors and project social workers. Health visitors, project and health centre, also regarded collaboration with other project workers — family aides, child-minding development officer — as highly satisfactory.

Collaboration between health visitors and general practitioners and workers in other agencies appeared to be of a high order, despite complaints by the former of the latter's inadequacies and ineptitudes. The researcher, who attended meetings between a health visitor and members of staff of a day nursery, child and family centre and rehabilitation unit, observed joint whole-hearted pursuance of the interests of the child and its family.

Relations between the two wings of the project enabled social workers and community workers jointly to sponsor four estate organisations, despite mutual criticism and even recrimination.

Interdisciplinary collaboration within the service wing was, according to its members, a continuing, almost taken-for-granted process, a view with which the researcher concurred. Sharing an office, workers continually up-dated one another about developments within families in joint care.

Besides sharing an office, the health visitors attributed levels of collaboration to the quality of relationships within the project. They maintained that 'the sense of family, of belonging, of a safe haven in which

feelings can be expressed was conducive to commitment and imaginative joint work'.

For much of the study period, the researcher's observations of relationships in the project tallied with project workers' accounts. What she noticed, but to which workers — if they did — made no reference, was a marked tendency to discount or belittle efforts and ideas stemming from outside the project. In other words, to bolster the good within by emphasising the bad without. The mechanism failed when a senior social worker left, which he did half way through the study. He was a founder member of the project and, as was apparent retrospectively, its leader. Pressures and divisions relating to the appointment of a successor induced or revealed high levels of internal discord and, in due course, several members resigned. It was at this point that the study ended.

The group dynamics observed by the researcher had much in common with a process which, in the literature, is referred to as 'destructive group think'. Shipley (1985[35]) described the process as follows: 'The group protect[s] itself from adverse information with self-appointed 'mind-guards'; stereotyping the enemy as too stupid to be a threat, or too evil to negotiate with; dealing with challenges to cherished values and assumptions by ignoring them or rationalising them away.'

Shipley pointed out that illusions of unanimity and invulnerability (closed-mindedness) and excessive conformity could also be attributes of workplace groups. She concluded that while physical and chemical work hazards have long been established as subjects for concern, less attention has been given to the psycho-social risk factors in work environments. Societies which overrate the capacity of people (especially, it might be added, of professional workers) for cool, logical and rational thinking have serious blind spots.

It is encouraging, however, that concepts and techniques pioneered by the Tavistock Institute and practitioners like Balint are increasingly being employed to deal constructively with psycho-social risk factors. A number of organisations, private, government and municipal, have on their staff workers trained in these techniques. Others make use of external

consultancy services, a practice which would seem better suited than an internal appointment for working with 'highly politicised' units such as those on Chalkhill.

A second observation relating to structures and levels of co-operation concerns project workers' attitudes and behaviour towards management. Health visitors and social workers complained frequently about lack of management support and involvement in furthering the work of the project. Yet, when members of the nursing or social work hierarchy visited the project, their reception was cool, if not hostile. It is likely that, in some degree, the field workers' complaints were in the nature of 'discharge', outlets for dealing with the difficulties and confusions inherent in finding 'a new way of working' and of meeting real or perceived expectations of others. It is likely, too, as a senior officer said, 'the team had to wing it — find a direction for itself.' It eventually did, operating on organismic lines including 'adjustment and continual redefinition of individual tasks through interaction with others' (Burns and Stalker 1961[36]).

A third observation related to differences in levels of managerial support available to project workers employed by the different authorities. Although social workers and health visitors complained equally about lack of support, to the researcher it seemed that without undue interference the local authority's social service hierarchy provided support that might be termed 'enabling'. The area manager maintained regular contact with senior project social workers and, with one of them, attended regularly middle management group meetings. At the request of project members he and, on one occasion, the assistant director of social services, attended project meetings and, despite some overt hostility from project workers, were enthusiastic about the project's direction and development.

In contrast, at the time of the study, the health visitors' hierarchy had little connection with the project. The two senior nurses — first-line management for the district's 65 health visitors and 20 school nurses —were 'for' the project but too stretched by their basic job requirements to attend project meetings or otherwise keep themselves informed of its

development.

Nurse management at middle level was less enthusiastic about health visitor involvement in the project. It seemed, too, that at this level much energy was consumed in interdivisional rivalries and interpersonal conflicts at the expense of meeting needs of front line workers. Although structural deficiencies — too few senior nurses to constitute adequate first-line management — were a major factor in the situation, it seemed that at the middle level, psycho-social problems contributed to the alientation of management from project workers.

