A HISTORICAL REVIEW OF THE CONCEPT OF SEVERE AND MULTIPLE DISADVANTAGE AND OF RESPONSES TO IT

A discussion paper for Lankelly Chase

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INDEX

Part I

**AN HISTORICAL REVIEW OF HOW SEVERE AND MULTIPLE
DISADVANTAGE AMONG YOUNG ADULTS HAS BEEN VIEWED AND
HOW THAT HAS AFFECTED WHAT HAS BEEN DONE**

Introduction

Seen from an historical perspective the concept of 'severe and multiple disadvantage' is the latest in a string of terms that have been used to describe those who have fallen outside the mainstream. There has been, and still is, a profusion of such classifications, classifications that incorporate much popular, professional and official judgement. Although popular usage is slow to change, professional and official terms change more often, particularly when those that have been used become discredited. That process has reflected shifts in attitudes, in understanding and in what are considered to be the pressing problems of the moment. However, such revisions make it difficult to trace the history of the responses that have been made to what we are now calling 'severe and multiple disadvantage'.

Whatever the language employed, the term remains a simplification, but a simplification that serves a purpose; namely, to group together individual variations into manageable categories. That, in its turn, affects the judgements that are made and the manner in which collective responses are arranged. The significance of definitions is amply illustrated in many official and other reports on disadvantaged people, especially those with mental health and 'mental deficiency' issues. One typology distinguished between the feebly minded, the moral defective and the psychopath; another employed a hierarchy that included terms like idiot, moron and imbecile[1]. Typically, quantitative measures (for example, IQ tests and, earlier, the measurement of head sizes) were used to make these assessments, leading to the classifications being one-dimensional, usually medical or psychological. Classifications like these largely determined what services were provided although, as we shall see, these offered little variety and were principally institutional.

Thus, the history of the way in which the severely disadvantaged have been treated has been closely associated with definitions. First, because they have been an integral part of how the 'problem' has been seen and what 'solutions' have been favoured. Secondly, definitions have been important because they have been used to indicate who is to be included in the group so described.

That, of course, has been significant in fixing the size of the 'problem'. Indeed, there has been a marked tendency to stop definitions becoming too wide so that the 'problem' could be kept within politically and financially acceptable limits. As a result those to whom the designation has been applied have been regarded as being distinctly different from other people and liable to be considered unworthy, undeserving or victims of their own shortcomings. Nevertheless, questions about how they should be treated have a long history – punishment versus compassion; treatment versus training; exclusion versus inclusion; eligibility versus ineligibility and so on.

Of course, there has never been just one multiply and severely disadvantaged group and different agencies have concentrated upon different categories. Indeed, it has been unusual for the extent of multiplicity to be acknowledged in what has been done. Typically, services have been preoccupied with single problems. Likewise, national policies (where they existed) have concentrated upon certain issues to the exclusion of others, partly influenced by the public clamour of the moment.

Some of these issues will be pursued further in the context of their historical significance but first we should draw attention to certain features of the concept and reality of severe and multiple disadvantage.

II

Important Features of Severe and Multiple Disadvantage

The effect of combination and accumulation

If a disadvantage is severe it is generally multiple. If it is multiple it is generally severe. However, there are complicated ways in which severity and multiplicity combine. For example, when less serious problems accumulate they may well constitute a severe disadvantage. Indeed, research by Rutter and his colleagues[2] on the mental health of young people has shown that each additional disadvantage compounds the severity of the overall problem and that it does so exponentially. Similarly, Gordon and Parker's survey of disabled children in Britain illustrated how one serious condition was usually combined with other disabilities and that the more severe it was the greater the number of additional problems and vice versa.[3]

Hence, the question of how different disadvantages accumulate is crucially important, both for understanding how situations worsen and how they get better. Does the process of accumulation differ depending upon individual situations, upon 'precipitating' factors or upon how long this or that disadvantage has been borne? It has been commonly assumed that certain disadvantages or conditions inevitably lead to others: drunkenness, idleness, delinquency, chronic ill-health, family break-up, homelessness, persistent unemployment, drugs, vagrancy and so on. For example, Rowntree and Sherwell, writing in 1899, gave pride of place to the heavy and rising consumption of alcohol.[4] In the 1960s the ravages of homelessness received much publicity, not least as a result of the film Cathy Come Home, ravages that were tellingly described by David Brandon at the end of the 60s. 'Homelessness', he wrote. 'means being without adequate material facilities – shelter, privacy, belongings and often food and money. It also means a dearth of psychological relationships – a state of anomie, of rootlessness, of not belonging anywhere'.[5]

Considerable attention, both professional and administrative, has been devoted to the determination of severity, not least in the debates about who should be reckoned to be poor (in the nineteenth century more often who was actually destitute). Likewise, the assessment of degrees of physical and mental disability has played a central part in

ascertaining eligibility for certain benefits (and at what level) as well as being linked with decisions about treatment. The history of war pensions provides a telling example, their level being fixed in 20% bands depending upon the assessed degree of disability that wounds and trauma have created.[6] Nor is this an irrelevant example when one takes into account the risks to today's young service men and women.

Although the assessment of degrees of severity has been a prominent feature of the welfare and medical systems, its multiple character has tended to be overlooked. Yet, if anything, it is a more complicated concept (and reality) than severity. If that were better appreciated the amelioration of disadvantage might be able to be more effectively organised. How, for example, are the different elements in multiple disadvantage related? Some are causally linked as when deafness produces social isolation. Others may follow in sequence or interact in ways that bring certain conditions into prominence, as in degenerative illness or when those suffering disadvantage are thrown together by force of circumstances.

Indeed, disadvantages (whether severe or not) can have a 'ripple' effect, one person's disadvantage being liable to create disadvantage for the people with whom they are closely associated. Studies of informal kinship care show that those who do the caring (principally women) can be disadvantaged in the process, especially when they are already poor, disabled, sick or grappling with the problem of caring for (and about) more than one person.[7] In the contexts of the family or community such clustering of disadvantages has been more readily recognised in regard to the family and community than it has in the case of the single individual.[8]

Although concern about the 'spread' of disadvantage has been prominent in the history of public health[9] it has also been significant in other welfare systems; for example, in the way in which the poor law endeavoured to prevent one generation of paupers producing the next[10] and, more recently, in attempts to combat what was termed the 'cycle of deprivation' [11] which in its various manifestations has a long and chequered history; witness the eugenics movement that attracted prominent supporters well into the late 1930s.[12] Indeed, a good deal of disadvantage has been attributed to inter-generational continuities, much of it (such as congenital syphilis) being seen as the shortcomings of parents being transferred to their offspring.[13]

Thus, both the idea and the reality of multiple disadvantage take several forms. These deserve to be recognised and taken into account in the policies and practices that are intended to address the problems of severe and multiple disadvantage.

The dynamics of disadvantage

Disadvantage is rarely static. In most cases there are several stages in its development: for instance, onset, progression, response to interventions and treatment and (one hopes) escape. Some disadvantages are permanent, others episodic or transitory and each has the possibility of getting worse or better. These are all important distinctions. The situation of young people who have begun life with a severe disadvantage, such as deafness or brain damage, is different from that of those whose disadvantages have occurred later in life, such as progressive hearing loss or the harms inflicted by severe addictions. In these latter cases there will have been a history of living without those

particular burdens, a matter that might be important in the kinds of help that are provided.

Some disadvantages can be reduced or eliminated by technical changes, such as digital hearing aids, power chairs, new drugs or the provision of prosthetic limbs. However, some severe disadvantages are associated with a lack of confidence or with a poor self-image and these aspects of multiplicity may be able to be addressed without great cost or resort to high technology; for instance, by orthodontic treatment, speech therapy, skills training or literacy programmes. Even though many of the severest disadvantages facing young people will not be quickly lessened by such measures, progress may depend upon the engineering of many small improvements rather than the pursuit of grand solutions. After all, much severe and multiple disadvantage has been created by the downward succession of just such increments, so perhaps an upwards progression (rather in the way that much advantage is created) can be achieved by equally modest steps. If so, this re-emphasises the need to recognise the importance of the apparently lesser components that make up the multiple nature of severe disadvantage.

Perceptions of multiple and severe disadvantage

Although there are recognisable patterns of multiple and severe disadvantage there are also wide variations. Likewise, there are considerable variations in public attitudes towards those who suffer disadvantage, attitudes that are shaped by many factors. Three in particular are noteworthy: age, gender and the nature of the dominant disadvantage.

Historically and culturally the designations child, young person and adult have had no fixed ages attached to them and for legal and administrative purposes almost all ages up to and including 21 (and in some instances beyond) have been, or are, employed in the United Kingdom to differentiate status, rights and responsibilities.[14] Hence, the choice of a particular age group, such as 16 to 30 adopted as a focus for its work by the Lankelly Chase charity, raises certain problems, particularly from an historical perspective. It spans many administrative boundaries between child and adult services, boundaries that have long created difficulties in ensuring the continuity and co-ordination of services; for example, upon being discharged from care at 18, being transferred from child to adult mental health services, having different housing rights, leaving school and so on. Thus, not being quite the right age to receive this or that service or financial benefit might itself become an added disadvantage. Conversely, certain 'welfare advantages' may come with getting older.

