

# The inter-relationship between parental problems and ethnic background: How do they impact on entry into local authority care?

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## Abstract

Both parental problems and being from certain ethnic minoritized populations are associated with an increased likelihood of children entering local authority care. This study explored the intersection of these factors in the UK. Population-level administrative datasets were linked to create a dataset of school-aged children living in households in Wales, between 2016 and 2020 ( $n = 431,584$ ). Multilevel logistic regression models were used to look at care entry for different ethnic groups, controlling for key factors. Crude odds ratios using sub-populations of children from different ethnicities were used to explore effects of risks on sub-populations. Models showed that when parental risk factors and levels of deprivation were controlled for, all ethnic minoritized populations were more likely to enter care than White children. Subgroup analysis showed substantial differences in the effects of risks for children of different ethnicities. The results suggest different reasons for care entry vary by children's

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ethnicity and highlight inequalities in care entry. The findings highlight the urgent need to carry out work to ensure that social care provision is non-discriminatory and culturally sensitive.

**Keywords:** ethnicity; learning disabilities; local authority care; mental health; neurodiversity; substance misuse

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## Background

The disproportional representation of certain ethnic groups in out-of-home care has been identified in a number of countries (Harris 2014) and is a serious social justice concern. The nature of over-representation varies from country to country depending on the nature of the populations. For example, in Australia, New Zealand, Canada, and the USA, indigenous populations are over-represented (Tilbury and Thoburn 2008), whereas in Sweden more recent migrants are more likely to enter care (Vinnerljung et al. 2008). In several countries with minority populations of Black children, including the USA, Canada, and England, they have also been found to be over-represented in the care system (Cénat et al. 2021).

Research in England, using the five broad ethnic categories: White, Mixed, Asian, Black and Other, has shown that, when no other factors are taken into account, Asian children are less likely to be in care compared with White children while Black and Mixed-heritage children are more likely (Bywaters et al. 2017; Bywaters et al. 2019). This pattern is also apparent in more recently published government figures (UK Government 2021a) and has also been found in Wales (Welsh Government 2022).

The disproportional representation of any ethnic groups in child welfare systems is a serious social justice concern and the underlying reasons need to be understood so that policy and practice can be developed to combat it. Possible reasons have been suggested, including that it may be due to biased practices in child welfare professionals, or alternatively that structural factors make children from certain ethnicities more vulnerable to out-of-home care (Cénat et al. 2021). Debates rage in the USA about between opposing camps, with one calling for abolition of the child welfare system due to its racism (Dettlaff et al. 2020) and the other arguing that the disproportional numbers of Black children in foster care are due to the effects of social inequality in causing family problems (Drake et al. 2023). There has, however, been much less discussion and research on this topic in the UK.

Several structural factors could be at work. An obvious one relates to deprivation, as living in an area of deprivation is associated with a greater likelihood of children entering care (Elliott 2020; Webb et al. 2020). There is evidence that all ethnic minoritized populations in the UK are more likely to live in areas of deprivation than the majority White British population (Jivraj and Khan 2015). Bywaters et al. (2017) explored this issue in a large sample from one area of England, and when they looked at the most deprived areas only, they found that, although children from Mixed backgrounds were still more likely to enter care than the White majority, it was not the case for their Black counterparts. This highlights the importance of controlling for deprivation in any study of the relationship between ethnicity and care entry.

Other factors that might account for the relationship include child-level factors and issues relating to the family. For instance, whether a child has Special Educational Needs (SEN) should be considered. This is a term used in the UK to refer to children who have a learning difficulty or disability that requires additional support at school. SENs are much more common among children who are in care than the rest of the population (Sebba et al. 2015). Children from different ethnicities show different patterns in diagnosis for different types of SEN (Strand and Lindsay 2009). So it may be necessary to control for SEN while looking at the relationship between ethnicity and care entry.

