

**Children's Services in the UK 1997-2003:  
Problems, Developments and Challenges for the Future**

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## **Abstract**

This article reviews developments in children's services since 1997 and considers their effect on children in need by examining government statistics, recent additions to the evidence-base, and data from two studies conducted by authors. It shows that there has been extensive service development, mainly beyond the Department of Health, and considerable effort to improve assessment and administrative data. The limits to what can be demonstrably achieved by children's services, particularly in a short period, are acknowledged, and it is argued that the approach of providing predominantly low level interventions to large groups may need re-thinking if significant and lasting changes to children's development are to be secured.

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## **Introduction**

Since 1997 children's services have undergone significant changes and more are afoot. The first term of the Labour government saw the introduction of a range of policies and programmes intended to improve services for children in need, in particular Quality Protects, Surestart and the Children's Fund. As this paper goes to press further developments may mark the most far-reaching change to the landscape of children's services since the creation of social service departments over 30 years ago (Kendall and Harker, 2002; NSPCC, 2002; Association of Directors of Social Services, 2002). The

launch of a National Service Framework for maternity, social services and children and adolescent mental health services is also likely to change mainstream provision.

This paper addresses two questions. First, has government delivered on its promises with respect to children in the UK? Second, have developments introduced since 1997 made any real and potentially lasting difference?

The paper focuses on children in need, defined here, as those whose health or development is impaired or likely to become so in the absence of remedial services (after the *Children Act* 1989). Children in need are served by children's services, which can be defined as a series of activities organised but not necessarily provided by health, education, social and police services on behalf of children with the intention of addressing an identified social need (Bullock and Little, 2002). By this definition, children's services include child protection, family support, adoption, and residential and foster care. Less attention is paid in this article to youth justice and mental health services since they are covered elsewhere in this volume.

There are limits to the influence of government and these should be taken into account when evaluating its performance. First, the period 1997-2003 is relatively short and it would be unrealistic to expect century-long trends of increasing crime, mental health disorders and misuse of alcohol and psychoactive drugs to be reversed (Rutter and Smith, 1995). Second, children in need are a heterogenous group. Some have impairment to

development that is extremely resistant to change whereas others will improve without support (Maughan, 2001). Third, the needs of some groups of children are poorly understood and little is known about effective interventions for them (Sheldon, 1986). Fourth, governments constantly face new challenges such as the rising number of unaccompanied refugee children, and what society defines as a social problem changes with emerging empirical knowledge.

This article starts by reviewing developments in children's services since 1997. It then estimates the effects on children in need before examining trends in service data such as numbers of children looked after or on the child protection register. Next, additions to the evidence-base since 1997 are described, and finally the potential effects of new policies on children in the community are charted using data from two recent Dartington studies.

### **(1) Developments in children's services**

There have been concerted efforts since 1997 to improve the prevention of children's social and psychological problems (Little and Mount, 1999). This is evident in the Surestart and Children's Fund initiatives and, in a different way, in the activity of the Youth Justice Board. Significantly these initiatives have involved a combination of government departments, together with a shift of responsibility away from the Department of Health (the body responsible for social services). Most family support is now provided by organisations working independently of social services and not responsible to the

Department of Health. The Department's youth justice responsibilities have practically been eliminated. The focus of this preventive activity has generally been on younger children, particularly the under-fours.

Developments led by the Department of Health have focused on children traditionally supported by social services departments – notably child protection cases, children looked after away from home and those put forward for adoption. The *Assessment Framework* (Department of Health, 2000) seeks to help social workers and other professionals to improve assessments of children at risk of impaired development. Quality Protects assists with establishing clear targets for children in need and has improved the quality of government reporting (The Quality Protects Website, 2003). Renewed attention to adoption has involved reviews led by policy-makers informing new legislation. Despite this activity, however, relatively little attention has been paid to actual interventions for the group of children identified above, in particular to what children's services professionals might do to reduce identified needs.