Indeed, much of the 'welfare system' is, and has been, constructed around an array of age categories that have reflected a mixture of political and economic considerations as well as public attitudes to the rights and responsibilities of people of different ages. Those who continue to be regarded as children (whether children or not) usually evoke sympathy. Generally, however, as age increases, less is likely to be excused and more expected, although these gradations have not always been the same, for example, the age of criminal responsibility, the age of majority (and minority, of course), the age at which this or that employment has been prohibited and so on. In our culture the 'transition zones' between childhood and adulthood have been (and remain) imprecisely defined.

Not only have public attitudes towards those who suffer severe and multiple disadvantages been influenced by their age but also by their gender. Men and women tend to be exposed to different combinations of disadvantage. For women these have often been associated with sexual exploitation and with unmarried motherhood, both of which have been variously attributed to moral laxity, to wanton behaviour and low intelligence.[15] Such opprobrium has constituted an additional disadvantage, not least when it has existed in conjunction with the services that have been offered. Furthermore, in the past many of these services were provided by religious bodies that emphasised the need for moral reform.[16]

Attitudes to disadvantaged men have had more to do with their participation in the labour market. Being unemployed without apparent good cause was considered to show that they were workshy, layabouts, idle, wastrels or scroungers. Indeed, a major part of the poor law system was constructed in order to deter the 'able-bodied' (principally men) from seeking (and obtaining) financial relief. Hence, the workhouse test and its associated principle of 'less eligibility', a principle that required that the circumstances of the pauper should never be made better than his employed counterpart.[17] However, women without paid employment were not exposed to such severe judgements, reflecting the expectation that it was men who should be the principal breadwinners and that women should be occupied with housekeeping, the care of children or only secondary outside work.[18]

The consequences of severe disadvantage may also be explained differently for men and women. Currently, for example, difficult behaviour among young men is likely to be classed as a conduct disorder whereas, in the case of young women, it tends to be described as an emotional disturbance, both of which interpretations have implications for professional and public responses to what may in fact be the result of a similar combination of disadvantages.[19]

There are, of course, other differences between the experience of men and women faced with severe disadvantages, as well as the way in which they are perceived. However, age and gender are not the only factors that have influenced how those who bear these burdens are regarded and treated. Although most severe disadvantages are multiple, some are more apparent than others and some attract more attention than others. Attitudes towards disadvantaged people tend to reflect assumptions about the causes of their most prominent disadvantage. Whatever the reality, some disadvantages are assumed to be self-inflicted, and therefore blameworthy, whilst others are understood to be outside a person's control and therefore deserving sympathy rather than condemnation. Examples, both historical and current, are plentiful. In the past those who were alcoholic, contracted venereal disease, committed criminal offences or fell into debt have enjoyed little sympathy and even now popular attitudes are often censorious.[20] On the other hand there are conditions such as blindness, congenital disability, injuries sustained in war, the consequences of medical errors (such as the use of thalidomide) that elicit widespread sympathy, not least in the readiness to make charitable donations.[21] The problem arises in those many cases that lie in the uncertain areas in between, especially where blameless conditions nevertheless result in difficult, challenging, unpredictable or threatening behaviour. Certainly, better understanding has helped, but even then the persistence of

such conditions, and indeed their worsening, can exhaust the energy and commitment of those who endeavour to help.

Indeed, for most helpers (whatever their status) there has to be some kind of reward for such commitment, as there has to be for those to whom help is being offered. We understand rather little about the nature of 'reward systems', especially how they survive or crumble over time. A sense of duty, of responsibility, of compassion, of religious mission or simple habit may all play their part. There is a natural tendency to shy away from acknowledging the arithmetic of giving and receiving, although it constitutes an important element in helping relationships, relationships the survival of which depends on the existence of a measure of reciprocity.[22] Not being able to reciprocate, or not feeling capable of doing so, can become yet one more (potentially serious) disadvantage.

III

Salient Features of the Historical Background

A few cautionary words are necessary before outlining some of the main features of the way in which, in the past, those suffering severe and multiple disadvantages have been regarded. In the first place there is (again) the matter of age. Typically, once they were 16 years old the disadvantaged were no longer considered to be children; they had to contend for whatever adult services were available; and that remained largely the case until after the Second World War when 18 gradually became the cut off point.[23]

Thus, the historical background of services for the disadvantaged between the ages of 16-30 cannot be separated from those available to the adult population. However, disadvantages do not begin at 16 nor do they end at 30. What has been available to children earlier remains an important consideration, as does the effect of services for young adults on their lives beyond 30.[24]

Such issues about age sound one cautionary note for an historical review. A second concerns the interpretation of disadvantage and, in particular, of severe disadvantage. Given that the concept of disadvantage is relative (that is, the 'absence of advantage') its historical distribution has influenced how it has been viewed. Mass poverty, mass unemployment, mass illness or mass despair have a different impact on the politics of welfare than pockets of disadvantage. When most do not suffer from gross disadvantages, the disadvantages of those who do are more likely to be classed as severe. What are regarded as severe disadvantages at one time or place are not necessarily the same as those at other times or places, a reality vividly illustrated today in the eastern Congo, or in Kosovo and Rwanda a few years ago.[25] Indeed, some of the most severe disadvantages have been created by political, religious and racial persecution, or by a combination of all three.

One final point to be borne in mind is that the term disadvantage is rarely to be found in conjunction with the provision of a personal service, principally because it was not easily quantifiable. Instead, we find more reference to destitution, to handicap and to disability.

Having re-emphasised these qualifications four features of past services for the 'disadvantaged' are particularly noteworthy: the early dominance of institutional provision, the fragmentation of personal services, the emergence of community care in the early 1960s and, finally, the contribution of the services that have been universally available.

The dominance of the institution

Institutions have figured prominently in the history of disadvantage. In the first place they were a favoured way of dealing with those who were judged to be destitute, mad or bad for whom there was the workhouse, the lunatic asylum or the prison. Walls provided the means of exercising control over troublesome behaviour, a control that was necessary if such behaviour were to be altered and improved. This might be achieved by systems of coercion but quite as readily by training and treatment. It was assumed that none of this could be ensured by occasional contact in unregulated situations.[26]

However, admission to an institution carried the likelihood that it would add yet one more disadvantage. Because admission was often a matter of last resort and a mark of social failure it was a stigmatising process. Such initial stigma was accentuated in at least two other ways. One was by association and the other through compulsion.[27]

Despite the desire of many administrators to separate the 'deserving' from the 'undeserving' and the 'reputable' from the 'disreputable', the reality of institutional life has been one of enforced and uncertain association. The choice of associates is limited and escape from the disruptive, distressing or frightening behaviour of other people well-nigh impossible. When those who live in institutions are regarded in an unfavourable light, those who are obliged to join them are likely to be seen in the same way irrespective of the reasons for their admission.[28]

The negative image of institutions has been reinforced by the legal compulsion that has preceded much admission. Until 1930, for example, the doors of public institutions for the treatment of the mentally disordered were closed to all but people certified by a judicial authority as 'a lunatic, an idiot or a person of unsound mind' and ordered to be detained. Not only was admission dependent upon certification but the order for commitment carried with it the prospect of its irrevocability. Furthermore, the same system of certification was applied to the 'mentally handicapped' as it was to the mentally ill. Indeed, the lack of understanding about the differences between these two conditions was superimposed upon the popular assumption that mental afflictions were hereditary. This made the act of certification an additionally distressing event. Relatives were liable to be upset by the public confirmation of mental weakness in the family. In that sense certification was often experienced as a matter of family shame. Even though it was possible for patients to enter a mental hospital on a voluntary basis after 1930, this relaxation did not apply to the 'mentally defective' until the reforms introduced by the Mental Health Act of 1959.

Institutional regimes did not affect only those who were admitted. In many cases they were also intended to convey a deterrent message to the far greater number who were

assumed to threaten to overwhelm the available resources or to disturb a precarious social order. The discipline of the institution had wider implications. Writing about the poor law, for example, Abel-Smith emphasised that it 'was an ever-present symbol to the … poor of the fate to which their poverty might condemn them.'[29] Some institutions served to regulate the behaviour of those outside their walls as well as that of those within.

