Developing social care:
the current position

Chapter 6: Children and young people

6.1 Policy context

This chapter focuses on children who are looked after and those who have regular contact with social services. Less attention is given to universal services, such as day care or child minding, or court services, and more is given to services provided to children in need. According to the Children Act 1989 (section 17 (10)), a child is in need if:

- He is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by the local authority;

- His health or development is likely to be significantly impaired or further impaired without the provision for him of such services;

- He is disabled.

The *Guidance and Regulations* for the Children Act emphasise that this definition of need is deliberately wide to reinforce the emphasis on preventive support to families. It encompasses a reasonable standard of health or development, significant impairment of health or development, and disablement. This represents a move from identification of the risk of harm (including maltreatment) to an assessment of the impact of that risk of harm on a child's health and development and the impact of *no* service provision on that child's health or development. In turn, this leads to the idea of safeguarding and promoting children's welfare (Aldgate and Statham, 2001, p22)

Over most of the period covered by this report, child social care was the responsibility of the Department of Health. But in 2003, this moved to the Children, Young People and Families Directorate, based in the Department for Education and Skills. The new Directorate works across government to make collaboration an integral part of the approach to children's services. Similarly, the new Minister for Children and Young People has a responsibility for integrating services and policy for children across government. A Youth Board will provide direct advice from young people on the development of national policy and practice (DfES, 2004, p44-45). These new developments are likely to have a major impact on child social care and collaborative working in the future.

Legal framework in England

The Children Act 1989 is the main legislative plank underpinning all work in children and family services for the last fifteen years. The Act marked a major change in child welfare legislation as it moved from a former concern about an undifferentiated group of vulnerable children to specific groups, defined in the context of child development. It also linked the identification of children in need to the provision of services.

The Children Act 1989 come into force in October 1991, and provided a unifying framework for most aspects of the law relating to the care and upbringing of children (Aldgate and Statham, 2001). A number of amendments to the Act are listed in the Children Act Report 1995-99 but the six main principles remain the same:

- The primary responsibility for the upbringing of children rests with parents; the state should be ready to help parents discharge that responsibility where doing so lessens the risk of family breakdown.

- Services to families should be arranged with the voluntary participation of parents. Where such services include looking after children away from home, close contact with parents should be maintained.

- The transfer to the local authority of parents' legal powers and responsibility for caring for a child should only be undertaken with a full court hearing following due legal processes.

- Court processes affecting a child must recognise that, although the interest of the child is the primary concern, the parent's legal status in relation to the child is at issue. Parents should be properly represented and be full parties to the court proceedings.

- The application of emergency powers to remove a child at serious immediate risk, which necessarily cannot be preceded by a full court hearing, should be of short duration and subject to court review if the parent or child wishes it.

- Where local authorities are caring for a child away from home, their legal responsibilities should be clear, as should the powers and responsibilities of parents in these circumstances.

Other Acts also have a direct impact of children's services. Some, like the NHS and Community Care Act 1990 or the Local Government Act 2000, have an influence on children and family services through their impact on the overall structure and organisation of health and social care (see section 4). Others have a direct influence on the types of services offered and the way they are delivered, as summarised below.

Children's Service Planning, advocated in the Children Act, came into force in 1996 and strengthened the requirement for local authorities to plan for children's services with the aim of securing a better range of services and better outcomes for children. One study in 1998 found the links made in Children's Service Plans between needs of the local population and services was tenuous and little evidence that financial information had been used as a planning tool. Around 80 per cent of the social services and education staff were aware of the Plan and at least some of its content but 45 per cent of staff said it had only some or no effect on their work and 38 per cent said it had only some or no impact on the area (Hearn and Sinclair, 1998).

In 2001, DoH, DfEE, DETR, Home Office, DCMS, and the Treasury and Cabinet Office issued joint guidance on the joint planning of services through the development of Children and Young People's Strategic Partnerships to be responsible for developing CYPS Plans. CYPS Partnerships sit within the overarching strategic plan for a whole authority, developed by the Local Strategic Partnership (guidance issued 2002) that considers all services for children from birth to age nineteen. The government provided up to £1m each to ten Trailblazers to explore ways of sharing information and multi-agency working. Non-Trailblazer local authorities have been allocated up to £100,000 each to undertake work on Identification, Referral and Tracking (guidance issued August 2003).

The implications of other legislation also need to be noted. The Protection of Children Act 1999 makes it much harder for unsuitable people to work with children. The Children (Leaving Care) Act 2000 placed new and stronger duties on local authorities to support care leavers until they are at least 18 years old. The Special Educational Needs and Disability Act 2001 strengthens the right of children with specific educational needs to be educated in mainstream schools and protects them from discrimination on the grounds of disability in their access to education. Revised Special Educational Needs guidance was issued in 2001. The Adoption and Children Act 2002 encourages more people to adopt looked after children by ensuring that they have the support required. It established an independent review mechanism for the assessment of prospective adoptive parents. The Act places a duty on local authorities to arrange advocacy services for children and to introduce an Independent Reviewing Officer to review meetings for looked after children.

The Care Standards Act 2000 regulates and improves standards in children's care services and created the post of an independent Children's Rights Director for England, regulated by the National Care Standards Commission. The Children's Rights Director is expected to investigate the views of children about issues that affect their welfare and report them to the Minister of State for Children. The Health and Social Care (Community Health and Standards) Act 2003 triggered the creation of a new independent inspectorate for social care in England, the Commission for Social Care Inspection (CSCI). One important new function is to promote improvements in social care services for adults and children provided by councils and independent sector

(private and voluntary) organisations. The CSCI has a duty to work with the Healthcare Commission and with Ofsted to deliver an integrated framework for the inspection of children's services.

The Green Paper *Every Child Matters* was published in September 2003 and has four broad aims: increasing the focus on supporting children and families; ensuring intervention before children reach crisis point; enhancing the integration of services; and developing capacity in organisations which work with children (DfES, 2003). *Every Child Matters* is the government's response to the Inquiry into the circumstances surrounding the death of Victoria Climbie (DoH and Home Office, 2003; *Victoria Climbie Inquiry, Report of an Inquiry by Lord Laming*) and highlights the importance of agencies and professionals working together to develop good quality family support services and to protect children and young people at risk of significant harm. The Green Paper introduces the main content of the new Children's Bill, due to come before Parliament in late 2004, which includes: the establishment of a Children's Commissioner and Local Safeguarding Children Boards; the identification of a Director for children's services and a lead member in each council; and arrangements for inspections and for private fostering. The Bill also includes arrangements for cooperation, Local Safeguarding Boards and Children and Family Court Advisory and Support Service (CAFCASS) functions in Wales.

The Bill also advocated the development of children's services authorities as a means of delivering integrated services that are easily accessible to users. Thirty-five pilot Trusts (Pathfinder Trusts) were set up to run for three years. No definitive forms are recommended, so these will take the form best suited to each local configuration of services and relationships. Although based on the flexibilities of the 1999 Health Act, including pooled budgets and joint commissioning, they will be led by local government and have the power to commission health as well as social care. The 35 pilot Children's Trusts are basically of three types: those that only commission services; those that only provide services; and those that do both commissioning and providing. They also vary in size from whole service Trusts, such as Hammersmith and Fulham, to single service Trusts, as in Nottinghamshire. More information on ten of the pilot trusts is given in *From Vision to Reality* (Inter-Agency Group, 2004).

All Our Lives (DoH, 2004) sets out the challenges for children services as a result of *Every Child Matters*. Social services and their partners will be required to:

- Ensure that children have a strong voice in policy-making and responses are given to their expressed views;

- Continue to develop a good range of support services for parents, families and children in the community;

- Sustain efforts to ensure that children at risk in the community are identified and 'tracked';

- Strengthen the leadership of children's services within councils;

- Establish new Local Safeguarding Children Boards as the statutory successors to Area Child Protection Committees (see also SSI et al., 2002, *Safeguarding Children*); and

- Further develop new organisations – Children's Trusts – to bring together local services, including education and social services.

Central government programmes

Quality Protects 1999-2004 is an £885m programme to transform outcomes and services for children in need, including looked after children, disabled children, and children in need of protection. It is aimed at improving the governance, management and delivery of children's services. Quality Protects Management Action Plans have been one of the key mechanisms within the QP programme, allowing councils to report on plans and progress toward the QP targets over a five-year period. A similar programme in Wales, *Children First*, is also intended to improve the management and delivery of children's services.

Choice Protects, announced in Spring 2002, includes a major review of placement choice and fostering services. The review will focus on helping councils to commission and deliver effective placements and services for looked after children. A grant of £113m was secured to support the programme and for 2003-2004, £19.75 has been distributed to local authorities to help them expand and strengthen their fostering services.

The Integrated Children's System comprises: the Framework for Assessment, Planning, Intervention, and Review; core data requirements (essential information for effective practice); and exemplars of structured information gathering tools which can also be used to generate reports. This suite of information systems is in part a good practice tool and in part a mechanism to ensure that aggregated data of a similar type is collated across all local authorities.

The Children's Workforce Unit at the DfES will develop a pay and workforce strategy, the initial phase of which is to feed into the 2004 Spending Review. A specific Skills Council for Social Care, Children and Young People will be developed.

The National Service Framework for Children was announced in 2001. It will produce national standards across NHS and social services for children, including maternity services. The Children's Taskforce, one of ten created following the publication of the NHS Plan in July 2000, oversees the development of the NSF, supported by six external working groups on: children needing acute/hospital care; maternity; mental health and psychological well-being; children in special circumstances; disabled children; and the healthy child and young person. The Children's NSF is now being developed jointly by the DH and DfES.

Preventive and early intervention services

Over the last five years, a strong programme of preventive services has developed, in part because of the requirements of the Children Act 1989 and in part a response to the rising numbers of longer-term looked after children. This programme involves long-term plans to improve the welfare of children; it should affect future needs for children's social care services by reducing poverty and crime, improving parenting skills, and improving the educational attainment and health of children and young people. Although some programmes support older children, such as Connexions and the youth offending services, many are aimed at young children from birth to school age or primary school age children.

The Children's and Young Person's Unit (the CYPU) was set up in November 2000 to take forward the government's agenda for children by promoting joined-up policy making for those at risk of social exclusion. It was seen as a catalyst for change in the strategic planning of preventive services. The CYPU was responsible for managing the Children's Fund, the Local Network Fund, On Track and the Identification, Tracking and Referral project. The CYPU was absorbed into the new DfES Children, Young People and Families Directorate in December 2003.

The Children's Fund is a £450m fund, launched in 2000 to develop services to support multi-agency working in preventive services for children and young people (aged five to thirteen) at risk of exclusion (NECF, 2003). It is aimed at encouraging partnership working between the voluntary, community and statutory sector and the participation of children, young people and their families in the development of these services. It provides resources to fund specific programmes to help children to overcome poverty and disadvantage. The Children's Fund helps partnerships focus on collaborative working to address needs related to education, health, anti-social behaviour, user involvement and capacity building. In all, 40 projects were funded from January 2001, 50 from February 2002, and 59 from December 2002.

The Local Network Fund runs alongside the Children's Fund as a five-year programme (2001-2006). Its £40m budget provides small grants of £250-£7000 to community

groups for small projects that address locally identified need for children and young people up to the age of 19.

On Track was established by the Home Office in 1999 as part of its Crime Reduction Programme and transferred to the CYPU in April 2001. It focuses on ascertaining what works in preventive services for children at risk of becoming involved in crime and offending behaviour. Twenty-four neighbourhood programmes have been established in England and Wales for four to twelve year olds.

 Sure Start was launched in 1998 to provide 230 programmes of services targeted at children from birth to four years old; it funds locality-based activities that bring together health, play and child care services. Following the 2002 Spending Review, Sure Start aimed to provide 524 local programmes by March 2004; an expanded budget of £1.5bn covered early years educational and child care spending, and programmes of health and family support. This expanded role came as the Sure Start Unit took responsibility for the national Childcare Strategy, also launched in 1998. The childcare strategy required each local authority to have in place an Early Years Development and Childcare Partnership (EYDCP), a strategic partnership of voluntary, community and statutory service providers, and to develop an Early Years Development and Childcare Plan.

The responsibilities of the Sure Start Unit were subsequently extended to cover children from birth to fourteen years. Early Excellence Centres were launched in 1997 to develop and demonstrate high quality education and care practice in services for young children and their families. Children's Centres are more recent (guidance issued 2003) and are targeted on the needs of children under five; they provide integrated care and education for young children, health services, family support and a base for childminders. Extended Schools is an even newer initiative (25 pathfinders announced in autumn 2003), allowing schools to develop as a base for a wider range of activities for its pupils, families and the community. All local authorities will receive funding by 2006. The Connexions service provides universal support for young people aged 13 to 19 years through personal advisors.

Youth crime prevention initiatives include Crime and Disorder Reduction Partnerships and their agreed Plans, the Street Crime Initiative, and SPLASH and Junior SPLASH summer activity schemes. Since late 2002, Children's Fund programmes are required to spend 25 per cent of their allocation on crime reduction programmes.

Legal framework in Wales

As in England, the Children Act 1989 forms the legislative framework for children's services in Wales. In 1999, the Welsh Office published the circular Children First: An Action Programme for Wales', which set out eight objectives (increased to eleven in

2001) and a number of targets. The *Framework for Assessment of Children in Need and the Families* (National Assembly of Wales, 2001), as in England, provides guidance on the development of a systematic approach to assessment. Similarly, there are requirements laid on local authorities to develop children's service plans (*Social Services Guidance on Planning*), to work collaboratively with a range of agencies (*Working Together to Safeguard Children*), and to establish Planning Partnerships (*Children and Young People's Framework Planning Partnerships).* All three were published via the National Assembly of Wales in 2000 and 2001. *Lost in Care* (2000) provides a report on child abuse in care services in Wales.

Following devolution, the National Assembly for Wales' strategy for the provision and delivery of children's services has included a Children's Commissioner and the development of an overarching Children's Strategy for Wales. The principal concern is the right of children to be seen as 'child citizens' and the agenda builds on the foundations for children's participation laid down in the Children Act. Child citizens have a right to have their voices heard and to participate in any decisions affecting their lives.

The new Children Bill relates only to England, except where the National Assembly for Wales has asked for provisions to apply in Wales. In some areas, a slightly different approach is being taken, such as a Lead Director for Children and Young People rather than appointing a single director of Children's Services. Legislation will involve the same duty to cooperate, but the implementation will suit the Wales existing partnership structures, and there will be a senior lead for children and young people's health on the Local Health Boards and NHS Trusts in Wales (DfES, 2004).

Legal framework in Northern Ireland

The Children (NI) Order, 1995 closely follows the pattern set by the Children Act 1989. Children's Service Planning was introduced in 1998. This includes preparation of a three-year Children's Service Plan. One of the proposals in the consultation document *DHSSPS Strategy for Children in Need: Developing the Strategy* (2003) was for a child care strategy that would support planning across the continuum of services, to facilitate better integration of work at Department, HSS Board and Trust level and to promote the development of management information systems to identify both services costs and the benefits to children. The Strategy will:

- be based on a clear set of regional objectives (similar to those set out in *Quality Protects*);

- provide a consistent approach to the assessment of need and planning of services (a realignment of the Children's Services Plans, but linking with relevant adaptations

to the *Framework for Assessment of Children in Need* and the Integrated Children's System);

- set out regional sub-objectives;

- be based on collaborative work;

- build on developments already in hand; and

- be based on a clear understanding of the responsibilities of those involved in the provision of children's services at all levels..

The 2003 Strategy also summarises recent activities in children's services in Northern Ireland.

- *Children Matter* (1998) – a review of residential child care services in Northern Ireland found insufficient places to meet demand, dated stock and a lack of specialist placements. In 2000, an Action Plan had been set in place to take forward the recommendations with, for example, 77 new places created by 2003 (total 409 places) and a further 77 places by 2004. Differentiation in placements will be taken forward in the regional sub-objectives.

- *Fostering in Northern Ireland: Children and Their Carers* (1998) found an insufficient supply of foster care places and increasing difficulties in recruitment and retention. There were also high levels of placement disruption. A *Code of Practice for Recruitment, Selection, Training and Support of Foster Carers* was launched in 1999 alongside the *UK National Foster Care Standards*, three of which were to be met by 2002-03 with a three-year plan to meet others.

- *Children First* (1999) sets out a strategy to improve day care and early education services by increasing the level of provision, improving quality and making day care more affordable.

- *Sure Start* was introduced in 2000, with 23 schemes under way in 2001 for children aged under 4 years. The target was for 16,000 children and their families to access Sure Start services. This target was met and this will be extended to 19,000 children for 2003-04.

- Trusts are required under the Children Order to establish a register of disabled children to facilitate service planning; trusts are currently taking this work forward.

- The Carers and Direct Payments Act (NI) 2001 gives all disabled people, including children, the right to an assessment and facilitates the use of direct payments. The SSI has started a regional inspection of services for disabled children.

- Until the late 1990s, few looked after children in Northern Ireland were adopted. The Department's 1999 circular *Adoption – Achieving the Right Balance* endorses a policy of bringing adoption into the mainstream of children's social services. Adoptions have increased since 1999: between 2.2 and 4.1 per cent of looked after children have been adopted each year to 2002. The Departmental target set out in its Priorities for Action 2001-02 are for 4 per cent each year. The SSI report *Adopting Best Care* (2002) provides key recommendations.

- A review report, *Secure Care* (2002*),* found the current provision of 15 secure places to be insufficient, of poor standard and to have inadequate child and adolescent mental health (CAMH) support. Plans are being made to replace the current facility and to provide 10 additional CAMH inpatient beds.

- The SSI report, *Promoting Independence: A Review of Leaving Care and After Care Services* (2002), found that young people leaving care faced numerous disadvantages. The Children (Leaving Care) Act 2002 made a number of amendments to the Children Order to address issues raised in the *Promoting Independence* report. Executive Programme funding of £1.2 million over three years has been set aside to help HSS Trusts develop leaving care and after care services and to establish a regional implementation group.

- SSI inspections and audits of child protection services are occurring in the light of findings from the *Lord Laming Inquiry*. Updated inter-agency, multi-disciplinary guidance is given in *Cooperating to Safeguard Children*. The Child Protection Advisory Group will be set up to complement the work of Area Child Protection Committees and will include members from the DHSSPS, the Department of Education, and other central government departments.

- The *Protection of Children and Vulnerable Adults (NI) Order 2003* is the legislation covering checks on the suitability of those seeking work with children or adults with a learning disability.

In summary, the legislative framework for Northern Ireland mirrors that found in England, although The Children Order was the first new child care legislation since 1968. There is a tendency for legislation to be passed slightly later, perhaps allowing the most obvious difficulties to be sorted out in England first. The principles underpinning the legislation remain the same, although differences in implementation are important as they allow for the organisational, political and historical context in which family and child services operate in Northern Ireland.

Market considerations

In adult services, there is a legal requirement to organise services along market lines, although now moving toward a cooperative rather than competitive model (see chapter 3). However, in child and family services there is no such legal compulsion. The Children Act 1989 does not require the separation of assessment and provision of services and only encourages, rather than requires, the commissioning of services from other agencies. Nonetheless, children's services are part of the whole array of social service activities and are increasingly enablers of service provision, rather than direct providers. For some services, there has been movement towards more contracting and commissioning, but this is often modelled on adult services and organisational structures (Morrison, 1996). Indeed, a major strand in the current *Choice Protects* programme is to look at how the commissioning of children's services can be improved. It should be noted, however, that at the time the Children Act was implemented, the private sector did not have the same foothold in service provision as in some other services (such as those for older people). Arms-length regulation of residential homes and schools has become more common in recent years.