Certain parental problems are also risk factors for children entering care. Being from a single adult house is a strong predictor of care entry (Bebbington and Miles 1989) and the make-up of households in the UK also varies by ethnicity (UK Government 2020a), so it may also be important to control for the number of adults in a household. Other factors for care entry include mental health problems, substance misuse, domestic abuse and forms of neurodivergence (Franzen, Vinnerljung, and Hjern 2008; Simkiss, Stallard, and Thorogood 2013; Melis et al. 2023; Warner et al. 2024). These factors are also present disproportionately in different ethnic groups. For example, in the UK both White and Black British adults are more likely to engage in illicit drug misuse than Asian adults (UK Government 2021b). Most minoritized populations have higher rates of abstinence and lower levels of drinking compared to people from White backgrounds, with abstinence being particularly high amongst South Asians, however Pakistani and Muslim men who do drink do so more heavily than other non-White minoritized populations and religious groups (Hurcombe, Bayley, and Goodman 2010). There are also differences in mental ill health prevalence among different ethnic populations. Common mental disorders are more prevalent for Black women than for women from other ethnic groups (UK Government 2020b) and schizophrenia is also more common among individuals of Caribbean and African descent (Fearon et al. 2006). Different patterns

of diagnosis are also apparent for individuals from different ethnicities in relation to specific forms of neurodivergence (Strand and Lindsay 2009).

These differences in risk factors between ethnic groups raise two important questions. The first is how much these explain the differences in the numbers of children from different ethnic backgrounds entering care. We know that when Bywaters et al. (2017) accounted for levels of deprivation, it impacted on the disproportionality of children from ethnic minoritized populations going into care. However, we do not know how much difference there would be between ethnic groups when all these parental and child factors are controlled for. Understanding this will tell us much more about how much of the observed differences are due to structural problems and how much is likely to be related to practice.

The second important issue to consider is whether the risk factors have the same impact on the likelihood of care for children from all ethnic backgrounds. This is crucial for unpicking the reasons why children from different minoritized populations are more likely to enter care. Webb et al. (2020), explored this issue in relation to area-level deprivation in the UK. While area deprivation is strongly associated with entry of children into care, that study showed that this does not apply to all ethnic categories equally. For some minoritized populations, particularly Bangladeshi, Indian, Mixed White and Black African, and Black Other, the social care gradients were not significant for any type of social care intervention. That study concluded by highlighting how important it is to look at the intersection of ethnicity with other factors. While we know that parental factors are associated with the likelihood of children entering care in the UK, we do not know about their intersection with ethnicity, that is, whether they have the same impact for children from different minoritized populations.

The increasing availability of linked datasets provides scope for examining some of these issues. This article reports on a study carried out in Wales, UK, using linked datasets that set out to answer two key questions:

- What is the likelihood of children from different ethnic groups entering care, when key parental risk factors, child SEN and area-level deprivation are controlled for?
- Do parental risk factors have the same impact on the likelihood of care for children from different ethnic minoritized populations?

## Method

This study was a retrospective, national-scale, observational e-cohort study of children entering care in Wales. Data were accessed via the Secure Anonymised Information Linkage (SAIL) Databank (<https://saildatabank>).

com) a privacy-protecting Trusted Research Environment, holding anonymous individual-level datasets about the Welsh population (Ford et al. 2009). Ethical approval was obtained from Cardiff University School of Social Sciences Ethics Committee and the project was approved by the SAIL Databank Information Governance Review Panel.

## Creating the datasets

Seven administrative datasets were combined to create a dataset of children aged 3–17 years living in Wales between 2016 and 2020. This contained information about whether the children had entered care, as well as additional information about the children and adults that they were living with prior to care entry. The administrative datasets used are shown in Table 1.

The LACW dataset was used to identify children aged 3–17 who had entered care between April 2016 and March 2020 ( $n=4,969$ ). Two groups were excluded: unaccompanied asylum seeking children, because they would not have been living with their families in Wales prior to care entry, and children who entered care for short breaks only under Part 6 section 76 of the Social Services and Well-being (Wales) Act 2014, as their care arrangements were for short term respite purposes only. Children aged 2 and under were not used because they could not be linked to the Education Wales (EDUW) dataset, and this was required to identify information about both their ethnicity and SEN.

**Table 1.** Datasets used.

Dataset	Description	Used to identify
Looked After Children Wales (LACW)	Local authority information submitted annually to Welsh Government about children in state care.	Children who entered care, local authorities from which they entered
Welsh Demographic Service Dataset (WDSD)	Register of all individuals registered with a Welsh primary care doctor	Household members living with children prior to care entry, local authorities, deprivation decile
Welsh Longitudinal General Practice Dataset (WLGP)	All interactions with general practices registered to share their data	Household risk factors
Patient Episode Database for Wales (PEDW)	All inpatient and day case activity	Household risk factors
Emergency Department Dataset (EDDS)	All attendances at Accident and Emergency Departments	Household risk factors
Substance Misuse Dataset (SMDS)	Data on individuals presenting for substance misuse treatment	Household risk factors
Education Wales (EDUW)	Schools and Pupil data covering state funded learning centres.	Ethnicity, SEN status



Information about children's households was derived from linkage to the Welsh Demographic Service Dataset (WDS), using Anonymous Linking Fields (ALFs) (Ford et al. 2009). Of the children who entered care, 4,636 (93.3 percent) had an ALF enabling them to be matched. To identify the households where children were living on the day before entering care, and the adults who were living with them in those households, Residential Anonymous Linking Fields (RALFs) were used. These use GP registrations so that individuals registered with a GP at the same address can be linked (Rodgers et al. 2009). Where a child entered care more than once during the period, their first entry into care was used. Of the 4,636 linked children 4,307 (92.9 percent) could be matched to a RALF for an address in Wales on that date.