The status of hospitals might be thought to be different. Yet their 'rise' only dates from the latter part of the nineteenth century. Before then most illness was endured at home.[30] Sick people were constrained to enter hospitals because they were destitute, homeless or lacked anyone to look after them. However, once started the late Victorian expansion of hospital provision proceeded apace. For example, between 1861 and 1921 the number of beds in voluntary hospitals increased from 15,000 to 57,000 and a hospital service emerged within the poor law – the infirmaries. Local authorities too began to build hospitals for infectious diseases – popularly known as the fever hospitals. The character and public image of the hospitals was changing, improved by advances in medicine, by the ambitions of the medical profession and by the professionalisation of nursing.[31] As Abel-Smith explained in relation to the infirmaries 'it was no longer necessary to drive patients into these institutions; on the contrary, the problem was to ration these limited resources amongst the different types of patients seeking care.' [32]

These changes serve to illustrate that, by and large, those services that are considered to be necessary on medical grounds have come to be more favourably regarded by the public than those that are not. Hence, both the classification of people's conditions and the designation of the services to which they are referred have been important in determining the acceptability of that service as well as the support that it is likely to enjoy.

The fragmentation of services

The 'severely and multiply disadvantaged' are not a homogeneous group. It is not surprising, therefore, that the services that have been available to them have been fragmentary. There are, however, other factors that have accounted for such fragmentation. Three in particular are notable: decentralisation, voluntary and charitable involvement, and professional developments.

Although the poor law system existed throughout the United Kingdom from the seventeenth century until the Second World War, boards of guardians exercised considerable discretion as to how that system was administered.[33] Each board set its own poor rate (the local tax); decided matters of eligibility for assistance and appointed its own staff. Indeed, the amount of local variation was further increased because those staff (such as relieving officers) could be given, or assume, a further degree of discretion. Hence, despite the efforts of central government inspectors to secure more uniformity in its administration, there was considerable variation in what help the severely and multiply disadvantaged might receive from the poor law in different parts of the country, not least as between England and Scotland and as between urban and rural areas.[34] Furthermore, it has to be remembered that boards of guardians were elected (albeit initially on a limited suffrage) and that decisions were taken by majority voting. In this the convictions, prejudices, sympathies and local

experience of the members played their part, although from the latter part of the nineteenth century the patterns of influence began to shift as a result of the election of more women and of others, including women, with socialist affiliations.[35]

Nevertheless, few of the services that were available from the poor law (and from its successor the local public assistance committees) were what, today, we would regard as personal services. These were more often provided by voluntary organisations: training for the blind or deaf, aid for the crippled, employment for disabled ex-servicemen, support for unmarried mothers, sponsored emigration and so the list could be added to. Although varied, such initiatives had four characteristics in common: many relied upon institutional care; little co-ordination existed (in fact, there was a good deal of competition for public support and therefore for funds), their financial states were often precarious and most concentrated their efforts on single, clearly identifiable conditions, often physical disabilities – handicaps as they were more often called. Many initiatives were local and often short-lived. Furthermore, there was no notion of a generalised 'disadvantage' that influenced the way in which such services were organised. All this added further to the picture of fragmentation and uncertainty; uncertainty about what might be available to whom, when, where and on what terms.

The third reason for the fragmentary nature of the personal services available to the disadvantaged has been the increasing specialisation within the professions involved. This has been especially marked in medicine but also in the development of social work that grew to include welfare officers, psychiatric social workers, probation officers, medical social workers (formerly almoners), court welfare officers, family welfare staff, moral welfare workers and several other branches.[36]

The emergence of 'community care'

Although the emergence of community care as a national policy dates from the early 1960s, the idea that help should be directed to areas of marked disadvantage has had a longer, albeit modest history. From the 1880s onwards these were the places of greatest poverty, disease and overcrowding. Improved housing was the obvious remedy; but little was done until the major slum clearance drive that began in the mid-1950s.[37] What was done was mostly the result of action taken by some of the largest urban local authorities and by some philanthropic organisation such as the Peabody Trust.[38] The settlement movement was also area-based and, amongst other things, was intended to improve the lot of those who lived in poverty-stricken parts of several cities.[39]

The identification of certain areas as a means of tackling disadvantage continued off and on into the twentieth century but mostly as government inspired initiatives. For example, there have been community development areas,[40] educational priority areas[41] and housing action areas[42] (most of which disappointed expectations).

By the mid-1950s another version of community care was afoot; namely, care in the community. This was driven forward by two main considerations. The first was the quest to reduce reliance on institutional care, especially in the fields of mental deficiency and mental illness. The buildings (still popularly known as asylums) were old and no longer met certain minimum standards, many having been neglected

during the war years and the decade after. Maintenance costs were high. Staff salaries were rising as better qualifications were sought and unionisation became more common. There was an economic imperative to find an alternative.

A second factor that encouraged the development of care in the community was a growing recognition of the psychological damage that was caused by long periods being spent in institutions; a damage that came to be attributed to 'institutional neurosis'.[43] This, and other shortcomings of the 'institutional solution' together with the 'economic imperatives' led to the government requiring local health and welfare authorities to prepare and submit plans for the 'development of community care' over the ten years from 1962.[44] Some of these plans were ambitious; most however, erred on the side of caution not wishing to provide any hostages to fortune, noting the likely impact of a growing wave of people being discharged from the mental hospitals and other residential provision, for example that for the blind, deaf or epileptic.

This scenario tends to imply that little community care had hitherto existed. This is misleading. In the first place in 1948 local authorities were given responsibility for providing 'welfare services' and although unevenly developed these did include much that was based in the community rather than in residential homes. Nonetheless, the major emphasis was upon the elderly and a number of other people with specific disabilities. If they were to be assisted the 'disadvantaged ' needed to fall into an identifiable category.

Prior to the promotion of the community care policy in the 60s there had also been various comparable services that were provided by voluntary bodies, many of them locally based. In 1965 Margot Jefferys published her study of social welfare services in one large county. Amongst the voluntary social welfare activities she listed moral welfare work, the NSPCC, the missioner for the deaf, an old people's welfare service, the CAB, a worker from the national spastics society and at least half a dozen other agencies.[45] However, all were concerned with particular classes of need.

It is also important to emphasise that both before and after the community care initiative of the 60s, most care and assistance was provided by families with little recourse to organised services whether public, voluntary or commercial. One of the abiding disadvantages has been to be without a close family or for those links to have been lost for one reason or another. Nevertheless, the community care initiative was potentially a significant step forward in the provision of help to the disadvantaged without resort to the 'institutional solution'. How did it fare?

Although progress was made it fell short of the aspirations that were expressed in the early 60s. There were several reasons, some of which still apply. First, the scale of what was needed was underestimated. Once more services became available, increased demand followed. This was especially the case after the reform of the personal social services in 1970 that created integrated social services departments. However, these departments became exposed to pressing demands connected with concern about child abuse on one hand and a growing elderly population. These became the priorities in most areas, accentuating the priorities being attached to the young and the old – not those in their 20s.

A second reason for the patchy development of community-based services lay in the latitude accorded to local authorities to decide upon the balance of their expenditures. There was no ring-fencing of monies for specific community services, although there were some exceptions later. Different local authorities faced different levels of need or were unsure what that level was or what it comprised.

The third reason for the disappointing development of community welfare services is to be found in the state of the economy and the pressures on local authorities to cut back on their expenditures. There was an increase of central government funds to support the development of the personal social services in the first years of the 1970s but this ended with the oil crisis later in the decade that obliged the Chancellor (Denis Healy) to go cap in hand to the IMF. Since then the general pattern has been one of curbing public expenditure, requiring local authorities to make difficult decisions about where cuts were to fall; and in some places they fell on those 'fringe' services that assisted minority but substantially disadvantaged individuals and families. Furthermore, some of the local authority grants to voluntary bodies were either reduced or withdrawn.

One further reason for 'community care' falling short of what was required of it has lain in the pattern of its distribution, a distribution that, as we shall see later, has tended not to reflect the pattern of need.

Universal services

It is tempting to think about the services that are required to combat severe disadvantage in terms of specific individuals or groups. However, looked at historically, it has been the development of universal services that has reduced the extent of severe disadvantage; in particular, public health measures from the latter part of the nineteenth century onwards, improved nutritional standards from the early decades of the twentieth century, compulsory education and, not least, the emergence of the 'welfare state' during and after the Second World War. It is worth recalling the five 'giant evils' that were depicted in the Beveridge report of 1942.[46] They were: squalor, ignorance, want, idleness and disease. All were tackled to a greater or lesser degree in the cascade of social legislation that followed. The poor law was dismantled; a national health service established; a social security system put in place; an educational programme launched; efforts were made to deal with the poor housing stock and commitments made to a policy of 'full employment' embraced. Although progress was, and has been, uneven these reforms constituted a major onslaught on disadvantage and particularly on multiple disadvantage. There were many who, before, had suffered the evils of all five of the Beveridge giants - particularly whole families and over long periods.

Together, the war and the 'coming of the welfare state' led to a more equal society and that had a bearing upon the distribution of disadvantage in terms of its necessarily relative character. The contribution that universal services have made (and can make) to reducing both inequality[47] and significant disadvantage should not be underestimated. Indeed, the success of specific schemes to aid particular groups has depended, in part, upon such 'services for all' and 'of right'.