There are two services where the independent sector has a fair foothold. Most day care services (not considered in this report) are provided by this sector and about half of all local authorities contract independent sector foster care services (cited from Waterhouse, 1995). Petrie and Wilson (1990) looked at contracting procedures for these services, suggesting that the aspects of fostering services that worked well bore 'the hallmarks of relational contracting'; a shared value and identity system, mutual dependence and trust, and a sense of shared risk. Difficulties arose where there were failures of communication, lack of consultation with foster carers and a lack of support. Overall, little evidence was found that the organisation of services into purchaser/provision systems produced benefits for the fostering services or the service user:

> the kinds of organisational structure needed to provide quality fostering services are those that promote closer and more personal links between foster carers and professional social work staff, rather than the more distant contracting relationship.

In another exploration of the role of the independent sector in child minding services for children in need in 12 authorities, there were similar findings (Dillon *et al.*, 2001). Local authorities intervened in the market to provide good quality care for children in need, usually placing these children with only a selection of child minders who were registered or sponsored in some way for this group. In some cases, the local authority paid

preferential rates or provided training and support, thus establishing a relationship between the provider and the purchaser.

Several of the Children Act studies undertaken in the early- and mid-1990s showed that the impact of the NHS and Community Care Act 1990 was often to separate children's and adults' services within the same department. This led to structural hurdles for social workers and other professionals who worked with both children and adults. Other studies found that the separation of long and short-term children and families' teams also caused problems in transferring children from assessment to long-term support teams (Aldgate and Statham, 2001).

The introduction of a more rigorous and clearly defined assessment procedure could be seen as a further development in changing organisational structures in children's services (see, for example, Morris and Shepherd, 2000) but a study of seven local authorities found that where commissioning and provider streams appeared to be set up this had not often resulted in major reorganisations (Kirkpatrick et al., 1999). Moreover, little evidence was found to suggest it promoted service responses based on assessment of need. (The Dartington Social Care Research Unit has a programme of work focussing on helping local authorities to match needs and resource more closely). The authors found that such reorganised structures could lead to fractured responsibility for children and like Petrie and Wilson were concerned about the impact on the culture of co-operation (p724) However, they also note that uneven application and development structures meant that it was hard to arrive at firm conclusions regarding the effectiveness of purchaser/provider structures in children's services.

A key issue in children's services is identifying the user: is it the child, the family or the local authority? Given the underpinning principles of the Children Act, all these groups should have a say in planning services, but neither children nor their parents have any power in the contracting process. Even five years after implementation of the Children Act, it was proving difficult to 'share power' with parents and children (see also Morrison 1996), particularly in child protection work where they have little choice about whether they want the service. For looked after children, the local authority has a duty to act as a 'good parent'.

Morrison (1996) suggests that the twin aims of the Children Act, working to safeguard and promote children's welfare while recognising that the major responsibility lies with parents (minimal intrusion), means that in child protection work, the state-parent partnership must occur within a continuum ranging from 'voluntariness' (that is parents agree with, or are part of, decisions about the children) on the part of a parent to compulsion by a local authority. Overlaying this state-parent relationship is an array of collaborative inter-agency relationships. Barriers to this collaboration happen within structures and systems, communication, status and perceived power, professional and organisational priorities and the extent to which the collaboration is perceived as

mutually beneficial. Each of these can also have an impact on parents, who should be working in partnership with one of the partners of the inter-agency partnership. Morrison notes that the 'anxious environment' generated by child protection procedures can only serve to increase the problems for staff and parents alike.

Where social services are working collaboratively for children's services, this rarely involves just one agency. It may involve the independent and community sectors, schools and other education services, health authorities and Trusts (both primary and secondary, particularly CAMHs, health care), Connexions and the Learning and Skills Council, police, youth justice, the probation service, family justice system, the guardians ad litem services (GALRO), and children and family court advisory support services (CAFCASS). *Working Together to Safeguard Children* provides a further guide to interagency working to safeguard and promote the welfare of children (see also the DH/DfES *Children's Services Planning: Guidance)*. Cameron and Lart (2003) in their review of joint working suggest that there is little information on the effectiveness of joint working and are concerned that 'our knowledge of the factors that promote or hinder joint working between the NHS and social services has hardly moved on since the studies carried out in the late 1970s and early 1980s'.

This increase in cross-agency working and the development of partnerships with programmes such as Sure Start can cause difficulties in tracking expenditure both for and in children's services. The sheer number of agencies involved increases the barriers to joint working (such as differential timing for restructuring, differential charging criteria, staff terms and conditions, and, crucially, different information systems) which can inhibit local assessment of needs and multi-agency planning. Moreover, if overarching and agreed definitions do not exist, there will be many differing perspectives on which children are in greatest need of services and therefore where resources should be targeted (CYPU, 2002). The CYPU also found that the existing accounting systems – and, indeed, the performance information – of individual agencies could provide only a partial picture of funding and performance in children's services.

Sources of summary information on children's services in England

Summary sources of information have proved invaluable in writing this chapter as so much research in children and family services is published in books and monographs and are beyond the scope of this review. Grateful thanks are extended to the compilers of these reports.

Progress since the implementation of the Children Act is set out in the *Children Act Reports*, of which the Department of Health has published five; 1995-1999, 1999 (supplement) 2000, 2001, 2002 (DfES). Each report is organised around the eight key objectives identified by the Quality Protects programme, which were then extended to

eleven, allowing integration of objectives for social services as a whole (see also *The Government's Objectives for Children's Services*, 1999). Progress along many of these dimensions is seen as measurable, using indicators from the Performance Assessment Framework (see section 6.6).

The first overview of research on children in the care of local authorities, *Social Work Decisions in Child Care*, was published by the DHSS (1989) and was widely disseminated. These overviews have become an important way of disseminating research evidence and now cover a range of topics: *Residential Care for Children: A Review of the Research* (1993*); Child Protection: Messages from Research* (1995); *Focus on Teenagers: Research into Practice* (1996); *Caring for Children Away from Home: Messages from Research* (1998)*; Adoption Now: Messages from Research* (1999*). Children Act Now: Messages from Research* summarises the research undertaken to evaluate the Children Act (Aldgate and Statham, 2001). A review of foster care research is almost competed and an overview of the research funded under the Costs and Effectiveness to Children in Need initiative is planned for 2005.

There have been four Annual Reviews of local authorities' Management Action Plans, with other more focussed reports on disabled children and services for children and families from black and ethnic minority groups. Management Action Plans, compiled annually by each local authority under the *Quality Protects* programme, provide information on their targets and attainment of these each year.

Statham (2000) provides a useful summary review of research evidence on the effectiveness of family support, using both UK and US evidence. June Thoburn and colleagues at the University of East Anglia have just completed a major review of services for children from ethnic minority groups. Knapp and Lowin (1997) reviewed the evidence on the economics of children social care. The 'What works' series, published by Barnardo's, and the Evidence Network provide topic specific summaries of research to promote evidence based practice.
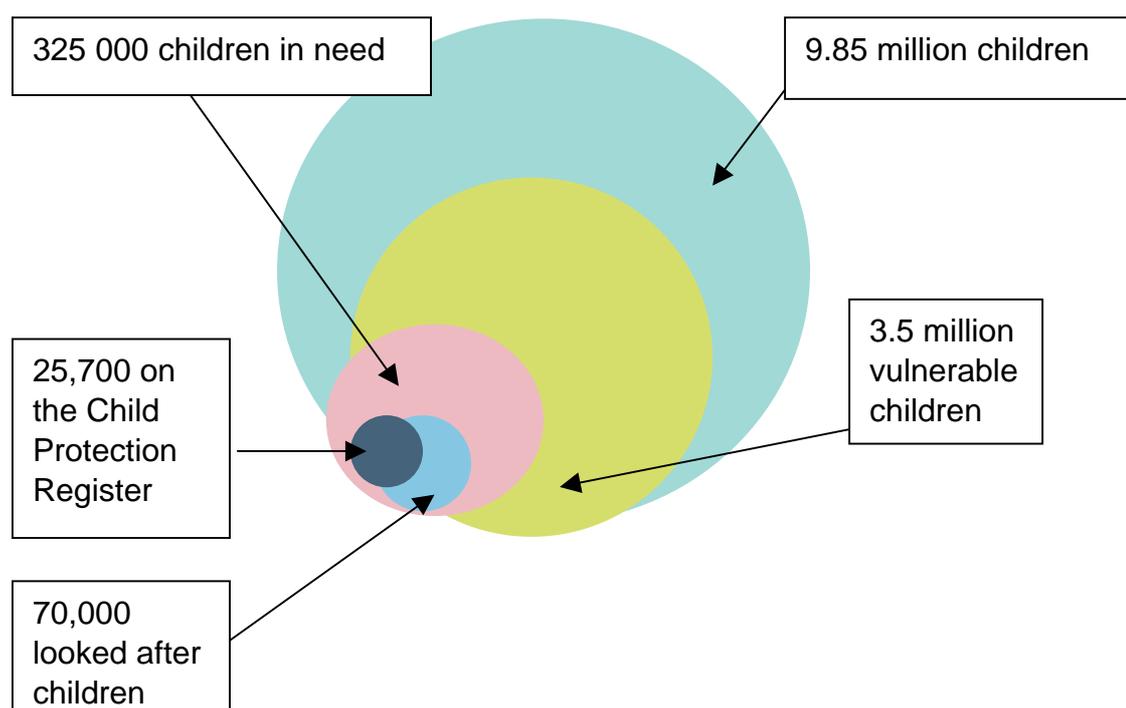
6.2 Needs

Children and their needs: an overview

In all three areas under consideration here – England, Wales and Northern Ireland – the proportion of children 0-15 years in the total population is around 20 per cent (2001 Census data). The trend for each country over the last 10 years or so is shown in Figures 6.1, 6.2, and 6.3. In England and Wales, the proportion has been fairly constant, although tending to decrease over time. For Northern Ireland, there is a drop over time of around 3 per cent: a much steeper curve culminating in children

representing 21.5 per cent of the total population in 2002. Thus by 2002, there were 9,820,000 children in England, a rise in the absolute numbers since 1991. In Wales and Northern Ireland, absolute numbers have dropped as well as the proportion of total population; in 2002 there were 581,000 children in Wales and 365,000 in Northern Ireland.

The number of children in any one area will have an impact on the number of children in need. The *Framework for the Assessment of Children in Need* (DH, 2000 and Welsh Assembly) suggests that the differing levels of children in need can be represented as a diagram with overlapping circles (p3); Diagram 6.1 shows this diagram, using the figures for England for 2002-03.

Diagram 6.1

325 000 children in need

9.85 million children

3.5 million vulnerable children

25,700 on the Child Protection Register

70,000 looked after children

It may be helpful to explain the terms used in the above diagram. Vulnerable children are those living in families with less than half the average income. Although it is likely that around three-quarters of these children will be living in poverty (p1), only a small proportion of these are 'children in need'. To provide an indicator of the latter, the figure is taken from the CIN Survey 2003, a bi-annual survey over a week of children's needs, the social services' response and the resulting expenditure[1]. The figure is not a direct measure of children in need, but of those who are receiving services, including all children who are 'open cases' during the CIN Survey week in February 2003. This means that at any given time, each local authority is providing some support for an average of 2200 children, around 20 per cent of whom will be looked after. The number of children looked after, usually those receiving an intensive package of support and who are commonly accommodated away from home, is also taken from the CIN Survey 2003.

The Children in Need (CIN) Survey 2003 data are only available for England, although similar surveys are being considered in Wales and Northern Ireland. In total, in the survey week in February 2003, there were 320,000 children 'on the books' of social services departments across England, of whom some activity was undertaken for 155,000 (Figure 6.4). Of the 70,000 looked after children, around 90 per cent received some services in the survey week. This survey usefully sheds light on the needs of (and services received by) children who are not looked after, but are supported in their own families or independently (CSF/I). Figure 6.5 shows that abuse or neglect was the primary reason for provision of services for the overwhelming majority of children whether looked after or not, followed by family dysfunction, disability, and where the family in acute distress. The group for whom a 'need' code was not stated is also quite large, however. Analysis of the 2001 Survey data found that around three-quarters of those in the 'not stated' category comprised children who had been referred to social services either in the week prior to the survey (13 per cent) or during the survey week (55 per cent; Bebbington and Beecham, May 2003). Over the three CIN Surveys, the number of looked after children receiving support has increased slightly and the number of CSF/I has fluctuated. Overall numbers receiving a service increased from 2000 to 2003 (Figure 6.6).

The number of asylum-seeking children was recorded at around 6 per cent of the CSF/I group and just over 1 per cent of the looked after children (Figure 6.7). A similar proportion was reported in the 2001 CIN Survey, which identified 17,880 child asylum seekers (Bebbington and Beecham, October 2003). Around a quarter of these were known as a consequence of absent parenting (unaccompanied asylum seeking children) and the remainder were predominantly from families on low incomes. This is a very different pattern of need codes than can be seen in Figure 6.5, covering all children

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[1] http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalDevelopment/ChildrenInNeed/fs/en

in England. Moreover, there is a clear concentration of asylum-seeking children in a small number of areas: just seven local authorities supported one half of asylum seeking children and the great majority lived in London. A special issue of *Child and Family Social Work* looks at issues around providing support for refugee and asylum-seeking children in several countries (2003, volume 8).

In Northern Ireland, there were 350 referrals to social services per 10,000 children in 2000-01, approximately 1300 children. In the same year, there were 14,650 episodes of social services involvement (Figure 6.8), of which 30 per cent were for child protection investigations and 9 per cent for children with a disability (Figure 6.9). One survey of social workers (124 of the 394 family and child social workers in Northern Ireland) found that 91 per cent said that child abuse was the most important reason for referral to social services. Thirteen per cent of their referrals became looked after children (Mooney and Fitzpatrick, 2003).

The CIN 2003 data suggest that 22 per cent of children in need are looked after. Figure 6.10 gives the rate per 10,000 population under 18 years for England and Northern Ireland over the past three years, with rates for both countries converging at around 52 children in 2001. In Northern Ireland, the numbers of looked after children decreased during the 1990s from 2607 children in 1987 to 2354 in 1998 (DHSSPS NI, 1999), but then may have begun to rise: at the end of March 2001, the equivalent number was 2414 (Mooney and Fitzpatrick 2003). Sixty-three per cent of looked after children were placed with foster parents, 22 per cent with their own parents, 11 per cent in residential accommodation and 3 per cent in other types of placement. These proportions have remained stable since 1996.

As illustrated in diagram 6.1, looked after children overlap with children on the Child Protection Register (CPR; see also Figure 6.11). The latter are a smaller group, but they are children for whom there are considerable concerns about their welfare and safety and who local authorities have a statutory duty to safeguard. Until 1999-2000, the number of children on the CPR in England stayed fairly constant at around 32,000, but subsequently fell to 25,700 in 2002 (DH, 2003, p24). In the main, this reflects a change in registration practices, recommended in *Working Together to Safeguard Children* to ensure that a prospective assessment is made of the likelihood of continuing risk of significant harm, rather than a retrospective view of evidence. The deregistration rate between 2000 and 2003 was generally greater for children under one year and the performance indicators show that the proportion of de-registrations *decreased* from 11 to 8 per cent for children who had been on the register for two years or more. The proportion of re-registrations has also dropped since 1997-98 and is currently between 11 and 15 per cent (Figure 6.12).

The number of CPR registrations *per year* has stayed remarkably consistent since the mid-1990s, however, at around 30,000. As shown in Figure 6.13, the proportion of

initial child protection conferences that led to registration is much higher now than in 1993 (the two lines have become closer together, perhaps indicating a better targeting of this planning mechanism. Data on s.47 enquiries (for children who suffer or are likely to suffer) have only been collected for the last three years, but the reduction in these figures of around 15,000 appears to be matched by a slight increase in the number of child protection conferences. This may again indicate a more appropriate use of the various planning mechanisms or simply a delay in initiating the conference.

The proportions of children of different ages on the CPR have changed little since the early 1990s. Around 10 per cent are under one year (with a very slight increase in the last four years) and around 30 per cent are in each of the other categories (1-4 years, 5-9 years and 10-15 years). A small minority – between 2 and 4 per cent over the period – are aged 16 or more (DfES Statistics for Education). Around 16 per cent of children on the CPR come from ethnic minority groups (DfES Statistics for Education).

In Northern Ireland, the rate of children on the CPR dropped slightly between 1999 and 2001 to 31 per 10,000 children, but still remains higher than the rate for England (Figure 6.14). Most children remain on the CPR for between two and 24 months (DHSSPS NI, 1999). The figures for Northern Ireland use slightly different age bands: 32 per cent of children on the CPR were under 5; 41 per cent were aged 5-11; 22 per cent were aged 12-15; and 5 per cent were aged 16 and over (data for 2001; DHSSPS NI). Compared to the 1991 Census data, these figures are a slight over representation of children under 5 and an under-representation of young people over 16 years old. Figure 6.15, covering 1998-99 to 2000-01, shows that the reasons for CP registration have changed in both England and Northern Ireland, although differences between the two countries exist. Despite the reasonably stable age breakdown, neglect remains the most common reason for registration in both England and Northern Ireland. Up to 1997-98, the number of registrations and de-registrations remained similar.

In Wales, there were 2100 children on the CPR in 2001, but the number has fluctuated considerably over the period from a low of 1600 children in 1994 to a high of 2650 in 1999 (Figure 6.16). The proportions in each age band remains fairly constant, although there is a slight rising trend for registrations of children under a year.

The CIN surveys (2000, 2001, 2003) identify nine broad need groups, such as abuse, parental illness, disability etc (see, for example, Figure 6.5). These were intended to capture the primary reason for a child to be receiving social services support. Although piloted for feasibility with social workers, they cannot capture the full dimensions of the needs of any one child or the severity of those needs, but do provide a useful 'shorthand'. In their overview of the research undertaken to evaluate the Children Act 1989, Aldgate and Statham (2001, p33) provide a more detailed summary of the circumstances of the children participating in the research.

The general impression from the interviews with children is of troubled and anxious children who would undoubtedly benefit from services. They were sometimes physically malnourished and lacked psychological nurture. They were often anxious about themselves and others close to them. Some lived in fear of being maltreated. Others feared being abandoned by family or being moved to a new carer. Some had low esteem and were anxious about school and peers. A deep sense of sadness pervaded those who had been neglected or abused or who had been separated from their families for a long time. A minority of children were detached from their families for a long-time and some serious concerns were expressed by researchers about their well-being.

Underlying these problems were issues relating to the capacity of the family and household to provide care, including parents' ill health, chronic or acute problems and mental health problems. And of course, there were wider 'environmental' issues:

Financial problems and low income permeated the children and families participating in the Children Act research projects, as did housing problems. Unsafe neighbourhoods made parents wary of using facilities in the area. Social isolation was a particular problem and social support and social networks appeared to provide a cushion against adversity.

Needs stemming from environmental factors

Environmental factors are those that are outside the personal and social characteristics of children or their families. For example, Gillham *et al.* (1998) found that 'living in areas of localised high unemployment [in Scotland], particularly for males, is likely to put families, otherwise vulnerable, at greater risk of child physical abuse and neglect.' However, few studies have looked at the overall picture of the association between environmental factors and children's needs – and the service response. One exception is a study by Bebbington and Miles (1989), which identified six common factors in the background of looked after children: household in receipt of income support; lone parent household; more than four children in the household; child of mixed ethnic origin; living in a privately rented home; and one or more persons per room. A child with all six characteristics had a one in ten chance of being admitted to care, compared to one in 700 for those in families with none of these characteristics.

