

Parental Risk Factors and Children Entering Care

*A Non-Technical Briefing on the
Quantitative Findings*

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Introduction

Background

A number of parental problems have previously been associated with children entering care. These include mental health problems, substance misuse, learning disabilities and types of neurodiversity. However, there are many things about the relationship between these factors in parents and children's entry into care that are not known. For example, do these factors have the same effect on the likelihood of care if they occur in mothers or fathers or if they occur in areas of high or low deprivation? How does their impact vary in different local authorities? We also don't know how the characteristics of the child affect the impact of these factors.

This briefing presents the findings of a study carried out to explore these factors. The study used routinely collected data from social services in Wales and linked it to data from health and education to look at the households children were living in before they entered care. Data from health services was used to identify different factors in the adults in those households. These adult issues included drug misuse, alcohol misuse, and learning disabilities, a range of different mental health problems (schizophrenia, bipolar, other psychotic disorders, anxiety, depression and eating disorders), different types of neurodivergence (cognitive learning difficulties, attention deficit disorder and autistic spectrum disorder), self-harm and being the victim of assault at home. The project also considered not just whether these factors could predict the likelihood of care but also the circumstances in which they had an effect. There were also a small number of focus groups held in local authorities to discuss the findings.

This is a non-technical briefing of the quantitative findings of the study. A separate briefing on the qualitative findings will also be made available. If you are interested in more technical details, then please email Dr Nell Warner: warnerah@cardiff.ac.uk.

Public Involvement

The project was developed with the input of care experienced young people, through the CASCADE Voices group, who advised on the sorts of questions that needed answering. Public involvement continued to be important throughout. Several consultations were carried out with the CASCADE Parents Group, a group of parents who have had lived experience of children's social care services. These included a consultation at the start of the project before data analysis began, a discussion about the findings of the quantitative stage, and what needs to be discussed with local authorities. Input from the parents group helped to shape the project. For example, feedback from the parents group suggested that learning difficulties, (such as dyslexia) might have an impact on the way parents interact with social services, particularly when they are given a number of documents to

read. Because of this it was decided to include these types of learning difficulties in the analysis. The project resulted in several findings relating to differential outcomes for children from different ethnic minorities, and because of this an additional consultation was carried out with parents from EYST (Ethnic Minorities and Youth Support Team).

Key findings and Implications

The project resulted in a number of key findings which have implications for social work practice and policy:

- Most of the issues looked at in the adults in the household were risk factors for children entering care, although there was no clear evidence that autistic spectrum disorders in adults were a predictor of children entering care.
- Depression is common in all households, with 23.8% of all households having a depressed adult. It is even more common in households where a child enters care (48.7%).
- Some risk factors appeared to have a bigger impact on the likelihood of care than others. Of the adult risk factors examined, drug abuse and being the victim of assault that takes place at home had the biggest impact on the odds of care.
- The risk factors tended to have a much stronger impact when they occurred in biological mothers as opposed to other adults in the household.
- In single adult households most risk factors had a bigger impact on the likelihood of care when they occurred in households headed by a woman rather than households headed by a man, however anxiety had a bigger impact in households headed by a man.
- Children from households in areas of high deprivation are more likely to enter care than those in areas of low deprivation, however the adult risk factors seem to have the same impact on the odds of care when they occur in areas of high and low deprivation.
- Most of the adult risk factors have the same impact on the likelihood of care if they occurred in households where the children were in receipt of free school meals. However, three risk factors: anxiety, depression and self-harm, had a greater impact on the likelihood of care if they occurred in households where children were not in receipt of free school meals.
- Most adult risk factors have less of an impact on the odds of care for older children with adult alcohol misuse, learning disabilities, and schizophrenia having no impact for the oldest age group. Parental drug misuse increased the odds of care even among 16 and 17 year-olds.

For older children, the child's special educational needs had a bigger impact on the odds of care.

- Overall, children from some ethnic minorities are more likely to enter care than others, however, when the levels of the risk factors in the households are taken into account, all ethnic minority children were more likely to enter care than White children.
- The adult risk factors have different impacts in households for children from different ethnic minorities. Alcohol misuse in parents is rare in the Asian population, but where it occurs it increases the odds of care, much more than it increases the odds of care in other ethnic groups. In contrast, most of the risk factors seem to have very little impact on the likelihood of care in the Black population.
- The impact of most of the risk factors on the odds of care did not change between 2008 and 2020, however between 2008/12 and 2012/16, parental depression started having a bigger impact on the odds of care.
- Depression and anxiety have also become more common in the population, and this may partly explain some of the increases in the numbers of children entering care between 2008 and 2020.

Background

We know that parents facing factors like mental health issues, substance misuse, learning disabilities, and neurodivergence are more likely to have their children enter care.^{1,2,3} However, there are many things about the relationship between these factors and care entry that we do not know.

For instance, existing evidence suggests that children's social services are often more involved with mothers than they are with fathers^{4,5}, and it has been argued that child protection is biased towards mothers, with fathers out of view^{6,7}. However, we do not know if this means that the parental factors described above have different impacts when they occur in mothers or fathers, or in other adults in the household.

Both household poverty^{8,9} and poverty at the community level^{10,11} are linked to children entering care. The parental factors we are discussing are also more common in low-income households and deprived areas^{12,13,14,15,16,17}. This suggests that children in poverty might enter care because their parents are more likely to have these factors, but we do not have any proof of this. We also do not know whether these factors have the same impact on the likelihood of a child being taken into care if the child lives in an area that is either more or less deprived.

Care entry rates vary widely among local authorities^{18,19}, and though there has been much discussion about why this might be, we don't really know the reasons why. We do know however, that the populations of different local authorities are different, with some local authorities having a greater proportion of their populations living in deprived areas and having parental problems. This raises the question of how much of the difference in care rates between local authorities is due to these different populations and how much is due to other factors, like social work practice.

There's limited research on whether these parental risk factors have the same affect on the likelihood of care for different children. Although one study indicates that parental mental health and substance misuse have a greater impact on younger children²⁰. However, we lack recent UK-specific evidence on this. It's also unclear if these factors affect boys and girls differently or if they contribute to the higher likelihood of care entry for certain ethnic groups.

In Wales, the number of children in care has increased significantly since the mid-90s,²¹ and this is a major policy concern²². One possibility, raised by social workers in Wales,²³ is that this may be due to increased family needs, risks, and pressures, including parental risk factors. However, it's unclear whether these risks have actually increased or if it's just the perception of an increase.

Aim of the Study

This study was developed to explore all these issues. It looked at whether parental risk factors have the same impact on children and families in different circumstances. It also looked at how much the parental problems explain the differences we find in which children enter care.

The study answered lots of important questions, and this report outlines some of the key findings. The findings outlined in this briefing answered the following questions:

1. How common are the risk factors in the households?
2. Does the sexⁱ of the parent who has a risk factor affect how much impact it has on the likelihood of a child entering care?
3. Do parental risk factors explain the connection between area-level deprivation, individual poverty, and entry into care?
4. How much do local authorities differ from each other in terms of how likely children are to enter care, once parental factors and deprivation in the local area have been taken into account?
5. Does the connection between risk factors and entry into care change depending on the child's characteristics?
6. What is the link between the child's sex and ethnicity, and the likelihood of entry into care, after considering risk factors?
7. How have the levels of risk in the population and the connection between risk factors and the likelihood of entry into care changed from 2008 to 2020?