A matched comparator group of children was also derived from the WDS. All children in Wales aged 3–17 during the period were identified and matched to RALFs in the dataset. Households from which children who entered were defined on the day before they entered care, so the comparison children required an equivalent index date within the 4-year period on which their household could be defined. To ensure the index dates of the comparison households accurately mirrored the households from which a child entered care, the distribution of care entry over the 4-year period for the care entry group was explored. The comparison households were then randomly assigned index dates using the same distribution. Because the majority of children who enter care from the same household enter care on the same date, this was done at the household level using RALFs rather than at the individual child level. This meant that in the comparison group all the children in the same households were given the same index date.

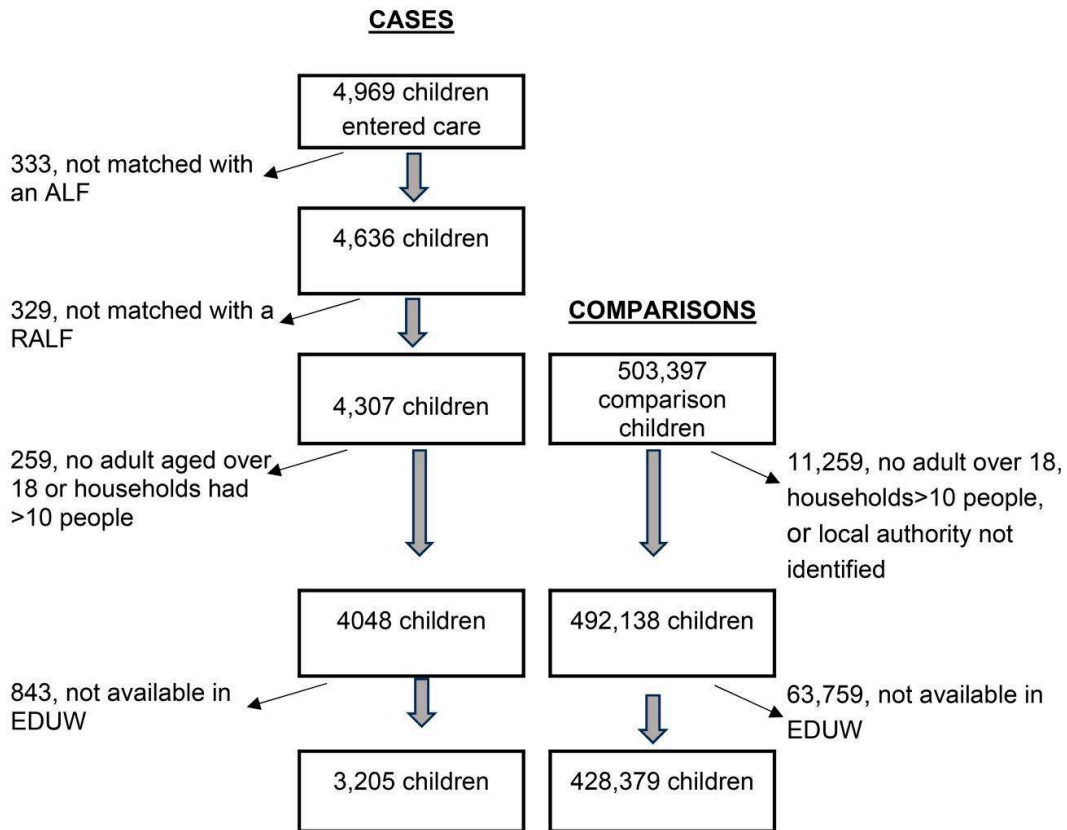
Comparison households that did not contain a child aged 3–17 on the specific index date allocated to them were then removed. Households were also removed if they contained no adult aged over 18, or more than 10 individuals, following previous studies using SAIL data to explore households with adverse childhood experiences (Evans et al. 2020).