The first Children Act Report (DH, 1999) stated, 'It is well-established that the need for children's personal social services is directly related to social disadvantage'. Whilst this is certainly true at the individual child level – and frequently shown for those who are using services – it is difficult to find robust statistical analyses of local need within an *authority* and the authority's overall service response.

In 1996, the York index was derived using indicators from the 1991 Census with the intention of explaining variations in the costs of services; it was used to inform the formula for deriving resource allocation for children's services from 1999 (Carr-Hill *et al.*, 1997). Its focus on 'small area data' for all children in contact with social services and its known association with child and family support (45 per cent of variation explained) has made it a useful tool for looking at the wider impact of poor environment on the supply of services. The socio-economic variables included in the York Index are the children in families reliant on Income Support, children with limiting long-standing illness, children living in flats, children living in lone parent families, and population density. The index shows a seven-fold difference between authorities (DH, 1999 p89). Yet this index does not capture the entire picture. In the *Children Act Report 1999*, for example, it only partially explained the variation in rates per 10,000 children for CPR status (20 per cent of the variation explained) or placed in foster care (50 per cent). This suggests that other influences, such as local authority policies and practices, may have a stronger influence on responses to local needs than the underlying need.

One further study is notable for its area-based approach to assessing needs and service response. Oliver *et al.* (2001) undertook secondary analysis of two Child Protection Register (CPR) indicators for 1999 and four 'looked after' indicators for all English local authorities, expressed as rates per 10,000 children. They controlled for socio-demographic differences between the local authorities, using the York index, and investigated the relationships between the indicators and their stability over time. They also interviewed managers and professionals in eight local authorities to find the extent to which local policies and practices may influence the findings.

The secondary analysis found that new registrations to the CPR and number of children on the CPR were inter-correlated and correlated with the number of children looked after and the number of children starting to be looked after (again inter-correlated). The number of operational staff was also correlated with these CPR and looked after indicators. There was some evidence to suggest that smaller authorities may have more CP registrations and more children looked after. The overall size of the child population was not associated with the indicators for stability of placements for looked after children, indicating that smaller authorities did no better or worse than larger ones. Correlations with the York Index were also high for these CPR and looked after children indicators, suggesting that the more deprived areas had relatively more children on the CPR and more looked after children.

Even after adjusting each of the indicators for socio-demographic characteristics, the CPR and looked after indicators were positively correlated, suggesting that some authorities were making greater use of the CPR than would be expected given their socio-demographic characteristics; those that did also have more children looked after. Visits to the local authorities found that in some cases wrong definitions had been used or that data returned to the DH was incorrect. Authorities consistently pointed out that

very low or high figures on particular indicators are not necessarily a sign of good (or bad) practice. The areas considered to be most in an authority's control were the way services were resourced and delivered, including staff policies and attitudes, the extent of inter-agency working, professional expertise and management skills, and the availability of family support services.

The introduction to the 2003 Northern Ireland *Strategy for Children in Need* notes that one in eight children live in a lone parent family and over a quarter of children are the dependents of claimants of Job Seeker's Allowance or Income Support. Using small area data (n=498), Percy *et al.* (2000) aimed to model a needs-based formula for Northern Ireland. This may replace the current formula based on the York Index, as this is derived from data on the population in England. The variables used, explaining 56 per cent of the cost variation, were: lone parents in income support, children living in one adult households, a rurality indicator, and local government district indicators to account for the impact of historical spending patterns. (There are 28 LGDs with an average population of 52,000, except for Belfast where the population is 279,000.) Yet again, a clear relationship between poverty (through social security payments), family structure or breakdown, urbanisation and expenditure on social services is evident.

Unmet needs

Health and looked after children

In 1991, the Department of Health's Working Party on *Assessing Outcomes for Looked After Children* identified children's health, and their emotional and behavioural development, as important to promoting their life chances. Brodie *et al* (1997) summarise health issues for looked after children as stemming from low income, poor diet, inadequate housing, parental stress (which may have an impact on a child's psychological well-being), and disability. Health concerns expressed by parents include suicide, non-compliance with medication, use of illegal substances, teenage pregnancy, and risky behaviour. Recent research suggests that, despite progress over the last 10 years or so, there are still deficits at the front-line in recording children's health data, monitoring their health and putting services in place to meet their health needs.

The recent ONS Survey of looked after children in England found that two-thirds had at least one physical complaint (Meltzer *et al.*, 2002). Williams *et al.* (2001) assessed health needs and provision of health care to 142 children looked after by four Welsh unitary authorities, together with 119 controls from the same areas and living in their own homes. Looked after children were more likely to: experience change in their GP; have incomplete immunisations; receive inadequate dental care; suffer from anxieties and difficulties in interpersonal relationships; wet the bed; smoke; use illegal drugs; and

have been cautioned by police or charged with a criminal offence. They also tended to have received less health education. (School-based programmes appear to be successful for some groups of children. Newens and McEwan (1995) and Chadwick *et al* (2001), for example, evaluate school-based health education programmes for children with severe learning disabilities.) On the positive side, looked after children were significantly more likely to have had a recent hearing or eye sight test and they reported less physical ill-health overall. The authors argue that, although there was still a long way to go, the concerted efforts of community paediatricians, working in collaboration with social services, had improved attendance and quality of medical assessments.

Gathering and keeping records on health information are often poor in social services departments, despite the introduction of the Looking After Children assessment documentation (Brodie *et al.*, 1997; Bailey *et al*, 2002). Bundle (2001) explored the data kept on 36 children living in a 32-bedded mixed resident children's home over a three-month period in 1998. Community child health records were found to hold much more comprehensive information for more children on birth, developmental and past medical history. Although all children were offered appointments with an optician, dentist and GP in the home, information in the children's home records on growth, hearing, and vision was very limited. These records also had only partial information about immunisations (the take up rate was very low overall), although they were more complete in their recording of current health problems, emotional and behavioural problems and substance abuse. Eleven children were recorded as having an annual medical exam, but with little information on the outcome. The health information in the Looking After Children records was very sparse and details for the previous child protection register status were taken from the community health records. Moreover, seven of the children's health records could not be obtained at all, highlighting the difficulties for social workers in obtaining good health-related information.

The identification of health needs alone is not sufficient to bring about a change. Ashton-Key and Jorge (2003) found that only just over half of looked after children in one unitary authority had received the full immunisation programme for their age. Although they provided the social services department with information on children's immunisation status, no child who had been looked after continuously for the period (1999-2000) had their immunisation programme brought up to date.

Looked after children tend to move placements and this mobility may prevent them accessing health care, particularly where there is shared parental responsibility and it is not the current main carer who is informed about appointments and needs. A more promising picture is given for the health of children for whom a decision has been taken to plan for adoption as placement in a stable foster care home often follows this decision (Colver *et al.*, 2002). Health records of 211 children in north-east England for whom a 'best interest' decision was taken between 1996 and 2001 showed that they had a greater than average number of health problems but almost all, including mental

health needs, were being dealt with appropriately. Thus increased stability, alongside the statutory medical assessment, can help services meet health care needs with the foster carer, social worker and health services working in co-operation.

Mental health and looked after children

The prevalence of mental health disorders among looked after children is high. The CIN Survey 2003 shows that socially unacceptable behaviour is the primary reason for social services support being provided for around 15,000 children (Figure 6.5). In addition, other problems, such as abuse and neglect or parental dysfunction, are likely to impact on children's mental health. Around nine per cent of children presenting to child and adolescent mental health (CAMH) services are children looked after by social services, compared to 0.5 per cent of the general population (Audit Commission, 1999).

In 2002, the ONS carried out a survey of the mental health of looked after children in England and collected information on a one in 18 sample of children between the ages of 5 and 17 years (Meltzer *et al.*, 2002). The response rate was 49 per cent, giving data on 1134 children from 134 authorities. (A similar survey for Wales and Scotland took place in early 2003 and is due to report this year.) In all, 45 per cent of the children had a mental health disorder, some of whom had more than one type of disorder; 36.5 per cent of looked after children were diagnosed with clinically significant conduct disorders, 12 per cent with emotional disorders such as anxiety and depression, 7 per cent were rated as hyperactive and 4 per cent had one of the less common disorders, such as pervasive developmental disorder, tics and eating disorders. Children aged 5-10 and 11-15 years were four to five times more likely to have a mental health disorder than their peers in private households, with conduct disorders accounting for the largest part of the difference in prevalence rates. There were notable difference according to where children lived: 68 per cent of children living in residential care were assessed as having a mental health disorder, compared to 51 per cent of those living independently, and around 40 per cent of those in foster care or placed with parents.

Only 4 per cent of the children surveyed were taking medication to overcome mental health problems. In the 12 months prior to the interview, almost all the children with a clinically assessed disorder had been in contact with at least one service about their mental health problem, commonly front line services; 80 per cent had been in contact with a social worker and 49 per cent had seen a teacher. Only a third of these children had been in touch with a specialist mental health service and 23 per cent with special education services.

These children also had other difficulties. Overall, 14 per cent of looked after children had been in trouble with the police in the past year, but those with a mental health disorder were over five times more likely than those with no disorder to have been in such trouble. They were also nearly twice as likely to have marked difficulties with

reading (37 per cent, compared to 19 per cent for children with no disorder), mathematics (35 per cent and 20 per cent) and spelling (41 per cent and 24 per cent). Overall, whereas 62 per cent of looked after children were found to be at least one year behind in their intellectual development, 35 per cent of those with a mental health disorder were three or more years behind, twice the rate among the no disorder group.

Higher rates of mental health needs have been found in the users of other specialised services for troubled and troubling young people (Nicol *et al*, 2000). Their initial survey identified 196 young people who were likely to have mental health problems (screen-positive) and in-depth interviews were undertaken with 76 of them and 40 screen-negative children. They lived in establishments managed by various agencies: 21 in education establishments; 4 in health; 51 in prison; 10 in probation; and 30 in social services. Seventy-seven were in care informally and 15 were detained under section 53 of the CYP Act 1933. The remaining children were cared for under various parts of the Children Act (15), Criminal Justice Act (11) and one under the Mental Health Act 1983. Over three-quarters of these children had a clinically significant psychiatric problem; conduct disorder, hyperactivity and substance abuse were particularly common, as was a high level of co-morbidity, but some problems were not identified by the initial screen. Sixty-six per cent of these children had been permanently excluded from school and 89 per cent had a reading age below 11 years. High levels of unmet need were found not only for psychiatric problems, but also substance abuse, social and life skills, and family problems.

Another group whose needs may require attention are children living at home with parents who have mental health problems. Their needs may not be assessed or addressed appropriately; it has been argued that child social workers may not recognise the seriousness of parents' mental health problems, possibly as a result of the demise of generic social work training (Barbour *et al*., 2002). One survey of 500 health and social care professionals found communication problems to be most common with adult psychiatrists and GPs (Stanley *et al*., 2003). Where parents' mental health was an issue, children's services' workers felt that their statutory responsibilities made it difficult for them to be also working on behalf of parents. The authors recommend that workers from child care and community mental health services should work together in such cases.

Education and looked after children

The extent to which looked after children were doing well in school was identified as an important component of children's welfare by the 1991 Working Party of *Assessing Outcomes in Childcare* (Parker et al., 1991) and this now forms one of the dimensions of the recommended assessment framework (see section 6.5). The ONS survey of the mental health of looked after children found 57 per cent of looked after children had

been absent from school for a day or more during the previous term, 30 per cent for up to a week and 18 per cent for more than a week (Meltzer *et al.*, 2002).

One recent study exploring education and care for troubled adolescents, across residential schools, children's homes and foster care homes, found that all the pupils at schools for children with emotional and behavioural disorder (EBD) were receiving full-time education, but only about half the children's homes residents were receiving such education. Many of the latter were excluded from school and, although educational arrangements were in place, they were refusing to attend (Berridge *et al*, 2002). The heads were able to give a more coherent account of their purpose and methods than the heads of children's homes but the schools tended to be larger and less homely. Neither pupils nor staff perceived the much greater distance from the pupils' homes as a problem. On one level it may appear that educational outcomes for looked after children may be improved with greater use of residential schools, however, the children in each type of facility were different. Young people living in children's homes had more complex and problematic backgrounds than the EBD pupils. Moreover, although levels of emotional and behavioural difficulties were similar, it was those living in the children's home that posed more behavioural problems, such as offending or going missing. Roughly half (124 of 257) of the children in this study were identified as 'difficult' adolescents, with at least one of five anti-social behaviours: convicted or cautioned for a criminal offence; excluded from school at some age; drank alcohol regularly; used drugs regularly; had gone missing from current placement.

Policies on the provision of inclusive or special education vary across England (see Farrell, 2001, for a discussion of the arguments); in consequence, the likelihood of children being sent to a residential school varies greatly. In one study of children with learning disabilities, autism, and physical or hearing impairment, there were 8 per 100 children with Special Educational Needs statements in one Inner London authority, compared to 0.2 per 100 children in a metropolitan authority (Abbott *et al.*, 2000). This study also found that joint social services and education funding was common, but delays in placing a child could occur where 'trading' took place to decide how placements would be funded. When placements were solely education-funded, social services were not always informed that the child was living away from home, despite a legal duty placed on education authorities to do so if a child has been accommodated for more that three months. Often, information was only passed where child protection issues were raised. Health authority funding for residential school places was increasing, but still rare.

Disabled children's needs

Children who are disabled form a special group within children 'in need' as defined by the Children Act 1989, but local authority responsibilities towards them are the same. They represent a diverse group, with a range of needs related to both physical and

learning disabilities. The Audit Commission (2003) review of services for disabled children found a disparity in the concerns of parents and children: parents referred to education, health, housing, or social care services, whereas children 'talked more about play, leisure, friendships and school. Both groups however, were concerned about transport.' (p8; Bryony Beresford at SPRU, University of York is currently undertaking research on averting social isolation and exclusion). Here, however, our focus is on social care services.

There are over 300,000 disabled children under the age of 16 in England and Wales (JRF summary, 1999). It costs on average £7355 per year to bring up a child with disabilities, compared to £2100 for a non-disabled child. Parents have fewer employment opportunities because of their caring responsibilities (see also Shearn and Todd, 2000), so family income tends to be low. Many families do not receive their full social security benefits, but even so benefit levels would need to be increased by £30-80 (depending on age and impairment) to meet minimum essential costs. Research under the JRF programme has found that housing is often unsuitable and health, housing, education and social services rarely work together, resulting in many assessments and uncoordinated service provision. Requests for respite care (short breaks) dominate parents' links with social services and respite care is the most commonly provided services for disabled children. Parents also use a mix of services from the education, social services and health sectors, however. It is rare for these children to be consulted or involved in decisions about their care. Parents highlighted needs for more information, 'one point of contact' (perhaps a link or key worker), and flexible support hours to meet their children's and the family's needs (see also, Hall 1996).

A study of the way three local authorities were implementing the Children Act with respect to disabled children suggests that there are still some problems (Morris, 1998). There were misunderstandings about care planning for children in respite care; some children used respite care without other involvement from social services, despite a requirement in the Children Act that these children should get social work visits 'from time to time, in the interests of welfare'. Few disabled children had an allocated social worker. Disabled children's wishes and feelings about their placements were not being sought, often because social workers lacked skills in non-verbal communication. Some placement reviews were long overdue and none of the areas had easily accessible comprehensive information on disabled children who used respite care.

Children tend to be reliant on their parents for information with only rare contact with social workers. Parents of children with physically induced incontinence reported a lack of information about the disorder, relevant management techniques and social security benefit entitlements (Cavet 2000). Nearly one in four families reported no contact with social workers, but high levels of unmet need in areas that social workers could help with, such as information about and access to services. Where there had been social work contact, it was only occasional and related to finance or help with adaptations and

equipment. Secondary problems, such as child protection, parental stress (this is often associated with lack of social support; Hutton and Emerson, 2003) or reluctance to go to school, were more likely to prompt higher levels of contact than a child's disability-related needs.

There is a considerable body of evidence suggesting unmet need for social services contact: 54 per cent of families with a severely disabled child had not seen a social worker in the previous 12 months (Beresford, 1997). Moreover, 60 per cent of families with children with cognitive impairment reported no social work contact since diagnosis, with 20 per cent of respondents reporting unmet need in areas of social services responsibility (Mencap, 1997). There is a shortage of respite care places to meet the needs of children with learning disabilities and challenging behaviour and the services that are currently available are not allocated according to the severity of children's behaviour or parents' levels of stress (Chadwick *et al.*, 2002). Thirty-one of the 111 children in this study of children with learning disabilities used respite care, yet another 23 parents wanted this type of support. There had been contact with social workers for only 33 per cent of the children and only 10 per cent had a domestic support worker (Beecham *et al.*, 2002). A study of young adults with hemiplegia shows a 25 per cent utilisation rate for social workers, just 4 per cent for a care assistant, and no other social services involvement (Beecham *et al.*, 2001). Hatton *et al.* (2000) suggest unmet needs for services are higher among South Asian families who have a child with severe learning disabilities than among their white peers. The situation is usefully summarised by one researcher:

> There is consistent evidence over a number of years on the high, and unchanging, levels of unmet need among families with disabled children. Most parents consistently use the words 'struggle' and 'battle' when describing their attempts to get services for disabled children (Sloper, 1999).

Although responsibility for children's services has transferred to the DfES, and partnership working with education is an important planning and provision issue, the needs of children in school are not directly addressed in this report. We note, however, that in 2002 the Audit Commission (*Special Educational Needs: A Mainstream Issue*) found that schools in England and Wales identified one in five children (1.9m) had special educational needs and required extra help in class. Around one in thirty (275,000) of these were considered to need more support than their school can provide. Following a lengthy assessment procedure, the LEA makes a Statement of Special Educational Needs, which identifies their needs and the 'additional or different' provision to be made. LEAs in England and Wales spent £3.6bn in SEN provision in 2001-2002 or 15 per cent of spending on the local schools budget. Around 60 per cent of SEN resources are spent on children with Statements.

6.3 Funding

The current system of allocating funds for social services (Formula Spending Shares) is based on the whole population of children in each authority weighted by an index of deprivation. The current formula for children's services in England, developed at York University, incorporates a weighting for population density and the proportions of households on income support, adults with limiting long-standing illness, one adult households, and children living in flats (Carr-Hill *et al.*, 1999). This is due to be reviewed in 2004-05. (Using small area utilisation modelling, the same group developed a formula for Northern Ireland; Percy *et al.*, 2000.) The previous SSA formula did not take into account all children seen by social services, only those looked after or on the Child Protection Register. Local authority averages were used and the numbers of children in need were modelled separately from the unit cost adjustment, rather than using small area data on expenditure per child. The current formula also contains an adjustment to reflect local costs of recruiting and retaining foster carers, applying to just over 19 per cent of the children's sub-total, the proportion of expenditure relating to foster care (Owen *et al*, 2002).

Figure 6.17 shows the increase in expenditure on children' services between 1994-95 and 2002-03. For 2000-01, such expenditure represented 22 per cent of the total expenditure on personal social services, which had increased by 6 per cent over 1999-2000. Expenditure on children's services had increased by only 2 per cent for that period, whereas in the previous year children's expenditure had increased by more than the average for the whole of personal social services (14 per cent compared to 11 per cent; Department of Health 2001 and 2002).

The way that these resources are spent on services can be seen more clearly in Figures 6.18 (1994-5) and 6.19 (2002-03). Around a quarter of the total resources was spent on commissioning social work services for both years. There has been a reduction in the proportion spent on residential care from 30 per cent to 23 per cent. This decrease in expenditure for looked after children is matched by an increase of around 5 per cent in foster care services and a one per cent rise in expenditure on adoption services.