Community development

All the respondents acknowledged, in one or other way that 'true prevention' involved tackling the social and economic conditions which created estates such as Chalkhill. But, given that Chalkhill and other similar estates have been created, a more pragmatic question is whether projects such as that on Chalkhill contribute towards bettering conditions and improving the quality of life for residents.

The majority in the study sample considered the answer was 'yes'. They thought the project had helped residents identify needs and develop strategies for meeting them. Evidence of its contribution included the community and leisure centres about to be opened and the many estate organisations and groups which were attributed to project initiative or support. A few questioned the validity of this evidence, maintaining that pressure on the council for the community and leisure centres predated the project and that many of the organisations listed on the chart were 'lightweight', with few members and of little significance for the estate as a whole. For example they pointed out that one consisted of four families who shared a deck taking tea together.

However, criteria such as size of membership, ostensible purpose, and longevity may not always be the right ones for assessing the impact of group activity on a community. For example, they do not take account of the personal growth associated, not infrequently, with office-holding or

just membership of a group, and the ripple effect of this growth. As data on the impact of the project's community work was limited to the views quoted, further comment must be mere speculation. However, an issue referred to by many — those impressed with the project's input as well as those who were not — that of sectionalism or groupings based on race, requires further consideration.

The sectionalists, supporters of groups such as Nutshell and Asian Forum, argued that members of black and ethnic minority groups needed to establish and reinforce their identities and could do so only in interaction with those with a common background and culture. Some among them maintained that, having done so, they would be equipped to participate in the wider community but others insisted that, because of their treatment in the wider society, sectional needs would persist.

Among those favouring an integrationist approach were some who conceded that development of sectional interest groups might be a necessary phase but that overlong perpetuation of separate development could not be in the interests of the community as a whole.

Protagonists on both sides referred to power issues. Sectionalists accused the integrationists of wanting a broader powerbase for themselves, to lead and represent the community as a whole. The integrationists thought the sectionalists needed to retain small ponds in which to be large fish. In all, residents of the estate were faced with the dilemma confronting all plural societies and for which there would seem to be no single or simple solution.

As the data have shown, development of sectional and of universal organisations occurred and was encouraged on Chalkhill. Link, the umbrella organisation, was devised to bring them together to further the interests of the estate as a whole. The first attempt to establish Link ended somewhat disastrously with participants fighting for scarce resources and over status. The second, initiated a year and a half later, appeared to have a measure of success. This was the Chalkhill solution to the dilemma.

The racial composition of the population served by the project required,

too, that decisions should have been made concerning the composition of project staff. Two project workers expressed doubts about the ability of a team made up mainly of white professionals to appreciate fully the problems faced by black people whose life circumstances and experiences were so different from theirs. A team with a racial mix similar to that of the estate may have been more effective in understanding and meeting needs.

The study data suggest that, if at all possible, community teams should include health visitors. There was unanimity about the singular contribution of the project health visitors to community work on the estate. As members of a universal outreach service they were in contact with populations which social workers, even community workers, were not likely to meet, and among whom were residents well able to participate in processes of identifying community needs and strategies for meeting them. Recognition of this contribution by workers of other disciplines gave to the health visitors 'dependency advantages' over the other workers rarely enjoyed by health visitors in other settings.

Into Decline: three years later

The project was conceived at a time when the ethos of the welfare state prevailed and it was believed that imaginative social planning backed by adequate state funding could redress many social ills including those in inner city areas. Planning to deal with the unrest and perceived increase in antisocial behaviour in these areas was based on concepts of community development — involvement of residents in identifying local needs and in planning and executing programmes to meet them. Urban Aid for such programmes represented government support for them. The Chalkhill project was a product of what might be termed an expansionary period in social planning.

In 1979 the Conservative Party, committed to a monetarist philosophy, took office and introduced policies based on this philosophy. By 1985 when the study ended, 'rate-capping' and 'the cuts' had foreclosed

project plans for a family centre and for the repeat of Fun Day, a successful event in the previous year. There were as yet few other perceptible changes.

By 1988, however, when a brief return visit was made to the project, the situation had changed. Staff turnover in the interim had been rapid and less than a quarter of workers in post at the time of the study were still there. The health visitors were the third intake since the end of the study. Veterans and newcomers alike considered the project had been 'in steady decline' for several years, a process occurring against a backdrop of retrenchment, turmoil and upheaval in the local authority as a whole. The social services complement had been reduced from ten to eight social workers and not all eight posts were filled. The post of child-minding development officer had been vacant for more than six months and it was not known whether it would be filled again or scrapped. Social workers other than the two attached to the health centre practices had been instructed to 'prioritise their caseloads and undertake statutory casework only'.