Children's ethnicity and SEN were derived from EDUW data. This meant that children that could not be matched to EDUW were also excluded from the analysis. This resulted in a sample of 431,584 children, 3,205 who had entered care and 428,379 who had not. Figure 1 shows the numbers of children excluded from each stage of the analysis.

## Variables

### *Child level factors*

Information about children's ethnicity was derived from EDUW by the child's most recent year of education. Ethnicity was categorized into five



**Figure 1:** Flowchart showing the numbers of children who were excluded from the study.

main groups used by the population census: Asian or Asian British (categorized as Asian); Black or Black British, Caribbean or African (Black); Mixed or multiple ethnic groups (Mixed); White; and any Other ethnic background (Other). These five main groups were used to ensure that the sample size remained sufficiently large for the analysis. Children’s SEN status was also taken from EDUW, with SEN flagged if they were either given a formal statement of educational needs or were receiving ‘school action plus support’. Children’s age and sex were available from WDDS. Ages were classified into four groups: 3 to 6, 7 to 10, 11 to 15, and 16/17 year olds. Age groups were used rather than a continuous age variable as the relationship between age and care entry is not linear.

### *Adult risk factors*

Adults aged 18 and over were identified, as people living in households with children on their index dates. The ALFs of those adults were linked to health datasets WLGP, EDDS, PEDW and SMDS to identify ten risk factors: drug misuse, alcohol misuse, assault at home, schizophrenia, anxiety, depression, self-harm, learning disabilities, learning difficulties, and

attention deficit hyperactivity disorder (ADHD). All these adult factors have already been identified as being associated with children entering care (Warner et al. 2024). We refer to them as ‘risk factors’ throughout this article because they are proven to be risks for children entering care. Since the removal of children from their birth families is one of the most drastic and coercive measures the state can take, so we feel the language of ‘risk’ is appropriate. They were identified using published and validated code lists. Read Code lists were used to identify risks from WLGP and IC10 codes were used to identify risk factors from PEDW and EDDS. Details of all code lists used are available in [Supplementary Table 1](#). EDDS was also used to identify the assault-at-home variable which was an indication that the adult had presented to an emergency department having been the victim of assault that had taken place in their home. Both learning disability and learning difficulty were considered. Learning disability was used to refer to people with an IQ of below 70 who had a significantly reduced ability to understand new or complex information and new skills and a reduced ability to cope independently. Learning difficulty described those with scholastic difficulties. Risk factors were identified in the individual adults in the households, and then combined to indicate that they were present in any adult in the household.

### *Local area factors*

Information about local area level deprivation was obtained from the Welsh Index of Multiple Deprivation (WIMD), a measure of area-level deprivation based on small geographical areas called lower layer super output areas, comprising approximately 1500 individuals (Welsh Government 2019). These were ranked into deciles from most deprived to least deprived areas.

### **Analysis**

Descriptive statistics, using frequencies and proportions, were used to explore the impacts of each factor on the likelihood of a child entering care, and the relationship between the child’s ethnicity and parental risk factors. To explore how risk factors affected the relationship between ethnicity and entry into care, a series of multilevel logistic models were fitted. At the first stage, odds ratios adjusted for local authority only were produced. Variables were then added to the model in four stages. Model 1 contained the child’s sex, age group and ethnicity. In Model 2, child’s SEN was added, and in Model 3 WIMD decile was added. In the final stage, the adult risk factors and number of parents in the household were added. Odds ratios alongside 95% confidence intervals were



presented, Multilevel models were used, because children in Wales enter care through twenty-two different local authorities. The household level could not be used as a level within the multi-level models, because some children who entered care from the same household entered on different dates over the four-year period, and the adult risk factors were calculated according to the dates on which those children entered care. This means that not all children within a household necessarily had the same household risk factors. To look at the differing impact of risk factors among different ethnic minoritized populations, sub-populations of children from each ethnic category were created. Crude odds ratios, adjusted for local authority only, were then used to compare the impact of the risk factors in different subpopulations. Adjusted models could not be created as some parental risk factors predicted failures of the models for some subpopulations. All models were weighted to compensate for the ALF match rate.

## Results

[Table 2](#) shows descriptive statistics for the dataset. As can be seen, children from the Black and Mixed ethnic groups were more likely to enter care than the majority White population, while those from the Asian and Other groups were less likely. There is little variation in the likelihood of care according to the sex of the child, but some variation in age group. Children aged 3–6 were more likely to enter care than the other age groups, followed by 11–15 year olds. Each of the adult risk factors child SEN and deprivation were associated with a greater likelihood of care.