Figures 6.20 and 6.21 provide information on the unit costs of residential and foster care over the last three years for different groups of authorities. Unit costs for residential care show a relatively high increase in 2002-03 (Figure 6.20). In part this is related to changes in the way resources are allocated to services in the PSS expenditure accounts (Department of Health, 2003). A similar impact can be seen on the unit costs for foster care (Figure 6.21), but in contrast to the picture for residential care, these are higher for the London Boroughs. This is likely to be due to their relatively higher use of independent sector foster care agencies (see below). The difficulties related to obtaining

sufficient foster carers in London boroughs – and therefore higher use out-of-borough foster carers – are well known.

Put together, expenditure on family centres, services for children under eight, other family support and other children and family services have stayed fairly constant at around 20 or 21 per cent. A clearer categorisation of services, however, came in with the new PSSEX accounting system (Figures 2.18 and 6.19). Of course, direct funding of programmes such as Sure Start has provided a real increase in resources available for preventive support. Grant income directly to children's services accounted for 13 per cent of gross children and families' expenditure in 2001, although could be as high as 29 per cent where authorities were receiving the Asylum Seeker grant. Of this grant income, around 44 per cent came from Quality Protects and 30 per cent from Care Leaver grants (Beecham et al, December 2002).

Leaving care services now comprise around four per cent of expenditure, compared to one per cent in 1994-95, reflecting the introduction of the Children (Leaving Care) Act in 2002 and accompanying grants. Relative spend on looked after children and other children in need is considered an important measure of social services' performance, linking with a number of initiatives (including the Children Act) to refocus services away from child protection. Figure 6.22 shows the proportion of children's services expenditure for children in need (but not looked after) from 1997-98; prior to this date, the proportion had risen slowly from around 20 per cent in 1984. Again, the sudden drop in 2000-01 is in part a function of changes in the guidelines on costs should be allocated to services but prior to this the London Boroughs appear to be spending around 10 per cent more of their budget on family support than other types of authority. On the whole, there are small year-on-year increases, although least change since 2000 can be seen in the Inner London boroughs. Secondary analysis of the CIN 2001 Survey data found that local authorities that spend above average on looked after children will also spend above average on children supported in their families or independently (Bebbington and Beecham, September 2003).

The Children in Need data provide an opportunity to drill down further into expenditure patterns[2]. Figure 6.23 shows that around 38 per cent of total weekly costs is spent on the larger group of children supported in families or independently. This is a slightly higher proportion than shown in the performance indicator and is due to the data being categorised by *children* rather than *services*. Thus, if some children supported in their families were accommodated for a short period of time, these costs would be allocated to looked after services in the performance indicators.

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[2] Some caution is advised as secondary analysis of the data from the CIN Survey 2001 found some implausibly high and low costs indicating very skewed data due to measurement error (Bebbington and Beecham, September 2003). We do not know to what extent the 2003 data are beset by the same problems.

Because of its capacity to link children's needs, service responses and costs, the CIN Survey is a very powerful tool for monitoring and managing resources. Figures 6.24 and 6.25 provide examples of the way data can be analysed – by type of service and by children's needs and by gender. For example, Figure 6.25 shows that the average cost of supporting boys aged 10-15 and 16 and over whose primary need is absent parenting is much higher than for other need/age groups – and higher that the cost of supporting an equivalent group of girls. This may be an entirely appropriate way of spending resources but such pictures illustrate patterns of expenditure. One of the difficulties noted in the Joint Reviews report *All Our Lives* (DH, 2004) is that some pressures in children's services are both unpredictable and outside a council's control. Examples would be court decisions about a child's placement, high costs of care for children with complex needs (perhaps up to £100,000 per year), the impact of market pressures on purchased services, and volatility of demand for specialist residential and foster care placements (p48). The CIN data allow councils to address these data locally by identifying these children and the support they use to allow better planning for their needs.

Secondary analysis of the 2002 CIN Survey data found that expenditure recorded in the CIN Survey was highly correlated with the PSSEX61 data, although the CIN-based estimate was around 15 per cent lower (Bebbington and Beecham, 2003). Higher costs were found to accrue for children living in London boroughs, those whose primary need for services was socially unacceptable behaviour if they were looked after or low income/absent parenting if they were supported in their families or independently. Costs were also higher for older children or those who were less than 12 months old, who came from certain ethnic minority groups or who were boys. Being on the Child Protection Register, an unaccompanied asylum seeker or receiving post-adoption support were other high cost categories. Multivariate analyses could explain about a third of the variation in the costs of supporting a child but there remained considerable differences between authorities. Higher levels of demand (numbers of children in need relative to the population) raised slightly the cost of children supported in families, but authorities with larger populations (giving greater opportunities for efficiency) tended to have lower costs for children looked after. Management and social work staffing levels were not associated with higher spending per child, nor were the quality indicators in the performance Assessment Framework.

An additional £100 million will be made available in 2004-05 and 2005-05 through a specific formula grant for safeguarding children and to help address pressures of children's services. The 2004 spending review suggested that current programmes, such as Sure Start, would be retained, and possible sustained in subsequent year. In addition, a Young People's Fund (£200 million) is to be established from the National Lottery focused for projects that promote youth inclusion both after school and in holiday periods.

Northern Ireland is typified by integrated health and social services under the control of a single government department, the Northern Ireland Department of Health, Social Services and Public Safety. Four Health and Social Services Boards are responsible for assessing health and social care needs in their regions, in line with central strategies. The delivery of services is devolved to local units of management, the eleven Health and Social Services Trusts. The Department allocates around £60 million to the four HSS boards for the commissioning of family and child care services, about 5 per cent of the total health and social care budget. As in England, allocation to the HSS is through a capitation funding formula, based on population size and a needs weighting. The needs component uses the same census variables as identified for England and Wales.

The introduction to the 2003 Strategy for Children in Need notes that in Northern Ireland in 1999-00, over £70 million was spent by Trusts on family and children services, equivalent to £156 per child aged under 18; one fifth was spent on residential care and one fifth on foster care. The expenditure on family and children's services in Northern Ireland is probably about 25 per cent lower than in England. Figure 6.26 seems to bear this out; the 2000-01 per capita expenditure for Northern Ireland is about £180 compared to £250 for England. Moreover, the proportion of personal social services expenditure for children's services is consistently around higher in England than in Northern Ireland.

Information for Wales is only available for the previous three years, but the data show a similar picture to that found for England: rising overall expenditure levels and rising costs per child. Figure 6.27 shows that expenditure on services for children not looked after is around a third of the total, slightly higher than in England.

6.4 Resource inputs

Staff levels

The average daily total of people employed in child care for 1997-1999 was 348,000. Simon *et al.* (2003) found that the increase in demand for care places increased demands for staff that are difficult to match. Most child care workers (aside from child social workers) have below average levels of qualifications and low annual and hourly earnings, compared to those working in other human services such as education or nursing. The hourly pay is two-thirds of the average pay for all women workers.

Children's service staff comprise only around 15 to 23 per cent of total social services area office or field work staff, but the numbers have increased over the past ten years (National Statistics, 2004). In 1994, there were 17,000 whole time equivalent area office or field work staff working in children's services; by September 2003, that figure had

risen by around 40 per cent to 25,200. The numbers employed in generic provision (that is serving several client groups) fell by almost half over the same period (from 6,600 to 3,600) with a move toward greater specialisation and the numbers of Guardians *ad litem* remained constant at 200 between 1994 and 2000 (when these data were no longer reported). The workforce remains dominated by women (currently 78 per cent), with only around 15 per cent of staff from black and ethnic minority origin groups (ethnic origin unknown for 10 per cent).

Absolute number of workers in children and family services have risen over this period (from 12,500 to 16,700) but the proportion who are social workers has dropped from 73 per cent in 1994 to 66 per cent in 2003. Nonetheless, children's social workers still make up 45 per cent (41 per cent in 1994) of all social work staff. (Social workers in hospital or specialist teams account for a further 27 per cent and 23 per cent are social workers for adults or older people.) Most social workers in children's services continue to work full-time; around 90 per cent over the period.

Data are collected separately for staff in children's homes; in 1994, there were 10,500 residential staff but by 2003 this had dropped to 8,400, reflecting both the contracting market as well as staff shortages. There was a rise in the number of whole time equivalent occupational therapists and equipment officers working in children services from 80 to 120. The whole-time-equivalent staffing figures cited in *Every Child Matters* are slightly higher for social workers than the Department of Health returns suggest (40,000 children and family social workers), but are more comprehensive. *Every Child Matters* states there are 3,000 education welfare workers, 7,000 Connexions advisers, 7,000 youth workers, 5,000 people working in Youth Offending Teams and 5,000 people working in the juvenile secure sector.

Lack of access to mental health services is a perennial problem in children's services. The Audit Commission (1999) reported that 41 out of 103 social services departments surveyed in 1998 said they employed staff working with children and young people with challenging behaviour or whose emotional development was causing them concern. Of the 128 whole-time-equivalent posts, most were psychologists, at a cost of £3,979,000. The proportion of authorities with such posts was similar across county councils, unitary and metropolitan boroughs and London boroughs, but only one of the 17 responding Welsh authorities reported having such a post.

Staff time

A key question is how much time is spent with children. The Children Act Report 2000 (Department of Health, 2001) combined data on staff numbers with data from the CIN 2000 Survey to estimate time spent by fieldwork and centre-based staff on children (p96). On average, a staff member saw six children during the survey week, spending 6.5 hours with looked after children and 18.9 hours with other children in need.

Secondary analysis of the returns for 17,028 staff from the CIN 2002 Survey showed that staff spent about a third of their time on non-child related activities, such as leave, management meetings, training and sickness. Unsurprisingly, administrators and managers spent most time on these types of activity, whereas social workers spent most of their time on child-related activities (Bebbington *et al*. May 2003). As part of their data collection to derive a resource allocation formula, Carr-Hill *et al* (1997) estimated that social workers spent nearly 50 hours per child each year on work directly related to children, with home visits absorbing 40 per cent of that time. Average attributable time varied across client groups; 102 hours for children in residential homes, 80 hours for foster care, 77 hours for children on the Child Protection register and 23 hours for disabled children. A similar exercise in Northern Ireland found time varied between 119 hours for children in institutional care to 36 hours for children not looked after (Percy *et al.*, 2000).

While none of the data on use of staff time are strictly comparable, they do illustrate a growing interest in trying to understand social workers' caseloads, together with other work pressures, which in turn will help to ensure that these resources are used to the best effect in future.

Recruitment and retention

SSI inspections show almost all local authorities are having problems in recruiting and retaining social workers and front-line managers. *Every Child Matters* suggests that the current national vacancy rate for children and family social workers is 11 per cent, rising to 20 per cent in London. Children's homes suffer similar problems, with a national vacancy rate of 10 per cent, rising to 17 per cent in London. A wide range of causal factors are thought to explain this situation. These include a poor public image and the low status of child care work, variable management and supervision, workload and bureaucracy, the introduction of new initiatives which run the risk of competing for a limited pool of staff, and complex pay issues, particularly for social workers where insufficient flexibility means employers cannot attract the workforce they require. New qualification structures, social work registration, the spread of good practice, and social workforce development grants may ameliorate the situation. The Audit Commission Report (2002) *Recruitment and Retention* provides more detail on these issues.

Every Child Matters reports the national shortage of foster carers to be 8,000. Placements for children from black and ethnic minority groups, teenagers, children with special needs and for groups of siblings are in particular short supply. Sellick and Howell (2004) provide a summary of research evidence and innovative practice in recruiting foster carers, training, retention, creating job satisfaction, increasing availability and differentiation (choice and appropriateness), and providing additional supports. They identify four key features that underpin many of the innovative practice initiatives. In particular, the authors note the long-standing finding that staff and carer

optimism and satisfaction is better in the independent sector than in the public sector (see for example, Bebbington and Miles, 1990 and Kirton et al., 2003).

Foster care, while being the placement of choice for many looked after children, is often referred to as being 'in crisis' with respect to vacancies, recruitment and retention. The recent SSI report *Fostering for the Future* found that only one of the seven authorities studied reported net gains of foster carers. Research shows two consistent themes: that foster carers are committed to their caring role and that they are more likely to remain as foster carers in the same agency when they are offered more money than they expected **and** extra support, rather than just large increases in allowances or pay (Kirton *et al.*, 2003). They want good advice on how to deal with difficulties, good information on the children before they were placed, and efficient and friendly administrative arrangements and many want more training, foster carer groups, and relief breaks (see also, Baker *et al*, 2000).

Staff satisfaction

The Audit Commission reports that, between 1991 and 1998, satisfaction among workers in the public sector has dropped and stress levels have risen (2002, p9). Yet a survey of 200 social workers in London and the Southeast found that 81 per cent were fairly or very satisfied in their current job and only 3 per cent were not satisfied at all (Leason, 2002). Key reasons for their satisfaction were interaction with people, making a difference to people's lives and making a difference to the community; only 28 per cent cited salary as the reason for their satisfaction.

Assessments and reviews

Consultation with professionals is common but multi-agency attendance at meetings is rare. Even in 1992, Bell (1999) found that all 22 respondents in her survey of social workers undertaking child protection investigations had consulted with other professionals, often as many as four, although children were consulted in only just over a quarter of cases and were represented in only a third. More recent evidence on the implementation of the Assessment Framework (see section 6.6) suggests that the Looking After Children records have helped to increase collaboration in assessment and to standardise procedures among professionals from different professional backgrounds.

Given the concern about the health status of children in need, particularly looked after children, and the drive toward multi-agency working, it is perhaps surprising that these professionals from the health sector continue to have a low profile in the assessment of children and review meetings. Around 30 per cent of 'designated doctor' posts for child

protection teams are unfilled but fears of complaints by parents and lack of proper training may deter community paediatricians (Dyer, 2004; Beckaya, 2004). Ayre (2001) provides an interesting analysis of the negative impact of media reports of child protection work over the last 30 years and the resulting distortions of the procedures.

Primary health care staff are considered important both for their knowledge about the child's health and the family context but again, participation in child protection conferences is low. In one London Borough in 1989, 56 GPs estimated that 202 child protection conferences had been held and that they had attended 85. By contrast, information from the social services department estimated that for a three-month period in 1989, GPs had attended only nine of the 144 conferences reviewed and sent apologies for non-attendance for a further 15. The discrepancy in this information suggests that GPs were not always informed or invited to attend, but commonly the reason given by GPs for non-attendance was timing (Lea-Cox and Hall, 1991). Some years later, Lupton *et al* (2000) found that GPs had participated in only eleven of 121 child protection conferences; the timing of meetings was again reported as problematic, as were increased workloads and lack of notice. The researchers reported that GPs felt that their role in child protection conferences was to raise initial concerns, whereas other participants expected them to participate in the ongoing risk assessment and care planning in the light of their knowledge about the family.

In considering attendance at family group conferences (a more participative meeting) as part of the child protection processes, health visitors seem to feel unprepared, due to lack of knowledge and specific training about their role and contribution (Gallagher and Jasper, 2003). They suggest that overall there has been a lack of appropriate dissemination about child protection practices and social services' expectations about the role of professionals from health and other agencies.

Concern has also been raised about the focus of child protection processes. Sanders *et al.* (1996) found that 90 per cent of the members of Area Protection Committees in Wales felt that the investigation of child abuse was dominant; prevention and treatment components were virtually ignored (see also, Bell, 1999). If policy sets the context for practice, the authors argue, it is likely that practice elements of child protection follow the same priorities. Munroe (1998) supports this argument and suggests that the work accompanying child abuse cases now focuses on finding evidence that will be acceptable in a criminal court. This has meant that police tend to take the professional lead in *investigations,* rather than social workers providing an *assessment* of a child's needs and those of the family.

An analysis of the reviews following child abuse fatalities found a depressingly familiar list of problems: lack of a comprehensive assessment or a poorly structured assessment; poor or lack of interagency communication; failure to accept responsibility; high numbers of professionals involved, sometimes due to staff turnover and sickness;

lack of GP involvement; insufficient training in identifying child abuse for some professionals, and withdrawal of support from parents, leading to increased levels of risk for the child (Sanders *et al.*, 1999)

Inter-agency working

The Children Act 1989 places a legal responsibility on agencies to work together to safeguard and promote the welfare of children in need. The accompanying *Guidance and Regulations* state that 'Sections 17(5), 27, 28 and 30 provide duties and powers in relation to co-operation between and consultation with different authorities including social services, education departments and housing authorities, health authorities and independent organisations (para1.13).

Both *Modernising Social Services* and the Welsh equivalent, *Building for the Future*, aim to ensure that children's services are seen in the wider context of public policies. This legislative framework, and the formulation of the government's objectives for children in terms of their developmental well-being, have given further impetus to joint working. The Children Act studies, however, suggest that within five years of implementation, progress toward co-ordination, co-operation and collaboration was slow. Each agency had a different perspective on the child (needing education, play facilities, or care while parents were working). A common language for children in need was missing. This was compounded by inadequate computer systems within social services for identifying and tracking children in need.

Joint working for individual children was also seen to be important, particularly for children with complex needs, to ensure that services were co-ordinated and timely. Jointly worked out needs-led criteria for services could facilitate joint-working, as could a high level of trust between professionals, good communication (particularly in court-based work) and a mechanism to resolve funding issues. Voluntary agencies were not always seen as an essential part of the planning process, but in England their involvement appeared to hinge on whether they were used on an *ad hoc* basis or had service agreements with social services.

Children's Trusts are intended to provide strategically-based partnerships; they are likely to build on local experience developed within programmes such as Sure Start and the various boards which oversee these initiatives. The forthcoming legislation will 'encourage and facilitate their development', rather than making them mandatory; Children's Trusts will sit at the upper tier, based in local government, and be formed though pooled budgets. Their primary purpose will be integrated commissioning leading to integrated service delivery (DfES, 2004). The recommendation is that most areas will have a Children's Trust by 2006.

Young carers

A survey in 1995 identified 641 young carers supported by 36 designated projects across Britain. By 1997, the figure had increased to 2303 in 69 projects, ranging in age from 2 to 18 years, with an average of around 12 years. Most young carers live in single households caring for ill or disabled mothers, but a significant minority (12 per cent in 1997) care for more than one person. An increase in the numbers of lone parent households is likely to signal a concomitant increase in the number of young carers. Many young carers were missing school as a result of their caring responsibilities and around a quarter had no outside support, other than the designated project (CCfR, 2002).

There are several ways in which local authorities have responsibilities towards young carers. The Carers and Disabled Children Act 2000 came into force in April 2001; it allows councils to provide services directly to carers to support them in their caring role, extend direct payments to carers, and strengthen the rights of carers to have their own needs assessed. These provisions also apply to young carers. The *Framework for Assessment of Children In Need* provides a framework both for their assessment and to ensure that they receive help from local and health authorities. Young carers are also identified as a particular group in the Wales strategy document *Caring About Carers*; the plans for 2002-03 included development of a Young Carers Implementation programme (Welsh Assembly Government, 2002).

Independent visitors

Independent visitors, usually volunteers, have an important role to play for disabled children and young people who are looked after and who have little contact with their parents. By 1996, about a third of local authorities were still not using Independent Visitors, despite provision being a legal duty under the Children Act 1989. Yet their services are highly valued. Knight (1998) interviewed 20 young disabled people who were all positive about having an Independent Visitor. They saw their Visitor as a friend who introduced them to new experiences, would substitute for family contact and would support them, sometimes in an advocacy role, in placement review meetings.

