photos by Sally Greenhill

Society at work

Lady from 'the welfare'

Joy Hendry

Nobody seems to know what a health visitor does—least of all health visitors, because it's a job you make very individual. But basically, health visiting was started a long time ago by local authority people who used to go round to people's homes and inspect them—look in rooms and see what was wrong (dampness and so on) and be very authoritarian and very unpopular.

People still think we're some kind of sanitary inspector. They get very shirty or very deferential, which is embarrassing. They start opening cupboards and showing you the drains. It's just as well I don't know anything about drains! Health visiting was taken over by nurses, and health visitors now have to be nurses who've got midwifery experience. They have a year's course in college, which entails sociology, social policy, psychology and extensive Preventive Medicine.

As I say, nobody knows what we do. I think it's a shame we don't tell them. We're called "the welfare"—and "the welfare" to people in the East End of London means the lady who will do anything, which is virtually what we do. But I'm sure we're not used in the proper way. I'm sure we don't do a lot of the things we could do for people because they don't know about us, and we're used for a lot of things other people would best be suited for. One of the problems is that we can't do the job properly because there are not enough of us. It's very much an emergency service, which is not terribly satisfying.

It's hard to describe a typical day on the job, because they're all different, but there are some things we have to do. By law, we have to find out where all new born babies are living. We have to do visits so that we know where they are, which is very good for keeping tabs on baby battering or anything like that. We should really be the first people to know if there is anything like that going on. So, if you are terribly organised, the day starts by seeing what routine things you've got to do, like phoning up hospitals and seeing when children are coming home. Then there are lots of letters and reports to write. All that gets done first and then you go out on visits.

But visits never turn out how you expect them to. That is why we never make appointments. You don't know how long you'll want to stay in somebody's house. Sometimes it's inconvenient, because you just arrive on the doorstep and they don't know you're coming or they obviously don't want to see you. Then I go quickly. But the next time they let me in and I never have any problems. Sometimes the first visit you make in a morning the person may be in a bit of a state and you stay there the whole morning.

This makes the work very erratic. You might go to see a new baby and find the father has just come out of prison or something and you end up having to talk to him instead. You also get a lot of people with problems that you've been asked to visit. People will come in and ask you to do certain things which are not necessarily the set work of a health visitor, but which come to be taken on—for instance, I know one woman who is just so depressed that she needs someone to talk to. So I go in once a week or once a fortnight just to say how nice everything looks and how well she's doing.

People use our clinic as an information bureau. They come in themselves. It's the only place they know. Other places are too official—the social security, for instance. The official places in the town hall they would never go into, but they like somewhere they've always known and which is very informal. Normally they're not kept waiting. It's a matter of principle with us that anybody who comes in is seen straight away. Even the clerks, the telephonist, the cleaner, give advice.

The clinic acts as a local information service, as I say, usually for social rather than medical problems—social problems that are not severe enough to go to the social services. People know they'll be kept waiting the whole morning if they go there, so we deal with them. People are just not able to approach authority themselves. If their gas gets cut off, they don't know what to do about it. We have to intervene on their behalf. We get housing problems, absolutely everything. And if we can't deal with it we usually know who can. We try to get somebody else. The problem is that there is often nobody else. In that case I always feel very strongly that you don't just keep passing people on and on. Very often I get landed with problems I can't cope with adequately because of this, but on principle I don't just let them go.

Other work that we have to do is to deal with referrals from the hospital. When any child goes into hospital we are informed. This is especially important when children keep turning up in out patient departments because they've had "accidents." We have to go and see if there's a reason why this keeps happening. Health visitors also go into the psychiatric block of Hackney hospital and the maternity hospital; and I work with a local GP. I sit in his surgery and deal with some of his patients. They're a very wide mixture, from psychiatric cases to old ladies who want a free sauna bath. There are lots of depressed middle-aged women. They come in and just want somebody who's got time to sit and talk.

I do two baby clinics a week. People can come exactly when they want to—there's no appointment system, again. Very often they come because there's nowhere else to go. They come just to sit and let the kids play. It's a social centre as well as an advice centre.

Most babies are born in hospital. But it is not always the best thing. It's a great problem, because a lot of girls have got nobody else to look after any other children they've got while they go into hospital to have another one. There are lots of women whose husbands have left or who are unmarried girls. Their going into hospital creates a social problem. What is more, hospital is not necessarily the best place to have a baby. Home is really the best place to be, because hospitals are very cold, impersonal places (perhaps I shouldn't say that, but they are).

