Outcomes in Children's Social Care

This article considers how to understand and measure outcomes in Children's Social Care. Even a cursory acquaintance with the work of Children's Social Care is sufficient to highlight the fact that while talk of "outcomes" and how to improve them is ubiquitous, deciding on appropriate outcomes is fraught with challenge (La Valle et al, 2016). The first section of the article considers two key challenges for deciding on outcomes, namely the sheer variety of the work and the question of who decides which outcomes should be measured. The middle section briefly outlines an approach to measuring outcomes, and the quality of social work practice, that we used in recent studies. It then considers lessons from these studies. The concluding section argues that a simplistic approach to outcomes is unhelpful, and that a more nuanced approach needs to include greater clarity about the purpose and nature of Children's Social Care in the United Kingdom (and other countries) and as a result a wider range of outcome measures.

Key challenges in measuring outcomes in Children's Social Care
There are myriad potential challenges involved in measuring outcomes in Children's Social Care, for instance the reliability and validity of measures, their usefulness in this specific context and the issue of when we should measure outcomes are all important (see Parker, 1998). A key issue is also that the idea of "outcomes" includes an implicit assumption of causality (the Oxford English Dictionary defines outcomes in part as "consequences"), yet simply measuring an outcome, even over time, does not establish what caused changes. This section considers just two challenges, but they are amongst the thorniest difficulties: the variety of issues worked with and who chooses the outcomes to be measured.

Challenge one: the range of the work.
From unborn babies to troubled teenagers, social workers work with a huge array of different children, each of whom has their own, unique, character and situation. The provisions of the law – to protect children from significant harm and help children in need – are deliberately broad and permissive. This provides an enormous challenge for evaluating outcomes in Children's Social Care. In this respect, the situation is more complicated than it is for medicine. For health services do have a coherent set of priorities, in that they focus on the health of people. This is broad – but it is a narrower focus than Children's Social Care. While health can focus on life expectancy or other health related measures, and education might look at school performance, and child mental health services can consider children's emotional and behavioural well-being, Children's Social Care can be provided for all, some or none of these areas – as well as many others. The remit – at least in the United Kingdom - is to prevent serious harm and help children meet their needs. Yet harm can occur across a wide range of domains, and need is a hugely diverse concept (as discussed further below). Ultimately what people need relates to the full diversity of conditions required for human flourishing.

Challenge two: who should decide on outcomes?
Perhaps the largest challenge in measuring outcomes is who decides what they should be. Child and family social work is a complex activity, that often involves unasked for intrusion in people's lives. Social workers have professional expertise,

and a mandate through law and related policy on behalf of society. They work with parents, who are the experts on their own lives and usually on those of their children. And they work for children, yet they simultaneously need to make decisions about the degree to which the views and wishes of the child can and should be acted upon. It is commonplace for these different stakeholders to have different views on what is the important thing to measure. For instance following an initial assessment a social worker may feel confident that a child is safe, a parent may be angry that a social worker has disrupted their family life and a child may feel happy that somebody listened to their concerns. The fact that child and family social work juggles these competing conceptions of what outcomes might be appropriate makes it irreducibly complicated. These complexities are the focus of this paper.

Measuring outcomes in evaluating Children's Social Care
An awareness of these key challenges influenced profoundly how we measured outcomes in some recent research studies. The rest of this article considers these questions by sharing experiences from these studies to explain a developing understanding (however limited) in relation to the nature of outcomes in Children's Social Care. These studies included a randomized controlled trial looking at the impact of training on social worker skills (Forrester et al, 2017a; Forrester et al, 2017b), two evaluations of the "reclaiming social work" systemic practice model (Forrester et al, 2013; Bostock et al, 2017), an evaluation of the Hertfordshire Innovation Programme project (Forrester et al, 2017c) and involvement in an ongoing project to support the development of good practice in Islington. Each of these projects had unique elements, but they also all included a common approach to data collection and analysis. This involved observing, recording and rating a meeting between a social worker and a family, followed by a research interview and – where possible – a follow-up research interview 3-6 months later with parents (and in some of the studies children). Overall this programme of work has involved collecting more than 600 observations of practice and research interviews with families from 10 local authorities. Findings can be found in the papers noted above. This article focuses on overarching lessons.