Hence, the erosion of such services has had and will have a knock on effect upon the scale of disadvantage and upon the ability of individualised personal services to achieve what is needed. They depend upon the bedrock of generalised services, particularly upon the benefit system and social housing. Where these are inadequate or unavailable the task of helping the severely disadvantaged becomes that much more difficult.

The Social Market

The most dramatic development in social policy in the last two decades or so has been the delegation of previously publicly provided social services to the so-called 'independent sector'. However, this term has (conveniently) conflated out-sourcing to private-for-profit enterprises and out-sourcing to non-profit voluntary agencies. The distinction is important because these are different systems with different philosophies. Here we concentrate on the former, not least because now, unlike earlier periods, it is they that are in the ascendancy.

To gauge the extent and rapidity of this change we offer the example of the children's services. Statistics published by the Department for Education and OFSTED show that in England in 2001, 12% of all looked-after children who were in foster homes were in those provided and supervised by the 'independent sector', almost all private-for-profit agencies. By 2013 this figure had risen to 36%. Between 1995 and 2000 the number of private children's homes in England increased from 182 to 256; that is by 40%. By 2013 there were 1,347, a further five-fold increase and by which time they provided 72% of the available residential places. In some local authorities over half of foster placements and nearly all residential ones are purchased from commercial companies. Similar developments have occurred in education, in the penal services, in re-employment schemes and, not least, in the health services.

There appears to be little evidence of this transformation abating. For instance, the 2008 Children and Young Persons Act (introduced by New Labour) permitted local authorities to delegate their look-after children function to a third party provider. However, apart from a couple of pilot ventures, no commencement order was issued until 2013 (by the Coalition government). The most recent proposal is that this permissive power should be extended to cover all children's services (including health) with only one or two exceptions.

These are profound changes. Some have been beneficial in terms of introducing competition, stimulating new ideas and running better services, especially in places where standards were traditionally low. But disquieting issues remain.

There is the matter of the durability of private providers. What happens if they are found to be unfit for what they are expected to do? What happens if they go into liquidation or become bankrupt, or simply decide to invest elsewhere instead? And the 'what happens' question is about the people for whom their services have been purchased. Then there are questions concerning their accountability and their capacity or willingness to engage in re-investment (in staff training, for instance). The evidence from the children's services indicates that the services purchased by local authorities are usually not located in the area of the commissioning body. What are the implications? In any case how much detailed and up-to-date information do the

commissioners have about the range from which it is now possible for them to choose?

Of course, not all these issues are unique to the private sector but they now appear in starker relief. Take, for example, the persistent problem of securing the co-ordination and co-operation of disparate services to meet complex needs. In 2013 there were 407 private and voluntary children's homes and 229 independent fostering agencies which, when added to 152 local authorities meant that there were 788 bodies in England providing services for looked-after children. What are the consequences of this proliferation, a proliferation that is occurring in may other services with which children's services need to work? The latest statutory guidance on Working Together lists 20 organisations and types of organisations that are required to follow the guidance.

There are three final queries about these changes that need further investigation: how far do they hamper the development of national policies; what are the implications for the voluntary sector and, last but not least, why is the private sector cheaper than the public (which is a large part of the rationale for favouring the market)?

IV

So, What Conclusions are to be Drawn?

We should be able to 'learn lessons' from the past as historical perspective helps to appreciate the nature of present services and the problems they confront. However, this is easier said than done and it is always possible to draw incorrect conclusions, especially from a brief review such as this. There is also the risk of misinterpreting what has gone before, not least in order to favour those interpretations that confirm what is already believed. We have endeavoured to avoid such pitfalls in suggesting what seem to be some of the more important conclusions that are relevant to improving what is done to improve the lot of those young people who face severe and multiple disadvantage.

Avoid creating additional disadvantage

Services run the risk of stigmatising their recipients. Whether intended or not, the terms upon which they are provided as well as the manner in which they are described can have that effect. One of the reasons for this has sprung from the assumption that a person's declaration of need confirmed their unworthiness. A second reason derived from the fear that without a measure of deterrence the scale of demand was liable to get out of hand. One further cause of stigmatisation has lain not so much in the deliberate design of a service but in the way in which it has been administered by those dealing with the needful face-to-face. This has been a particular problem with ill-trained and poorly paid staff but who nevertheless exercised great freedom in the manner in which they interacted with the disadvantaged. There is also, of course, the damage done by untested theories and their associated therapies, some of which have been enthusiastically embraced.

We need to be sure, therefore, that the character of the help being offered to the disadvantaged does not add to their troubles, whether intentionally or not.

Multiplicity

There has been a long history of the multiplicity of a person's disadvantages being overlooked or played down. One of the reasons is the difficulty that a 'system' experiences in addressing several, often diverse, problems in an integrated fashion. Indeed, much organisational reform has sought to diversify functions and responsibilities, often in line with the advance of specialisation in the helping professions. Even when a diagnosis (for want of a better term) has explored and identified the various problems that a person confronts, what is then done has had a tendency to concentrate on single issues, reflecting what help can actually be mobilised.

Thus, it is important for second, third or fourth order problems not to be ignored; if they are they may worsen and accumulate in ways that increase the severity of existing disadvantages.

Chains of Events

Much severe disadvantage is the consequence of one disadvavantage leading to another. Furthermore, some of these downward increments are comparatively small events. Nevertheless, they can have damaging repercussions. We need to know more about such chains of events, how they relate, which (if any) are the prime movers and how far the sequences vary from one person to the next. What are the most important predictors of upward or downward mobility in advantage/disadvantage?

Unless we have some reasonably sound understanding of such matters it will be difficult to know how best to mitigate disadvantages, either on an individual or a collective basis.

The Balance of Advantage and Disadvantage

There is a danger that some of the severely disadvantaged will be seen only in that light. There is a long history of the most disadvantaged being disparaged, discounted or blamed. It was often assumed that they could make little or no contribution to their own well-being or to the community more generally. Yet we all experience a mixture of advantages and disadvantages and a mixture that can change over time. Couched in a somewhat different way the equation might be expressed as a balance of capacities. That shifts the question of what the disadvantaged require to what they are able to contribute.

In focussing intently upon severe disadvantage there is the risk that the capacities (advantages) of those so described will be overlooked. No one is solely disadvantaged. It follows that they should not be treated as if that were the case.

The importance of visible signs and symbols

Some features of disadvantage, such as physical disability, are highly visible while others, such as deafness or mental illness, are not. This can lead to misinterpretation when members of the public try to fit what they see into familiar categories. This in turn is likely to affect their expressions and displays sympathy in a way that should not be confused with illwill.

The signs and symbols of disadvantage vary in their visibility and some disadvantaged people are viewed unsympathetically because of misperception and interpretation.

Part II

The Three Further Questions

In addition to the historical review we were asked to comment on three other more general matters that help explain the current context of disadvantage. The first was to explain why the needs of the severely disadvantaged have so often failed to be met. The second was to consider how and why welfare systems change. The third question was why the state (both nationally and locally) has become the primary provider of welfare services.

I
Who Gets Overlooked and Why?

The original question was posed in a different way; namely, 'why do public systems consistently overlook high risk groups?' We have re-phrased it somewhat differently for two reasons. First, because high risk groups are not consistently overlooked and secondly because the question implies that only public services by-pass these groups. We are also assuming that 'high risk' and 'severe disadvantage' are describing much the same thing, although this may not necessarily be so. With these provisos in mind we suggest that there are a number of inter-locking reasons why the needs of the severely disadvantaged fail to be met.

The Costs

Helping the severely disadvantaged can be a costly business both financially and socially.[48] It is liable to make high demands on scarce resources not only because of the complexity of the problems to be faced but also because of the likelihood that their amelioration will require long-term commitments. Organisations that have a range of responsibilities face difficult decisions about the division of their budgets. They are exposed to contending claims, some of which are orchestrated in compelling ways whilst others exercise little purchase on the political system. Furthermore, an existing division of resources is likely to be broadly continued and only be modified at the margins. In general one of the disadvantages of the severely disadvantaged is their lack of powerful champions and, in any case, those who are able to exercise this power usually choose to do so in the cause of clearly identifiable groups.