The problem of battered babies is something that worries us a great deal. I think health visitors know more of the younger children who are being or are likely to be battered than anybody else. But we aren't

able to do anything about it because our ability to intervene only goes so far. We can shout, scream, send reports and try to get the child away from home, but we haven't got the authority to work with courts or children's homes. So our jobs can be very frustrating.

The main thing we can do is spot potential batterers. That can be very evident from people who arrive at the clinic—mothers or fathers who haven't got a good relationship with the baby. They sit with the baby on the end of their knee and very often have a compulsion about washing the baby's clothes.

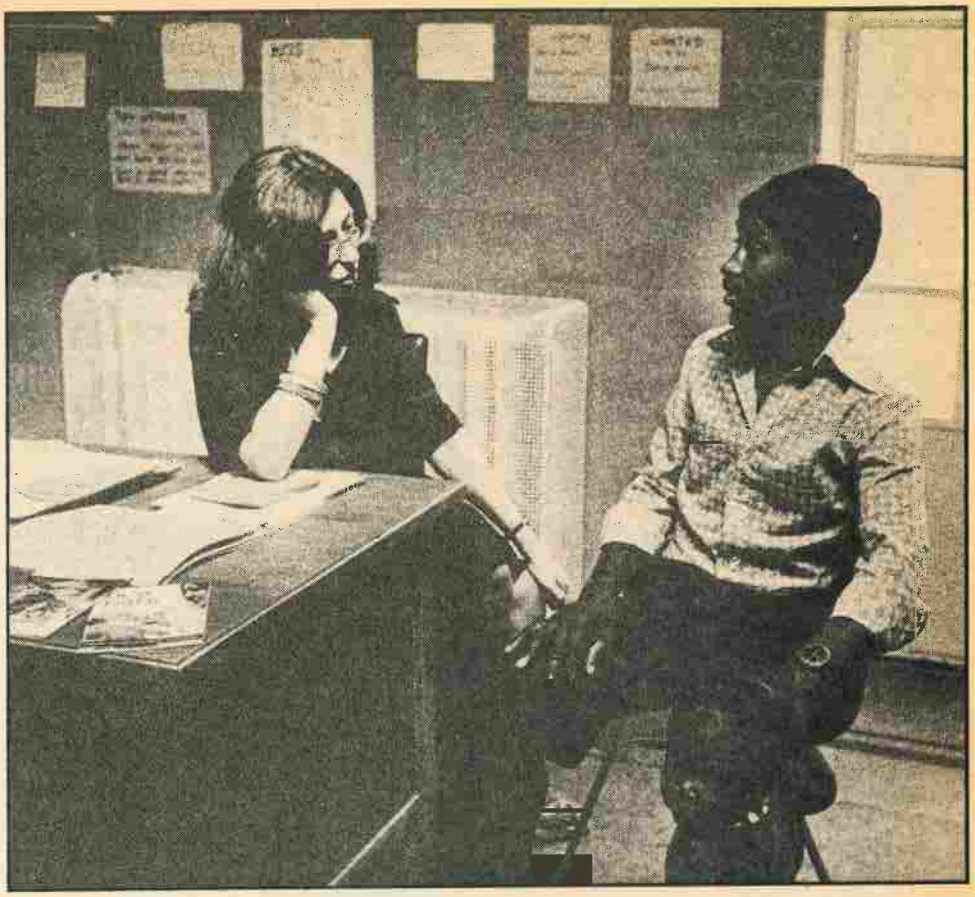
I've been on a visit and watched a mother remove a child's dress a couple of times while I'm there because the baby was sick. She took off the dress and put on another one—twice. She didn't want her baby to smell like a baby. Some of them can say this, that they "feel very strange about it." You can often trace it back to the time when they had the babies. Some of them were unwanted, some of them wanted so much that when they actually came the parents were disappointed. Others have very unrealistic views about what children dren are and what children should do. They expect a baby to coo nicely, to lie gurgling in the arms, take a feed and go to sleep. This is not the way babies are.

Mothers who respond like that to babies are the hardest to deal with, because it's very much harder to change their attitudes than others. The other ones are potentially easier. For example, if somebody has had to leave their baby in hospital because it was premature, you can discuss with them what sort of problem is involved. You can tell them that they're likely to feel a bit of difficulty with their baby and not have a very strong bond initially. Premature babies do look rather ugly and people feel they're rather repulsive. But you can discuss that and get out of a problem before it exists.