6.5 Services

Part III of the Children Act is concerned with providing services, either co-ordinated by or provided by social services, for children in need and their families. The identification

of services with certain groups of children was an important development in child care legislation. Under the Act, local authorities have a duty to provide a range and level of services that are appropriate to the needs of children in their area. They must provide *family support*, such as advice, guidance and counselling, activities, home help, family centres, assistance with travelling to use services, and services that will promote contact between the child and family where the child is living away from home. Financial assistance can be provided in certain circumstances. New duties were imposed to provide supervised *day care* and *out of school activities* (not considered here). Local authorities are also empowered to provide *accommodation* for some children in family placements, community, voluntary or registered children's homes, or other appropriate arrangements. Disabled children have a right to services to minimise the effect of their disabilities and to give them a chance to lead lives that are as normal as possible. New legislation covering adoption and leaving care services was passed more recently.

This section is organised around those service groups. First, we look at the provision of accommodation for children, most commonly used by looked after children. (These account for only just over 20 per cent of children seen by social services, but absorb around two-thirds of social services expenditure.) We consider the trends and evidence for residential care, foster care, and adoption. We then address family support services. Social workers comprise 66 per cent of the children's social services workforce and provide the greatest part of family support services. A small amount of information exists about family centres but, as with most of the preventive services, there is little research evidence as to their effectiveness. Finally we look at two other areas of interest: services for children leaving care and for disabled children. The Children's Act also requires social services to provided assessment of children's needs, therefore as a final note to this section we consider the use of the Looking After Children documentation, which is intended to facilitate comprehensive but differentiated levels of assessment.

Accommodation for looked after children

In England, the number of children looked after at 31 March dropped between 1992 and 1995 from 55,550 to 49,800 children, but thereafter numbers rose slowly and in 2001 and 2002 there were 59,700 looked after children. By March 2003, the number stood at 60,800; 55 children per 10,000 under 18. The total number of children looked after at any time during a year is higher: the figure has remained fairly constant at around 80,000 children since 1998. The number of children *starting* to be looked after in any given year, however, has gone down by 24 per cent since 1994-95 and now stands at 24,600. Together, these data imply that more children are being successfully supported in their families, but that those who do become looked after remain so for longer periods. Figure 6.28 shows that the changes are small, but the proportion of children whose final period of care is less than a year is dropping and the proportion with

placements of one to two years is rising. (These data exclude children accommodated for a series of short-term placements, such as respite care.)

Figure 6.29 shows that the proportions of children looked after in different types of placement in England have remained fairly constant over the past three years, with around two-thirds of looked after children placed in foster care and only around 15 per cent placed in residential homes. Figure 6.29 also shows that the proportions of children in the different types of placements have also remained fairly constant in Northern Ireland, although a lower proportion are placed in residential homes than in England and a higher proportion are placed with family members.

For Wales, there is again a small rise in the numbers of looked after children from 3,030 in 1990 to 3300 in 2002 (as with England, a rise of about 10 per cent), although the figures dropped below 3,000 between 1990 and 1998. In 1980, roughly equal numbers of children were placed in children's homes, foster care and their family, but by 1990, only just over 25 per cent of looked after children were in residential care and just under 25 per cent were placed with their families (Figure 6.30). By 2001, the absolute number of children placed in residential homes was similar, but now represents an even lower proportion of all looked after children.

Figure 6.31 allows us to estimate occupancy rates for children's homes in Wales. These are calculated for March 31st, rather than for all looked after children during the year, and have remained around 80 per cent since 1999. Occupancy rates for children's homes in England are lower overall (72 per cent) but about the same, if just local authority managed establishments are considered (81 per cent; National Statistics, 2002). The average occupancy rates for foster care in England in 1997 was 78 per cent, although varying considerably with only 45 local authorities below this level (50 per cent being the lowest rate) and 40 above 90 per cent (DH, 2000, p84). However, occupancy rates calculated with snapshot data on numbers of children do not take into account the total number of children being accommodated over the whole year. It must also be noted that spare capacity may help facilitate choice in placements. That is, low occupancy rates may improve the likelihood of there being a place that is appropriate to a child's needs and one in which the child has had a say in the decision about their placement. Improving choice in placements is one of the foci of the *Choice Protects* initiative. The SSI (2002) found that of seven councils inspected, only one had sufficient choice of placements to match the needs of all their children, and only one could place 80 per cent of their looked after children (p21).

Residential care

In 1995, there were 1,139 children's homes in England, of which the local authority managed two-thirds; registered for-profit residential children's homes accounted for only

16 per cent. By 1997, the number of homes rose to 1,232, but by 2000 the number had fallen back to1,146 homes; over this period, total capacity dropped from 10,869 to 9,164 places. In 2000, 59 per cent of the children's homes were local authority maintained and 22 per cent were registered for-profit residential children's homes. Fifty-eight per cent of the children in residential homes were aged 10-15 years and 35 percent were under 10 years.

The *Children Matter* report on children's homes (1998) had found the existing number of places to be inadequate to meet demand and had listed 31 recommendations to improve the level of residential provision. During the 1990s, the number of homes in Northern Ireland had dropped from 55 with 648 places in 1990 to 203 places in 29 homes in 2001. As independent sector homes have hardly been used at all during the 1990s, this contraction in capacity has occurred almost entirely in the statutory sector. There were 27 maintained homes and 8 voluntary sector homes in 2000.

These data suggest that the market share for for-profit children's homes is increasing in England. But research suggests that being outside the local authority structure posed problems for private sector homes in the mid-1990s. These included getting paid on time, working with several authorities with different expectations, accessing local authority services (hence these homes often provide education on site), and difficulties of balancing professional and financial considerations (Gibbs and Sinclair, cited in DH, 1998, p73-74). None of these challenges were new and have been echoed in discussions of the independent provider sector (both for-profit and non-profit) for older people and adults. This research also showed that the residents of private sector homes were also more likely to be showing difficult behaviours than residents of local authority managed homes (see also Hicks *et al*., 2003), but such homes were more likely to have an emphasis on treatment. On the other hand, children in for-profit homes were more likely to live further away from their family and to have less contact with their families; the homes also put less emphasis on preparation for independence.

Another study, funded under the Department of Health 1990s research initiative on residential care, explored the characteristics of 48 homes in five authorities, their staff (n=300) and the 1200 residents of the previous year. Six-bedded 'general purpose' units were the norm, although varying between 4-20 beds. Heads of home gave clear accounts of how they were trying to improve outcomes, such as health or schooling, but were 'bothered by lack of autonomy, problems stemming from local authority reorganisations and unclear or conflicting remits for their homes'. There were around 60 staff hours per week per place (range 23-141 hours), but the high turnover of children (six out of ten leaving within two months of arrival), made the caring task more difficult. Children staying more than six months took up about half the beds. Almost all the residents were between 12 and 17 years old and most had been adolescents when they were first looked after. Seventy per cent had been excluded from school or frequently truanted, 60 per cent had some involvement in delinquent behaviour, and more than 30 per cent had been violent, run away or put themselves or others at risk (see Biehal and

Wade, 2000 for more information on running away). Residential care was the preferred placement for these children, as social workers saw them as too difficult for fostering (Sinclair and Gibbs, cited in DH, 1998, p77-80).

A study of management arrangements, undertaken around the same period, found a large number of unplanned placements in children's homes. The extent of such placements was determined by the size of the local residential and foster care sectors and the level of investment in preventive services. They found a common picture of 'a continuous process of bargaining and compromise between field social work teams under pressure to place children and resource managers keen to gate-keep this process in order to protect the specialist statements of purpose and functions of children's homes' (Whipp *et al.*, cited in DH, 1998, p88).

Comparing like situations over time is a revealing exercise. Commonly used residential homes in three local authorities were studied by one research team; 20 in 1985 and 12 in 1995 (Berridge and Brodie, 1998). An important finding was that only four of the homes visited in 1985 were still open ten years later and only four of the original 136 members of staff interviewed were still working for the same employer. (A recent survey of residential staff found that they tended to see residential work as part of a career path leading to field social work or management; Choice Protects Team, 2002) On the positive side, the homes had more staff than in the earlier period and staff were slightly better qualified and had more experience. However, the homes had 'inherited a more challenging clientele' (p171). (Both of these factors will cause unit costs to rise.) On the less positive side, the external management support was not as good as ten years before, and staff felt such support to be insufficient. Relationships with social workers were worse than with other professionals (such as the police), but relationships with birth parents had improved. Staff still lacked basic information on the children's ethnic origin, religion, CPR status and educational needs. Inter-agency working and multi-professional involvement were felt to have deteriorated – a particularly worrying finding, given the aims of the Children Act.

A subsequent study comparing residential schools and children's homes found that some of these negative aspects remained (Berridge *et al*, 2002). Eleven homes (not the same homes as in the earlier study) and eight residential schools were visited in 2001. Heads of children's homes could give less clear accounts of their purpose and methods than could heads of schools, and only half the residents of children's homes were receiving education. However, the residents in children's homes were older, more delinquent, had experienced greater problems in their upbringing and had more moves between placements. Weekly costs for residence in children's homes were higher, but the authors note that residence at schools is likely to be longer, commonly lasting right the way through secondary school years. No information on outcomes was available from this study, but work in this area is continuing.

Follow-up studies of children in residential homes are also rare. In one (the study of 48 children's homes, discussed above), 141 children, fairly representative of the national picture of looked after children, were interviewed at two points in time, separated by 6-9 months; changes in the children's mood, adjustment and relationships with their families were assessed (Gibbs and Sinclair, 1999). These scores were then assessed against a measure of the home's approach and the strategies employed to achieve change. Despite some methodological problems, some positive associations between the two sets of variables were found, but changes in children's outcome over the period were very small. It may be that longer-term change is difficult to achieve, but that the environment can influence immediate behaviour. This was not a study from entry-to-care onwards, but a cross-sectional study with a follow-up. Even so, the authors suggest that the most appropriate role for most children's homes is 'not as an agent of change but as places of transition – brief resting places where small changes take place but which are springboards to longer-term and more supportive environments' (p7).

A recent survey of residential staff found that they felt they fulfilled a substitute parenting role in supporting children's education. Staff reported that there were education facilities on site, such as computer rooms, books and newspapers, and that they helped children with their schoolwork and liased closely with teachers and schools. They felt that they offered a safe environment to children and had a strong role in encouraging children's individual personal development. Seventy per cent of staff said they were responsible for organising children's basic health care, such as sorting out GP appointments and liasing with other professionals, but accessing CAMHS support was still problematic (Choice Protects Team, 2002).

One of the main messages to come out of the residential care research funded by the Department of Health during the 1990s is that children's homes form an important part of the 'care provision continuum'; for some children residential care is the most appropriate placement choice. However, research has consistently shown that homes need more support from external management sources, good internal management, qualified and experienced staff, and their residents need more support from a range of other professionals. Research has also shown that residents of many children's home are difficult to manage, with the high turnover surely leading to unsettled care environments (for more information on turbulence in children's homes, see Sinclair and Gibbs, 1999). However, research evidence is thin on the ground to inform policy and practice on how to ensure that the right children are considered for placement in children's homes and that they can get into the type of home that best suits their needs.

Foster care

In England, 34,548 children were looked after by foster carers in 1990 and 37,900 in 2000; an increase of about 10 per cent. On average, two children are now placed with

each foster carer, slightly more than in the 1980s; foster carers have also become more diverse over time in terms of age, ethnicity and marital status (Kirton *et al*, 2003). In Northern Ireland, there were 1,428 children in foster care, placed with 1141 registered foster carers at 30th September 2001. In Wales, mirroring the picture in other parts of the UK, the proportion of looked after children placed with foster parents grew over the period from 40 per cent in 1980, to 66 per cent in 1990, rising to around 80-85 per cent from 1997 and onwards (Figure 6.30). The proportion of children placed with parents or with family members diminished rapidly over the 1980s and now stands at around 12 per cent of all looked after children. Between 1992 and 2001, there were increases in Wales in both the number of approved foster carers (1565 to 1892) and the number of places (2416 to 3295), but the number of places in each foster home has risen slightly from 1.5 to 1.7 (Figure 6.32).

But as the SSI inspection of foster care services *Fostering for the Future* reports:

> For many years councils have had difficulties in finding appropriate foster care placements for the children they look after. The reasons for this are now well rehearsed. The proportion of children requiring foster care has increased and their needs are now more diverse, At the same time, changes in women's working patterns and families' expectations about their lifestyles mean that fewer people come forward to foster. Some existing foster carers have moved to independent agencies because they did not feel sufficiently valued, rewarded, and supported by their local councils. As a result most councils can no longer find suitable placements for all the children needing foster care within their own resources. Councils are therefore either placing children with foster families outside the terms of their approval or paying significantly more for placements through independent fostering agencies (SSI, 2002, p1).

None of these challenges are new (see, for example, National Foster Care Association, 1997; Waterhouse, 1997), but this inspection of seven councils found that most of them had not developed 'sufficiently radical strategies to address them effectively' and that 'the lessons learned in commissioning services for adults were not being applied effectively to children's services'. Most of these authorities were having problems recruiting sufficient foster carers to meet their aim of being the primary provider. Moreover, in most authorities, not enough black and ethnic minority group carers were being recruited nor those who would foster disabled children. The inspection found that councils were not sufficiently clear about the conditions required to attract and retain foster carers – or how these conditions might be achieved.

That local authorities have not been meeting these challenges appears to be associated with the growth of independent fostering agencies (IFAs) over the last ten years or so. Estimates suggest there were eleven IFAs in 1993, 63 by 1998 and 120 by 2001. By March 2000, IFA foster carers looked after 31 per cent of all fostered children, and until

the Care Standards Act 2002, most placements were not regulated. IFAs are generally small-scale non-profit operations (only around 20 per cent are for-profit organisations) and are almost entirely funded by local authority placements. IFAs report that they are used when local authorities cannot find an in-house placement or an appropriate in-house placement, and that they often offer specialist placements that have extra therapeutic or educational supports attached. Extra support is provided for foster carers through much higher levels of social work, support groups and respite care. (Comparisons have consistently shown that IFAs provide better support for foster carers than local authorities.) IFAs are also more likely to have a professional orientation; they do not always offer higher financial rewards, but remuneration is usually better structured (sometimes as a salary) and often includes recognition of carers' skills or children's levels of needs. Kirton *et al* (2003) report that the shift towards a more professional view of foster carers is progressing, albeit haltingly and unevenly.

One survey of IFAs dispelled two common myths. First, they do not only 'poach' local authority foster carers: only one-third of IFA foster carers had switched from a local authority. Most IFAs have their own induction and on-going training courses. Second, not all placements with IFAs are short-term: nearly one third of IFA placements are made as long-term arrangements (Sources: Sellick, 1999; Sellick, 2002; Sellick and Connolly, 2002; Kirton *et al*, 2003).

inship care has recently come under scrutiny. At 31 March 2001, 6,600 children were looked after in foster placements with family or friends; numbers increased slowly from 14 per cent in 1996 (4,800 children) to 17 per cent in 2000, although the figures are likely to be higher if children supported under the discretionary Section 17 payments or Residence Order allowances are included. The figures also exclude private arrangements. The increase in use of kinship care is in part associated with greater interest in maintaining children's social networks and can have positive benefits for the children involved. The Choice Protects Team (2003) in summarising the information to date, noted that these carers are often grandparents. They may be poorer than other foster carers, have differential access to a range of financial supports, receive less training, have less understanding of the social services processes, such as assessment, and make less use of the supports available.

Sellick and Howell (2004) suggest four key features that underpin many of the innovative practice initiatives in foster care recruitment, training, retention, job satisfaction, increasing availability and differentiation (choice and appropriateness), and in providing additional supports. First, there has been a growth of partnership and service level agreements between sectors, which illustrate improving relationships and a willingness of the part of local authorities to use independent sector services. These, as evidenced by the 2002 SSI report *Fostering for the Future*, are not yet widespread: 'For the most part though, independent fostering agencies were not regarded as potential partners but as necessary care providers during times of crisis or shortage' (p2). The SSI were also concerned that the lack of well-developed commissioning or

contracting arrangements meant that councils were 'not in a position to apply a disciplined approach to defining the quality and cost of the foster care services that they needed to develop' (p33).

The second key feature of innovative practice was the increased use of information and communication technology to support training, matching, participation and evaluation. This is an important development in a service where the providers (foster carers) may be geographically isolated both from each other and from organisation headquarters. The impact of specific training for foster carers, however, may not always be seen on the children in their care. One study, evaluating the impact of training in communication and attachment, found that foster carers felt they were better carers, that the children they were looking after were better behaved and that their relationship with the child had improved (see also Golding and Pickden, 2004). Yet there were no significant differences in the children's mental health, attachment or self-esteem after foster carer training (Minnis *et al*, 2001).

Third, despite the rapid expansion of foster care generally, as well as of IFA foster care, there is little in the way of independent evaluations. In particular, child outcome measures are rarely used to assess the effectiveness of foster care compared with other care environments. Triseliotis (2002) echoes Berridge's earlier concerns about fostering research. He notes that there are few longitudinal studies of long-term fostering and that many studies have small samples, no control groups, an absence of before and after profiles, and fail to combine qualitative research with more objective measures. Triseliotis reviewed the outcomes of long-term fostering by comparing the results of previous 'snapshot' studies, taking into account changes in the policy context, (in particular, most children in foster care today would have gone to residential care in the past because of their special needs, whereas those who would have been fostered are now supported at home; p24). Despite this, there is a trend for fewer long-term foster care placements to break down now than in the past, suggesting an improvement in the delivery of services (p26).

However, long-term foster placements are rare. In their cross-sectional 14-month follow-up of fostered children, Sinclair and Wilson (2003) found that only six per cent of the sample had been in the same placement for more than six years. These authors found that the child's wanting to stay in that placement was associated with the placement *not* breaking down and it being rated as successful by the child, the foster carer and the social worker at 14 months. Difficult behaviour was often a reason given for the placements breaking down but the foster carer 'not giving up' was as important to the success of the placements as offering stability, care and love. The interaction between foster carer and child was the most difficult to predict at placement, but was as important to the placement success as the other two factors. It is these interpersonal issues that can make an evaluation of 'what works for whom' in child social care quite complex (see also Statham, 2000).

Sellick and Howell also note that there are only a few studies that evaluate the effectiveness of strategies to recruit and retain carers, despite the known associations between carer support, retention and reducing the risk of placement breakdowns. (In the 2002 SSI inspection report, only a third of foster carers thought that support had improved since they had first been approved and 18 per cent thought it had got worse; p27.) Research In Practice (2003) and the Choice Protects Team (2003) summarise what is known about encouraging recruitment and retention of foster carers. As with residential care, the big questions remain unanswered: for which children does foster care work and under what circumstances and at what cost? However, there is an increased willingness on the part of IFAs to be scrutinised and evaluated. The authors note that the perennial finding (citing Bebbington and Miles' work in 1990) of greater staff and carer optimism and satisfaction in the independent sector. This should be considered central to an effectiveness evaluation and it may well have a positive impact on outcomes for the children.

The final key feature of innovative practice in fostering services is the role of independent sector organisations in developing specialist placements and schemes for children commonly thought of as difficult to foster, such as children with complex health and social care needs and those requiring secure placements. One review of foster care research found only 13 studies in the previous twenty years in which foster care was the main focus, although there was more literature on specialist or professional foster care (Berridge, 1997). These are often descriptive studies involving small number of children or a single agency and therefore provide less robust evidence.