Our approach to measuring outcomes attempted to address the key challenges noted above in the following ways. First, we used service-user defined definitions of outcomes. This was generally the parent. A particular advantage of both the measures we used was that they provided measures that could be applied across the diversity of issues that child and family social work addresses. This is because both were subjective "distance travelled" methods. The main one of these was Goal Attainment Scaling (GAS) (Kiresuk and Sherman, 1968; Kiresuk et al, 2014). GAS involves identifying the problem or issue that the service user wants to address. It was developed in health settings, and has been used to evaluate client satisfaction with goal achievement in relation to physiotherapy (King et al, 2000; Palisano et al, 1992), adult mental health services (Kiresuk and Sherman, 1968) and occasionally in Children's Social Care (e.g. Harris, 2014). Use of GAS required a clear and detailed description of the current situation in relation to the identified issue – a process which requires the researcher to have many of the skills of a good social worker to achieve a specific enough description. The parent then described what positive change by the follow-up period (generally just 3 months) would look like. As for the description of the current situation, the specific behavioural changes imagined for this improvement needed to be specified. Finally, parents described what it would be like

if things got worse. At follow-up the researcher asked the parent to describe the current situation in relation to the focus issue. We scored the GAS differently to some other researchers, with no change equalling zero, achievement of goal being a 2 and moving to the poor outcome being a negative 2. Partial achievement or some move backward were scored as +1 or -1 respectively. In addition we allowed for goals to be exceeded with a relatively rare +/-3 score. This generates an ordinal range from +3 to -3. In a separate article we describe the process and findings in relation to GAS in greater depth (Lynch et al, in preparation). Here the broader conceptual issues are considered but first it is necessary to describe a second client-centred measure we used: the Life Rating Scale.

The Life Rating Scale simply asks parents to rate the current quality of family life from 1 (the worst imaginable) to 10 (perfect). It was developed specifically for the first of our studies, however similar rating scales have been used extensively across research studies. This approach has particular similarities to the rating scales extensively used by the Child Outcomes Ratings Consortium (CORC) (Bringhurst et al, 2006; Miller et al, 2003). Indeed, in later studies we added these measures.

In addition to parent-centred measures of outcomes we also used some standardised research measures. Standardised measures have been shown to measure problems reliably and the scores have validity. There are various ways in which researchers understand validity, but the most important are when measures on such instruments either correlate with "real world" events or predict them. For instance, the Strengths and Difficulties Questionnaire (SDQ) has been found to be relatively good at identifying children with levels of behavioural or emotional difficulty that lead to them requiring additional help or having problems with the police (Goodman, 2001). Table 1 lists the instruments or measures we used most often.

It became rapidly obvious that using all the instruments from Table 1 on every family was impracticable. It would have taken hours, and for most families there was not a "problem" in relation to each individual measure. We therefore tried an alternative approach. Parents were asked whether they or anyone else, including their social worker, had concerns in relation to a checklist of common problems. Where the parent identified a problem as present the appropriate standardised instrument would then be given to them. This might be thought of as a hybrid approach to measuring outcomes – parents identify whether a problem exists and then a robust research instrument is used to measure the extent or nature of the problem.

Insert Table 1 around here

There proved to be problems with this approach, which are discussed below, but it is worth mentioning the plan for analysis, even if it was not possible to carry it out because the sub-samples who used different instruments were too small for analysis. Our intention was that the combination of parental self-identification and standardised instruments would allow us to describe the prevalence and nature of problems in the identified area. We planned to compare change over time between instruments by calculating the z-score for each (a measure of the standard deviation) and therefore allowing comparison of relative change against population distribution between different identified issues. Put simply a shift of one on z-score would be a

move of one standard deviation within every measure used; it would be an equivalent move within the population for that problem.

What did we learn?
Some of the limitations of user defined outcomes are relatively obvious (see Cytrynbaum et al, 1979; Seaberg and Gillespie, 1977). One is that we used the parent's view, and this is only one perspective on the work of Children's Social Care. Ultimately the most important perspective is that of the child, though often children are too young or in other ways not well placed to make a fully informed decision about outcomes.

A second limitation is that there is a lack of comparability in the size of goals identified. For instance, even if families had relatively similar presenting issues they might decide on completely different goals. For instance, two families might have a child with the same level of behavioural problems, but one set of parents sets a slight reduction as a goal while a second aims at complete cessation of the problem. Indeed, a third family might identify being less stressed by the same problem as their goal. There are therefore problems in comparing the extent of change for GAS. The same is true for Life Scaling, which depends on subjective expectations about acceptable and perfect family life which are unlikely to be comparable across families.