The demands on the health and welfare services exceed their supply. Rationing is endemic although its necessity is liable to be denied.[49] One means of rationing is to limit the size of the potential demand, which takes us back to definitions of eligibility. The tighter these are drawn the greater the number of needful people who will be squeezed out. Although that is one reason why some of the disadvantaged get ignored, stringent eligibility criteria also have the effect of delaying help until problems worsen, defeating the aim of early prevention.[50]

Discretion

We have already touched upon the impact of discretion in the determination of who gets what but its significance needs re-emphasising. It is important for two principal reasons. One derives from the fact that most front line staff are hard-pressed. Just as managers and politicians have to decide how to allocate the available resources, so too do field workers whose resources are primarily their time and their energy. They make decisions about how much of these resources they devote to the needs of different people.[51]

The work can be unrewarding especially when there seems little prospect of improving matters or when the behaviour of those they seek to help is aggressive, uncooperative or they are believed to be able to help themselves. The despair and anger of staff can cause them to back away from such people or withdraw the service altogether. There is a natural temptation to concentrate upon helping those whose problems are less demanding, where there is the prospect of improvement and where, as a consequence, there is some reward for the efforts made on their behalf.

The literature on how professionals and volunteers cope with stress shows that naïve optimism is likely to lead to pain and frustration for those involved which, if not dealt with, often masks an authoritarian approach that is unsympathetic to those who reject seemingly beneficent offerings. Such rejection early in a young person's life – in education, employment, housing or personal relations – can lead to a severely disadvantaged later life.

Although employees might have a statutory duty to provide help, how they discharge that duty is open to interpretation. This is manifest in the requirement that local authorities use section 20 of the Children Act 1989 to accommodate homeless 16-18-year-olds. A roof is usually provided but more likely in bed and breakfast or supervised lodgings rather than a professionally staffed hostel.[52]

Even in highly codified organisations such as the social security system considerable discretion is exercised in the interpretation of regulations and in the manner in which interviews are conducted. Fatigue, exasperation and disapproval all play their part in what can amount to discrimination; and the role of reception staff in setting the 'tone' should not be overlooked.[53]

In the same way that staff in formal organisations exercise discretion about how they deploy their resources, so too do informal carers who can reach the end of their tether, often after long years of providing demanding support. This, of course, is especially true in families. Despite a social framework of strong assumptions about family obligations they are, in fact, not obligatory and can be and are renounced for a variety of reasons but mainly because the 'costs' of carrying on have become too great.

Co-ordination

If someone is suffering multiple disadvantages it is almost certain that their needs will be complex and that they will therefore require the help of a number of organisationally separate services. Yet one of the enduring issues in the social services has been their lack of co-ordination. Innumerable committee reports, white papers and circulars have highlighted these shortcomings, castigated the apparently

un-cooperative and exhorted them to do better; but little has been done to explain this enduring weakness.

The two most plausible explanations focus on scarcity and domain.[54] All organisations have an interest in conserving their resources for fulfilling their primary tasks. Co-operation with another agency is usually seen as a diversion of scarce resources. Hence, the quibbles about whose responsibility this or that problem is and about who pays. The more bodies that are involved the more complicated the equation becomes as it does in times of austerity and depleted funds.

Most organisations have a specified domain that their staff are anxious to protect from encroachment. Questions about who does what are closely linked to 'boundaries of responsibility', hence the fears about the consequences of administrative reform. Both professional identity and job security may be thought to be in jeopardy.

The consequences of these organisational characteristics are daunting for those whose needs cross boundaries of responsibility. There is the danger of being passed from one agency to another when a person's problems are not clear cut, when they are 'difficult' and demanding or when there are grounds for deciding that they are someone else's responsibility. The more disadvantaged the person and the more numerous their needs, the greater the likelihood that they will be shunted from pillar to post and in the process fail to have their difficulties properly addressed, engendering frustration, anger, discouragement and a sense of abandonment, further disadvantages in negotiating the complexity of the 'system'. However, there is sometime a clear step in the process of status deterioration, such as 'going to prison' or 'entering a home' and some agencies specialise in helping extreme cases and, sometimes, offer a better service than was available before.

The Balance of Advantage and Disadvantage

If you come from a severely disadvantaged family, live in a severely disadvantaged area or went to a disadvantaged school (often one and the same) you 'start' with a burden of disadvantages that then tend to accumulate. If you possess a good stock of advantages the experience of future disadvantages is likely to be able to be better managed and their ill effects minimised. These advantages, or 'protective factors', are likely to include such things as good health, family support, positive relationships, a clear identity, a sound education and resilience. One might add intelligence, courage or moral stamina. Nevertheless, one should not discount sheer chance in obtaining an advantage: particularly luck in the person you meet and later marry or who becomes your partner. Then there is the luck of not being born in a country devastated by war or natural disaster or of being born in a country where civic rights are broadly respected - especially the rights of women and children.

The disadvantages associated with poverty are obvious and it may be that it is these very disadvantages that explain why the poorest fifth of the population that fares worst when it comes to the distribution of personal social services.[55]

Unlike the disadvantaged who possess valuable advantages, those who do not are less likely to be able to secure the services that they need. Advantage tends to breeds advantage, not least in gaining access to help and support.

Rootlessness

Those who are homeless and sleeping rough are clearly amongst some of the most disadvantaged. Having 'no fixed abode' presents many problems, not least of them being the difficulty in gaining easy access to key services. Many key documents are based on addresses; for example, the electoral register or certain health records. When they are not readily available to welfare agencies they are liable to cause delay. Furthermore, many commercial services (such as banks or insurance companies) require prospective customers to have an address. Consider too how often one is asked for the first line of your address and your postcode in order to establish that you are who you say you are. The lack of an address is a disadvantage that quickly creates others.

Even with an address geographical mobility can have similar repercussions to not having one at all. Certain groups of the disadvantaged move a lot. They move to escape debt, violence or unwanted relationships. Some also move in quest of casual seasonal work or cheap accommodation in out-of-season seaside towns. There are others like illegal immigrants, deserters or people wanted by the police who move to elude detection. Whatever the reason, highly mobile but disadvantaged people find it hard to establish new contacts with helping networks, whether they are formal services or friends and family. Mutual aid tends to be strongest in immobile communities, even when they are poor. Indeed, non-cash reciprocity depends upon the same people still being around to fulfil the implicit exchange.

In summary

So, the answer to the question of why the severely and multiply disadvantaged do not always receive the help that they need is complicated, as one would expect with such a disparate group. Although we have highlighted five explanations there are certainly others and, of course, these five factors often overlap and accentuate the problem. If we were to draw one conclusion however it would be that some types of disadvantage are more socially approved than others and that those who benefit most are young people who are 'nice', 'deserving', help themselves and are visible. But numerous poverty and disability studies have revealed that there are also thousands of multiply disadvantaged people and families who are invisible or inadequately assisted.[56]

II

Changing Policies, Changing Systems

The second additional question that we were asked to address was when, why and how 'systems' change, in this case welfare systems. However, the vast literature that deals with questions like these is not confined to the politics of welfare. Some focus upon administrative systems, including management; some tackle international relations; others deal with specific forms of change or offer illustrative case studies. All we can do in this brief review is pick out some of the themes that appear time and again in the explanations that are offered. However, to start with it is important to be

clear what kinds of change are being considered. One useful classification distinguishes development that modifies existing activity, reform that retains broad aims but changes the means and innovation that introduces something radically different.[57]

However, these categories are not necessarily associated with particular processes of achieving change. For instance, new legislation can lead to all three types or its intentions be subverted by those who are charged with introducing the new arrangements. This is illustrated in Michael Little's discussion of the inertia that the introduction of new practices can encounter[58] or in Jean Packman's description of the failure of new policies in social services departments to be followed by those who should be implementing them.[59] Likewise, ministers may drag their feet in issuing a commencement order for legislation already on the Statute Book or the legislation may allow certain things to be done rather than making them mandatory. So, we should not assume that the outward appearances of change are an accurate reflection of what is actually happening. Indeed, as much can be learnt about the politics of change from what fails to change as from what does; for example, by looking at what Richard Titmuss called the forces of anti-welfare.[60] Furthermore, it should not be assumed that all change is progressive; some will be disadvantageous to the cause of 'welfare' in general or to particular groups. Bearing these thoughts in mind let us consider the general conditions that are likely to have to exist if change in policies and practices is to be realised.

Effective change depends upon a threefold set of conditions: that what is proposed is viewed as legitimate, that it is regarded as feasible and that it is able to mobilise sufficient support.

Legitimacy refers to the extent to which governments and other organisations feel that it is appropriate for them to be concerned with a particular issue and to acknowledge some responsibility for its solution. Feasibility means just what it says. Is a change judged to be capable of being achieved given the current technology, manpower, knowledge or likely opposition? Support describes the backing necessary in order to see through a change successfully. That backing may be secured by forming broad alliances, by winning votes, getting financial guarantees or enlisting the help of those with personal or organisational power.

Ensuring that these conditions are in place requires diplomatic skills and these, in their turn, rely upon a keen understanding of the relevant political environment. That comes from experience as well as from careful reconnaissance and preparation.

What, more particularly, are the factors that are likely to bring an issue into sufficient prominence for it to generate change? The answer is far from straightforward but we suggest five that are commonly in play.