One very recent development in England is treatment foster care, intended for young people with severe levels of challenging anti-social behaviour for whom other approaches have not worked (see for example, Redding and Britner, 1999; Jivanjee, 1999). The Department of Health has allocated £5m between 2002 and 2004 to support the introduction of treatment foster care and an evaluation of the programme is due to start in autumn 2004. Success in task-focussed, short-term foster care is associated with very rigorous selection of foster carers, sensitively managed matching and introductions, regular contact between children and their families (which is key to successful reunification), more frequent visits by link social workers to foster carers, and greater efforts by social workers working with the children's family (Sellick and Thoburn, 1996).

Adoption

The idea that children should have a stable home and the notion of permanency planning were incorporated into the Children Act 1975 and the Adoption Act 1976, making it easier for looked after children to be adopted. Despite this, there was no substantial rise in the number of children adopted until after 1988. A peak of 2,700 was reached in 1992, falling back to 1,900 in 1996 and then rising slightly to 2,000 in 1998.

However, over this period, adoptions of looked after children formed an increasingly higher proportion of all adoptions: from 7 per cent in 1975 to around 40 per cent in the 1990s. By 1996-97, of a total of 5,360 adoptions, 37 per cent were of looked after children, 60 per cent were by step-parents or relatives with a few inter-country adoptions (220) and around 50 arranged directly through voluntary organisations. This change of focus away from children being considered 'available' for adoption to finding families for children who needed a permanent home meant finding skilled adoptive parents as well as supports for the new challenges of contested adoptions, maintaining contact with birth families, and post-adoption support. There was both a review of adoption and a White Paper in the early 1990s, but both a new review and new White Paper were required in 2000 before the Adoption and Children Act 2002 was passed.

The proportion of children adopted each year in England has risen from four per cent of all children looked after on 31st March 1999 to five per cent in 2000 and 2001 and six per cent for 2002 and 2003 (3,600 children; Figure 6.33). Adoption rates were lower in the London Boroughs compared to metropolitan, shire or unitary authorities. Four per cent of looked after children in Northern Ireland are placed for adoption. A study by Lowe and Murche (cited in DH, 1999) found that 71 per cent of shire counties had approved 20 or more families for adoption in the previous year, but only 20 per cent of the district boroughs and 8 per cent of the London boroughs had reached this figure. The average number of children placed for adoption was 17, with the highest number being 79. The Department of Health statistics for 1998 show that 62 per cent of authorities had fewer than 10 children 'placed for adoption, 23 per cent had between 10 and 19, 10 per cent between 20 and 29 and only 5 per cent of authorities had 30 or more children placed for adoption.

Ten studies within a Department of Health research programme were undertaken in the early 1990s and are summarised in the 1999 report *Adoption Now: Messages from Research*. In these studies, disruption (where the child leaves the placement) rates varied from 2 to 24 per cent. More recently, Rushton and Dance (2004) found a disruption rate of 27 per cent six years after placement but the recent literature review suggests an overall disruption rate of 20 per cent, ranging between 10 and 50 per cent depending on the composition of the sample and rising with the child's age (Rushton, 2004). The duration of an adoption and whether a foster carer has adopted the child also have an impact on disruption rates. These findings emphasise the need for careful selection of adoptive parents and careful matching of children and parents, yet there is little evidence on how to achieve a 'good match' or on the associations between assessment and selection of adoptive parents and outcomes. Rushton (2004) also notes the paucity of evidence showing clear indicators of what constitutes a good match, although there is much discussion about the importance of same-race placements in both adoption and foster care (see, for example, Rushton and Minnis, 2000).

Whilst numerically, these children represent only a small part of social services work with children, the potential for good child welfare outcomes is high if sufficient preparatory work can be done.

In terms of their preparation to live with new families, children in the 1990s studies wanted to know as much as possible about the prospective families and wanted the families to know about them. The transition period often caused anxiety and could last for quite a while. Social workers' efforts at preparation revolved around life story work, but this may not always be sufficient.

The process of preparation for prospective adoptive parents is also well described in *Adoption Now,* but this research generated little evaluative evidence to guide authorities. Many carers expressed concern about the provision of information on children placed with them; in some studies, 20 percent of parents did not feel they were properly informed about the impact a child's background might have on their behaviour. One of these studies also found that social workers had discussed issues with only around half of the adoptive parents' children. Parents also wanted more preparation for the court hearing, particularly that a postponement might happen.

Adoption Now also reported that the early period of an adoption placement required careful support, but help for children with emotional and behavioural problems was thin on the ground. Where specialist mental health provision did exist, it was concentrated on children who had been sexually abused. Schools (often special needs schools) were considered to be supportive, but there was less support when it came to child care arrangements for parents in work. Early high levels of social services support dropped but even so, at the end of the first year, support from the child's social worker continued for 63 per cent of the families and was offered by the family social worker for 74 per cent. Where visiting occurred, it was about every 5-6 weeks and social work help could be sought in times of crisis, typically provided through emergency duty officers or teams or a dedicated telephone number.

A more recent survey of 120 local authorities in the UK found that although local authorities were responding well to the new set of adoption-related responsibilities, progress towards developing adoption services was uneven (Rushton, 2003). For example, service managers found it very hard to assess the level of need for post-adoption support, even though 40 per cent of the authorities had recently established, or were in the process of establishing, post-adoption teams. These teams were commonly just one full time person and, for many, their core tasks were to develop systems, such as monitoring procedures, newsletters and resource databases, rather than to provide a direct service. Thirty per cent of the authorities did not see adoption as a specialism, so the children and families' services would undertake this work. The remaining 30 per cent were contracting an independent organisation to take on this work. The authors advocate the introduction of regional adoption support resources. Accessing CAMH services remained as problematic as it had been in the studies of the 1990s. Despite

different organisational arrangements, authorities in Northern Ireland appeared just as aware of the need to work closely with other agencies as in England and Wales.

The financial situation of families who are caring for some very troubled children is a matter for concern. Only 61 per cent of the large Lowe and Murche sample (children placed 1985-87; DH 1999, p130-133) received an adoption allowance, and reflected very different practices in payment throughout England; the allowance was generally seen as a discretionary payment and is means-tested, rather than an automatic right. It was more common for respondents to say they had been denied one-off payments for items such as furniture, school uniforms or special lessons, than to have been provided with these extra resources. Thoburn *et al*'s study (children placed 1979-86) found that 30 per cent of those interviewed were sometimes or often short of cash. The loss of the foster carer allowance provided a disincentive for foster carers to adopt. None of these issues appear to have been resolved in the past ten years or so. A longer-term follow-up of 80 non-infant adoptions of the early 1990s found that only 30 per cent were receiving adoption allowance after the Adoption Order was made and 44 per cent of adoptive families considered themselves to be struggling financially (Selwyn and colleagues, 2003; not yet publicly available).

It should be noted, of course, that the children who are adopted today, and indeed over the last 20 years or so, are far less likely to be infant adoptions from unmarried mothers and far more likely to be children with troubled pasts adopted in older childhood. For example, in a study of 100 pre-adoption medicals (1994-1998) in one local authority Mather (1999) found that 57 were in the care of the local authority because of abuse, neglect and poor parenting and 69 were likely to have serious medical, developmental or emotional problems. In addition, 60 were reported to have significant emotional or behavioural problems; many had several concurrent problems, but only a few had any contact with CAMH services. Thirty-six had physical problems and four were globally developmentally delayed. Only ten of the 38 school age children were achieving normally at school.

Such findings have led researchers to consider a wider range of outcomes than just the disruption rate. These include attachment, sense of security and belonging, personal and social functioning, parenting styles as well as qualitative information on children and carers' perspectives (Triseliotis, 2002). The accumulating evidence on the very challenging behaviour of some adopted children prompts the need for prospective longitudinal studies that compare outcomes across a range of domains for children who are permanently placed in a range of living environments (Rushton, 2004).

In 1975, legislation for England and Wales was passed allowing people who were adopted since 1927 to have access to their original birth certificate. It is likely that more than 40 per cent of all adopted women and 33 per cent of all adopted men will receive their records at some time in their lives. In 1977, there were 5,018 applications. This fell to 2,016 in 1978 and 1,149 in 1979. The figures then show a gradual increase to the

1990s when the figures level out at about 3,500-4,000 per year. For births from the mid-1960s the application figures fall gradually in part as a response to the more open discussion of adoption (Rushbrooke, 2001).

Family support

In 1986, a review of social work effectiveness experiments with all client groups found that there was some evidence for positive effects under particular circumstances. Social workers were more effective when there was a clearly identified target problem, when a contractual and a task centred or behavioural approach was used, when the work with a client was intensive and when there was good co-ordination with other agencies. By 1992, a picture painted from a search of over 50 journals was less optimistic. Ninety-six evaluations of social work practice were found, most in the US and only one in seven with children. The authors conclude there is a dearth of empirical data, with evaluation made more difficult as social work practice relies as much on personalities and relationships as it does on professional practice (Statham, 2000, p13).

The literature search undertaken for this study revealed no evaluative evidence for social work practice, although papers were found that describe how social workers work, the essential elements of social work practice, and how the organisational context affects their working practices. These tend to be single authority studies or more theoretical papers in which the implications for practice are drawn out. Fisher *et al.* (2000) found that foster carers thought good social workers: showed an interest in how they were managing; were easy to contact and responsive; did what they said they were going to; were prepared to listen and offer encouragement; took account of the family's needs and circumstances; kept them informed and included in planning; ensured that payments, complaints etc were processed as soon as possible; attended to the children's interests and needs and involved foster carers where appropriate.

One of the few studies to evaluate a specific social work intervention looked at both the costs and effectiveness of a home-based social work intervention for children who had deliberately poisoned themselves. Compared to routine care in out-patient psychiatric services, the social work intervention had similar outcomes and costs but parents expressed high levels of satisfaction with the social work intervention. However, the small sample size led to large confidence intervals in the cost measure (Byford *et al.*, 1999). Too small a sample is a perennial problem in economic evaluation, but the absence of comparison groups and before-after-designs in child care research mean that little information on the relative cost-effectiveness is available (See also, Byford et al., 2003; Edwards and Thalanany, 200; Knapp and Lowin, 1998; MacDonald, 1999; Sefton et al. 2003). Barratt (2003) summarises the views of 100 staff in children's services. Even if sufficient evidence were available, they are uncertain about the nature of research evidence in social care and its role in informing decision-making, policy and

planning. Inadequate dissemination methods and limited access to internet resources may exclude some practitioners and teams.

Most projects in the early 1990s evaluating the Children Act (Aldgate and Statham, 2001) reported deficiencies in recording and collection of basic information and the lack of standardisation in the recording methods. One of the aims of the *Framework of Assessment* and *Looking After Children Records* was to improve record keeping as an aid to good decision-making (DH, 2000). A study of the implementation of the Assessment Framework in 24 local authorities included interviews within the authority and an audit of 2248 referrals and subsequent assessment records (Clever *et al.*, 2004; Department of Health, 2003). Both national and local government had underestimated the degree of training required to implement the approach and its related documentation. Few social workers had received training on any of the attached standardised scales and questionnaires and rarely used them. There was no exploration of the impact of assessment on the child's subsequent pathway through social services support. but full implementation of the Assessment Framework and associated records substantially increased parental involvement in and satisfaction with the assessment process. A third of social workers said that the introduction of the Assessment Framework increased collaborative assessments.

The documentation had substantially increased social workers' and managers' workloads and only two-thirds of referral and initial assessments (39 per cent of the referrals) were completed on time. Social workers recorded that no further action should be taken on 45 per cent of these cases, 29 per cent should receive some form of social services support and 25 per cent should be referred to another agency. Only a third of core assessments (3 per cent of the referrals) were completed on time. Lack of computers, relevant software and skilled staff caused problems with recording the information electronically. On average, these core assessments took 22 hours to complete, although complex cases took an average of 36 hours. Organisational, staffing and resource issues hindered practitioners from meeting the time limit of 35 working days for completing core assessments. The Children Act Report 2000 (prior to full implementation of the assessment framework) used the CIN 2000 data to show that 92 per cent of social worker time was spent on ongoing work, rather than work during 'intake/referral' (first 24 hours after referral) or 'initial work' (within the next seven days). By the 2001 CIN Survey, this proportion had reduced slightly, with 4.5 per cent of time spent on 'intake/referral' work and 5.5 per cent on 'initial'.

The Department of Health and the Social Services Inspectorate have heavily backed the *Looking After Children* assessment system. Although at the practice level, its implementation appears to have been useful (although some parts of the documentation are used more often than others) the second policy aim, to provide aggregated data to feed into local and national policy and planning, has been implemented much more slowly (Bailey *et al*, 2002). Researchers found that incomplete LAC information meant that the reviewing officer and the child's social worker needed to summarise LAC

information for each child at the end of a review meeting to develop the basis for the aggregated data. Although the resulting data was considered useful by social services department decision-makers, it was at a cost of extra social work time

The Children Act Report 2002 reported that that, nationally, only 54 per cent of referrals in 2002 had received an initial assessment within the required seven days and only 52 per cent of core assessments were completed on time. While the implementation of the assessment framework appears to be improving the quality of social work assessment, this is variable between authorities (SSI, *Safeguarding Children*). Moreover, the impact of social worker and other professionals' workloads is considerable and is in part responsible for the delayed timescales.

Family Centres were found to be heavily used and valued by users in the Children Act studies of the early 1990s – 80 per cent of users said they had made a difference to their families' lives – but we know little about people who chose *not* to use them. This satisfaction rate is similar to that found for short-term foster care. Studies generally view these centres as part of an open-door strategy for children under-five, rather than a service targeted at families likely to place their children at risk of significant harm (Aldgate and Statham, p130). Two recently competed studies led by Geraldine McDonald and John Carpenter will considerably advance our knowledge in this area.

Leaving care services

New duties were placed on local authorities in section 24 of the Children Act to prepare young people for leaving care and to advise and befriend young people who left care after their 16th birthday up to the age of 21. There was no blueprint for the ideal leaving care system, but it was argued that it should have a sense of direction, good management and adequate resources.

Leaving Care services are slowly coming on stream in many authorities. Stein's 1997 review suggests that specialist schemes work well in relation to accommodation, improving life skills and, to some extent, furthering social networks. Placement stability appeared to have the greater impact on educational outcomes and financial systems needed reviewing to ensure needs for longer-term financial support could be met. 'For many young people, the best approach would be for their "prime" foster carer to be responsible for preparing them for adulthood with the specialist leaving care team offering resources rather than intensive substitute support.' However, the studies were usually small exploratory studies and the author recommends that more outcomes studies (including randomised controlled designs) are undertaken, including the use of comparison studies with non-care leavers. More studies are also required of specific groups, such as ethnic minority groups, young parents and young people with special needs.

Care Leaving Strategies (Department of Health, 2002) provides information on a number of good practice examples around England. These include projects for creating a care leaver strategy, improving preparation for leaving care, providing an appropriate range of accommodation, tailoring individual support, accessing education, training and employment, improving care leavers' participation, and providing care leavers with clear information. New research into the costs and effectiveness of leaving care social work teams (Biehal, Byford and colleagues at York University) is due to report this year.

Youth Offending Teams

Youth Offending Teams (YOTs) were established under the 1998 Crime and Disorder Act 1998 and fully implemented in 2000. They are formally based in social services, but were originally part of the remit of the Youth Justice Board. They are interagency teams with staff from education, probation, police, health and social services. They should provide an integrated and appropriate response to young people who have offended, reduce youth crime by helping young people confront the consequences of their offending, tackle issues which otherwise may contribute to the initiation or maintenance of crime and facilitate effective delivery of youth justice services. Only one paper was found on YOT teams, exploring how mental health support could best be accessed for YOT users, given the high association between children's mental ill-health and criminal behaviour (Callaghan *et al.*, 2003). Part of the role of primary mental health workers (PMHW) is to cover the interface between YOTs and children and adolescent mental health (CAMH) services, as a combination of direct work with young people and consultation, liaison, training and joint working. Focus groups in one local authority where PHMW were based full-time within the YOT identified the importance of having someone on-site for assessment, consultation and direct work, although participants expressed some concerns about the boundaries between these three activities. Many felt that PMHWs had generated access to and greater responsiveness of CAMH services (although delay in provision was still common). Having a mental health professional on the YOT reduced the stigma of having a mental health problem for some of the young people.

Services for disabled children

Secondary analysis of the CIN Survey 2001 provided some up-to-date information about disabled children who use social services support (Bebbington *et al.*, July 2003). The 132 authorities judged to have reliable data reported 11,000 looked after disabled children who were open cases, around 82 per cent of whom received a service during the survey week; 64 per cent were boys. Just fewer than half these children were receiving planned short-breaks - one third in foster care and two-thirds in residential care. (Eighty-three per cent of users of planned short-breaks were disabled.) Among

looked after disabled children *not* using short-breaks, just over a quarter were in residential care, compared to nine per cent of other looked after children, and 63 per cent were in foster care. For disabled children supported in their families (39,605 children), only 47 per cent received a service in the survey week, commonly an individual session with a worker – a profile very similar to that found for non-disabled children. Only 102 authorities could provide data on the specific area of disability of each child (for example, autism, mobility problems, difficulties with personal care etc.).

Multi-agency key worker services (link workers or key coordinators) have been a feature of evidence-based recommendations in both policy and research. A key worker is someone who is 'a named person whom the parent approaches for advice about and problems related to the disabled child and who has responsibility for collaborating with professionals from their own and other services' (Mukherjee *et al.*, 1999). Research has shown positive effects for families, yet less than one-third of families of disabled children have such a service. Even where such services are available, it is often on an *ad hoc* basis, relying on the initiative on one person (Sloper *et al*, 2004). Workers performing the key worker role may come from a number of different agencies, depending on the particular need of the child. The researchers and steering groups concluded that to implement a key worker service, it was necessary to address the following issues: joint working context and resources; good planning with clear definition of roles, good information systems; an awareness of the constraints in different occupations; and the provision of support for key workers. In 2002, a survey of the 225 children and disabilities teams revealed 35 had some form of care co-ordination team, but only 30 provided key workers for families (Greco and Sloper, 2004). Of these, only five employed full-time key-workers, while in the others professionals provided key working to a few families as part of their wider professional role.

Several of the Children Act studies describe the burgeoning use of respite care (planned short breaks lasting not more than 90 days in any one year). One study showed the benefits for both families and children. Parents felt more in control of their lives, and 80 per cent of parents' expectations were met in terms of anticipated benefits, such as recuperation, feeling less lonely and coping better with everyday life. Respite care was less successful in changing children's behaviour and improving relationships with partners over the few months of the study; these may need a longer intervention. There were also measurable changes in the families' support networks, and relationships with extended family members had improved. Children benefited where they were well attached to their family in the first place, and in the majority of cases, children's' quality of life was improved (Aldgate and Statham, 2001, p50). The success of the service depended on multi-agency access, clear assessment processes, including parental capacity to use the service appropriately, focussed casework and the careful selection, training and support of carers. Good user and service outcomes were achieved, because of the realistic targets set for children and families, with carefully timed intervention, time-limited support subject to sensible implementation of

regulations. Parents were grateful to have received support when they needed it (Aldgate and Statham, 2001, p103).

Services for children of black and ethnic minority origin

Even by 2000, the SSI was still reporting that information on children's ethnicity and first language was poorly monitored, with only 71 per cent of the 394 files assessed having these data (Cooper, 2002). The CIN 2001 Census found similar problems with missing ethnicity data for 16 per cent of children in supported in families and for 3 per cent looked after children (Bebbington and Beecham, January 2003). There are variations between authorities, with four reporting ethnicity for less than half their children in need and only 14 reporting ethnicity for 99 per cent or more. Sixteen of the London authorities report that more than half their children in need come from ethnic minority groups. The CIN data show that 83 per cent of looked after children are white and 82 per cent of children supported in their families are white, but there are differences in the proportions of different groups between looked after and supported children. Among Asian children, the number supported in their families is high, compared to the number looked after. Children from some, but not all, ethnic minority groups tend to come to the attention of social services younger than white children, particularly Indian and Pakistani families and those from mixed race backgrounds. Black children are disproportionately represented among children 16 years or older.