In practical terms we often experienced problems in agreeing realistic goals with families, with some focussing on changes of circumstances that were beyond the control of either them or their social worker. Furthermore a significant minority of allocated families did not think they had any particular reason for having a social worker, and therefore setting goals was impossible. Some of these issues were addressed in later studies, where we introduced both a parental identification of social worker goals and direct social work identification of goals in adaptations of the GAS. These yielded a wealth of information about the degree of understanding of one another's goals and the extent of agreement (or not) about those goals. We explore these issues in a paper currently in preparation (ref).

Yet, despite these very real caveats, the user centred goals seemed important and useful. They provided a picture of the types of issues that parents identified as important, and the degree of improvement in relation to these issues. In later studies they also allowed us to explore agreement about problems and goals between social worker and parent, which is an important issue in its own right. They were particularly successful in meeting the two criteria that led us to select them, namely that they allowed a single measure to cover the range of social work practice and that they were user-centred approaches to selecting outcomes in Children's Social Care. In addition, and perhaps for this reason, they helped facilitate more helpful and natural discussions with families (Law and Jacob, 2015).

In contrast the standardised instruments were problematic, and we found it difficult to use many of them. For those we gave to the whole sample a problem was that a large proportion of families did not have the "problem" identified. This made them valid for evaluating prevalence of a specific type of issue, but they placed a burden on respondents that was too often disproportionate. However, far more importantly, even when a problem was identified – and this happened relatively often with the

General Health Questionnaire (GHQ) and the SDQ – this did not mean it was the focus of work for either the family or the child. This is a major limitation: we cannot evaluate Children's Social Care against their ability to ameliorate problems that they are not trying to help with. That would be like judging the success of GPs by whether they reduce client blood pressure, even if the actual problem is bunions, or cancer.

It might be thought that this problem might have been addressed by our proposed process of parents selecting issues that were of concern and then using standardised instruments. There is some potential in such an approach, and we will seek to develop it in future studies, however it ran into several practical problems. First, parents very often did not identify problems that social workers may well have thought were central. Second, a key practical issue was research fatigue. Our approach was to allow parents to identify any issue that was a problem, but having done so once or twice they were reluctant to continue to do so as they did not want to continue answering further questions. This provided a powerful incentive to stop identifying areas of concern. In future a focus on the main issue may be worth exploring.

Even if we were to identify the main issue, there are real questions about the helpfulness of different research instruments. Almost all the instruments we used were developed in other settings and with the foci defined by them. Thus, for instance, the GHQ is excellent for identifying raised anxiety or depression in adults. It is also highly sensitive to change: a stressful week can result in a positive score while a good week can mean one no longer self-rates as "at risk". It is questionable how useful this is for child and family work, where if we have concerns about mental health problems they are likely to be more pronounced and enduring. In contrast, however, the SDQ is good at identifying problems in behaviour and emotional well-being of children, however it is less sensitive to change. Indeed, it asks questions about well-being over the last 6 months. This may be appropriate for some purposes, such as long-term work with a child with such problems. It often did not seem appropriate for the shorter-term interventions involved in allocated social work. For instance, a teenager's difficult behaviour might have led to the parent asking for them to come into care. The initial social work intervention could quite appropriately be to support the parent to cope with the emotions and feelings involved. Here, even though the child's behaviour may be the presenting issue the aim is not – at least in the short term – to change this, but simply to stabilise the situation and offer the parent support. In such a situation the GHQ might actually be more appropriate than the SDQ.

The problems here begin to take us into the heart of the problem with most approaches to measuring outcomes in Children's Social Care, which is that Children's Social Care are not a therapeutic service. Many of our approaches to evaluation rely on a broadly medical metaphor in which a professional provides help for a specified problem. This is not without challenges for therapeutic interventions – particularly about consistently defining help that is provided by a particular individual, for a specific problem, in a unique context. Yet it nonetheless works comparatively well, because whether it is an alcohol counselling service or a clinic to help people with depression, there is broad agreement about the nature of the presenting problem and the purpose of the service being provided. An alcohol counselling service that did not help people to reduce or stop drinking would not be doing its job.

Yet applying this approach to Children's Social Care is profoundly problematic, because identifying outcomes for social work is far more complicated than for counselling.