The bivariate analysis of child ethnicity and adult risk factors is shown in [Table 3](#). Many risk factors, including adult drug and alcohol misuse, common mental health problems, and being from a single parent household, are more common among the children from White and Mixed ethnic backgrounds. Schizophrenia is more common in the adults of the Black children.

### The odds of children entering care, controlling for risk factors

[Table 4](#) presents a series of regression models used to identify how much different child characteristics predict the likelihood of care, both before and after the risks are controlled for. The first column shows crude odds ratios, followed by Model 1, looking at the child's sex, age-group and ethnicity. Children from the Mixed ethnic groups were significantly more likely to go into care than White children, while odds ratios for the other ethnic minority populations were not significant. The odds

Table 2. Descriptive statistics.

	Child enters care n (%)	Child does not enter care n (%)	% of Children with risk that enter care
All households	3205 (100)	428379 (100)	0.74
<b>Ethnic background</b>			
Asian	59 (1.8)	10114 (2.4)	0.58
Black	46 (1.4)	3223 (0.8)	1.41
Mixed	146 (4.6)	12841 (3)	1.12
White	2917 (91.0)	395347 (92.3)	0.73
Other	27 (0.8)	4994 (1.2)	0.54
Ethnicity data missing	10 (0.3)	1860 (0.4)	0.53
<b>Sex of the child</b>			
Female	1563 (48.8)	207555 (48.5)	0.75
Male	1642 (51.2)	220823 (51.5)	0.74
Data missing	0	1	0
<b>Child age group</b>			
3 to 6 year olds	978 (30.5)	112463 (26.3)	0.86
7 to 10 year olds	820 (25.6)	118572 (27.7)	0.69
11 to 15 year olds	1079 (33.7)	140763 (32.9)	0.76
16 and 17 year olds	328 (10.2)	56581 (13.2)	0.58
<b>SEN</b>	1544 (48.2)	82553 (19.3)	1.84
<b>Risk factors in adults in household</b>			
Drugs	530 (16.5)	8656 (2.0)	5.77
Alcohol	412 (12.9)	10034 (2.3)	3.94
Assault at home	48 (1.5)	1003 (0.2)	4.57
Schizophrenia	144 (4.5)	4138 (1.0)	3.36
Anxiety	809 (25.2)	56128 (13.1)	1.42
Depression	1587 (49.5)	102386 (23.9)	1.53
Self-Harm	223 (7.0)	6378 (1.5)	3.38
Learning disabilities	104 (3.2)	3941 (0.9)	2.57
Learning difficulties	97 (3.0)	4348 (1.0)	2.18
Autism	34 (1.1)	2786 (0.7)	1.21
ADHD	138 (4.3)	6048 (1.4)	2.23
<b>Number of adults in house</b>			
1	1291 (40.3)	85098 (19.9)	1.49
2	1214 (37.9)	233049 (54.4)	0.52
3	457 (14.3)	71652 (16.7)	0.63
4 or more	243 (7.6)	38580 (9.0)	0.63
<b>WIMD decile</b>			
1	880 (27.5)	53407 (12.5)	1.62
2	622 (19.4)	47318 (11)	1.3
3	433 (13.5)	44052 (10.3)	0.97
4	336 (10.5)	44117 (10.3)	0.76
5	239 (7.5)	38993 (9.1)	0.61
6	205 (6.4)	40262 (9.4)	0.51
7	191 (6)	40161 (9.4)	0.47
8	145 (4.5)	37943 (8.9)	0.38
9	90 (2.8)	39808 (9.3)	0.23
10	64 (2.0)	42318 (9.9)	0.15

ratio for Black children was the highest, but not statistically significant. In Model 2, the child's SEN was added. Controlling for SEN had relatively small effects on the odds ratios for the ethnicity variable. Model 3 controlled for area-level deprivation, and the odds ratios for Asian