## **(2) Estimated effects on children in need**

The broad prevention activity is likely to produce two potential scenarios. The interventions may improve children's development and, in the long term begin to reduce the burden on children's services. Given the complexity of children's needs, the level of impact is likely to be low. Alternatively, an unintended effect may be to identify previously unreported needs and so increase the burden on children's services. This hypothesis can be tested by analysing

changes in service data and looking for increases in, for example, children looked after in the younger years. This point is re-visited later.

With respect to the narrow social services population, it would be unrealistic to expect much change in children's development, other than improved outcomes attributable to better assessment and the meeting of government targets. The target populations for Quality Protects and the adoption legislation are tiny, for example in 2001 just 32,000 or so children had been looked after for over two years and 3,100 looked after children were adopted (Department of Health, 2002). Consequently gains will take a long time to show and effect sizes on overall child development will be modest.

A further set of potential effects concerns the status and performance of agencies. Much new development has occurred beyond the traditional social services arena, while at the same time existing provision has continued to bear criticism from inquiries and inspections (The Victoria Climbié Inquiry Website, 2003). Interpretation of these changes suggests a connection to the reducing the status of social work. Attendant problems of recruitment hinder the delivery of good quality services.

### **(3) Trends in service data**

The results of evaluations assessing government initiatives post-1997 will take time to emerge, and it will be several years before some of the main effects on outcomes are evident. In the meantime, service data illuminate some important themes.

The number of children in England looked after has continued an upward trend that began in 1995 when there were just under 50,000 children looked after at any one time. Today the figure is nearer 60,000. The number of children beginning a looked after episode has decreased by 18 percent since 1997 and the number ceasing to be looked after has followed an almost identical pattern, falling by 16 percent (Department of Health, 2002). The greater volume of children cared for away from home would seem, therefore, to be explained by increasing lengths of stay, especially among those already long looked after. There is no support in these data for the earlier hypothesis that increased prevention activity might lead to more children in care or accommodation.

The number of children in England whose names are on the child protection register has continued a downward pattern first apparent in 1995 and possibly induced by the then government policy to use family support as a child protection mechanism (Department of Health, 1995). Since 1997, there has been a 15 percent decrease in names on the register, from 31,600 to 26,800 (The Health and Personal Social Services Statistics Website, 2003). Again, however, the dominant theme has been the overriding influence of operational factors first identified by Little and Gibbons (1993). The figures do not capture level of need, rather they reflect how authorities use the register, and huge variation in procedures remain.

The Department of Health censuses of children in need (2000 and 2001) describe for the first time all children known to social services departments including those supported at home. However, there is no comparable data for pre-1997, so it is not possible to assess the affect of government initiatives using this source.

In summary, since 1997 there has been a rise in activity sponsored by new initiatives, such as SureStart, and fewer new children being looked after, but those that are in care or accommodation likely to stay longer and/or be adopted. There are fewer names of children on the child protection register but there is no indication that the task of protecting children has lessened in any way. Indeed, a substantial proportion of family support activity – considered in the fifth part of the analysis in this article – is devoted to protecting children from maltreatment. There is no indication that any changes in services as indicated by administrative data reflects changes in government policy since 1997.

#### **(4) Additions to the evidence-base**

Emerging research evidence is difficult to tie to an evaluation of government policy since there is such a time lag between commission and publication. The Department of Health has continued with programmes and overviews of research that began with *Social Work Decisions in Child Care* in 1985. Since 1997 there have been research overviews on residential care, adoption and the *Children Act*, 1989 (Department of Health, 1998, 1999 and 2001) but all report on the situation prior to 1997. Ongoing programmes of research on parenting, and costs and outcomes will shed light on the post-1997 situation.

Department of Health sponsored research has traditionally been strong on process - what agencies and courts do to support children in need - and outputs - how many children get help. There has been less emphasis on outcomes, that is the impact of the intervention on child health and development, although the *Looking After Children* materials represent a brave attempt to reverse the trend and the results of research using emerging data from the project should also break new ground (e.g. Skuse et al, 2001).