Social work is not therapy: so what is it?

It should be obvious from some of the examples mentioned already that the social work role is far more complicated than simply somebody who is there to help people. It may be something of a simplification but in broad terms a teacher's role is to educate, a Doctor's to promote health and fight illness, a therapist's to help somebody with a particular issue or problem. Yet what is the role of a child and family social worker? The answer seems more complicated. To answer this we need to think about what the purpose of Children's Social Care really is.

To help think about this it is worth considering an unexpected finding from one of our first studies to look at the relationship between social work skills and outcomes. The full results are presented elsewhere (Forrester et al, 2017b). Here it is sufficient to say that we defined and rated workers in relation to key skills frequently identified as important. These included, for instance, empathy, collaboration, purposefulness and focus on the child (see Whittaker et al, 2016 for a full description). We found the relationship between key practice skills and family outcomes was weaker than we had envisaged Forrester et al, 2017b). Indeed, it barely existed. Put simply: the quality of social work, the nature of the service received, makes little difference to most families allocated a social worker. And this was for families who have been allocated and received 3 or more visits. This lack of relationship would be, we imagine, even more true for the many families who received one or two visits.

There are various possible explanations for this weak relationship. One may be that we were measuring the wrong things. A second is that the way a social worker talks to a family may only be a small part of the quality of practice, which also includes for instance working with other agencies and assessments. A third is that even the total of practice is only a small part of what is happening for a family at any time, and we therefore do not know what size of impact good as opposed to bad practice might make. We as a discipline have not done the research required to calculate effect sizes for social work practice (see Coe, 2012).

All of these are likely to be factors worth considering, but we felt that two others were particularly important. The first is that in general families see very little of their social worker – most families receive just a brief assessment without full allocation, even allocated families usually see their worker 3 or fewer times and only a minority of families are seen 8 or more times. It is open to question what such a minimal intervention would be likely to do. This may be what is called a "dose effect" relationship in medical literature, which is simply to say that for some drugs – and for some interventions – you need to have a certain amount for it to work, and the more you have the more impact it will be likely to have. This may be important for understanding this relationship, but we believe a more important consideration is that you actually have to have a problem for help to make a difference. The findings from the Life Rating Scale (LRS) are useful for shedding light on this. LRS asks for a rating of family life from 10 (perfect) down to 1 (as bad as can be imagined). Across studies parents tended to rate family life as 2.5 to 3 at the time of the referral, but by

the time of the research interview (just after allocation) this had risen to an average of 6.5 to 7 (varying by study) (Bostock et al, 2017; Forrester et al, 2017b; Forrester et al, 2017c). Of course, this is not a validated instrument – and we would not therefore conclude that this was the simple truth about family life – yet it does seem to capture a common pattern. Families identify the time of the referral as a serious crisis, but in general they describe very substantial improvement by a few weeks after allocation.

It would be nice to ascribe this improvement to the involvement of Children's Social Care, however this seems unlikely. As noted, we found little relationship to the quality of practice. More importantly, parents only identify the change as being due to social workers in a small minority of cases. Instead, they tend to describe something happening and the situation either resolving itself or being resolved by themselves fairly quickly; and often the "crisis" and main source of stress that the parents identify was the involvement of Children's Social Care. The simplest explanation for this pattern of results seems to be that Children's Social Care receive many referrals of acute or chronic needs in families, but that the bulk of these resolve themselves fairly quickly or turn out not to have been particularly serious. This interpretation is supported by our analyses which found that in families where there are 8 or more visits the quality of social work makes a *big* difference – there are very strong relationships between skills and outcomes. This may be because they have seen more of their social worker. At least as important is that these are the families that have the serious problems which a social worker needs to help with.

Of course the identification of social workers as filtering out many of the families they work with is not new. It was a key finding from the studies that informed the "refocusing" initiative in the 1990s (Department of Health, 1995; Gibbons et al, 1995). Yet it points to a major problem in measuring outcomes in Children's Social Care. A very large part of the job of social workers is to assess whether or not families need a service. In this respect their role is less like a therapist and more like a GP. As for a GP they will have very large numbers of children referred to them, and their most important role may be to identify those where there are serious problems from those where there are not.

Yet there is more to the social work role than this; it is even more complicated. This description of the role fails to take into account a key feature of Children's Social Care in the United Kingdom, namely that to a large extent they are working with families – or at least parents – who did not want social workers involved. This fundamentally changes both our understanding of what outcomes we should be measuring and also our conceptualisation of what Children's Social Care are for. It adds yet another layer of complexity.