The CIN data also show that compared to other ethnic groups, there is a high proportion of disabled children from Asian backgrounds. Abuse and neglect is a common reason for receiving services among children of mixed race backgrounds, who are also more likely to be on the Child Protection Register; socially unacceptable behaviour is most common among white British and black Caribbean children. The difficulties of finding same-race foster placements were confirmed for 'other Asians' and black Caribbean children, for whom there were slightly higher proportions in children's homes, but this was not true for children of mixed race backgrounds.

Expenditure per child was also compiled through the CIN Survey. Spending on mixed race or black children was not shown to be particularly high, but it was lower than average for children of Indian, Pakistani and Bangladeshi origin. Children of mixed race and black background are more likely than others to become known to social services, but their needs and pattern of services are not greatly different from the white majority. Children of Indian, Pakistani and Bangladeshi origin are comparatively unlikely to become looked after, but when they do, are less likely to be in conventional placements and typically cost a lot less to look after. Disability is more likely to be the factor that precipitates the social services' response.

A major review of research on services for children of minority ethnic origin focuses on family support, child protection, looked after services and social work (Thoburn *et al.*, 2004). There is no doubt that issues around providing services for children from ethnic minority groups are complex and more research had been undertaken on support for Asian families that other groups. There was tremendous variability in the way local authorities responded to the needs of children from ethnic minority groups, but on the whole, their needs for services were found to be similar to other children in need. But 'how' services are provided was often as important as the 'what'; for example, there is information about parenting styles and aspects of social work that are associated with successful placements. Different approaches are needed for different needs and preferences, overlaid by the complexity and centrality of inter-personal relationships in children's social care services. The review found assessments were often incomplete and families did not always feel included or consulted (although a not an uncommon pattern for all children). However, the rates of un-satisfaction and dis-satisfaction with services were similar for ethnic minority families as for all users, although the shortage of culturally specific support systems – often the first to be cut during times of resource constraints - meant packages of care were not always appropriate. The review found particular problems associated with use of the court system, where extra support was needed not just for language interpretation but also to help children and their families understand the processes. Encouragingly, the review found that although placement patterns are different (and black children are less likely to be in suitable placements), outcomes for looked after children from ethnic minority groups tended to be no better or worse than for white children. However, understanding more about the factors that led families from ethnic minority groups to seek social services support in the first place will improve support both within and away from family care.

Service gaps

There are some very obvious gaps in services for children in need. Among the most commonly noted is the provision of information to carers. Research clearly shows that foster carers, residential workers, adoptive parents and parents of disabled children all want more information about the children in their care, as well as about services available. Carers also often feel they do not get enough support. The cumulative evidence for foster carers (21 per cent of foster carers in 2002 SSI inspection of fostering) and parents of disabled children is strong, but other evidence includes the study of residential care more than ten years ago that reported poorer relationships with social workers and poorer external management support. Young carers do not appear particularly well supported. Support from other agencies for children was also a common *cri de coeur*, particularly support from education (over and above mainstream resources) and CAMH services. These two services, of course, are in short supply generally but there is evidence of high levels of need among children in need and especially looked after children. One notable finding was that children in foster care who

had contact with an educational psychologist were less likely to have a placement breakdown, possibly because of the impact on school attendance (Baker *et al*, 2000).

6.6 Outcomes, costs and cost-effectiveness

The Government's eleven Objectives for Children's Services (Department of Health, 1999) form the structure for this section, the first eight of which are specific to children and were originally identified under the Quality Protects programme. Progress towards these objectives is seen as measurable and, for around half of these objectives, data from the Performance Assessment Framework indicators are summarised below. Additional research evidence is also provided where it is available.

The evaluation of the Year for Management Action Plans (MAPS; Department of Health 2003) notes that there has been significant improvements on the objectives referring to secure attachment, protection form harm, services for care leavers and participation of young people. Authorities have struggled to meet targets for timely assessments and qualification levels for staff.

To ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood.

Figures 6.34 and 6.35 show the trend in the two performance indicators linked to this objective. Figure 6.34 shows the changing picture of stability for children who have been looked after for more than four years. It combines a measure of placement in foster care (the preferred placement for looked after children) with staying in that same home over two years. The proportion nationally has remained at 50 per cent of looked after children over the last six years, but there is variation between authorities. The Children Act Report 2002, for example, reports that only a few councils had fairly constant values for the previous three years, with movement both up and down in others; certainly, this is the picture when the data are shown separately for the five different types of authority. Inner London boroughs appear to perform slightly better on this indicator than other authority types and metropolitan districts perform less well that the national average.

A national target was set by the government for all local authorities that they should reduce to 16 per cent or less the proportion of looked after children who had three or more placements in one year. Reducing the number of moves between placements gives children greater opportunity to form stable relationships with their carers. Progress on this indicator is shown in Figure 6.35, with the national average now standing at only 12 per cent. There is considerable variation in attaining this target not only between types of authority (Figure 6.35) but also between authorities. The annual Children Act

Report 2002 (using a revised methodology) shows that 40 per cent of authorities met this target in 2000, 49 per cent in 2001, and two-thirds by 2002.

Increasing the proportion of looked after children who are adopted is the final governmental measure of progress for this objective. Of course, there are many looked after children for whom adoption is not appropriate (DH, 1999). These include: children who are looked after on a voluntary basis; those subject to a care order; those placed with parents; those fostered with relatives or living independently; those subject to an emergency protection order; and children and young people on remand, detained, or in prison or a youth treatment centre. The targets in 1999 were to increase the proportion of looked after children who were adopted by 40 per cent, thus aiming for 3,800 children by 2005, and to reduce to a year the time between a decision to adopt and adoption for 95 per cent of these children. The Children Act Report 2002 found that 3,400 children had been adopted during the year ending 2002, up from 2,200 in 1998.

In the Department of Health funded studies which looked at placements in the late 1980s and early 1990s (see *Adoption Now*), the period between placement with the adoptive families and panel approval of that placement was an average of 17 months, although there were large variations. Between panel approval and submission of an application to court, the average time was just over 5.5 months, or two months longer where a freeing order was made. For infants, it took just three months before an application was lodged with the court, but four times as long for those aged five to ten years at placement, and ten months where the adoption was contested by birth parents. Delays at this stage were found to be due to lack of social worker experience in completing the requisite forms, difficulty in locating the information required, and prioritising this work against the pressures of child protection work. Guardian *ad litem* reports could take 24 weeks, the timing extending with the complexity of the case. However, around 75 per cent of applications were resolved at the first hearing.

The average duration of time between the decision and adoption since the new Act is shown in Figure 6.36; this has fallen slightly over the three-year period, but the impact of age is quite marked. The Children Act Report 2002 states that for 80 per cent of adoptions in 2001, the 12-month target had been reached, so there is considerable variation around this average.

Research provides additional data on the rate of placement breakdown, although many factors pertain to service responses, rather than to children. Triseliotis' 2002 review of outcomes for children looked after in long-term foster care or adoptions found no longitudinal studies, but compared the outcomes measured for cross-sectional studies over the last 20 years or so. He found very low rates of breakdown in both long-term foster care and adoption for pre-school children, but rates of around 15 per cent for adoption and 30 per cent for long-term foster care for children who were placed between the ages of 5 and 12 years. One recent longitudinal study of 133 children

found breakdown rates of 27 per cent for adoptions and 34 per cent for foster care, suggesting a further narrowing of the gap between these permanent placement types (Rushton and Dance, 2004).

Collishaw *et al.* (1998) reviewed a number of studies from the international literature that together find that adopted children show fewer problems in childhood and adolescence than children from broadly comparable birth circumstances, but somewhat higher problem levels than children in intact families. Difficulties appear to centre on increased risks of disruptive 'externalising' behaviours, but there is some evidence of higher rates of emotional problems in adolescence; children adopted later in childhood (who may therefore have been subject to more disrupted early experiences) may face greater problems in peer relationships. In many of these studies, risks are higher among adopted boys. In the longer-term, one Scandinavian study found no difference between adopted and non-adopted children at age 23 and behaviour problems in the adopted children were not continuing into adulthood. In contrast, results from New Zealand found adoption to be associated with a history of childhood conduct disorder, with increased risk of anti-social personality and drug misuse in adult life, especially among males (n=24, mean age 26).

From the 1958 National Child Development Study birth cohort Collishaw *et al.* (1988) found 180 of the 543 children born to unmarried mothers were placed for adoption (often in materially better circumstances) and compared their later circumstances with other children born to unmarried mothers and a sample of legitimately born children. At age 33, adopted women showed no higher rates of relationship breakdowns, and their emotional problems were lower and perceived social supports more extensive than children who stayed with their unmarried mothers. Employment difficulties were found among adopted men in the earlier analysis at age 23 (multiple periods of unemployment and greater likelihood of being sacked; Maughan and Pickles, 1990) and these had continued; their social supports were also more restricted than for men in the comparison groups, although both adopted men and women showed good education attainment levels.

As the *Adoption Now* report notes, breakdowns also happen *before* an adoption order is made and these figures do not appear in the performance indicators. These studies suggest that up to a quarter of those placed with a family for adoption do not get adopted; some remain as fostered children, while others move on to another placement.

Another form of placement disruption has long been common in children's homes. A study of children in residential care in four authorities in the mid-1990s found 2227 incidents of running away over a twelve-month period, involving 272 young people; these represented 25 to 71 per cent of each authority's residents. Just four homes in the sample accounted for 42 per cent of children going missing, suggesting that some factors within the homes may have made a difference. However, there are often pre-

disposing factors: nearly half these children first went missing from their family homes and they were more likely to have entered care later. Persistent runaways were also less likely to be attending school, and more likely to have committed offences and been involved in substance abuse. (Biehal and Wade, 2000).

Other outcome measures are also important. While stability in a placement gives the opportunity for long-term relationships, it does not measure the quality of that placement. It may be, for example that even though a placement eventually breaks down, it was of considerable benefit to the child (Minty, 1999). Tresiliotis (2002) summarises the evidence. More than half the children in foster care display high levels of emotional and behavioural problems, whereas the figure for adopted children is lower at between a third and a half. And while some studies show that children in long-term foster care seem to do as well in the longer-term as comparable children who are not looked after (see Minty, 1999), others suggest that 'maladjustment' is more frequent, but children who have been adopted do as well as community controls. Adopted children's sense of security is also better than children in long-term foster care, who continue to have concerns about not 'belonging' to anyone and about having to 'move on'. Tresiliotis points out that these are not reasons to remove long-term fostering as an option for permanent placements, as adoption is not suitable for all children requiring permanent care. They are, however, perhaps good reasons to improve some factors that promote insecurity in long-term foster care.

In a retrospective study of permanent placements in one local authority between 1986 and 1990, there were 129 adoption placements, 80 long-term (permanent) foster care placements and 25 placements with foster carers with a view to adoption (Holloway, 1997a). One hundred and eight of these carers returned questionnaires about the success of the placement, 73 of which were still extant (Holloway, 1997b). In all, 81 per cent of carers thought that the placement was successful and 13 per cent thought it was not very or not at all successful. Carers reported that 31 per cent of the children attached to their new mothers within a week and another 14 per cent within a month. The most common reasons for disruptions were behavioural in the home or school (n=50), contact with birth family (16), and legal delays and uncertainties (n=16).

Ten studies on adoption within a Department of Health research programme were undertaken in the early 1990s. The summary report *Adoption Now: Messages from Research* identified predictors of successful adoptions arising across the studies. Although this does not answer the question of 'what works', it does take the level of information a good step forward. The younger the child, the lower the likelihood of poor outcomes. The child's past experience was also important: the longer the child had been looked after and the greater the number of moves, the higher the probability of breakdown. Other features from a child's background that increased the risk of instability were earlier rejection by parents, abuse or severe deprivation. Behaviour problems of all types were associated with poorer outcome, particularly defiant,

aggressive or sexualised behaviours. The presence of birth children increased the risk of poorer outcomes, although there were mixed results concerning age differences.

Factors contributing to the stability of placements

Jackson and Thomas (1999) found that factors contributing to the stability of placements are: adoption, remaining with the child's own family, returning home within six months, placement with relatives or previous acquaintance with foster carers, school success, intensive social work in the early stages of placement, absence of behaviour problems, maintenance of a child's social networks, placement with siblings, older more experienced foster carers and higher rates of payment for fostering.

In a cross-sectional three-year follow-up of nearly 600 children fostered in 1998, foster care was found to offer limited permanence for children (Sinclair *et al*, 2003 and see section 6.5). The likelihood of placement breakdown, particularly for teenagers, was associated with factors about the child, the placement, the school and birth parents. The challenges to both stability and secure attachment included:

- Repeated efforts made to return some children to their birth families;

- Expectation, and practice, that all but a small minority of children would move on by the age of 18;

- Variable responses to foster carers' requests to adopt and financial and other barriers to them adopting;

In 1996, the Barnardo's review on what works in *family placement* concluded that there are still many gaps in our knowledge (Sellick and Thorburn, 1996). The authors suggested that it was essential that longitudinal studies were undertaken to help identify what works and check whether existing knowledge is still relevant. Smaller cohort studies of children with special needs were also required. All research should incorporate specific outcome measures and carefully describe the different methods used at different stages of the placement. Although more research has been done since that review was completed, we still concur with these authors' conclusions.

To ensure that children are protected from emotional, physical, sexual abuse and neglect (significant harm).

To assess progress on this objective the government use a service-related measure of decisions made, rather than actual harm, that is figures relating to the Child Protection Register.

As shown in section 6.3, the number of children on the Child Protection Register (CPR) in England stayed fairly constant at around 32,000 until 1999-2000, but subsequently fell to 25,700 in 2002 (DH, 2003, p24). Addressing concerns about the use made of planning mechanisms and interventions made after a child was registered, the proportion of de-registrations of all CPR children *decreased* from 11 to 8 per cent for children who had been on the register for two years or more. The proportion of re-registrations has also dropped since 1997-98 and is currently between 11 and 15 per cent (Figure 6.12).

Old Virtues, New Virtues expressed concern that too many children were placed on the Child Protection Register in a 'flurry of activity and intervention', but then they and their families were left unsupported (Audit Commission, 2004). Again, there no direct measures of whether interventions were – or were not – put in place following registration, but as Figure 6.36 shows, although overall rates are rising, not all councils are managing to get these reviews completed on time. Research data tends to support the concerns in *All Our Lives.*

All Our Lives reports that SSI inspections in 2002-2003 found that 81 of the 150 social services authorities in England were serving most people well through their child protection services; 30 councils were not serving all children well and had uncertain or poor capacity for improvement. The overall indicators suggest that six councils were not serving children well. Moreover, the Victoria Climbie (Lord Laming) report stated that 'Checks on child protection services across the country revealed that there was no room for complacency.'

Recommendations to increase children's safety and to create environments of excellence for children living away from home were made in the 1997 Utting Report, *People Like Us.* By 2002, children's homes were generally performing well against the National Minimum Standards (36 standards in 8 broad headings), with the exception of procedures for vetting staff and visitors, and managers monitoring the home's operation (*All Our Lives*, p20).

To ensure that children in need gain maximum life chance benefits from educational opportunities, health care and social care.

The Children Act studies (Aldgate and Statham, 2001) found that by the late-1990s thresholds to services were often linked to service criteria and concerns about significant harm. Several contemporaneous SSI studies on family support, disabled children and looked after children reinforced this finding. On the one hand, this perspective helps to meet the government's objective on significant harm. On the other

hand, one of the aims of the Children Act was to make access to services easier; it gave social services a duty to publish information on services available to families with children in need, and to make sure that people who might benefit from the service receive the information in a way that takes account of language and cultural needs of minority ethnic groups. The Children Act studies found that a controlled approach to publicising information was linked to a fear of overstretching resources due to over-demand. However, open-access through 'one-stop shops' (resource or family) centres appeared to contradict this fear, allowing non-stigmatised short and long term services as well as providing information about and referral on to more appropriate services.

Currently, one of the best sources of information on children in need who are not looked after comes from the Children In Need Survey. This provides information on the number of children in need, that is open cases with social services, which receive a service (Bebbington and Beecham, May 2003). Around 53 per cent of children supported in their families (that is, *not* looked after) received a service of some sort during the Survey week, compared to 91 per cent of looked after children. Of those who were seen during the Survey week, 81 per cent saw an individual worker (usually a social worker), compared to 77 per cent of looked after children. Few of these children (6 per cent) received one off payments, but more received some form of group work (such as at a family centre). The figures for looked after children were 10 per cent and three per cent respectively. Social services departments received nearly 12,000 referrals during the Survey week (excluding looked after children), of whom nearly two-thirds received a service on the day of referral and 85 per cent received a service during the week.

More services for children in need are provided through organisations and partnerships outside social services departments, such as those funded by the Children's Fund or Sure Start. Of course, the level of success of such preventive strategies may not be evident for another twenty years, so the only indicators available as yet are process data, such as the way partnerships are being formed or the numbers of children in contact with services. The first annual evaluation report of the Children's Fund (NCEF, 2003) suggests that over the first two years, there have been considerable changes in membership, roles and strategies of the Children's Fund Partnerships. National voluntary childcare organisations were represented on about half the Partnerships and smaller local organisations were being supported through capacity building. Involvement of children, young people and their families was slower, and they often needed to learn how to participate. Partnership working in commissioning services was sometimes *ad hoc* rather than strategic. Children's Fund services tended to attract more children in the seven to twelve age range and take up from black and ethnic minority children remained constant at around 30 per cent. The requirement to spend 25 per cent on crime prevention was felt to impede services for those at risk of social exclusion. The evaluation of Sure Start is in its third year of a six-year programme, but one of the early findings suggests that Sure Start programmes do influence parenting and family

behaviour (National Evaluation Summary, *Towards Understanding Sure Start Local Programmes,* June 2004*).*

The Audit Commission/SSI report *Old Virtues, New Virtues* summarises the findings from the joint reviews of social services between 1996 and 2003. Overall, they suggest that there are more services designed to prevent family breakdown and promote children's well-being. The services are valued, but this investment is not yet resulting in fewer looked after children.

In looking at programmes to promote health for particular groups of children, the Campbell Collaboration has some useful reviews. For example, despite the high drop-out rate among high-risk parents, *group-based parenting programmes* for children aged 3-10 years can be effective in improving behaviour problems and may be more effective than individual programmes (Underdown *et al.*, 2003) Downstream cost- savings in adulthood are likely (Scott *et al.*, 2001). In the UK, there has been rapid expansion in the number of group-based parenting programmes, delivered through a myriad of organisations across different sectors. At present, there are no prescribed standards for parent educators and not all programmes follow models identified as successful through research. The effectiveness of such programmes for teenage children is not proven, as there are too few studies and many are too small to provide valid results (Caren and Barlow, 2003). School-based programmes are another route for disseminating information to young people, but currently evidence on their effectiveness information is limited to a few specialist interventions. Llewellyn *et al.* (2002) provides some useful pointers to implementation of home-based programmes for parents of children with learning disabilities and a randomised control trial is underway.

To ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care.

Figure 6.37 shows that the proportion of looked after children receiving health checks is improving, although even by 2003 around 30 per cent missed their annual health assessment. As section 6.5 notes, the absence of good recording of health and education data in care records is worrying and implies that social services personnel often do not have a full picture of a child's health or educational needs. Without these data, staff cannot ensure children get appropriate supports and therefore children are less likely to gain maximum benefits.