New sources of evidence have emerged alongside these traditional sources. Child development researchers have become increasingly interested in interventions, for example work by Rutter et al (1998) on anti-social behaviour, has pointed the way for changes in policy and practice. Interventions designed to deal with specific constellations of risk in children's lives are also being subjected to more rigorous evaluation, and there are many excellent summaries of this evidence (e.g. MacDonald, 1999). Most of the evaluations concern US programmes, which is ironic since children's services in that country remain generally poor by comparison with those in UK. However, there have also been numerous short-term evaluations and policy reviews sponsored by the array of government departments now interested in child development and children's services (e.g. Ghate and Ramella, 2002).

Different sources of research evidence have contrasting strengths and weaknesses. The Department of Health model is especially strong on system dynamics and socio-legal issues

but weak on child development outcomes and the effects of interventions. The new sources of data on children in need are strong on prevention, outcomes and intervention effects but weak on understanding the broad systems that make specific interventions work. Attempts to link these strands of work are much needed.

#### **(5) Potential effects of new policies on children in the community**

Attempts to address the questions set out at the beginning of the paper are hampered by a lack of useful data. Moreover, most of the evidence that does exist focuses on children with chronic needs or those long-embedded within service provision. Another perspective emerges by looking at the progress of all children referred to health, education, social and police services for support and by examining a cross-section of children in the community.

The Research Unit has undertaken two studies that provide such data. The first tracks referrals to children's services in one rural district in England. It took place in 1998 and collected data on just over 800 children (Little and Madge, 1998). The second examines need and service-use among children and families in two moderately deprived communities, one an ethnically diverse Inner-London housing estate (Area 1), the other a rural neighbourhood (Area 2) (Axford et al, 2003, *Children Supported and Unsupported in the Community*, Dartington Social Research Unit, unpublished). It draws on semi-structured interviews with parents/carers undertaken in Summer 1998 and Winter 2000 (Area 1) and Summer 2001 (Area 2). Each sample contained approximately 500 children. What do these studies show?

First, it is evident from the community study that in any assessment of need, three broad socio-demographic factors loom large. These are low income, poor housing and, in the inner-city sample, minority ethnic group status – which, for some brings attendant problems of racism and learning English as a second language (Table 1). Many social and health needs are associated with these three factors, for example reducing social inequalities would significantly improve children’s well-being (Wilkinson, 1995), yet the ability of children’s services to influence them is limited.

INSERT TABLE 1 HERE

Second, the inter-agency study showed that most referrals to social services for help with social needs come direct from families. Half of the referrals came from the child or parent, with health providing the largest number of agency referrals (16%). Most referrals come first to health (mainly general practitioners and health visitors) and education (teachers and education welfare officers). Indeed, the ratio of referrals to health and education compared with social services is 2.6:1 and 2.1:1 respectively. Some social needs cases are referred first to the police, in particular domestic violence incidents, children left home alone and parental mental ill-health that places children in danger. This pattern suggests, perhaps unsurprisingly, that parents seeking help turn first to places and people that figure strongly in their lives or those of their children. They use emergency services when major problems occur.

Third, the inter-agency study suggests that the volume of referrals for help for a social need to children's services is much greater than previously thought. Extrapolations suggest that one in three children in the district studied would be referred to health, education, social or police services for a social need each calendar year. In poor neighbourhoods over a three to five year period it would not be unreasonable to hypothesise that 60-70 percent of children come to the notice of children's services.

Fourth, a community-wide perspective offers an interesting view of the kind of provision offered to meet children's needs. The community study showed that much service provision is extremely low level and characterised by support from voluntary agencies such as the Citizen's Advice Bureau (38% of children lived in a family that had used this service) and assistance from social services in the form of small amounts of advice, information and money (in the region of £10). The inter-agency study found that support for a social need offered by health visitors and GPs consisted mainly of advice (36%), general support (48%), monitoring and surveillance (18%) and assessment (21%). An even clearer picture emerges from a measure of the duration and intensity of social services provision from the first phase of data collection in Area 1 of the community study (Table 2). Most of the activity is short-term (less than three months) and of low intensity (one hour or less per week).