**Table 3.** Adult risk factors and child ethnicity, bivariate analysis.

Risk factors	Asian n (%)	Black n (%)	Mixed n (%)	White n (%)	Other n (%)
Drugs	167 (1.6)	40 (1.2)	302 (2.3)	8587 (2.2)	52 (1.0)
Alcohol	111 (1.1)	31 (0.9)	295 (2.3)	9926 (2.5)	36 (0.7)
Assault at home	14 (0.1)	7 (0.2)	27 (0.2)	996 (0.3)	<5 (n/a)
Schizophrenia	146 (1.4)	55 (1.7)	162 (1.2)	3865 (1)	41 (0.8)
Anxiety	750 (7.4)	193 (5.9)	1496 (11.5)	53978 (13.6)	305 (6.1)
Depression	1335 (13.1)	412 (12.6)	2927 (22.5)	98350 (24.7)	579 (11.5)
Self-harm	81 (0.8)	15 (0.5)	177 (1.4)	6271 (1.6)	37 (0.7)
Learning disability	82 (0.8)	27 (0.8)	89 (0.7)	3802 (1)	26 (0.5)
Learning difficulty	78 (0.8)	26 (0.8)	122 (0.9)	4177 (1)	23 (0.5)
ADHD	53 (0.5)	17 (0.5)	164 (1.3)	5889 (1.5)	26 (0.5)
Number of adults					
1	640 (6.3)	614 (18.8)	2945 (22.7)	81388 (20.44)	422 (8.4)
2	4538 (44.6)	1400 (42.8)	6483 (49.9)	218286 (54.81)	2552 (50.8)
3	2200 (21.6)	649 (19.9)	2192 (16.9)	65630 (16.48)	1165 (23.2)
4+	2795 (27.5)	606 (18.5)	1367 (10.5)	32960 (8.28)	882 (17.6)

children became significant. Asian children were significantly less likely to enter care than White children once area-level deprivation was controlled for. Though not significant, the odds ratio for the Black group decreased, in line with [Bywaters et al. \(2017\)](#). Finally, the adult risk factors were added. When this was done the odds ratios for the ethnic minoritized populations increased compared to the reference category, White (although the effect was very minimal for the Mixed group). For the Asian and Other groups, the odds ratios that had been below one, suggesting they were less likely to enter care, became greater than one, showing that when all the parental risk factors are controlled for then they are more likely to enter care than White children. For Asian children this was statistically significant, suggesting that the reason that fewer children from Asian backgrounds enter care is that their parents are less likely to have the adult risk factors.

### The impact of adult risk factors for children of different ethnic minoritized populations

Subgroup analysis was carried out to explore the differential impact of the adult risks for children in different ethnic groups. It was not possible to build regression models as for the Black and Other ethnic groups, for certain household risk factors there were no cases at where children had entered care. No children from the Black group entered care from households containing adults with drug misuse problems, alcohol misuse problems, anxiety, self-harm, learning disabilities, learning difficulties, or ADHD. No child from the Other ethnic group entered care from

Table 4. Regression models, whole dataset, n = 429,713.

	Crude OR			Model 1			Model 2			Model 3			Model 4								
	OR	P > z	[95% conf. interval]	OR	P > z	[95% conf. interval]	OR	P > z	[95% conf. interval]	OR	P > z	[95% conf. interval]	OR	P > z	[95% conf. interval]						
Female <sup>a</sup>	1.01	0.794	0.95	1.08	1.01	0.783	0.95	1.08	1.29	0.000	1.20	1.37	1.26	0.000	1.18	1.35	1.25	0.000	1.17	1.34	
Ethnicity <sup>b</sup>																					
Asian	0.83	0.071	0.67	1.02	0.83	0.072	0.67	1.02	0.91	0.376	0.74	1.12	0.78	0.006	0.66	0.93	1.38	0.002	1.13	1.68	
Black	1.77	0.157	0.80	3.89	1.76	0.154	0.81	3.85	1.86	0.117	0.86	4.05	1.33	0.491	0.59	3.04	2.13	0.080	0.91	4.97	
Mixed	1.56	0.003	1.17	2.08	1.54	0.003	1.15	2.06	1.61	0.001	1.21	2.16	1.51	0.009	1.11	2.07	1.60	0.004	1.16	2.19	
Any other	0.78	0.318	0.48	1.27	0.78	0.315	0.48	1.26	0.86	0.570	0.52	1.44	0.76	0.305	0.46	1.28	1.23	0.453	0.72	2.10	
Age group <sup>c</sup>																					
7–10	0.75	0.000	0.70	0.81	0.76	0.000	0.70	0.82	0.67	0.000	0.62	0.72	0.68	0.000	0.63	0.74	0.69	0.000	0.64	0.74	
11–15	0.85	0.003	0.76	0.94	0.85	0.003	0.76	0.95	0.68	0.000	0.61	0.76	0.71	0.000	0.64	0.79	0.74	0.000	0.67	0.83	
16 + 17	0.74	0.066	0.53	1.02	0.74	0.072	0.54	1.03	0.58	0.001	0.42	0.80	0.61	0.002	0.44	0.83	0.65	0.006	0.47	0.88	
Child SEN	3.92	0.000	3.54	4.35					4.37	0.000	3.99	4.79	3.74	0.000	3.44	4.08	3.31	0.000	3.05	3.60	
WIMD	0.79	0.000	0.77	0.80					0.81	0.000	0.79	0.83	0.85	0.000	0.83	0.83	0.85	0.000	0.83	0.87	
Parental risk factors																					
Drug misuse	9.59	0.000	8.39	10.96													3.79	0.000	3.25	4.42	
Alcohol misuse	6.19	0.000	5.42	7.08													2.49	0.000	2.14	2.90	
Assault at home	6.46	0.000	4.91	8.50													2.65	0.000	1.86	3.78	
Schizophrenia	4.84	0.000	3.88	6.05													2.05	0.000	1.58	2.65	
Anxiety	2.20	0.000	1.93	2.52													1.25	0.000	1.11	1.40	
depression	3.09	0.000	2.75	3.48													1.96	0.000	1.72	2.24	
Self-harm	5.02	0.000	4.12	6.12													1.20	0.132	0.95	1.53	
Learning disabilities	3.61	0.000	2.61	4.98													1.84	0.002	1.25	2.71	
Learning difficulties	3.09	0.000	2.32	4.12													1.70	0.001	1.24	2.32	
ADHD	3.32	0.000	2.67	4.13													1.42	0.004	1.12	1.81	
Adult number	0.73	0.000	0.68	0.78													0.66	0.000	0.62	0.71	
Constant					0.01	0.000	0.01	0.01	0.01	0.000	0.01	0.01	0.02	0.000	0.01	0.02	0.02	0.000	0.02	0.03	
LA variance					0.10		0.06	0.16	0.10		0.06	0.17	0.10		0.05	0.19	0.11		0.06	0.22	