ⁱ We use the term sex rather than gender as this was identified from GP records which might be more likely to identify the biological sex rather than what someone identifies as.

Method

The study looked at the households children were living in before they entered care. It did this by using routinely collected data from social services in Wales. This is the data that all local authorities collect every year and provide to the Welsh Government about which children have been in care. This data is available through a facility in Swansea University, called the SAIL databank. That data was linked to data from health services and education so we could find out quite a lot of information about the children and the people they were living with before they went into care.

The SAIL databank contains lots of different types of data that are collected from different places, including data from the government and from the NHS. The data in the SAIL databank is all completely anonymous, so there are no names or addresses, and no one can be identified. Instead, all the people whose data is in the SAIL databank have a code number, and that means that researchers can link up data about individuals from, for example health, education, and social services, and use that to do research. As well as people having a code number, addresses also get a code number and that means that you can do research looking at individuals who live in the same household, which is what we did for this study.

Most of the analysis was carried out using data collected between April 2016 and 2020, and it included 293,332 households in Wales, all of whom had at least one child aged between 3 and 17. The reason that the study focused particularly on 3 to 17 year olds, was because there were problems with the quality of the data for the younger children. We are hoping that this will be resolved with time, so that future studies can look at these children as well. Of the 293,332 households that we looked at 2,652 had a least one child that had entered local authority care between 2016 and 2020.

We also looked at the adults in the households, and we linked our data to data from health services to find out whether or not those adults had a range of different factors: drug misuse, alcohol misuse, assault at home, bipolar disorder, schizophrenia, other psychotic disorders, anxiety, depression, eating disorders, self-harm, learning disability, learning difficulties, Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorders (ASD)ⁱⁱ. We also looked at whether the adult in the household who had these factors was the biological mother of one of the children, or another woman or a man.ⁱⁱⁱ

We had initially wanted to look at domestic abuse as well, however we didn't think the quality of the data on domestic abuse was very good, so we decided to look at assault at home. This was

ⁱⁱ For some factors, we measured this in terms of whether the factor had been present in the two years before the first child in the household went into care (or a random date in the study period for the households from which no children went into care). This was the case for drug misuse, alcohol misuse, assault at home, other psychotic disorders, anxiety, depression, eating disorders and self-harm. For all the other factors: bipolar disorder, schizophrenia, learning disabilities, learning difficulties, ADHD and ASD then a diagnosis at any time was counted as someone having the factor.

ⁱⁱⁱ Unfortunately there is no way of knowing using the data in the SAIL databank who the children's fathers were.

defined as someone who presented to A & E because they had been a victim of assault that was carried out in their home.

We looked at both learning disability and learning difficulty. By learning *disability* we mean people who have a significantly reduced ability to understand new or complex information and new skills and a reduced ability to cope independently. This equates to an IQ of below 70. In contrast we use the term learning *difficulty* to describe those with scholastic difficulties. We decided to look at parental learning difficulties, following feedback from parents whose children had been involved in children's social care and who we had consulted while developing the study. This feedback had highlighted how, when parents have literacy problems as a result of cognitive learning difficulties, this can cause problems with the way they can engage with social services, particularly if there is a lot of written material for them to read.

As well as these adult factors, we used some other information available in the data relating to the children, including their age, sex, ethnicity, whether or not they had special educational needs^{iv}, and whether or not they were entitled to Free School Meals. We also found information about where the household was, including the local authority and how deprived the area it was in was.^v

While most of the analysis was carried out using data from 2016 to 2020, we also carried out a small amount of analysis using data from earlier years: 2008/12 and 2012/16.

We analysed the data using lots of different methods. This included producing charts and tables with the numbers and percentages of households who went into care and how common the parental factors were in those households. We then created statistical models which enabled us to answer the questions we had in more detail. In addition to this we carried out focus groups. They were carried out in two local authorities who had lower rates of children entering care than expected, and were used find out why practitioners thought this was.

^{iv} Special educational needs was defined as either Statemented or receiving School Action Plus support

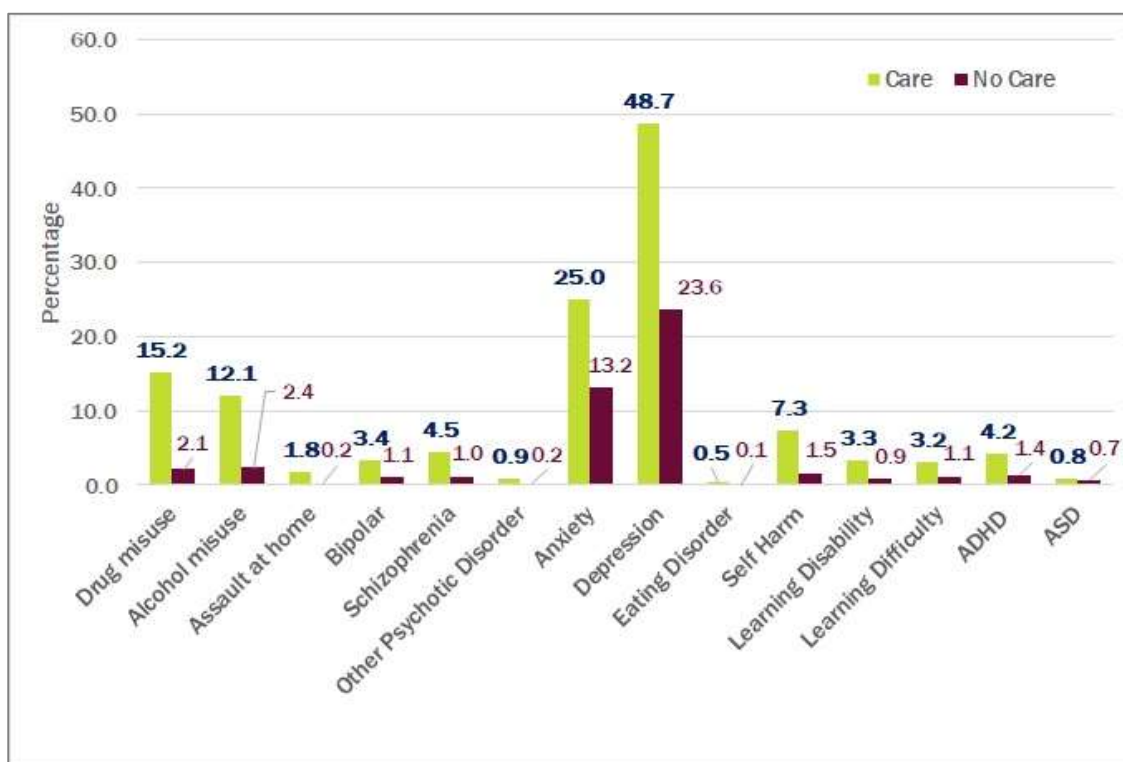
^v We used a measure of deprivation called the Welsh Index of Multiple Deprivation (WIMD) which divides Wales into small areas and ranks them from the most deprived to the least deprived. We looked at the WIMD in terms of 10 deciles, with decile 1 having the 10% most deprived small areas in Wales through to decile 10 which had the 10% least deprived areas in Wales.

Findings

How common were the parental factors?

First of all, we looked at how common all these factors were in the data. This is illustrated by Figure 1^{vi}. The lime green bars show the percentage of households from which a child entered care that had at least one adult with a factor, and the plum-coloured bars provide the same information for households from which no one entered care. Most of the adult factors are more common in households in which a child enters care. Some were common in the whole population, particularly depression: 23.6% of the households from which no one enters care had at least one depressed adult. However, it is even more common among those where a child enters care, with 48.7% of these households having a depressed adult.