INSERT TABLE 2 HERE

A community-wide perspective also shows that the decision to offer help does not correlate in a way that might be expected with aspects of children's development. For example, children going through major life transitions, such as moving school, are no more likely to get support than children in general, although those living in temporary accommodation are given priority for support. It is also noticeable that, despite the emphasis on early years given in the Surestart programme, other children's services are less likely to differentiate cases by developmental stage, instead offering a 'one-size fits all' approach.

There is, however, some association between level of need and provision of help. Every child in the communities surveyed was assessed for the seriousness of their needs. In Area 1 at time 1, eight percent of children were deemed to be suffering actual or likely *significant* impairment to their health or development, with some actual or potential impairment in another 27 percent of cases. The more serious the need the more likely children are to receive help from social services, but even so over a quarter (27%) in the impairment category and a fifth (18%) in the most serious category go without support (Table 3). There is no space to report findings in any detail here, but it is also the case that the duration and intensity of the intervention increases with levels of impairment to development but again the association is far from perfect.

INSERT TABLE 3 HERE

The inter-agency data also shows that there is a lot of exchange between the primary children's services agencies. Notwithstanding isolated disasters, the situation in the context of potential child maltreatment is good compared to other countries. Much of the interchange concerns who should do what. Crucially, despite most children having multiple needs, few benefit from inter-agency co-operation at the point of service delivery. Usually one agency carries all the responsibility.

The fifth observation concerns outcome. Given the level and complexity of social needs presented by significant proportions of children in the communities surveyed and the fairly low level of interventions available, there is no logical reason to expect much impact on children's developmental trajectories. Even well-designed and carefully focused interventions generally report modest effect sizes (Little et al, forthcoming), so these low level interventions are unlikely to achieve much beyond offering a benign safety net for families.

## **Discussion**

Government has the power to change priorities - through legislation and resource allocation - and to produce organisational change. However, to improve children's development it is necessary to change what is done for children, be that by their families or by service agencies. In the last 30 years, policy makers, managers and, arguably, applied researchers, have been more interested in legislative and organisational change than in how to develop interventions. The two go hand-in-hand and, logically, organisation should be

driven by the intervention (which in turn should be driven by some analysis of the needs of children) and not vice-versa. Linked to this challenge is the requirement to find a healthy balance between the amount of resource devoted to thorough assessment on the one hand and to the actual provision of services on the other. The continuing struggle to replicate at the point of service delivery advances in inter-agency co-operation at the planning level should further contribute to better outcomes.

Children's services require better administrative data. There have been important strides forward since 1997 but on critical dimensions it is inadequate for monitoring developments in children's services. In particular more information is needed on: children supported at home versus children supported away from home; activity by health, education and police services on behalf of children in need versus activity by social services; and outcomes versus process and outputs. Members of the Dartington team have written about the array of approaches now available in this area with proposals for specific developments (Little et al, 2002).

The article also highlights limitations to how much change is possible. Part of the problem concerns the evidence-base; many of the developments since 1997 have made good use of what is known about child development and effective interventions but there is still much that is not properly understood. In particular, more sophisticated knowledge is needed about implementing new services and integrating them into existing provision. Fitting together new strategies of prevention, early intervention and social prevention to achieve

better outcomes presents a further challenge (e.g. Little and Mount, 1999). Connected to this are the restrictions on reforming radically large systems like children's services; it is telling that much innovation in recent years has occurred outside of orthodox provision.

These barriers are often overlooked, particularly in the context of rapid policy development such as that since 1997. But their ramifications are far-reaching. At the aggregate level, trends that have emerged over several decades may take several decades to reverse, while for individuals complex needs often remain intransigent despite the best efforts of skilled professionals. Consequently there are limitations on the amount of local impact that can be achieved; with one third of children identified as having actual or likely impairment to their health or development and just under half getting minor interventions, change is likely to be slight.