Health visiting and community nursing services in the health authority as a whole were organised into localities along the lines proposed by the Cumberlege report and management, with the exception of a senior nurse, showed little interest in the project. In one manager's view, said a health visitor, projects were finite; if successful, they were transformed into institutions, if not they might as well cease to exist. And, she concluded, that seemed to be true.

The health visitors, like their predecessors, shared an office with project social workers and a belief in the value of collaboration and teamwork. There was, however, little opportunity for collaboration. Pressures on the social workers — 'too much work and too few of them' — and their instructions to confine themselves to statutory work, left little scope for preventive casework or community work such as was undertaken in earlier days. The health visitors felt keenly, too, the absence of a child-minding development officer in the project and the fact that the area office could take no new referrals for child-minding. In fact, they said,

and the social workers agreed, the project was a patch social services office responding reactively to client need and they, the health visitors, merely had their desks in the office.

Summary and conclusions

The views of participants in the study and the researcher's observations suggest that a multidisciplinary neighbourhood project can help to prevent or alleviate distress in communities such as Chalkhill. It has much to commend it as a setting for health visitors. It enabled them to participate fully in provision of comprehensive integrated care; to make a valued and unique contribution to promoting community development and to gain a high level of job satisfaction.

The history of the project suggests that organisational structures devised for the project, its location above the health centre and its connections with it, provided the framework for team building and team working. The data demonstrate that physical and organisational structures are not ends in themselves but means to accomplishing social purposes. They can open and foreclose social and economic opportunities but it is human motivation and behaviour which determine how the opportunities are used. Organisational planning must take account of psycho-social risk factors and of the dynamics of intra- and interpersonal conflict and make provisions for dealing with them.

Information on subsequent developments in the project, that is development between 1985 and 1988, shows clearly that while an enabling structure is not the whole answer, it is an essential prerequisite for achieving social ends.

In summary, the data suggest that circumstances and events which made for multidisciplinary collaboration included:

- commitment to the project by its sponsoring authorities;
- adequate funding and staffing;
- workers of different occupations sharing common space; which in turn, provided opportunities for —

- gaining knowledge of each other's skills and expertise;
- strong affective links stemming from a sense of beleaguerment and of neglect;
- an organismic internal organisational structure in which division of labour was, in considerable degree, determined by worker ability to meet client needs;
- effective and appropriate leadership which was revealed retrospectively.

Circumstances and events which hindered or delayed progress included:

Initially

- delays in obtaining accommodation and equipment;
- heavy caseloads;
- initial differences in orientation between members of the different occupations;
- lack of support from the health visitors' management hierarchy.

After 1985

- changes in the social and economic climate leading to:
- retrenchment — reduction in staff and funds for development programmes;
- instructions to social workers to deal with statutory work only;
- lack of enthusiasm and support by the social workers' as well as the health visitors' management hierarchies.

Committees of enquiry into the deaths of children, for example the Beckford inquiry (London Borough of Brent 1985[37]), and child abuse, notably the Butler-Sloss inquiry (DHSS 1988[38]), have repeatedly called for communication and collaboration between health visitors and social workers. The Chalkhill project, with a structure designed precisely for such collaboration, was failing for want of support and resources.

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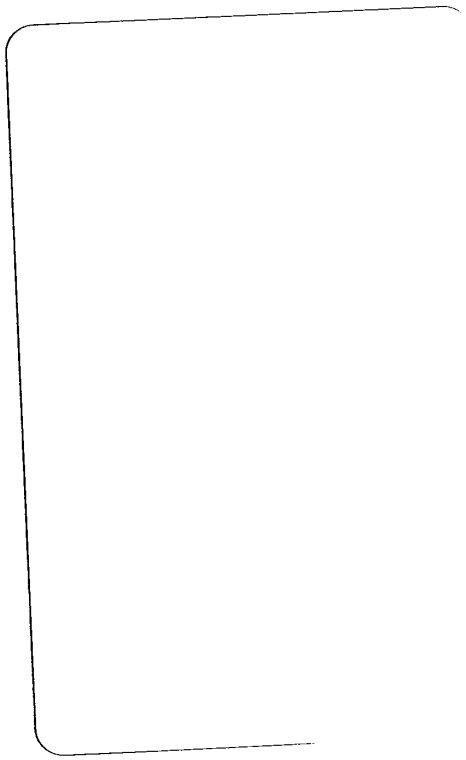