Figure 1. The Percentage of Households with parental factors



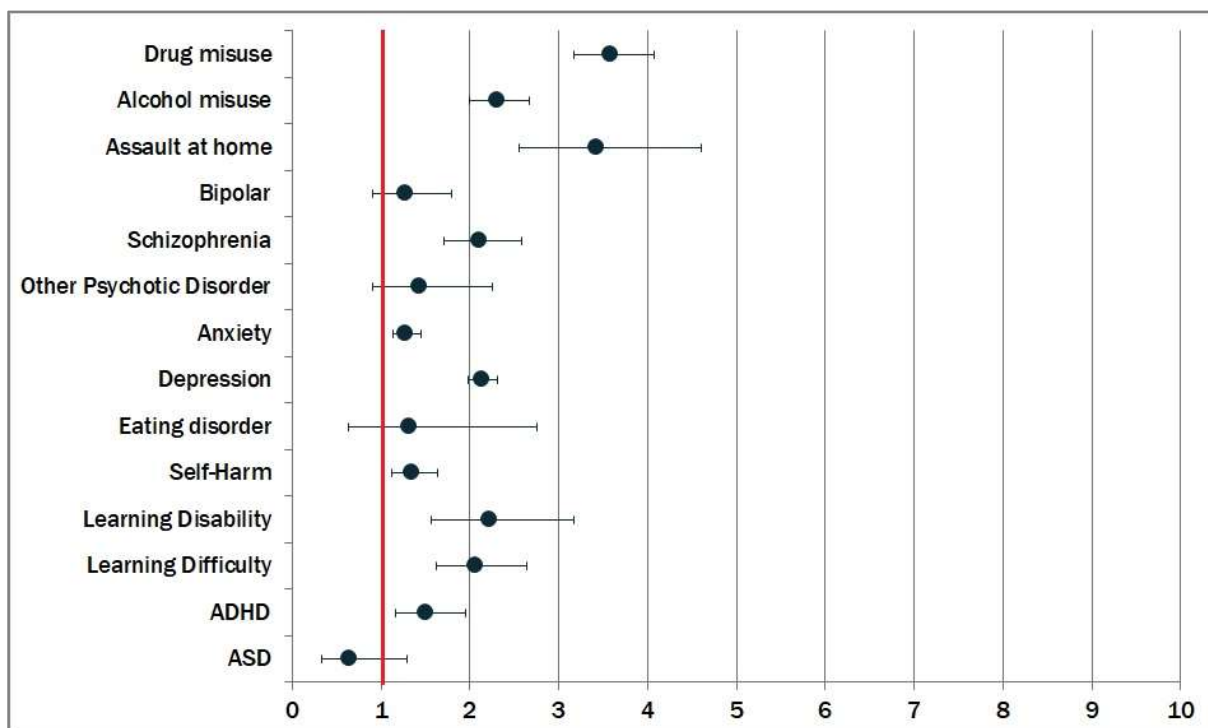
Looking at the parental factors like this is very valuable, however we also know that all the factors are also related to each other. For example, depression may be more common in households where there is a drug issue, parents might be more likely to have been the victim of an assault that happened at home if they abuse alcohol and so on. Because of this it is useful to look at how

^{vi} A risk was considered to be present if it was present in any of the adults in the household.

much of an impact each of the factors have over and above that combined impact. To do this we used special types of statistical models, called **regression models**.

The results of a regression model ^{vii} we ran with this data are shown in Figure 2 below, in a chart called a **Forest Plot**. The parental factors are listed down the left-hand side and next to each factor is a dot, which represents something called an **odds ratio**. If a risk factor had no impact on the odds of a household having a child enter care then its odds ratio would be 1, marked by the red line on Figure 2. The factors with odds ratios above 1 are those that increase the odds of care, and the higher above 1 they are, the greater the impact. Factors that increase the odds of care are known as **risk factors**. Figure 2 shows that in this model drug misuse and assault at home have the biggest impact on the likelihood of a child entering care.

Figure 2. Forest plot showing impact of risk factors on the odds of a household having a child enter care



Each of the dots (odds ratios) also has some horizontal lines coming out of it and these are called **confidence intervals**. They show how confident we are that the odds ratios are in the right place. Where those confidence intervals overlap with the red line passing through one, we are not really

^{vii} Called a multilevel binary regression model. In the model we used we also took into account some other things that might be related to the risk factors and likelihood of children entering care: the number of adults in the household, the age of one of the children and the level of deprivation in the area where the household was.

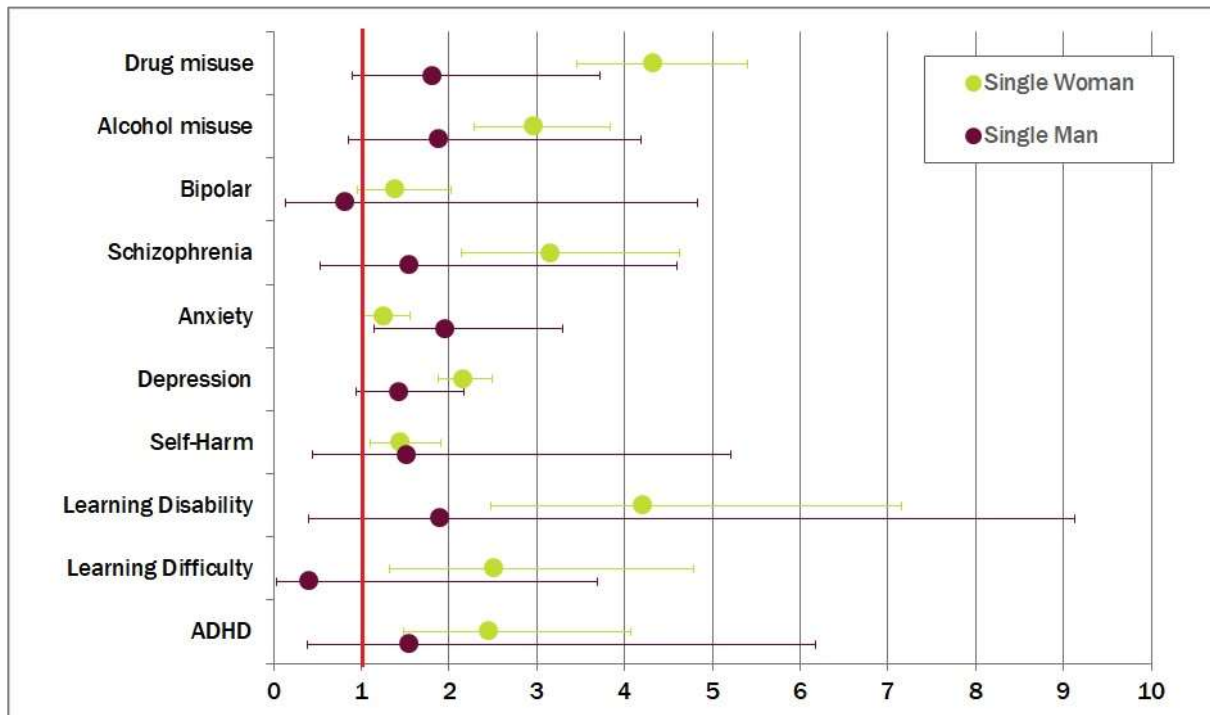
sure that the risk factor definitely has an impact over and above everything else. So for example, when not in the regression model, other psychotic disorders in parents increase the odds of a child going into care, but when put in a model with the other risk factors, we can't be confident that it is having an effect. This could be because people with other psychotic disorders also have some of the other risk factors explored. As you can see from Figure 2, there is no evidence that bipolar disorder, other psychotic disorders, eating disorders or autistic spectrum disorders have an impact on the likelihood of care when all the other risk factors are taken into account.