Mothers who have got babies they didn't want are more difficult to cope with. They can hate them. It's ghastly. They just hate them more and more each day. They very often hide it even from their husbands —they often won't admit it to anybody. Friends and relatives come to see the baby and the mothers just don't know what to do because they feel nothing for it whatsoever.

They are often hard to detect—they won't show it, even to us, and they're not likely to find out what's going wrong. The only easy way to find out is if there's a baby who's very unpleasant and screams a lot. I usually say, "I'd go round the bend," and they usually say, "Well, it's not very easy," and we start from there. It's up to you, the health visitor, to ask questions. That's the way I usually start. These mothers are usually perfectly ordinary people who just can't cope with the problems they've got.

A battered baby does not have to be physically injured. We have a confidential register for any baby which we think is severely at risk. No injury need be done at all for a baby to go on it. The only thing that happens if they're on the register is that we have to send a report every couple of months via the divisional nursing officer to the community physician. This doesn't do much, but just makes sure that somebody is actually visiting.



Health visitor at work visiting clients (facing page and overleaf) and discussing a problem at the baby clinic (above)

In an emergency, there is always the hospital, of course. If a child comes down to the clinic, is obviously being battered and the mother is willing to take the child to hospital—which they very often are—the hospital will take it in without question, even if there is no visible injury. They believe at the hospital that if you take the child away in a time of stress you alleviate the problem. The hospital will also, through the medical social workers, put an emergency care order on the child.

The main problems with battering—and these are the cases that get in the papers —are families with an immense number of problems to sort out. There are probably quite a lot of children and they get knocked about by people other than the mother. The mothers always find places to take them when they get hurt but they're too busy to bother much. It gets on the grapevine where to go. Or they take them to a particular GP who is elderly and not very aware of battering problems. So all the kids' minor injuries go undetected.

There are other people who, unfortunately, are quite blatant about neglecting or bashing their kids. Some people use this as a lever to get social benefits or attention. For instance, we have one case of a mother who threatens to throw her baby out of the window or to hit one of her kids if we don't come. These are very difficult to deal with. They've just got so many social problems that—mostly—they receive no attention because they have problems that social workers just can't cope with.

But cases of battering are not always as sensational as this. In legal terms, a battered baby is one that has injuries which are probably non-accidental. But in health visitor's terms, a battered baby is any baby who's wilfully neglected, either physically (some children just don't get fed properly) or mentally—like children who aren't played with at all, children who are shut up when the parents go out, children who are told they're not wanted. We include them as battered babies, though I'm sure nobody else does. Kids who are not mentally stimulated at all are just regarded as being just as battered as those who are physically hit. Mental battering is harder to prove and harder to do anything about. But we still try.

Being a health visitor has completely changed my whole attitude to people—and it's still changing. But there are days when I think it's the worst job you can have, because there's no direction, nobody telling you what you ought to do. There are certain things you have to do, by conscience, but there's nobody telling you to do them. There are so many things to do that you don't know where to start or finish. It's frustrating, because there's so much you can see that needs doing, but you can't even get started.

But I wouldn't change now. When I started I thought I would go on to do social work training, because I felt frustrated at where our job ended. As soon as we've got a certain way with a family we have to hand over to social workers, because they're the people who have the power to get things done, not us. That really frustrated me and I wanted to be a social worker. But my ideas have changed now, because basically health visiting is preventive. We're for everybody, not just people with problems. A lot of people get missed because in social work, and even voluntary work, you get the people who shout and scream the most. We try not to. We actually go and fish out people, which, I think, is much more worthwhile. We try to prevent things happening.

The other aspect of our work is that we're helping to make some kid's lives a bit richer than they are normally. It's difficult, initially, because you never know what you've done—whereas if you're doing very practical things in social work, you feel it's more positive—you're getting things. But I have at long last come to realise that material things are not what people want. I feel I have succeeded if I have helped a mother and baby enjoy each other. Then they've got something nobody can take away from them. They may not have anything else, but they've got something worthwhile to built on. We have to see kids up until they're five, but it doesn't just stop at that. If you know people you don't just stop when their kids are at a certain age.