Figure 6.38 shows that the proportion of looked after children missing 25 days of school remained stable at around 12 per cent, although research findings show much higher levels of absenteeism for some groups of children (see for example, Meltzer *et al*, 2003; Berridge *et al.*, 2003). Attending some form of educational establishment is a pre-requisite for gaining educational opportunities. Figure 6.39 shows that the proportion of

children attaining at least one GSE or GNVQ on leaving care has risen over the last four years, but the average figures, both nationally and for different types of authority, fall some way below the PSA targets of 50 per cent by 2001 and 75 per cent by 2003.

In 2000, the SSI report on education outcomes for looked after children in Wales reported that most looked after children in the four authorities studied (n=526) were in full-time education using mainstream schools, special schools, a pupil referral unit and further education colleges; for the minority who were not at school, often as school refusers living in residential homes, very little provision was in place. Delays in completing assessments and arranging educational placements often occurred for the most needy children, increasing their disadvantage. Non-compatible systems in SSDs and LEAs made meeting needs more difficult and, although reviews were held on time, they did not give enough emphasis to educational needs and how these could be met.

The Children Act Report 2002 reports the new PSA targets for 2003-2006, which focus on engagement in education and narrowing the gap in educational attainment between looked after children and the general child population: outcomes in English and Maths for looked after 11 year olds must be 60 per cent as good as those of their peers (currently only 46 per cent of looked after children obtain this); no more that 10 per cent should reach school leaving age without having sat a GCSE equivalent exam (currently 42 per cent); and 15 per cent of looked after children should have five GCSEs graded A*-C (currently 7.5 per cent, compared to 50 per cent of all children).

One notable finding from the studies on adoption of Romanian children is that, although these children were severely deprived both physically and psychologically at the time of adoption at four years, their 'catch up' was very substantial and at six years these improvements had been maintained (Rutter and ERA, 1998; Croft *et al.*, 2001).

Morris (2000) identified seven barriers to change in the social care of looked after children:

- public attitudes to children generally and looked after children can get in the way of listening to them and acknowledging their human rights;

- poor relationships between children and social workers and difficulties in applying the concept of 'being a good parent';

- low social worker and senior manager skills in building good relationships with children;

- the lack of a national strategy on residential care to ensure sufficient provision (including specialist provision) and to raise the quality and status of the sector;

- poor resourcing of foster carers (payment, training and social work support);

- lack of support for residential care workers and foster carers with respect to helping children to maximise their educational potential;

- and the absence of assessment of social care services against whether they promote children's human rights and whether they can adapt to meet children's needs.

In summarising change as measured through the performance assessment framework, *Old Virtues, New Virtues* notes that more needs to be done because

> outcomes for looked after children still lag markedly behind the rest of the population, the numbers of children within the looked after system continue to grow, there are major gaps in the system for children with disabilities, and financial crises continue to destabilise councils' social services (p49).

For looked after children, this report notes that improvements have been most noticeable in the role of councillors as corporate parents and scrutineers, the development of stronger links with education and monitoring of educational progress, the stability of care, the involvement of the young person in decision-making (see below), greater emphasis on local care, and more support for care leavers.

To ensure that young people leaving care, as they enter adulthood, are not isolated and participate socially and economically as citizens.

In 1996, the DH-sponsored research summary *Focus on Teenagers: Research into Practice* painted a grim picture for teenagers using social work services. 'Outcomes for these young adults were poor and many teenagers were prone to acute loneliness and depression, anti-social behaviour such as drug or alcohol abuse, early parenthood, a lack of qualifications, poor job opportunities and homelessness' (p28), with children leaving care at 16 being particularly vulnerable to poor outcomes.

There is a downward trend in the number of children who are leaving care aged 15 or over from 1999 (12,000 children) to 2001 (9,100 children). Within this, the proportion of children who stay in care until 18 years old has increased from 30 per cent to 34 per cent, with a concomitant decrease for the other age groups. Thus, a higher proportion of children are being supported for longer into their teenage years. Although data are shown only for two years, Figure 6.40 suggests that more care leavers are becoming involved in employment, education and training.

The impact in adulthood of children's difficulties or disadvantages can be high, as can the costs. For example, Godfrey *et al* (1999) estimate the per person lifetime costs of being 'not in education, employment of training' at age 16 to be £52,000.

The evaluation of the Year 4 MAPS reports that nearly all councils reported improvements in their services to care leavers, however, few councils were addressing the needs of disabled young people or those from black and ethnic minority groups. Across all authorities, 65 per cent of care leavers have remained in contact with social services at age 19.

There is very little research evidence on the effectiveness of care leaving services, in the main because the development of such services is quite new, having had an added boost with the Care Leavers Act 2000 and associated grants. We know of only one research project of care leaver services (Biehal, Byford and colleagues), due to report later this year.

To ensure that children with specific social needs arising out of disability or a health condition are living in families or other appropriate settings in the community where their assessed needs are adequately met and reviewed.

The focussed analysis of the Management Action Plans for 2002 provides some of the best information on progress on this objective (Council for Disabled Children, 2003). There has been an increasing emphasis over the annual MAPS on joint planning mechanisms and multi-agency services; with this has come, for a third of authorities, information on how they are working toward pooling funds and a broad agreement that joint planning and commissioning is the way forward. However, the role of voluntary organisations and service users in joint planning is rarely mentioned. Indeed, user involvement in service planning is not yet common practice. For joint working at the operational level, most information in the MAPS focuses on the development and operation of multi-agency teams to provide early identification and support; however, few authorities had information on operational practice, such as joint protocols for assessment.

Most authorities are also still only at the development stage for improving their consultation mechanisms and in improving access to information – both of which tend to be targeted at parents, rather than children. The report notes that only a small number of authorities have a Children's Disability Register in place and these are rarely of sufficient quality to act as a planning tool. Childcare, respite care and play and leisure services form the central core of authorities' support for disabled children and their families. There was an increasing recognition of the need to offer not just greater capacity, but also to provide a wider range of respite care options. There was some development of key working services for children under 5 years and for looked after

disabled children, and some use of the direct payments system (one third of authorities each, with around 10 families).

As well as giving examples of good practice, this MAP Report also identifies a set of factors common to those councils making improvements to their services. These are; commitment to better partnership working, redirection of resources to local inclusive services, identification of the need to implement support systems and services for specific groups, use of innovative mechanisms to improve communication, the use of the assessment framework as an integral part of individual planning and implementation, comprehensive transitional arrangements are in place.

There are still considerable unmet needs. The Children's Act Report 2002 summarises three studies. A survey of 3000 families with a severely disabled children found that the majority of them had unmet needs, especially families from ethnic minority groups and those with pre-school children. A literature review concluded that disabled children's services do not cater well for black children, and services for children from black and minority ethnic groups do not cater adequately for disabled children. The third study found high level of unmet needs for support among teenagers with autism spectrum disorder. Autistic children form about 2 per cent of the children in need population (Bebbington *et al.*, 2003).

Beresford *et al.* (1996) review what works in services for families with a disabled child and summarised here. Information is a pre-requisite to help families, alongside personal support. A contact in the form of a key worker is recommended to enable families to define needs and access further information on services. Their role in coordinating services has been shown to be highly valuable to parents and reduces unmet needs (see also, Liabo *et al*, 2001). Good practice at diagnosis includes providing information on the child's disability, the services available, how they can support their child's development and the financial benefits to which they may be entitled. Provision of short-breaks, including provision during school holidays, has been shown to help families continue to care for their child. Home-based support that fits in with normal family routines, and particularly domestic help, has been shown to significantly reduce mother's levels of stress. There is robust evidence of the effectiveness of interventions which strengthen parents' coping processes and which meet their need for specialist parenting skills. Informal support and support groups have been shown to be beneficial. The list of 'what works' for parents of children with learning disabilities is similar: careful assessment, group work combined with practical activities, home-based education (combinations of these two being very effective) and planned use of residential supports (McGaw, 2000; Redmond and Richardson, 2003).

The Choice Protects Team (2003), in their review of services for disabled children living away from home, suggest that there is a need to improve multi-agency planning and service provision as well as multi-agency assessments before a placement decision is

made, that there should be combined reviews of care plans and SEN statements and that multi-agency guidance should be developed about reviews, support and contact with families.

To ensure that referral and assessment procedures discriminate effectively between different types and levels of need and produce timely service responses.

The Children Act studies found much inadequacy in the assessment of children in need (see also SSI, 1997; DH/SSI 1998). Assessment often did not happen and there was little evidence from the studies that services were matched to children's needs; instead, it is argued, they drew on existing services in a 'sticking plaster' approach (Aldgate and Statham, 2001, p119).

There is not yet much evidence on the implementation of the Assessment Framework and the Looking After Children documentation. Current research information suggests that they improve the quality of record-keeping (although some parts are completed more fully than others), and there is some evidence, through three years of SSI inspections, to suggest that they improve the quality of decision-making (Department of Health 2003). One study has found improved parental participation and involvement in decision-making and the Year 4 MAPS report found that half of the authorities reported on involving children in the assessment process. However, the Assessment Framework documentation requires considerable training to use to their best advantage, are time-consuming to employ and, as yet, have not been used successfully as a planning tool. In 2002, 261,500 initial assessments were completed, of which 54 per cent were completed within the required seven days (the required time scale) although there was considerable variation between authorities.

In contrast to the studies of the 1990s, current evidence, although limited, suggests that children are receiving assessments and that the differentiated system appears to discriminate between children with needs for different levels of services. There is no information yet as to whether this assessment process leads to better service planning, better and more timely service packages, or better outcomes for children.

An evaluation of one authority's family support services identified the conditions required to improve assessments: sufficient time for staff to carry out assessments and recording, practical administrative support and IT backup, and opportunities to develop practice and professional skills (MacDonald and Williamson, 2002; cited in Children Act Report 2001). This evaluation was carried out prior to the introduction of the Assessment Framework, but the more recent evaluations mirror these findings.

To actively involve users and carers in planning services and in tailoring individual packages of care; and to ensure effective mechanisms are in place to handle complaints.

In the early years after the Children Act's implementation, users were rarely part of the planning process in social services departments; in the independent sector, particularly in family centres, however, there seemed to be participation in both planning (though local control of management) and delivering services (helping with groups, planning activities within the centre and improving accessibility or user-friendliness (Aldgate and Statham, 2001).

Although an important objective in all areas of social services work, there is still no regular data that measures the extent of participation; authorities have spent around 6.5 per cent of the Quality Protects grant on improving participation (Children Act Report, 2001).

Evidence for the SSI inspections suggests that the level of participation by children and families is variable across authorities, with some showing evidence of systematic participation and others, while recognising the importance of user involvement, were progressing more slowly.

Positive outcomes for Family Group Conferences (FGCs) have been found. Evidence from smaller studies in the UK is supported by evidence from international studies (Choice Protects Team, 2003, p9). Re-abuse rates for children involved in FGCs were six per cent compared to 16-25 per cent for others. Most professional (78 per cent) thought FGC plans were successful (or successful in parts) after 18-24 months. Social workers assessed that 32 per cent of FGCs prevented children becoming looked after and only 21 per cent made no difference. Most family members attending FGCs (88 per cent) thought the process and intermediate outcomes were good or very good and nobody though they were bad.

Evidence from research suggests that participation by children and families in decisions about their lives is variable across services as well. Involvement in assessment is probably improving. The involvement of disabled children is particularly problematic. Morris (1998) found that disabled children were often not consulted either about decisions affecting their lives or about their day-to-day care. Mitchell and Sloper (2002) found 'listening to children' was rarely experienced by disabled children and their parents, yet was one of the most desired attributes. The Audit Commission review of services for disabled children and their families found that social workers were not often skilled in alternative methods of communication and this further inhibited the participation of disabled children.

To ensure that though regulatory powers and duties children in regulated services are protected from harm and poor care standards.

The creation of the National Care Standards Council will help considerably in collecting data concerning the implementation of regulation for all services for children in need living away from home; at the moment, the only PAF indicator is the proportion of children's homes inspections completed that should have been carried out. This stood at 100 per cent for 2000-2001.

Old Virtues, New Virtues notes that continuity of care is still problematic, driven by staff shortages, particularly in children's social workers, which means that many looked after children are 'unallocated cases'. (The evaluation of the Year 4 MAPS reports that 97 per cent of children in Children Protection Registers have an allocated social worker.) On the other hand, the investment in preventive services through initiatives such as Sure Start, together with the development of services such as Family Centres, has led to a wider range of services being provided, and a better focus on preventive care.

To ensure that social care workers are appropriately skilled, trained and qualified, and to promote the uptake of training at all levels.

The Children Act Report 2002 suggests that there are as yet insufficient data to give a clear picture of the levels of training for staff in children's services (Department of Health 2003), but the national minimum standards now require 80 per cent of care staff in children's homes to hold the Level 3 NVQ by 2005. In April 2003, there were 9385 residential care staff of whom 30 per cent held this award; in 2001, the figure was 21 per cent. Attainment levels are only one-third of what was planned two years ago with the problems in recruitment and retention making it more difficult to release existing staff for training (Year 4 MAPS evaluation).

The SSI inspection in 2001 analysed over 1000 staff profiles and concluded that they showed a reasonably experienced workforce; 61 per cent had six or more years experience. Sixty-eight per cent of workers said that they had received training in assessment, but training in care planning had fallen to 27 per cent (cited in The Children Act Report 2002).

Data on staff working in children's services are given in an earlier section; no specific research evidence on the impact of training has been uncovered in this review.

To maximise the benefits to service users from the resources available, and to demonstrate the effectiveness and value for money of the care and support

provided, and to allow for choice and different responses for different needs and circumstances.

There is little information in the Children Act Reports on value for money, perhaps reflecting the short period over which some data have been collected and the focus of many national data collections on intermediate rather than final outcomes. The 2002 Children Act Report notes that the SSI inspections found that most councils were over-spending their budgets for children's services, commonly associated with over-expenditure on placements to which the increase in numbers of looked after children had contributed. (On this issue, the Children Act Report 2001 found that authorities were more likely to keep within their overall budget if they spent less than nine per cent of their total expenditure on external placements.) The SSI inspections found a positive correlation between councils' level of performance and levels of spending 'although not a perfect one'. (Kirton et al., 2003 found poor associations between foster care expenditure and the performance indicators.) They also noted that there was some evidence of pooled budgets in YOT and CAMH services, but very few areas where plans for joint commissioning had come to fruition (p59-60).

Old Virtues, New Virtues notes that the ability to link sound projections of activity with finance is crucial to delivering a balanced budget. While things have moved on in the intervening years, a similar sentiment appeared in the joint Reviews Annual Report of 1997.

> local authorities simply do not know how many people receive social services of what quality and at what cost. Without this basic information, local authorities cannot be sure users get a good deal; services will not improve consistently and best value for money will not be achieved.

The Year 4 MAPS evaluation reports that only a third of authorities councils have financial management systems linked to service objectives but some still have problems with IT systems. This meant management information is not easily available. Alongside the introduction of the PAF indicators, the introduction of the CIN Survey has considerably enhanced councils' ability to assess local needs for support, as one of the first efforts to collect information about the full scope of the work of children and family services. The incorporation of expenditure data in these surveys also allows a wider range of children and families staff to understand cost issues.

There is, however, very little research data on the costs of children's services in England and other parts of the UK – and even less that assesses cost-effectiveness. In 1997, a review of the evidence in the economics of child social care found very few such studies (Knapp and Lowin 1997). Common errors in the studies that were found (mainly cost studies) were incomplete cost measures, failure to make like-with-like comparisons and no explanations for the wide cost and outcome variations. The

situation is not much improved today. Our review found only one study that brought costs and outcomes together (Byford *et al*, 1999).

There is little evidence on cost-effectiveness that can be drawn in from child and adolescent mental health research (Knapp, 1997; Romeo *et al.*, 2004). In a systematic review of primary care treatments for children with mental health problems Bower and colleagues found some evidence of effectiveness where specialist staff work with children in primary care settings and some evidence that showed education interventions could increase the skills and confidence of primary care staff. However, the evidence is not strong and the quality of the research is variable. In response to concerns that looked after children were needing but not receiving CAMH services the Royal College of Psychiatrists released an information booklet (Richardson and Joughin, 2000). This publication aimed to improve understanding of current developments in CAMH services and of joint working between health and social care. Vignettes are use to describe children with symptoms of mental health problems and CAMHS professional provide evidence-based answers to questions that social workers, foster carers and residential workers asked about that vignette.

More information on the links between costs, needs and outcomes will become available over the next 18 months or so, as findings become available from the research funded under the Department of Health's research initiative into *Costs and Effectiveness of Services to Children in Need*. Where information is already available, we have included it in this report. Other projects funded by this initiative cover issues in adoption, family centres, home-based support, foster care, residential care, looked after children, mental health needs, adolescent support teams, and transitional support.

There is a little more information about costs, as summarised below.

In a recent study of 30 local authority homes and 15 independent sector homes (Hicks *et al.*, 2003), the latter were performing as well as the former (and, on some measures, considerably better); moreover, the independent sector homes tended to care for more difficult children. Clear strategies for promoting education and good behaviour led to more positive staff attitudes as well as better outcomes for the residents. Differences in cost (mean £1543 per week, range £620 to £3820) did not lead to better outcomes, once residents' needs had been taken into account, and there was no difference in costs between the independent and local authority homes, once the costs of education had been removed from the former group.

Scott *et al*. (2001) estimate that the adult (up to age 28) costs to public services of children with conduct disorder are around £70,000 per person per annum and £24,300 for children with less severe conduct problems. These can be compared to the per annum costs for the no-problem group of just £7,500 per person. Antisocial behaviour at age 10 was a powerful predictor of the total cost to public services used by age 28,

increasing steeply with increasing anti-social behaviour. Costs to the criminal justice system were highest, followed by education and social services. NHS costs, often the organisation where such problems are treated, comprised only a small proportion of the costs.

In foster care, IFA fees range from £430 to £1250 per child, some of which include school placement. Although there is no definitive evidence on comparative costs of IFA versus local authority placements, it seems likely that the higher needs levels of IFA-placed children and the extra support services for children and foster carers do push charges up (Sellick and Connolly, 2002).

In an early study of leaving care services, the costs to all agencies of supporting users was estimated as £2,500, with social services contributing 50 per cent of these costs (Biehal *et al.*, 2000).

Information on the costs of support for disabled children has been summarised in a paper for the NSF External Working Group on disabled children (Beecham and Sloper, 2003). No evidence on the cost-effectiveness of services support disabled children was found and the information on costs was scattered, incomplete and some was quite dated. For disabled children in communal establishments, reanalysis of the OPCS data showed average weekly costs for the placement and other services was between £554 (private residential homes) and £1128 in local authority residential care (1994-95 prices). Average annual support costs for 111 children with severe learning disabilities with behaviour problems were £15,700 to the public sector, with 70 per cent of these costs accruing to education services for school (1997-98 prices). Young adults with hemiplegia ranged between £5,600 and £40,000 per annum (1999-2000 price levels), with around 40 per cent of those costs associated with disability. A study of 24 technology dependent children found support costs often exceeded £100,000 per year and disputes over who should fund equipment and drugs were common. For short-breaks in residential homes, the cost is £175.50 per day (12-24 hours) if purchased from the voluntary sector, £177 for social services establishments and £241 for NHS establishments. Family based short-breaks cost on average £61.17 pre day (1991-2 prices). The cost of multi-disciplinary teams for young adults transferring for children's to adult services were found to be between £79 and £114 less than routine support and promoted greater participation in society.