It is worth considering the literature on "need" to understand some of this complexity. There are those who argue that needs are an objective reality. Theorists such as Doyal and Gough (1991) or perhaps most famously Sen (1998) argue that humans have core needs. These are suggested to be the resources or capacities that are needed in order to be healthy and autonomous. In particular these theorists, and others such as Plant (2009), argue that meaningful freedom requires more than negative freedoms (that is the absence of constraint), but also the resources for positive freedom. For instance, freedom of speech means little if one does not have shelter or sufficient food. They go on to argue that the resources or capacities

required are universal – there is an essential human nature and therefore universal needs – but that the way they are manifested varies between cultures and at different times.

These are powerful arguments, and such thinking seems central to any attempt to argue for a fairer and more equal society. Yet they pose two profound problems for social workers in practice. First, in theory if there is objective truth, we can simply assess what people need and give that to them. There is a danger, if this is the case, that what appears a progressive position might in fact become inhumane in practice, as the state knows what people need and provides it for them (Ignatieff, 1984). This is not a theoretical problem. At its most extreme it was a central problem of state communism, which rapidly became centralised, bureaucratic and struggled to treat people as individuals. It is also a problem that can be seen every day in Children's Social Care offices and other public services across the country. Workers treat people as if the worker knows the truth. The views of parents or children are not considered important. Concerningly, we found this was probably the dominant way in which workers talked (down) to parents across studies. It is perhaps a product in part of an unexamined positivism in which the social worker's role is to discover the true needs or risks in a family.

The second problem is that even if there is such a thing as objective "need" – by which we mean an agreement about fundamental human needs – these do not equate to "social needs" (Sheppard, 1995). Agreeing that people need shelter, transport or love does not mean that society or more specifically the state has a duty to provide for such needs. Ultimately this is a political decision, and we as a society have to agree what services are provided by the state and which are not.

Sheppard provides a clever argument based on this idea and applied to social work. He argues that there is no such thing as objective need, but that society agrees what needs we collectively provide for. It is then the job of the social worker – along with other public servants – to provide for such needs. In Sheppard's formulation, socially agreed needs, as defined through law and policy, can be treated *as if* they were objective needs. They provide the framework within which social workers provide for the needs of individuals.

There are problems with such an approach. One is that the job of social work is not simply to administer provision for needs already defined by society. Social workers can and should critique and challenge unfair or discriminatory policies. In other words, in addition to an element of the role being to assess and meet social needs, as a profession social work has some independent role to critique whether provision is appropriate. This relates closely to a second and perhaps more important problem. Sheppard's position fails to place sufficient weight on the views and wishes of those receiving a service. Here there is a crucial difference between Children's Social Care and some other public services. A housing officer provides for socially agreed need by discovering the objective truth of individual's housing situation. There are legally defined terms that need to be assessed, but they are tightly defined and in general the housing officer's role in assessing need is comparatively straightforward. The same may be said about the provision of medical care or education: what we provide is in general defined fairly clearly by the state. In contrast, the social work task in assessing need or risk is more complicated. Here the views of individuals on what

they think they need, on how they perceive the risks or abuse of their child, are central to the process of assessment. This is because the process of assessment in Children's Social Care is essentially dialogical. It involves creating and then resolving a dialogue between the needs of the service user, the state's law and policies and the professional expertise of the social worker.

The reason that assessment is essentially and irreducibly dialogical in Children's Social Care is that fundamentally Children's Social Care are not just there to provide services. They do this but it is not their main raison d'etre. The primary role of Children's Social Care – as for statutory social work across the UK – is to defend individual liberty within a free society. This is obviously quite a substantial claim and requires some explication.

Children's Social Care and the Defence of Individual Freedom
Such a formulation of the aims and purpose - the telos - of Children's Social Care requires a fundamentally different view of what outcomes are and how they might be measured. This argument was also one that was made by Sheppard. Sheppard argues that statutory social work for both adults and children is centrally concerned with freedom and the limits of freedom. In a liberal society the ideal is that each individual should be free to do what she wishes to do provided she does not hurt others (Mill, 1966), or as put in the French Declaration of Human and Civil Rights:

"Liberty consists in the freedom to do everything which injures no one else."