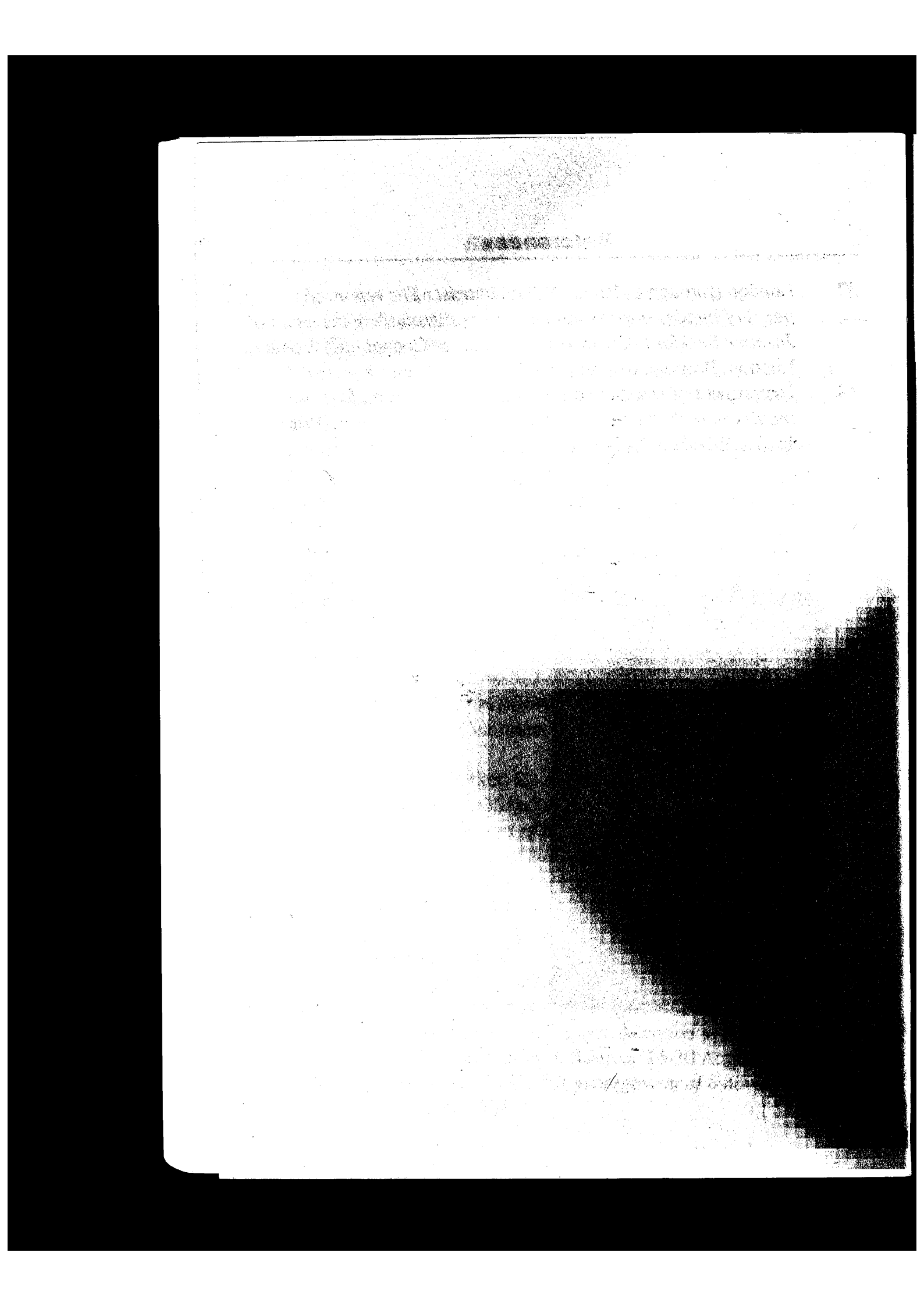

Inner Cities
health visitors
Social workers
teamwork

A brave attempt

How can health visitors help tackle disadvantage on a problem housing estate? Chalkhill is a large council estate in the London Borough of Brent with serious problems. Researcher Hessie Sachs set out to examine the role of the health visitors in the multidisciplinary project established to make Chalkhill a better place to live. ***A brave attempt*** chronicles the benefits and difficulties for health visitors of working in a team of social workers and community workers, and describes the project's work in the context of the local community, and of health and social services management.

The achievements and failures of the project are described in the light both of the early history of the estate, and of public expenditure cuts in the mid 1980s, which frustrated workers' plans and undermined management commitment.

Hessie Sachs has undertaken research on both health matters and community development in South Africa and England.

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