Upheaval and crises

Pride of place in the politics of crisis must go to war. War upsets the established order. Fresh ways of doing things become imperative; new problems demand prompt solutions and weaknesses and shortcomings are exposed. The most obvious example is from the Second World War during and after which the welfare 'system' underwent

its most far-reaching shake-up.[61] One example will serve as illustration. Both troops and civilians were injured by enemy action. The existing health system was quite inadequate to deal with these casualties. Free medical care had to be provided which it was politically impossible not to make universally available or to abandon after the war. There was no going back to pre-war arrangements.

However, it was not only the 1939-45 war that had an impact upon social welfare. The Boer War (1899-1902) revealed the extensive unfitness of young men that precluded them from joining up.[62] The figures were alarming, especially in the context of a resurgent Germany. Clearly our country's security was in jeopardy if nothing was done about the health of the nation's children. The quality and availability of milk became a pressing issue; a school health service was introduced and free school meals provided in the most deprived areas.[63]

The 1914-18 war also led to important changes in social policy; in housing for example. Housing shortage intensified during the war giving landlords the opportunity to charge rack rents, often from the families of soldiers at the front; and it should be borne in mind that most housing (some 90%) was privately rented. Anger against exploitative rents and profiteering grew; a political response could not be avoided. Rent control was introduced in 1916 and although it was intended to be a temporary measure it lasted for nearly 50 years.[64] Furthermore, the slogan 'homes fit for heroes' was widely heard. There was a groundswell of demand that its message should not be ignored. Post-war legislation to encourage the building of council houses soon followed and as it progressed it began to break the stranglehold of private landlords.[65]

However, it was not only the two major wars that gave rise to significant changes in social policy. The cost of the Korean war, for instance, called for economies elsewhere, one of which was the imposition of prescription charges for the first time.[66] Throughout, the cost of wars has required reductions in expenditure, some of which have fallen heavily upon social provision. On the other hand some social expenditures have risen in wartime, especially in the health services. One other important consequence has been the dramatic reduction of unemployment (almost to zero during the Second World War) that has reduced calls on the benefit system.

Although a major factor in accelerating changes in social policies war also encouraged public sympathy for the 'no-blame' victims, such as war orphans, widows, bombed-out families and during 1939-45 the establishment of various communal facilities such civic restaurants. War has also stimulated the development of new technologies and treatments. The 'shell shock' phenomenon of the First World War caused an important page to be turned in psychological understanding and theory whilst the recent wars in Iraq and Afghanistan have produced major advancements in trauma treatment, surgery and rehabilitation; similarly the Royal Belfast Infirmary has become a pioneering burns unit as a result of the Troubles.

Wars alter the political calculus in wide-ranging ways. Scandals can do so in more particular cases. For example, the excessive physical punishment of boys at the Court Lees approved school in 1967 has been credited with the demise of the approved school system. In fact, it was a death waiting to happen. What it did was to strengthen the hand of the Secretary of State (Roy Jenkins) in his wish to dismantle the system. It

was enough to tip the balance in his favour where before he had considered it too politically costly to proceed.[67]

The moral of this example is that crises and scandals become agents of change when there has been a build up of previous disquiet and when there are influential individuals or prepared organisations (usually pressure groups) ready to seize the opportunity. There are however occasions when a particularly awful scandal makes some kind of government response (whether national or local) unavoidable. Typically, child abuse, the abuse of elderly people in residential homes, extensive fraud or widespread corruption compel governments to act, usually by introducing more 'safeguards' rather than more far-reaching changes, often after having set up a committee to investigate the matter As investigative journalism and the use of the social media have grown these kinds of pressures on governments have increased and are likely to go on in doing so.

Worrying trend and revelations

When a problem gives evidence of getting worse, particularly at a faster rate than before, governments can be impelled to do something about it. In this, the availability of statistical trend data (and especially extrapolations) has been very important. There are many examples: public expenditure figures, demographic data, crime statistics, disease patterns, educational performance or unemployment levels. However, the first two in the list will serve as illustration.

Governments are keen to keep a tight control on expenditure, not least because of the electoral implications of increases in taxation. Hence, the demand that any proposed change should be carefully costed and that if new expenditures are required that they should be limited and controllable. New schemes that threaten to be expensive or where the financial implications are uncertain will be more difficult to defend and easier to attack. Conversely, schemes that promise savings are likely to have a head start although the prospect of savings now has more political purchase than promised savings some time in the future.

There is a long history of what might be termed political demography. Actual or expected changes in the size and structure of the population have had a considerable influence upon the ways in which social services have developed, in particular where these changes have been particularly marked and threaten to increase the demands upon such services. A rising birth rate, a rapidly ageing population or new patterns of migration offer good examples. Yet demographic forecasting is a difficult and hazardous affair. For example, the Royal Commission on Population took five years to produce its 1949 report and even then, as we now know, got some things wrong.[68] This emphasises the point that it is not whether or not the statistics are correct that is important but whether they are believed to be accurate – and by whom – and whether they are capable of being seriously challenged by alternative figures.

Indeed, facts and figures are the mainstay of many campaigns for change and those who are able to command the most plausible material are in a stronger position than others to advance their case successfully. Discovering and deploying such material becomes progressively easier with the aid of computerised search and analysis

instruments. It is a well-worn political maxim that if one seeks to effect change then it is important to possess better relevant information than those who oppose you.

Association and opportunity

A proposal for change that promises to resolve or ameliorate more than a single problem increases its chances of success. For example, family allowances were only introduced in 1945 (and not before) because by then they were seen as a way of checking a declining birth rate, combating malnutrition amongst children, maintaining the work incentive, forestalling wage demands and helping to curb inflation rather than as a means of reducing inequalities between rich and poor and between men and women, which had been the aim of their earlier advocates.[69] One formulation of this process suggested that governments look for an 'economy of solutions'; for instance, problems that lend themselves to treatment in existing programmes, or by existing administrative machinery are likely to make better progress than those that require quite new agencies or ways of working.

A proposed change is likely to be viewed more favourably if it can be shown to offer a solution to more than one problem. Conversely, the proposal that seems to exacerbate or create problems elsewhere will face opposition or lack support, especially when it threatens established status, transfers costs, challenges established ways of doing things or reduces benefits. Such threats may lead to bitter disputes that poison relationships and damage the chances of a new measure being successfully introduced.

There is another sense in which 'association' can be important in influencing the fortunes of a proposal or issue; namely, the nature of the support that it attracts. Where this is well regarded by a government, it will meet a more favourable wind. Eminent backers help, as do associated organisations that wield power and influence and which share a current government's broad philosophy. On the other hand the progress of a cause will be hampered if it is associated with individuals or groups that are viewed with suspicion or disfavour by a government in office. This has been the case where the support has had a strong political character that is at odds with that of the government, where there is a reputation for militancy or where its general activities are disapproved by substantial sections of the electorate; for example, where funds are being offered by the tobacco industry.

One aspect of 'association' is the convergence of events that present the opportunity for introducing change. Prior to the 1908 Children Act that was heralded as the children's charter, Herbert Samuel the Under Secretary of State in the Home Office said that it was 'a propitious moment' for making these important advances and, leading up to the 1989 Children Act, David Mellor, health minister in the Conservative government, that it was 'an historic moment' for a major reform of the children's services. At other times minister and others have spoken of the time being 'ripe' for changes to be made. What these kinds of remarks reflect are political judgements that an issue has reached a sufficiently 'critical mass' and has gained sufficient support to elevate its priority.

Research: Science and Technology

We have already noted some of the effect that 'facts' can have upon the course of social policy. They serve to demonstrate that a problem exists, its magnitude and its likely consequences. But not all facts make a political impact. They may be repudiated, disputed or ignored. The reception they receive depends upon a least two factors. One is the scientific robustness of the work upon which they are based. Another is the political and economic climate into which they are launched. Let us consider the first of these.

The physical and medical sciences are generally regarded as providing evidence of a fairly high level of reliability, although not certainty. Furthermore, the evidence is such that it is not readily susceptible to popular dispute; and there is often confirmatory evidence. Achievements are notable: the reduction of water-borne diseases, immunisation and the production of sulphonamides, antibiotics and penicillin. Technology has made similar but less obvious contributions to social policy; for example, in prosthetics, in house building or in the screening of fine particles in order to combat air pollution. However, not all 'breakthroughs' in science and technology have had beneficial results. The thalidomide tragedy still blights the lives of those affected, new but flawed high-rise building techniques led to the collapse of Ronan Point. Of course the development of more sophisticated weaponry has transformed traditional warfare into conflicts in which whole populations suffer and, as we have argued, such wars have had a profound influence on social policy.

In spite of the failures of the physical and medical sciences the level of confidence that is placed in their results remains high; and that is largely because of the rigour of their methodologies. In social areas the picture is less clear cut and the relationship between research, policy and practice more complex. This stems from two things. First, the level of probability that the social sciences can achieve is considerably less than that common in the physical and medical sciences and, secondly, the theoretical and methodological underpinning of the social sciences is less well developed. This leaves their results more vulnerable to challenge; and not simply scientific challenge but political and popular challenge as well. Furthermore, many of the issues that social research strives to explore touch upon sensitive matters and strong convictions.