Of course, there are many examples of laws that contradict this basic principle, from those enforcing the wearing of seatbelts to those banning the use of drugs. Yet these exceptions notwithstanding the broad principle underlying both law and public policy is that people should be free to act as they wish so long as others are not hurt.

This conception of individual freedom is in fact the foundation for those who argue about need. Doyal and Gough, Plant and Sen all argue for a conception of need that is based on individuals requiring resources in order to be able to be autonomous and truly free. There are, however, problems with this Kantian conception of freedom, even from within this worldview. The most obvious is that it has at root the idea of a rational individual making decisions that they can be responsible for. The problem is that the rationality of human beings is often compromised. Examples might include where a person has a learning difficulty, a mental health problem or where the individual is a child or young person. In each of these examples in the United Kingdom professionals – and in particular social workers – may be involved in deciding to what degree the individual has capacity to behave rationally and therefore have their views acted upon (Sheppard, 1995). Simultaneously, social workers are expected to assess the risk of harm. Where people are considered not able to make decisions for themselves (for instance, because they are too young) and where the evidence or risk of harm is too high (for instance, because of child abuse) then social workers are empowered by law to intervene to protect (though with checks and balances provided through the court system).

This fundamental role of the statutory social worker involves them in complicated considerations about the views and capacity of children, the nature of risks to the child, whether parents are able and willing to ameliorate those risks and whether

concerns about some or all of these factors are sufficient to allow the freedom of parents to bring up their child to be over-ruled. In a profound sense social workers are practical philosophers, teasing out complex value-based decisions on behalf of society. Wisdom is perhaps their primary virtue.

This is a very different conceptualisation of what child and family social work is about to one that seeks to evaluate through a focus on outcomes. Not only is a social worker not like a therapist, but they are also not like a GP. In this formulation they are more like a police officer or a judge. We do not usually evaluate the outcomes of a police investigation or a court case. These are areas where fairness, due process and the protection or balancing of rights are crucially important. So it is for child and family social work. This has important implications for thinking about outcomes in Children's Social Care. For instance, it suggests that the process is important in its own right. Given a little thought, this is relatively obvious. If you had a social worker come to your door to ask about your children, the way that they talked to you and your children might not affect any "outcomes", but that does not mean respect, clarity and empathy would not be important, because they are crucial elements of good service in their own right. Due process – which in Children's Social Care includes respect, appropriate use of authority, fairness and proportionality amongst other things – is an outcome to be measured because it is important in and of itself, not merely because it is a means to an end.

How to begin to think about outcomes in Children's Social Care
This formulation of the work of Children's Social Care has profound implications for understanding how we might think about outcomes. Often, almost by accident, we fall into the trap of thinking about outcomes using a metaphor taken from medicine or therapy. In those settings the test of effectiveness is whether change occurs. Yet it should be clear that something more complex is occurring in Children's Social Care. There are some practical implications for our understanding of outcomes that flow from this.

First, often the work of Children's Social Care is to identify whether or not children need a social worker or not. This is assessment, but it is also a complicated judgement about whether unwanted state involvement needs to be enforced with some families.

Second, because this is the case, many of the families that social workers work with show little impact related to the involvement of a worker. In our research, most had a point of crisis and they tended to resolve it fairly quickly without help. Alternatively, some see little change but over time the social worker decides there is insufficient concern to justify further work. This does not mean a social worker should not have been involved, but it does suggest that they would not influence the outcomes.

By this stage it may be easy to despair of the possibility of identifying and measuring outcomes in Children's Social Care. Yet the argument of this paper is not that the task is impossible, but rather that we need to fully understand the complexity of this undertaking. The danger is that we naively apply simplistic concepts of outcomes; indeed, I would argue that that is generally what happens in policy and inspection, and too often in research.

Identifying outcomes is, in fact, crucially important for Children's Social Care. It allows us to compare services or ways of working and identify those which tend to be better. It allows us to make judgements about which services are more helpful or effective. Ultimately identifying outcomes for Children's Social Care therefore offers a key way to build improvement into every element of the services we offer to children and their families. So how might we measure outcomes following the complexity outlined thus far? In this section some suggestions are made in response to the arguments made thus far.