Do the risks have the same effect in mothers and fathers?

So far we have just been looking at risk factors that occur in any adult in the household. However, we were interested to know if it made a difference which adult in the household had the risk factor. So, we carried out some more analysis to find out. The first stage of this suggested that most of the factors have a bigger impact if they occur in biological mothers rather than any of the other adults in the household. However, we didn't know how much that might have been affected by the different composition of different households. So, in order to make it simpler we decided to do another piece of analysis just looking at single adult households. We looked at single adult households that were headed by a man and single adult households that were headed by a woman. There were 53,518 households headed by a single woman (either the mother or another woman), and 4,774 households headed by a single man. The results are shown in Figure 3. This is a Forest plot, similar to the one shown in Figure 2, but this time there are two odds ratios shown next to each risk factor. The green dots show the odds ratios for the risk factors in households headed by single women and the dark red dots show the odds ratios for households headed by single men.^{viii}

^{viii} This model controlled of the age of one of the children and the level of deprivation.

Figure 3 Forest plot showing impact of risk factors on the odds of a household having a child enter care, single adult households headed by men and women



As you can see, most of the green dots are to the right of the black dots, and this means that most of the risk factors have a bigger impact on the odds of care if they occur in single women as opposed to single men. Look for example, at the odds ratios for drug misuse and for alcohol misuse. The confidence intervals for most of the odds ratios with single men cross over the red line so we are not even confident that they have a significant effect in single men. There is one risk factor that appears to buck this trend: anxiety. The odds ratio for anxiety in men is higher than that for women, so anxiety has a bigger impact on the likelihood of care if it occurs in single men rather than single women.

These findings are concerning as they suggest that there is inequality between men and women in the factors that will lead to children entering care. We do not know why this is happening but it is important that we find out.

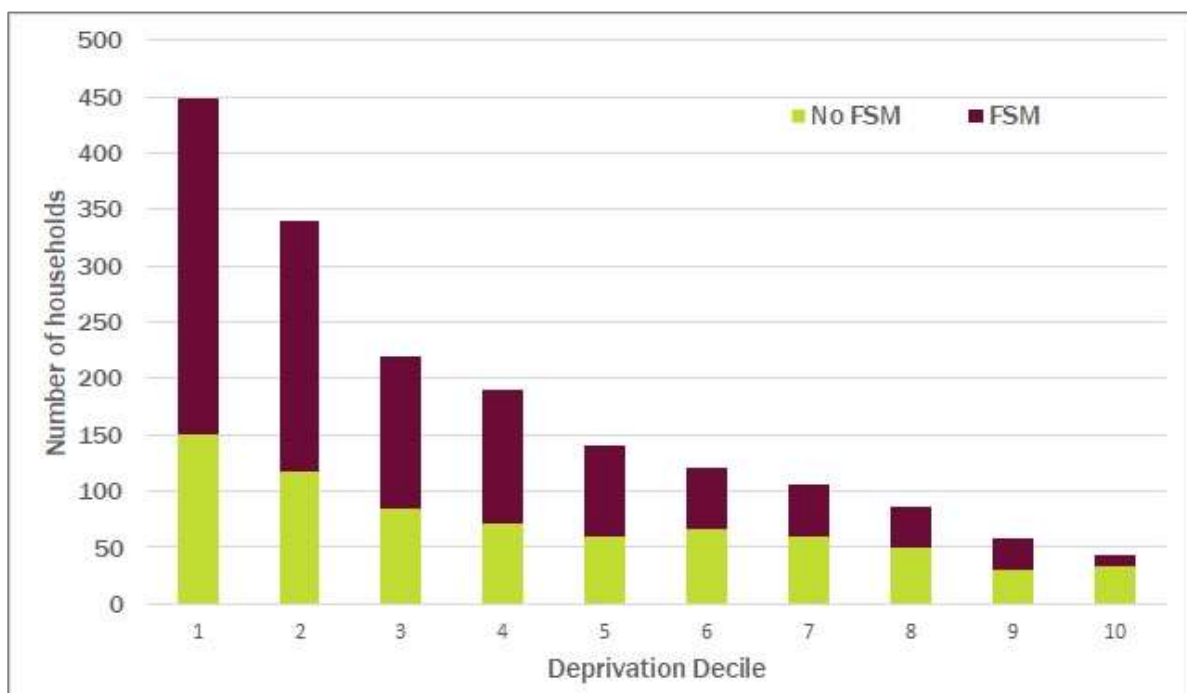
The relationship between the risk factors and both individual level poverty and area level deprivation

Many people are aware that children from households with a lower income are more likely to enter care. They also know that children from more deprived areas are more likely to enter care. An obvious question is whether children from more deprived areas are more likely to enter care just because they are more likely to have a low income or if there are other reasons. So, we did some more analysis to find this out.

We did this by looking at whether or not the children in the households were eligible for a Free School Meal (FSM), and this meant that this part of the analysis was limited to only those households where the children were in mainstream education. We compared this to the deprivation in the area that they were living in. Figure 4 shows all the households that had a child enter care, according to how deprived the area they were living in and whether or not they received FSM. Decile 1 is the most deprived and 10 is the least deprived (see footnote at the bottom of page 8)

Unsurprisingly, a lot of the children who are receiving FSM are in the most deprived areas. However, when you look at those who are not receiving FSM, there is still a relationship between area level deprivation and children entering care, although not such a strong one. We are aware that FSM will not be a very perfect measure of low income in families, and that there will be some families who are in in-work poverty and not eligible for it, and this could explain some of the pattern that we see.

Figure 4. Stacked Bar Chart, number of households from which a child enters care by deprivation decile and FSM



We also know that the parental risk factors we have been talking about are all more common in households with low incomes and in more deprived areas but there were certain questions about this relationship that we didn't know. So we built some more statistical models to find out how much of the relationship between the FSM and area-level deprivation and care entry was because of the risk factors. These models showed that **some** of it was definitely because there were more

households in these areas where the adults had the risk factors that we were looking at, however it didn't explain all of it^{ix}

We also looked at whether the risks have the same impact in areas that are more deprived. So while children from households in areas of high deprivation are more likely to enter care than those in areas of low deprivation, the risk factors seem to have the same impact on the odds of care when they occur in areas of high and low deprivation. Most of the risk factors have the same impact on the likelihood of care if they occurred in households where the children were in receipt of free school meals. However, for three risk factors: anxiety, depression and self-harm, they had a greater impact on the likelihood of care if they occurred in households who were not in receipt of free school meals.