Social research (and that includes economics, psychology and geography) may have a considerable impact on theoretical developments within the disciplines involved in refining theories and understanding but little effect on policy. For example, although the research undertaken in the 1950s at the Institute of Community Studies in East London provided new insights about kinship networks, it failed to inform the patterns of family relocation in high-rise developments on the city fringes. Whether research influences policy depends so much upon the political (and professional) situation of the time. In short, to understand its impact we have to understand that context.

Nonetheless, matters may be improving. There is much more research available than, say, forty years ago, and there are numerous institutes across the country linking research, policy and practice in new ways. In the behavioural sciences there are now validated programmes to treat specific conditions, often developed from a mixture of theoretical work and testing; and we can now identify the chains of effects that produce severe and multiple disadvantage. We also know more about the nature and extent of crime, of people's leisure needs and activities and have far more reliable and

extensive statistics about social conditions. The studies and surveys that have produced these results are more reliable and therefore less easily dismissed. Yet there are other studies, undertaken with equal care, that have only limited effect upon policy. It is hard to see how the plethora of poverty studies over the last 150 years has influenced taxation policies, benefits systems, wages policy or other opportunities for effecting positive re-distribution.

The key answer to the question about the impact of research and its development upon policy and practice revolves around the possibilities of its application and in this the consequences for policy and those for practice should probably be differentiated. Practice may be a more receptive arena than policy but even there the issue of application (or implementation) remains. For example, the models being developed by Lankelly Chase offer guidance on what needs to be done to help young people facing severe and multiple disadvantages, but for those working face-to-face with them it only goes so far and further development is needed if practical benefits and better outcomes are to follow. Research might teach interaction skills or show how best to handle potentially violent situations, but it offers limited help when trying to comfort a screaming baby or persuading a truculent adolescent to be home by ten.

So, while the application of science and research, and the infrastructure that supports it, has grown and become more significant, the effects have been uneven - because of the politics, because of problems of application and because of the subjects with which it deals.

Origins

Issues do not arise spontaneously. They are formulated and championed by particular interests. The same applies to the solutions that are proposed. A key question in understanding how things change or remain unchanged is to know where initiatives for change have arisen. There is a big difference between those that originate within governments and those that are pursued 'outside' especially when these are critical of the existing state of affairs, typically opposition issues. However, when a critic's issue becomes inescapable there is a tendency for it to be annexed by the administration. For example, in 1962 Cole and Utting published a damning report on the economic circumstances of old people.[70] It was a telling indictment of government policy. The response was for the government to commission its own study of the issue that, in fact, confirmed the Cole and Utting findings.[71] Important changes followed in the pensions system but partly as a result of the election of a Labour government in 1964: one other convergence.

 Governments can also annex outside but sensitive issues when these are raised through the private members' bill system. When such bills look like making parliamentary progress they can be taken over by the administration in order to maintain control. That happened with the private member's clean air bill that Gerald Nabarro introduced in 1954.[72]

Pressure groups of various kinds endeavour to influence the course of policy. Those that are successful tend to be persistent, patient, well-informed, politically skilful, opportunistic and regarded as useful by government. Wilder claims, discredited assertions or suspect affiliations weaken their influence. However, most are single

issue protagonists struggling to be heard in competition with other pressure groups. When that issue has little political salience the going is hard but when it has moved up the political agenda their opportunities increase, especially if they know more about the matter than government and have developed a reputable expertise. Nonetheless, being single-issue campaigners their success may skew developments to the detriment of other less well-grounded pressure groups.[73]

Ideology

Parties in power, whether locally or nationally, subscribe to certain ideologies. The decontrol of rents in 1957 by the Conservative government and the promotion of comprehensive education in the 60s by the labour administration are good examples of ideologically driven policies. The present government's desire to see the private market more involved in the provision of health and welfare services certainly reflects an ideological preference. Indeed, much of the ideological influence on social policy has revolved around the balance to be struck between public and private forms of provision.

Whilst a party remains in power, an issue will gain advantage from possessing the appropriate ideological flavour. When political power changes hands, however, these same characteristics are likely to prove a handicap. This poses difficult tactical problems for some pressure groups, particularly those concerned with long-term or permanent issues. Many carefully avoid associating their campaigns with any one party and endeavour to present their aims as non-political and to gather cross-party support. The Howard League for Penal Reform has acted in this way, as have many of the children's charities. This is easier to do when their concerns are generally viewed as non-political: for example, children's welfare, the claims of wounded ex-servicemen, the elderly or the victims of crime. So, in understanding the politics of pressure it is as important to know what kind of issue is in play as it is to know whose issue it is.

The problem with ideologically driven programmes is that the ideology can easily trump the evidence. Conviction politics have their strengths but also their weaknesses. They can create coherent change, often quite rapidly; but they are also liable to expose differences within parties and generate new and extensive opposition as well as undermining support on other fronts. Conviction politics are welcomed by those who approve what they achieve but castigated by those who dislike what is happening: but how they are viewed depends upon the ideology that guides them.

However, other forms of conviction can influence policy and practice. A religious dogma, a particular explanation of a problem or an uncritical espousal of this or that remedy can gain such political or professional currency that they override contrary evidence and, as a result, hold up much needed changes. Although strong convictions can be the agents of change they can impede it and lock policies and practices into unhelpful and sometimes dangerous continuities.

In summary

There are other factors than these that need to be taken into account in explaining how and why 'welfare systems' change or do not change. For example, we might have

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included the contribution of committees of inquiry, the role of significant individuals, the influence of developments in other countries (particularly Germany and the USA), the part played by technical advances, the impact of the media, modifications in public opinion and a number of other considerations. No two changes will be accounted for in exactly the same way. However, what is plain is that no single factor will offer an adequate explanation. That is to be found in their convergence at particular junctures but in different combinations and it is this that makes explanation and generalisation such a complicated matter.

III

Why is the State Involved in the Provision of Welfare Services and why is its involvement like it is?

This question raises several issues which need disaggregating: the first is what is the responsibility of the state and how does the extent of this affect the nature of its involvement? The second is how is this responsibility divided between direct state control and delegation to voluntary and private-for-profit agencies? Thus, a plethora of arrangements is possible meaning that there is no straightforward answer to this question. So much depends upon what period we have in mind, which services and the prevailing ideological assumptions. However, we suggest several factors that have influenced both the timing and the extent of state involvement in the provision of social services.

Feasibility

States cannot assume responsibilities for providing social services without the means to do so. In that respect two factors are important. First, there has to be an adequate system of administration and that has depended upon the establishment of a competent and sufficiently large civil service. Major reforms occurred in the 1870s that introduced open competition for all departments except the Home Office and the Foreign Office (where posts continued to be filled by patronage for many years). An important spur for improving the competence of the civil service was the evidence of what a more professional service was able to achieve in Germany[74].

Adequate administrative arrangements have also required a reliable, efficient and properly funded system of local government to which responsibilities could be delegated. This waited upon reforms that addressed the problems of political corruption, great local variation and the multitude of small authorities. Major steps forward occurred in the 1880s, for example, the Local Government Act of 1888 that withdrew almost all their administrative powers from the justices and transferred them to elected bodies – the county councils.

Another necessary condition for the development of public services was the ability of central departments to regulate what went on locally. This relied heavily upon the control that went with Exchequer funding but also upon the creation of various inspectorates, especially in the Local Government Board and the Home Office. The influence that these inspectors were able to exercise depended upon their visits to

local areas, the frequency of which was increased by the spread of the railway system. However, some aspects of services are beyond any organisational influence. Foster care is a good example. Governments and local authorities can set regulations, recruit train and fund carers, but find it difficult to influence what happens in the families even though it is probably the main concern of the children whom the services are seeking to help.

A further requirement for the development of public services was the creation of an adequate taxation base, both nationally and locally. Nationally, the big step forward followed the establishment of progressive income tax in Lloyd George's People's Budget of 1909.[75] Likewise, the income from local taxation (the rates) increased dramatically from the mid-nineteenth century, not least as a result of urbanisation.

Access to capital was also important. The development of an international money market and the ability of government to sell its bonds and securities enabled it to embark upon social expenditures that exceeded current revenue. The Public Works Loan Board, first set up in 1817, was also able to expand its activities and became significant in facilitating local authority capital schemes such as workhouses, schools and housing. It was especially attractive to local authorities and other local statutory bodies such as the health boards or the improvement commissioners (concerned with drains, sewerage and such like) because the interest rates that were charged reflected the rates at which governments could borrow rather than what would have had to be paid on the open market. However, in the 1950s the Loan Board became the lender of last resort, although access to long-term capital finance was made easier in 1964 but restricted again in the 1980s.[76]

Such developments made it possible for governments to assume greater responsibilities for the provision of services, but they were also a response to the problems that had to be dealt with, especially problems of social and economic regulation.