Reference categories:

<sup>a</sup>Male, <sup>b</sup>White, <sup>c</sup>Age 3–6.

households with adults who had self-harmed or had learning disabilities or learning difficulties.

Crude odds ratios for risk factors are shown in [Table 5](#). Some clear differences can be seen in the impact of the risk factors in the different ethnic groups. First, for Black children, certain risk factors commonly associated with children entering care did not have significant effect, including parental depression and WIMD. Only two of the crude odds ratios were related to children entering care: the child's SEN, and the number of adults in the household.

Differences were also evident for the Asian group, where the effects of some risk factors on the likelihood of care were higher than they were for other groups. This was particularly apparent for alcohol problems where the odds ratio was significantly higher than that of the majority White population. The impact of anxiety on the odds of care among the Asian population was also statistically significant.

## Discussion

By using population-level linked administrative data, this study explored the inter-relationship between a child's ethnicity and parental problems for care entry, and produced some important findings.

First, it examined how the impact of ethnicity on care entry changed when different risk factors were controlled for. Controlling for area-level deprivation reduced minoritized children's chances of entering care compared to White children, but further controlling for parental problems seems to generally increase their chances. When SEN and area-level deprivation were controlled for, Asian children were less likely to enter care than White children; however, once parental risk factors were added, Asian children were significantly more likely to enter care.

The effects of parental risk factors also vary by ethnic group. Very few risk factors had an impact on the likelihood of care for Black children, whereas for Asian children some risks, particularly alcohol misuse and parental anxiety, had a significantly greater impact than they did on the rest of the population.

These findings are deeply concerning. We wanted to find out whether the differences in care rates for children from different ethnicities were being driven by biased practices, or alternatively by structural factors, as discussed by [Cénat et al. \(2021\)](#). [Bywaters et al.'s \(2017\)](#) finding that when only children from deprived areas are considered, Black children do not have a higher rate of care than the White population had suggested that some of these effects could be due to structural factors. When we added area-level deprivation, it reduced the odds ratio for the Black and Asian children in our data, so the same interpretation could potentially apply to our study. The odds ratios for the Black children