Local authority differences

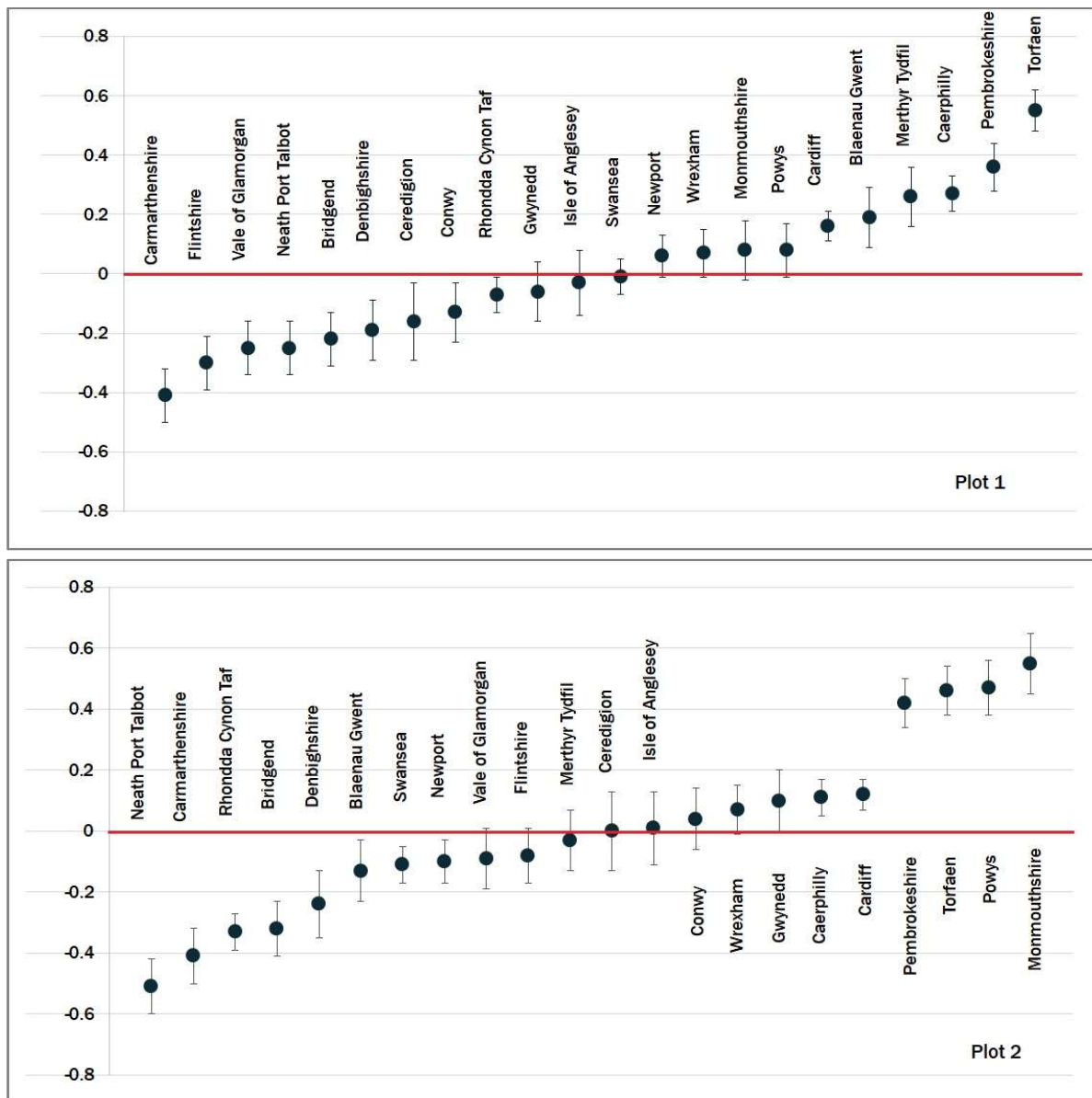
We know that the rates of children going into care vary by local authority, and that some of this may be due to practice within those local authorities, and some of it may be due to the different populations that those local authorities have. The levels of the risk factors that we were looking at and the levels of deprivation vary across local authorities. So we developed some special statistical models to look at how much variation there was in different local authorities when the area level levels of risks were taken into account. These models are shown in Figure 5.

There are two plots shown in Figure 5. In each plot there are 22 dots. Each of those dots represents a local authority in Wales, and how likely that local authority was to have children entering care. If a local authority was as likely to have a child enter care as the "Welsh average" then their dot would have been on the red line. Local authorities that were more likely than average to have households with children entering care appear above the line and to the right of the plots, while those that were less likely than average appear under the line and to the left.

As you can see, there are two plots in Figure 5. The first of these is based on a statistical model which didn't include any of the parental risk factors or the level of deprivation. So this model showed how much local authorities varied from the typical Welsh local authority without taking into account anything to do with the nature of the local area being considered. As you can see when we look at this, Torfaen was the local authority that was most likely to have households from which children entered care, and Carmarthenshire was the local authority that was least likely to have households with children that entered care.

^{ix} We do know our risks won't have fully captured all the people in the population with a particular problems, because not everyone will have presented to health services with these problems, so it may be that if they were able to capture the levels of these problems better they might account for more of the relationship between FSM and care entry.

Figure 5. Group Level Residual Plots, Models 1 and 2



The second plot shows the same thing, but this time developed from a statistical model that took into account the levels of risk factors and local area deprivation in each local authority. When compared to Plot 1, local authorities which had higher levels of risk factors and deprivation tended to move to the left, while those with lower levels moved to the right. The original model had suggested that there was one local authority, Torfaen, that was much more likely to have been placing children in care than the other local authorities. However, from this plot you can see that once we have taken the levels of deprivation and parental risk factors into account then there were four local authorities that were all relatively similar to each other: Monmouthshire, Powys, Torfaen and Pembrokeshire. These were all more likely than the Welsh average to take children into care.

Again, we must emphasise as we did above, that this only relates to the period between 2016 and 2020 and to 3 to 17 year olds, so we cannot say that this is representative of what is happening

today or with the entire age range. However, it does illustrate the importance of considering the population within a local authority when considering the rates of children entering care.

This section of the analysis was followed up by focus groups carried out in each local authority. These were carried out in local authorities where the rates of care were lower than expected. They highlighted issues relating to culture of support, and relationships with both managers and families, as being important in helping to keep the numbers of children in care low. More information about these is available in a separate briefing.

Child Factors

The next thing that we looked at was whether or not the risk factors had the same effect for different children. We did this by considering children in different ways. We looked at the child's age group, the sex of the child and the child's ethnicity. At this stage as well as looking at the parental risk factors we also considered whether or not the child had special educational needs^x