Regulation and control

The involvement of government in the provision of services has owed a good deal to its need to ensure public order and safety. The development of the police and the penal system are obvious examples but so too are the establishment of a system of compulsory education and the suppression of disease.

The spectre of revolution has haunted the corridors of power. The French revolution, the upheavals in Britain and on the continent in the early 1830s, the much more extensive revolutionary movements of 1848, the Paris Commune of 1870, the Russian revolution of 1917 and the rise of communism in France and Germany in the years after the First World War were vivid reminders of the possible consequences of popular discontent. The 1926 General Strike in Britain, although brief and defeated, was also significant. It has been argued, for instance, that a contributory reason for the social welfare reforms introduced by the 1906 Liberal government (old age pensions, a limited scheme of health and social security insurance, a Children Act, school meals, labour exchanges, etc) was the election of the first Labour MPs (29 of them) that was interpreted by some as an indication of 'mounting pressure from below'.[77]

Seen in this light the involvement of the state in the provision of social services has been, at least in part, a necessary concession in order to prevent social disorder or the spread of rampant disease.

The creation and preservation of social capital

Successful states depend upon the creation and maintenance of human capital. In particular, this means having an appropriately sized and skilled labour force that is also healthy enough to do the work required. This has been, and remains, a significant preoccupation of governments. However, what is demanded of a country's 'social capital' changes in response to technological developments and the pattern of economic cycles.

The two main ways in which labour market requirements have shaped public social provisions are to be seen in education and health. The need for a compulsory national educational system became obvious and undeniable by the last quarter of the nineteenth century. Economic changes as well as further economic development necessitated a better-educated workforce; and this could not be achieved without state intervention – by its ability to compel and by its money.

Similarly, the unfitness of the workforce and particularly of the future workforce, that is the children, could not be ignored. Poor maternal health, malnutrition, contaminated water and milk had all taken their toll, the evidence for which was compellingly set out in the 1904 report of the committee on physical deterioration.[78] Maternity and child welfare clinics began to appear, the infant mortality rate fell (but not until 1923), children were less stunted and more were capable of engaging in school-based physical training. Much of this had to be achieved by public health measures.

The rise of legal, political and social rights

It is evident that one of the reasons for the public provision of services is that other systems, principally the market and voluntary agencies, have been either unable or unwilling to do what was required. However, what was required was determined by the gradual establishment of rights consistent with the idea of citizenship, a progression that was described by T.H.Marshall in 1949. First came civil rights, then political rights and, finally, social rights. Only when all three existed could full citizenship be enjoyed.   Social rights he wrote meant having adequate economic and welfare as well as being able to live the life of a civilised person according to the standards prevailing in the society.[79]

He went on to add that the institutions most closely connected with the achievement of these aims were the educational system and the social services. Both were essential for the realisation of citizenship and for the realisation of a more equal society and that, in particular, required taxation and social security systems that aimed to secure the more equal distribution of income, of life chances and social protection, objectives that were only attainable by state interventions.

Although Marshall's analysis was a creature of its time his explanation of the close relationship between public social provisions and citizenship was not. What have changed are the assumptions about the kind of services and forms of organisation that are necessary to buttress social rights.

Public responsibility, independent agencies

As discussed earlier in the paper, there has been a rapid expansion in the use of the private market to supply health and welfare services and it is important to stress that this is not a renunciation of the state's responsibility to ensure their availability but simply another way of discharging that responsibility. There appear to be a number of reasons for this different interpretation. One is ideological and reflects the conviction that the public sector is over developed, incapable and inefficient and that greater diversity and efficiency is offered by the private and voluntary sectors. This is associated with the belief that contracted-out services are cheaper, which they may or may not be depending upon such issues as standards, investment and staffing.

There have been other reasons too why central and local governments have chosen to have welfare services provided indirectly through agents. One has been because the service in question has a small coverage, such as the industrial schools and reformatories in the nineteenth and early twentieth centuries. Although most were established and run by voluntary organisations they were almost wholly funded by the exchequer. A second reason for governments to fund but not to run services has been the desire to spread responsibility for controversial provisions, particularly those for disparaged and disapproved members of society. In addition, governments have sometimes wished to support experimental schemes without having to assume full responsibility if they fail.

The questions that arise concerning the advantages and disadvantages of contracting out service provision were discussed previously but what needs to be reemphasised is how important it is to understand the particular strengths and weaknesses of different 'systems' rather than making uncritical ideological commitments to the one or the other.

The politics of comparison

It is tempting to see the development of public services as particular to individual countries. In fact, international comparisons have played their part in persuading governments to extend the range of services for which they are responsible. This is not solely a matter of national pride. It also arises from the desire to strengthen commercial and military potentialities in the light of increasing competition abroad. For example, the British system of social insurance that originated in 1911 was undoubtedly constructed with the German system in mind, a system that seemed to improved production and industrial harmony. However, the 1911 National Insurance Act did not copy the German scheme: it claimed to be better. Furthermore, it could only be introduced by the state (as it had been in Germany) if the British commitment were to be clearly demonstrated. In any case, the contemporary insurance industry was in no position to administer what was wanted and, if they had been, working class support would have been lost.

There are contrary examples. Where there is a conviction that social provisions are better provided in countries that leave much of it to the private market or the voluntary sector, it will be argued that the role of the state should be limited. A lot therefore depends upon a government's international reference points. There are those systems that will be broadly approved and those that are ignored; for instance, social policy successes in Cuba, Costa Rica or Sri Lanka that have relied heavily on the state provision of services have been largely overlooked. Whatever the pattern of international reference points their influence in shaping the preferred 'model' of social welfare should not be under-estimated.

Betterment

The preceding comments are liable to give the impression that the state's close involvement in the provision of welfare services is a matter of unavoidable necessity or political calculation. That would be misleading. There are clear examples where the driving force behind the state development of services has been a genuine desire to better the condition of the people even though that may have been tempered by the considerations that we have discussed. Parties, ministers, civil servants and prominent individuals or groups have been motivated by real concerns to improve the 'welfare of the people'. In some situations, their influence has been significant.

In summary

The state becomes involved in the provision of welfare services for a complicated and changing set of reasons. It is hard to generalise, but the rationale springs from a combination of political necessity (economic, social and strategic), the shortcomings of other systems, an adequate administration and an adherence to values that demand social improvement.

CONCLUSIONS

It is a maxim of historians that we can only understand the present state of affairs by analysing our history. But there are several ways of doing this: one is to discuss changes using a time-line composed of important milestones and a second is to draw out general trends, in this case with regard to understanding definitions of and responses to severe and multiple disadvantages. Both methods have been used in this essay.

There is no doubt that we are now far more knowledgeable and sensitive than ever to the needs of young people facing severe and multiple disadvantages. Several chains of effects have been charted which show how factors accumulate and combine to produce inauspicious situations. These sequences are predictable and we can intervene at critical points to divert or reverse them. But difficulties arise when separate causal chains coincide and interact. For example there is a clear avenue by which a young person loses their job, can't pay the rent and becomes homeless. But there is less certainty about what else might happen to exacerbate or ameliorate the situation; for example he or she might start using drugs, begin a dysfunctional relationship or, to be more positive, win the lottery. This interaction between the separate causal chains is much more difficult to predict as it can be a matter of chance or a one-off event. To minimise possible damage when such events occur, much more creative thinking and adventurous practice are needed, and it is encouraging that agencies like Lankelly Chase are aware of this complexity and pursuing front-line initiatives.

In tracing the history of severe and multiple disadvantage, the paper has discussed the changing definitions, principles, issues and solutions to the problem. It has particularly stressed the importance of whose definition prevails and why, as this determines the size of the perceived problem and who is eligible for help. As definitions also shape perspectives, the ways that knowledge about disadvantages has accumulated has been discussed.

Looking at history of services, important factors shaping responses include: perceptions of disadvantage, national catastrophic events and research findings. In terms of solutions, different approaches have seemed appropriate at different times and the paper has emphasised the institutional legacy, fragmentation of services, growth of community care, the introduction of universal services, the impact of science and growth of social markets.

Yet another set of factors had to be identified to explain who gets help and why. Here, cost, discretion, coordination, the balance of advantage and disadvantage and rootlessness have been suggested as important. A similar array was found with regard to the question of why the state gets involved in some situations and not others; here, wars, feasibility and international comparisons take front place.

The paper opened by emphasising that the concept of severe and multiple disadvantage is extremely wide and difficult to grasp and highlighted the danger of selecting cases to support favoured theories. It has tried to take a broad view and identify the questions that help us understand the historical development of services

and disaggregate the dimensions within each one. It is for readers to judge whether it has been successful.

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