A multi-faceted approach to measuring outcomes

Here the argument is that measuring outcomes will require outcomes to be part of answering four key – and related - questions for Children's Social Care. These are:

1. What is the quality of the service or practice being offered?
2. Are the right families being worked with? And is the involvement of Children's Social Care proportionate?
3. How helpful do parents and children find the help being offered?
4. What difference is made to specific problems?

What is the quality of the service or practice being offered?

Often the discourse of outcomes fails to understand that the quality of the service experienced by children and their parents is important in its own right. As mentioned above, in this respect we hope we have made a helpful contribution. Across the studies we have developed a coding scheme for three key dimensions of practice, namely "good authority", "care and engagement" and (where appropriate) support for behaviour change (ref). These have now been applied to around 600 meetings between social workers and families. The findings suggest we have much to do to improve the quality of practice with families, but the point here is to emphasise that as well as being important for exploring the links between skills and outcomes the quality of practice is important in its own right.

Yet it is worth making two further points in relation to the quality of practice as a key measure in its own right. The first is that sometimes a rather naïve approach is taken to evidence based practice which talks about interventions or services as working or not working as if they were similar to pills. In fact, the quality of delivery is crucially important, and has an enormous influence on outcomes. It is therefore rarely appropriate to evaluate outcomes without researching the quality of service delivery.

A second point flows from this, which is that the focus of evidence based practice has often been around discovering whether definable "interventions" make a difference to certain outcomes. Yet this leads to a very narrow type of evidence based practice, with specific, defined interventions becoming the focus. For the bulk of the work of Children's Social Care it is likely to be more helpful to discover the key elements of practice that make a difference (see Barth et al, 2012). This requires a different type of methodology – one that is beyond the remit of this article – but central to it is evaluating the quality of practice so that links between practice and outcomes can be researched.

Are the right children and families being worked with?

This is a crucially important element of the work of Children's Social Care. It is vital in its own right, but it also provides the context for evaluating outcomes in a meaningful way. Put simply, there is no point assessing whether a service is making a difference if it is working with the wrong families and children. Unfortunately, it is also the area that I am least certain about, so here I can only make some general points.

Whether the right children are being worked with can be thought of in terms of minimising false negatives and false positives. A false negative might involve a case that was closed where there are serious concerns about a child. False positives might be families that are allocated a social worker while not needing one, particularly if they do not wish to have Children's Social Care involved in their lives. There has been relatively little research on the extent of false negatives in relation to Children's Social Care in the UK, for instance by examining what happens to children after a case is closed to identify those where this was perhaps not appropriate (see Forrester 2008 a and b). This may be because even a re-referral of serious harm does not necessarily mean that the decision to close a case was wrong. Not only are such judgements plagued by the problem of hindsight, in which researchers or inspectors or others make a decision with information not available to the worker at the time but, in addition, avoiding negative outcomes is just one element of the social work role. The desire to avoid such outcomes often needs to be balanced against the views of the child or the proportionality and legal justification for being involved with a family against the parent's wishes. Such considerations mean that sometimes social workers rightly close cases even though they know there may be a re-referral in relation to a relatively serious incident.

There is even less research on or discussion about "false positives". This would be involvement with families that is not justified. There is certainly ample evidence that families find the involvement of Children's Social Care to be very often difficult (see Department of Health, 1995; Cleaver and Freeman, 1995). Yet sometimes there is a need for such involvement. It is difficult to know whether this involvement is required or not. An illustration of this dilemma is provided in work by Thoburn and colleagues (1997). As one element of a study they used independent researcher judgement to identify children whose names should not have been placed on the Child Protection Register. However, at follow-up a large proportion of these children had experienced significant harm. The researchers argued persuasively that nonetheless there were grounds for not placing these children's names on the register. Yet the possibility remains that the expert researcher judgement was wrong – at least for some of these children. This study highlights the difficulty in identifying "false positives". It is difficult to know which children should not be worked with and whether involvement has been proportionate.

This area seems to be the one where there is the least current research. Yet understanding outcomes in Children's Social Care is almost impossible until we can be clear whether the "right" families are being worked with. This is partly because this accurate or appropriate targeting of services is an outcome in its own right. It is also important because the outcomes we achieve will vary depending who we work with. We cannot evaluate outcomes without addressing the issue of proportionate intervention and whether the right families are being worked with.