The child's age group

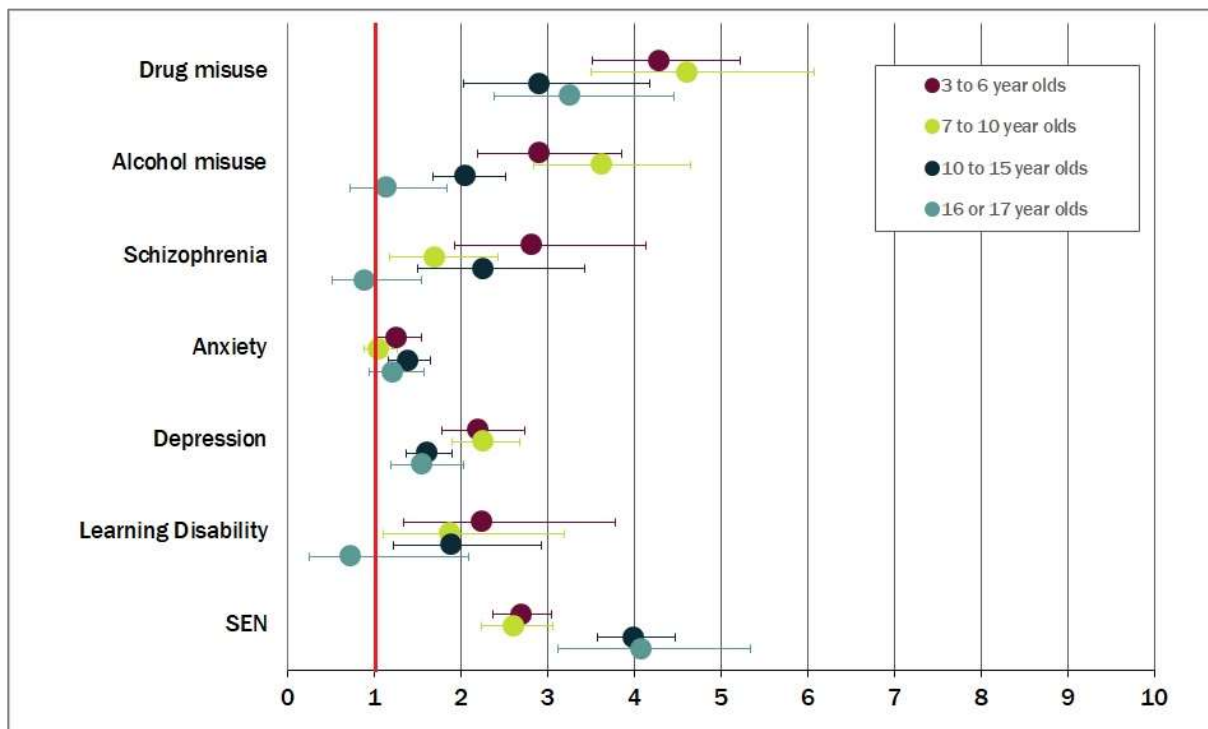
The first thing we looked at was the child's age group and how that affected the impact of the risk factors. We did this by using separate statistical models for children from different age groups, and as we did before we plotted a Forest plot to show the odds ratios in different colours for the risk factors on the odds of care for children in different age groups: 3 to 6 year olds (plum-coloured), 7 to 10 year olds (green), 10 to 15 year olds (dark blue) and 16/17 year olds (light blue).^{xi}

As you can see, most of the odds ratios are higher for younger children. For some risk factors, including alcohol misuse, schizophrenia and learning disabilities, effects are no longer significant for the oldest children. For drug misuse the difference is not very big and the confidence intervals tend to overlap so we cannot be confident that of a difference according to age, and parental drug misuse still has an impact even for the oldest children. The child's SEN is a significant factor for all children, however it has a bigger impact on the odds of care in older children.

^x Defined as the child either being statemented or receiving School Action Plus support.

^{xi} The ORs shown are derived from the regression model which also included ADHD, learning difficulty, self-harm and assault at home and controlled for deprivation and adult number.

Figure 6. Forest Plot of Odds Ratios, by the child's age group

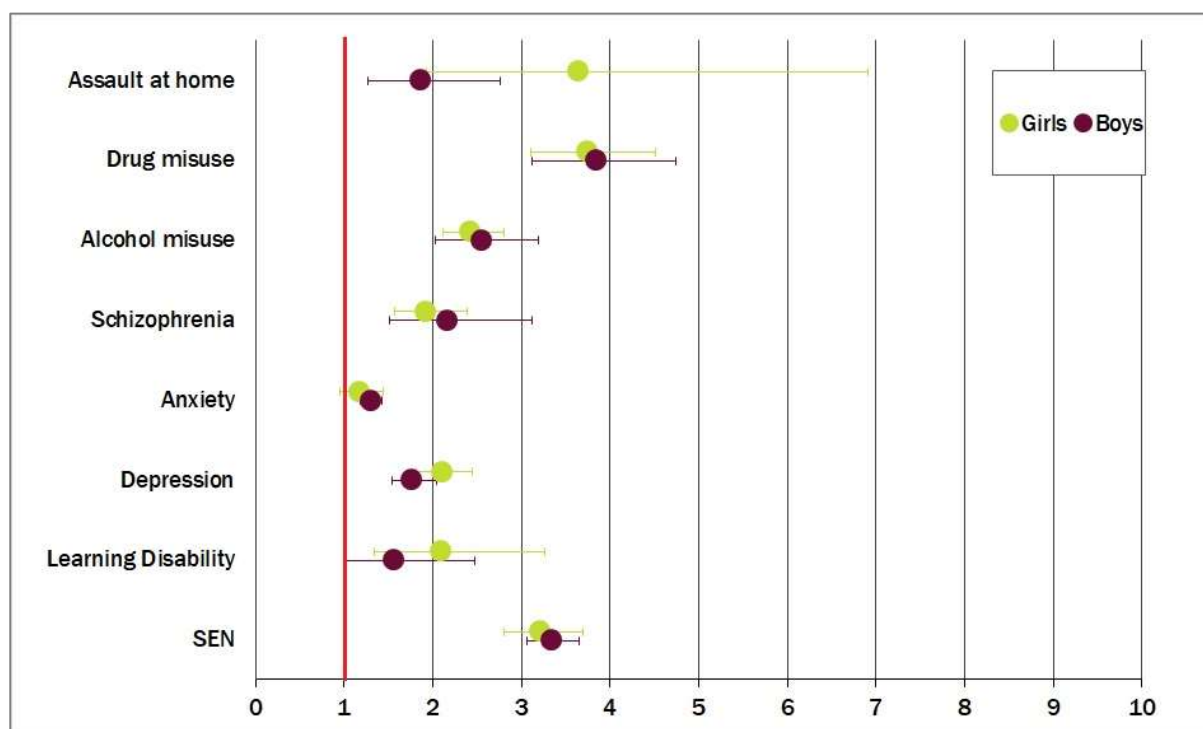


Sex of the child

The next thing we looked at was the sex of the child, and whether the risk factors had the same impact in girls and boys. A forest plot showing the results of that model^{xii} is available in Figure 7. As you can see, most of the risk factors have a very similar impact on the likelihood of care entry for girls and boys. However, there is one exception. In households where an adult had been a victim of assault that took place in their home then, this had a bigger impact on the odds of care for girls than it did for boys.

^{xii} The ORs shown are derived from the regression model which also included ADHD, learning difficulty, self-harm and assault at home and controlled for the child's age group as well as deprivation and adult number

Figure 7. Forest Plot of Odds Ratios, by the sex of the child



The child's ethnicity

We also looked at whether the risk factors had the same impact for children from different ethnic backgrounds. We did this using the five overarching classifications of ethnicity that are used in the UK: ^{xiii} (1) Asian or Asian British; (2) Black, Black British, Caribbean or African; (3) Mixed or multiple ethnic groups; (4) White and (5) Other ethnic group^{xiv}. We know from existing data published by Welsh Government²⁴ that children from certain ethnic minorities are the most likely to go into care, particularly children of Mixed ethnicity, and children who are Black, while children from Asian backgrounds are less likely to enter care. We wanted to find out how much this might be due to different levels of risk factors in different ethnic populations, and so used a statistical model to look at this. We developed a model that was able to work out the likelihood of a child from different ethnic backgrounds going into care once we had taken into account a lot of different factors. These factors included the child's age, sex and SEN, deprivation in the area they come from, the number of adults in the house and all the adult risk factors. When we took all these things into account and looked at how likely it was for a child to enter care, then children from all ethnic minorities were more likely to enter care than children from White backgrounds.