The findings presented here beg two important questions about the nature of children's services. The first is characterised by a choice between 'thin' and 'thick' children's services. At present, a lot of children are getting a little support – the thin approach. This observation holds for orthodox provision and new initiatives such as Surestart, and is reflected in data from the community study reported above, which showed that each year about two-fifths of children in the communities surveyed receive some help beyond universal supports. By broadening provision since 1997, the government has effectively encouraged a thin approach. An alternative would be to offer much more assistance to a much smaller group of children – the thick approach. This is supported by child

development research, which suggests that sizeable and enduring interventions are needed to interrupt most chains of risk in children's lives. That said, there are many counter-arguments in favour of thin children's services, not least the safety net that they offer.

The second question concerns the hardy annual of 'what is social work?' Bullock et al (2000) suggest that it includes three components – face-to-face clinical work, care management, and advocacy or brokering. Accepting for now this definition, empirically there is a lot of social work being offered in England and Wales. However, while much of it is offered by social workers, a significant proportion of whom are specifically trained for the task, children in need are more likely to be assessed and receive support from a professional who is not a social worker. GPs, health visitors, teachers, Surestart managers and volunteers, police officers and youth justice workers all do social work.

In some ways, then, the rapid changes in children's services since 1997 appear to have bypassed the social work profession. Arguably government has redistributed some of the profession's traditional functions, notably helping clients to secure their rights and influence decisions concerning them, and left behind the more controlling elements such as investigating abuse (Jordan, 2002). The developments described here prompt questions regarding the kind of training that is required to help the range of professionals that make up children's services discharge their social work responsibilities and to do so with some consistency. Should some of the support of children in need only be discharged by social workers trained for that task?

The authors have no answers to the questions raised here but do feel strongly that those addressing these difficult matters should use empirical evidence regarding the operation of children's services.

## **Conclusions**

There is little doubt that government since 1997 has been more engaged with improving the well being of children and families who traditionally have looked to the support of children's services. Significant changes in provision have been introduced, most notably the SureStart initiative. The effects of these programmes are being evaluated and it will take some time before results are clear. The focus on orthodox social services has arguably been less exciting and, in any case, short of radical change, it is unlikely that development in this world can be expected to have marked changes on the well being of UK children.

The authors are not qualified to judge whether or not the government has delivered on its promises but it is evident that it has delivered a lot, and that the delivery has presented significant challenges to orthodox and new children's services. From the evidence available, it seems unlikely that change since 1997 has brought about real and lasting difference to the development of children in need. Such improvements will come from a greater interest in new interventions specifically designed to address particular constellations need in children and, arguably, a thick approach focused on a few who can really benefit supplemented with a safety net (the thin approach).



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Table 1: Socio-demographic characteristics of children living in Areas 1 and 2

	Area 1	Area 2
In families unable to afford 2+ socially perceived necessities	48%	17%
In benefit dependent households	48%	21%
In homes that are short of space	56%	50%
In homes that are damp	38%	34%
From a minority ethnic group	84%	1%
Total	N=464	N=500

Note: Socially perceived necessities were defined as: a cooked main meal every day for each child and adult, warm winter clothes for each child and adult, heating when needed, family holiday away from home once a year, a family day trip away from home once a year, basic toys and sports gear for the children. This method is based on work by Gordon et al (2000).

Table 2: The duration and intensity of social services provision to children living in Area 1 at Time 1

Duration	Intensity of Service			
	Low (%)	Medium (%)	High (%)	
	One hour pwk	1-5 hours pwk	Over 5 hours pwk	
One-off	26	3	0	29%
Short-term (2 days- 3 mths)	21	11	1	33%
Long-term (more than 3 mths)	19	14	6	39%
Total	66%	28%	7%	N=318

Table 3: Relationship between impairment and receipt of social services for children living in Area 1 (Time 1)

Seriousness of need	Received social services (%)	Total (N)
No impairment	47	376
Impairment	73	159
Significant impairment	82	48
Total (N)	342	583