How helpful do parents and children find the help being offered: toward service user defined outcomes

There is great potential for user-defined measures to be used more extensively. They explicitly address one challenge (by providing the views of those who use services) and they also allow us to address a second (by allowing coverage of a wide range of issues within a single measure). However, while distance travelled measures seem to have great potential what is required is evidence that these types of approach – whether carried out by a parent, child or social worker – are related to more objectively definable outcomes. This is not a simple task, but more research is needed if we are to have confidence in the validity of user-defined measures of outcomes.

What difference is made to specific problems?

One of the challenges this article has wrestled with is to capture the breadth of work of Children's Social Care. Yet the development of a robust evidence base in disciplines such as medicine or psychology has been made possible by identifying specific treatments for particular problems. There is a manifest need for this more focussed use of outcomes in relation to identified problems in Children's Social Care. This would require work in two areas.

The first area for development is to refine our understanding of what standardized measures are useful (reliable, valid and with utility) specifically for Children's Social Care. At present almost all the measures we use are developed in psychology, with a few US measures for social work. There is an urgent need to develop, test and refine measures of key outcome measures for a UK population. This in itself has two components. We need to understand better which existing measures are most appropriate. We also need to develop and validate measures that are specific to the work of Children's Social Care. Each of these is a major research challenge.

The second area for exploration is the use of existing data on service use. Some of the recent Department for Education Innovation Programme evaluations gathered data on the use of other services to evaluate whole system change. A promising approach was that implemented by Hertfordshire, who collated data – at an aggregate not an individual level – on the involvement of various services with families prior to and after allocation (see Forrester et al, 2017c). This included police involvement, hospital attendance or admission for adults and children and school attendance. Such data has the potential to provide really useful indications of the impact of allocation within Children's Social Care. For instance, in that study they found that after allocation families had far fewer police involvements and reduced use of hospital services. Collecting such data and examining impacts over time has great promise, as on the face of it reductions in "negative" service use (that is service use that would usually indicate a problem) might indicate improving impacts. However, it is important that we understand the nature of these measures. As noted above, for instance, reduced police involvement appears likely to be positive – but could be because after allocation victims are reluctant to involve the police for fear of Children's Social Care removing children. Further work is needed to establish the validity of these measures.

Conclusions

The paper has argued that the concept of outcomes in Children's Social Care is complex and multifaceted. It has been suggested that the accuracy and proportionality of assessments and the quality of the service are important foci for evaluation of Children's Social Care in their own right. Some of the complexity of measuring outcomes has also been explored, with the tension between service user defined and expert measures being a recurring theme. Effective evaluation in this field would be likely to benefit from both, and a clearer idea of how they relate to one another would be helpful in that respect.

Overall the message is therefore that there are not simple solutions to the challenge of evaluating Children's Social Care. The aspiration is that by better understanding the nature of these complexities we can develop a more sophisticated and nuanced approach to understanding and evaluating Children's Social Care, both for research and for service evaluation.

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Table 1: Common Measures or Instruments Used

Title	Focus	Comment	Reference
Working Alliance Inventory (client or parent version) (WAI)	The quality of the "working alliance" (often considered synonymous with engagement). 15 items with 3 sub-scales (Bond (quality of relationship); Goals (agreement about focus of work); Task (agreement about tasks to be carried out).	The WAI finds small to medium relationships with outcomes in counselling. There are three versions of the WAI (worker, client and observer).	Horvath and Greenberg,1989
Goal Attainment Scaling (GAS)	Parent identifies main focus for their work with social worker. Describes in detail current situation and hoped for improvement, and worst case scenario.	Follow-up considers change in relation to previous situation and goals. We scored from +3 (exceeded), through to -3 (2 was achieved goal).	Kiresuk et al, 2014
Strengths and Difficulties Questionaire (SDQ)	25 items divided into 5 subscales (emotional; conduct; hyperactivity; peer problems; prosocial behavior)	Widely used, with good psychometric validity	Goodman, 2001
Family Environment Scale	The full instrument has 10 subscales. We use 3 focussed on relationships (cohesion, expressiveness and conflict)	Reliable and valid with different populations. Useful for exploring arguments and/or violence	Moos and Moos (1994)
Life Rating Scale	Parent or child completed rating of family life from 0 (worst imaginable) to 10 (perfect)	Client centred description of change	Forrester et al, in preparation
General Health Questionnaire (12 items) GHQ-12	Widely used screening tool indicating risk for anxiety, depression.	Extensively used, sensitive to change and allowing for comparison with wide range of samples.	Goldberg, and Hillier 1979