This is a very concerning finding, as it suggests that the reason why children from Asian backgrounds are less likely to go into care than children from White backgrounds is because their parents are less likely to have the sorts of parental risks we have been considering, but once this is taken into account, care entry is in fact *more* likely.

^{xiii} See this website: <https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups/>

^{xiv} These will be referred to as 1. Asian, 2. Black, 3. Mixed, 4. White and 5. Other throughout this text

We also did some analysis to find out whether the risk factors have the same impact on the likelihood of care for children from different ethnic groups and found that the effect that they have varies considerably according to ethnicity. For example, alcohol misuse is not very common in the Asian population, but where it occurs, it increases the likelihood of care much more than it does for children from other ethnic populations.

In contrast we could not find any definite evidence that most of the parental risk factors increased the likelihood of Black children going into care. This may be partly because of the relatively small numbers of children from this ethnicity in the Welsh population compared to other ethnic groups. It is always much harder to be sure of the findings from statistical models when you have smaller populations. However, our study and other studies have also shown that, although living in an area of deprivation usually increases the likelihood of children going into care, this does not apply to Black children. It seems that the sorts of parental issues we have been looking at play less of a role in the likelihood of children from this ethnic group entering care as well. The only things we found that we could be absolutely confident increased the likelihood of Black children entering care were having fewer adults in the household and the child having SEN.

Changes since 2008

All the findings that we have talked about so far used data that covered the period between 2016 and 2020. We also repeated some of the analysis using data from earlier time periods. We did this because we knew that the numbers of children who entered care had been rising and we wanted to find out if this was in any way related to the parental risk factors.

There were two things to look at here. The first was whether the proportions of individuals in the population with the risk factors had changed over time. If there were more households where adults had specific problems that were related to children entering care, then that might mean that more children were likely to enter care. The second thing was whether the risk factors had the same impact on the likelihood of care during the earlier time periods as they did between 2016 and 2020.

We therefore redid the analysis using data from three time periods:

- 2008 to 2012
- 2012 to 2016
- 2016 to 2020

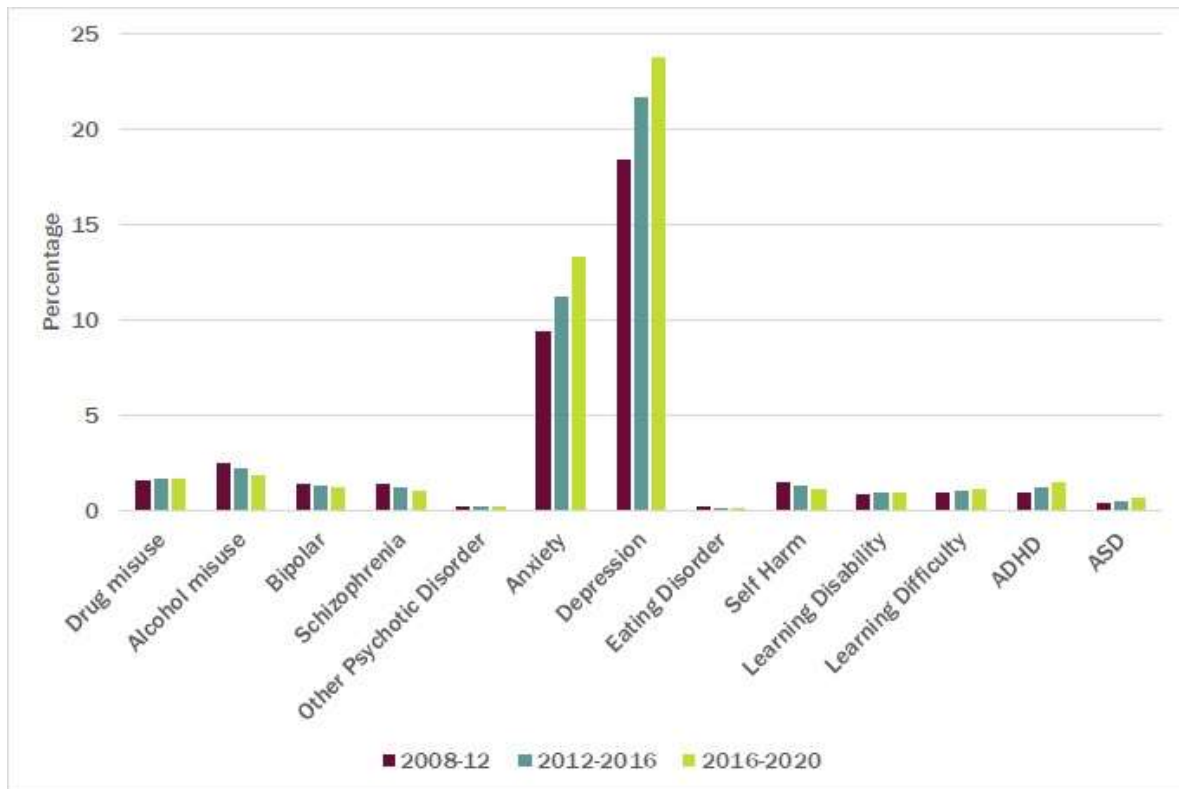
Two of the datasets^{xv} that we had originally used to find the parental risk factors weren't available for these earlier time periods, and this meant that we could only find the parental risk factors using data from GP appointments and hospital inpatient data.

Figure 8 shows the percentages of households in each of the three datasets with each of the risk factors. As can be seen, some of the risk factors, particularly anxiety and depression have been

^{xv} The Accident and Emergency Department data and the substance misuse dataset

getting more prevalent in the population, while others such as alcohol misuse have been getting less prevalent.

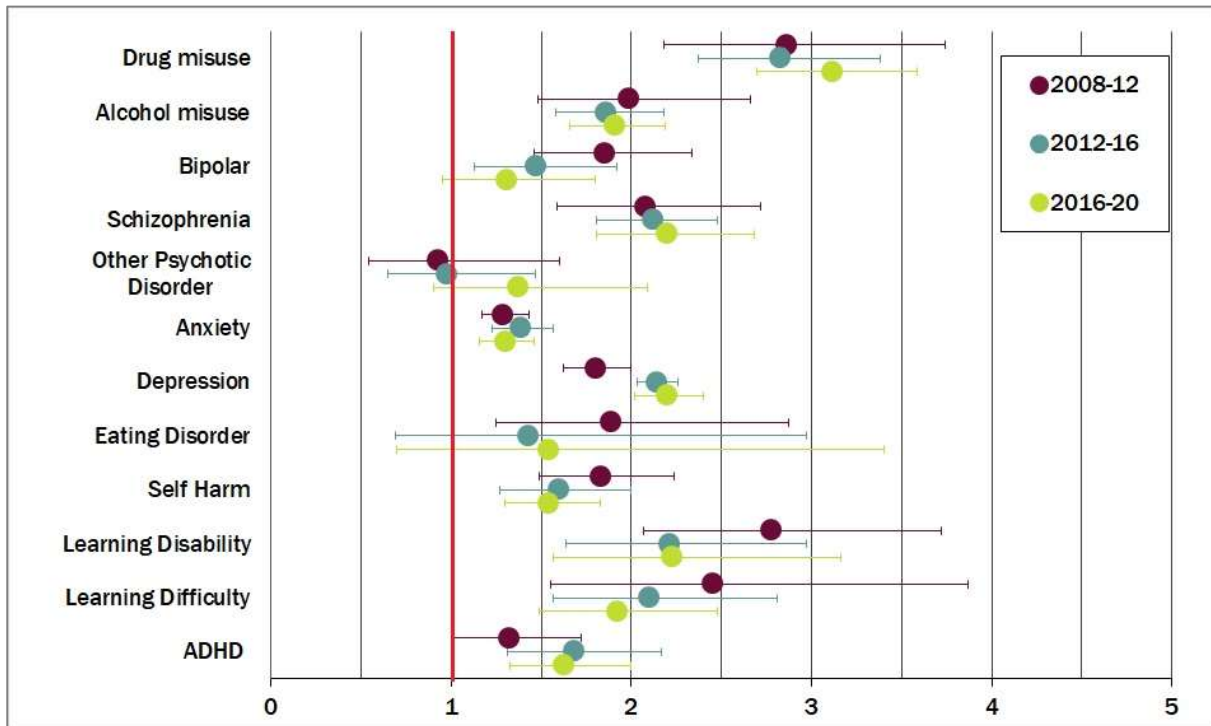
Figure 8. Percentage of households in population with parental risk factors, changes over time