I work in a small area in south Hackney and always meet people on the streets and in the estates. I walk round the area and people know me. Shopkeepers know me, the crossing men know me. That's nice, because it means I'm part of the place. I'm not somebody who dives in and deals with great problems. I live quite close—I've gradually moved nearer and nearer from the posh part of London. I think it helps to live locally, because a lot of professional people who work in areas like this live outside and don't know the problems of living here. A lot of health visitors now live locally. They come in useful—for instance, I get all my neighbours' problems as well as my problems at work. It helps to see things in perspective if you live locally.

My attitudes have changed since I have been a health visitor. I was very idealistic when I came to Hackney—everybody is when they start. I thought everybody wanted advice. I saw so much going on that I thought I could change. But now there's much less I want to change. I accept far more how people are than when I came. A lot of it has been just learning about people's life styles. I accept completely different standards for different people—especially Indians.

I remember going to a house and having to sit on the floor and being given glass after glass of a peculiar lime drink. I didn't know what the hell it was. I thought the house was incredible. It was completely disorganised. They couldn't speak English and I couldn't speak their dialect. We just sat and smiled at each other, drinking this lime

juice. I used to go there quite often. The woman there was in a terrible state because in India she'd had help in the house. Somebody in a lower class had come in and done it for her. She had no idea how to cope. I don't know how I would have dealt with that if it had been an English family. But somehow I accepted going in and sitting on the floor. Then I introduced her to in Indian neighbour and she learned how to cope. Things like that make you realise that there are different standards for different people.

Why should you change people? You occasionally get a family who are filthy and you ask them to do something about it, but it's always rather a delicate matter. And how far do you go? When are people really filthy or just happily dirty and not terribly concerned? If it's a case where they live in indescribable housing conditions and mother's died or something and there's nobody to wash their clothes and send them to school clean, there's something you can do. But if they're kids who're quite happy like that and they're just in a mess, then you leave them in a mess.

We're in a nice position, because we're not able to force anyone to do anything. My job doesn't force me to make these sort of decisions, whereas a social worker, who probably has to go to court, has to. In my job, you can form your own opinions and tell people what you think. You can say, "This is what I think you should do," but you can't make them do it. When I tell people what I think they should do, it's usually taken in good grace because they're not going to do anything about it—superficially anyway. Also I have an advantage as a health visitor over a social worker because I have time to sit and talk. People are very resentful of somebody very strange who comes and tells them what to do. But we usually get to know people before they get their problems, so our advice is much more acceptable.

There are problems and problems. Sometimes I find families classified as "problem families" are no problem to me. They have usually got multiple social problems, but they're very easy to talk to. I might have to spend a lot of time with them, but they're nice to visit. My problems are people I can't get through to or people I don't like. There are people you don't like, even if you're a health visitor. That's difficult, because you've got to put yourself out to do something about it.

I don't really want my job to be much different. I just wish there were more of us health visitors. So many leave Hackney—mainly because of the housing problem, the ones who leave just can't afford to stay. They're leaving in droves now and there's no one coming in. It would be so much better if we were up to our official number.

I just want to be able to do my job properly but this makes it very difficult. I know much more clearly now what needs to be done than when I started—and I feel much more able to do it. It takes a lot of experience to be competent enough. And you can extend it in so many ways without encroaching on anybody else's work. There has been quite a lot of ill feeling towards us from social workers in the past because a lot of health visitors have claimed they have done social workers' work, but in fact our jobs do overlap. We deal with the fringe of the social work area. We refer people on and we have people who are not in a state of crisis, but who have lots of problems, so we help them keep going.

Rather than change the job itself, I would like to change our way of doing it. We could be more positive. At the moment everything is geared to just holding people up, giving them emergency help. But this is not the way things should be. People are coming to rely more and more on social workers, health visitors, and so on, for things they didn't need in the past. They used to have a chat with a neighbour—now they have a chat with us. I think we've encouraged them, rather than get them to do a bit of self-help. That sounds very Victorian, but it's the only way things will work. Where people are trying to help themselves, it's much better.

This article is an abridged extract from "Working Lives 2," a collection of essays on people's working experience in Hackney, east London (available from Centerprise, 136 Kingsland High Street, London E8, paperback 95p, hard £6).

Joy Hendry's views have changed since making the original tape for this article. She now believes that "change and influence on a one-to-one basis is not enough . . . So much of the concept of 'optimum health' lies in the adequate provision of housing, education and a stable income."