We then re-ran the regression models we ran earlier with each dataset relating to different time periods. Figure 9 is a forest plot showing how the odds ratios for each parental risk factor vary for different time periods.

As can be seen, for the majority of the risk factors the odds ratios over the three cohorts are remarkably similar, suggesting that the impact that the risk factors have on the likelihood of care has not changed over time. There are some exceptions, the odds ratios for depression and ADHD increased between the 2008/12 and the latter two cohorts, meaning that these two risk factors started having a greater impact on the odds of care. The other interesting thing to note is that the impact of bipolar on the odds of care, which was not statistically significant for the 2016 to 2020 cohort, did have a statistically significant effect in the earlier cohorts.

Figure 9. Forest Plot, Odds ratios for different time periods compared



Discussion and Conclusion

This study used routinely collected data from children's social care and linked it up to data from health and education, to answer some key questions about the relationship between parental problems and children entering care. We looked at how much impact different types of problems had on the likelihood of children entering care, and whether this varied for children in different circumstances. We also looked at how much difference things like the local authority a child is in, or their ethnicity, make to the likelihood of them entering care, once we have controlled for parental risk factors and deprivation in the local area. We have some really important findings. Some of these could benefit from further research so that we know why they are happening, and some may be useful for local authorities and policy makers in considering how to do their work.

Most of the factors we looked at in the adults in the households were risk factors for children entering care, although there was no clear evidence that autistic spectrum disorders in adults were a predictor of children entering care. Parental cognitive learning difficulties like dyslexia were a predictor of children entering care, and this may suggest a need for social services to consider whether parents will need be able to understand written materials in the way they work with them. Depression is common in all households, with 23.8% of all households having a depressed adult, but it is even more common in households where a child enters care (48.7%). The people we looked at will only have been counted as having a risk factor if they had engaged with NHS services in relation to it, so it is likely the proportions of all these risk factors in the population will be even higher. Some risk factors appeared to have a bigger impact on the likelihood of care than others. Of the risk factors examined, parental drug abuse and parents being the victim of assault that takes place at home had the biggest impact on the odds of care.

The risk factors tended to have a much stronger impact when they occurred in biological mothers as opposed to other adults in the household. In single adult households most risk factors had a bigger impact on the likelihood of care when they occurred in households headed by a woman rather than households headed by a man, however anxiety had a bigger impact in households headed by a man. Although we knew that there were previous pieces of research suggesting that social services engage more with mother than with fathers, we were quite struck by this difference, and the potential inequality that it highlights. We do not know why it is happening and further research may be needed to find out why. However, it also has important practice implications, and children's social care services will need to work to ensure that there is equitable treatment for parents regardless of their sex.

The findings showed that part of the reason why households from areas of deprivation, and where there are FSM have more children entering care, is because of higher levels of parental problems. We had suspected this, but our findings have provided important proof of it. The clear relationship between low income and children entering care is a considerable concern, and it is important that research in this area continues so we fully understand this relationship. Our finding that risk factors seem to have the same impact on the odds of care when they occur in areas of high and low deprivation was also important and may suggest that families in different areas of deprivation are receiving equitable treatment from children's services. We also found that most of the risk factors have the same impact on the likelihood of care if they occurred in households where the children were in receipt of FSM, but three risk factors: anxiety, depression and self-harm, had a greater

impact on the likelihood of care if they occurred in households who were not in receipt of free school meals.

Overall, children from some ethnic minorities are more likely to enter care than others, however when the levels of the risk factors in the households are taken into account, all ethnic minority children were more likely to enter care than White children. This suggests that the reason that children from Asian backgrounds are less likely to enter care is because their parents are less likely to have certain parental risk factors. This is a serious concern, and an equality issue. Children should not be at a greater risk of entering care because of their ethnic background. We need to understand why this is happening and ensure that all children are treated equitably regardless of their race. Our findings also show that the risk factors have different impacts in households for children from different ethnic minorities. Alcohol misuse in parents is rare in the Asian population, but where it occurs it increases the odds of care, much more than it increases the odds of care in other ethnic groups. In contrast, most of the risk factors seem to have very little impact on the likelihood of care in the Black population. This suggests different reasons for children from different ethnic groups entering care and more work is needed to fully understand this.

We also found that some adult risk factors including alcohol misuse, learning disabilities, and schizophrenia had no statistically significant impact for the oldest age group. This was perhaps less surprising, and it is easy to understand that these issues may be much less of a concern for 16 and 17 year olds when compared to younger children. Parental drug misuse increased the odds of care even among 16- and 17-year olds. This could suggest that there are different pathways through which parental drug misuse will lead to children entering care. For older children, the child's special educational needs had a bigger impact on the odds of care.

We looked at changes over local authorities and these illustrated how important it is to consider the risk factors present in the populations of different local authorities when considering the numbers of children entering care. We also talked to social workers in local authorities where the rates of care were lower than expected. These highlighted issues relating to the culture of support and relationships with both managers and families, as being important in helping to keep the numbers of children in care low.

The final part of our analysis considered changes over time. The impact of most of the risk factors on the odds of care did not change between 2008 and 2020, however, between 2008/12 and 2012/16, parental depression started having a bigger impact on the odds of care. Depression and anxiety have also become more common in the population, and this may partly explain some of the increases in the numbers of children entering care between 2008 and 2020. These two facts combined suggest that at least part of the reason for greater numbers of children entering care is related to parental depression. In interpreting this we need to be careful. Parental depression and anxiety are very common in the whole population and the vast majority of people who are depressed do not have their children entering care. It may be that there is a factor that is causing the increases in parental depression that has also caused the increases in the numbers of children in care. Further research on all these issues is needed to fully understand the reasons for the increasing numbers of children entering care.

Conclusion

By using existing data this study has been able to find new and important information about the relationship between adult risk factors and children entering care. This includes the differential effects of risk factors according to the sex of the adults, and in children of different ethnicities. It also highlights the importance of factoring in the impacts of these risk factors when considering how the rates of care differ over local authorities or for children of different ethnic minorities, and provides some understanding of the issues that may have lead to the increased numbers of children in care.

If you would like more information about any of the findings of this report, please contact Dr Nell Warner, email: warnerah@cardiff.ac.uk

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