**Table 5.** Crude odds ratios and ethnicity subpopulations.

	Asian, n = 10,171			Mixed, n = 12,977			White, n = 398,102			Black, n = 3,238			Other, n = 4,939		
	OR	P> z	95% CI	OR	P> z	95% CI	OR	P> z	95% CI	OR	P> z	95% CI	OR	P> z	95% CI
Drug misuse	12.72	0.000	3.61 44.90	8.59	0.000	5.08 14.51	9.76	0.000	8.40 11.34				2.49	0.235	0.55 11.27
Alcohol	21.78	0.000	9.80 48.44	3.99	0.000	2.32 6.85	6.23	0.000	5.40 7.19				4.87	0.043	1.05 22.57
Schizophrenia	2.52	0.329	0.39 16.05	7.62	0.000	3.78 15.37	4.76	0.000	3.85 5.88	4.19	0.067	0.91 19.41	7.16	0.125	0.58 88.39
Anxiety	4.21	0.000	3.22 5.49	1.95	0.001	1.34 2.84	2.22	0.000	1.91 2.58				3.38	0.043	1.04 11.02
Depression	2.93	0.148	0.68 12.61	1.87	0.000	1.40 2.50	3.22	0.000	2.85 3.64	2.80	2.25	0.014 1.18	2.25	0.014	1.18 4.30
Self-harm	2.03	0.539	0.21 19.48	7.64	0.000	4.70 12.43	5.02	0.000	4.09 6.16						omitted
Learning disability	4.48	0.044	1.04 19.27	1.13	0.912	0.14 9.12	3.79	0.000	2.74 5.22						omitted
Learning difficulty	4.72	0.029	1.17 18.99	2.17	0.365	0.41 11.64	3.18	0.000	2.33 4.34						omitted
ADHD	8.07	0.023	1.33 49.02	1.30	0.689	0.36 4.71	3.39	0.000	2.71 4.24						omitted
Adult Number	0.71	0.051	0.50 1.00	0.53	0.000	0.37 0.75	0.75	0.000	0.70 0.81	0.49	0.000	0.37 0.64	0.63	0.002	0.47 0.85
SEN	2.85	0.021	1.17 6.94	3.22	0.000	2.30 4.52	4.03	0.000	3.58 4.54	2.59	0.000	1.52 4.43	4.19	0.000	1.91 9.22
WIMD decile	0.87	0.003	0.79 0.95	0.81	0.000	0.78 0.85	0.78	0.000	0.76 0.80	0.92	0.376	0.78 1.10	0.88	0.000	0.83 0.93
Age group*															
7-10	0.43	0.000	0.33 0.56	0.66	0.019	0.46 0.93	0.76	0.000	0.71 0.82	1.13	0.516	0.78 1.62	1.53	0.569	0.35 6.63
11-15	0.43	0.000	0.33 0.55	0.77	0.187	0.52 1.13	0.86	0.009	0.77 0.96	0.87	0.800	0.29 2.58	2.66	0.012	1.24 5.71
16+17	0.64	0.093	0.38 1.08	1.30	0.325	0.77 2.18	0.72	0.051	0.51 1.00	0.78	0.721	0.19 3.13	2.35	0.014	1.19 4.65

were not, however, statistically significant, in any of the models. This is likely to be because of the relatively small population of Black children in Wales compared to other parts of the UK, limiting our ability to reach a robust conclusion. However, the fact that when we added the parental risk factors, the odds ratios for all the ethnic minority groups increased, suggests that bias may have a bigger role than previously thought. It suggests that the reason that children from Asian backgrounds have been consistently under-represented in the care system is because their parents are less likely to have the sort of risk factors that result in children being taken into care. Once these adult risk factors are controlled for, all ethnic minoritized populations are more likely to enter care than the majority White population. This is a very concerning finding.

Further research could develop understanding of why this is happening, but our findings are in line with Bywaters et al.'s argument (2019) that the assumed culture of 'strong extended family support' does not seem to drive the underrepresentation of Asian children in the welfare system. The results suggest that the lower prevalence of parental problems among Asian parents is more likely to be working behind this pattern. We do not know whether bias is occurring within social work practice, or if it occurs at an earlier stage, in terms of referral to social services. So work is needed to examine the intersection between ethnicity and parental risks at different stages of concern about children. Unfortunately, no data on referrals to social services are available for Wales, but if such data are available in other jurisdictions, then that would help researchers to unpick at which stages the process bias occurs.

While this research was carried out in Wales, UK, over-representation of ethnic minoritized populations in children's social care is common to many countries internationally (Harris 2014). The finding that all ethnic minoritized populations are more likely to enter care than the majority White population, once risks are controlled for, suggest that the prevalence of care among children from ethnic minoritized populations in Wales is quite likely due to biased practice, as opposed to structural factors. Similar studies would need to be carried out internationally to identify if similar effects are seen elsewhere.

Within the UK, the findings have immediate effects for policy and practice. They highlight the urgent need to carry out work to ensure that social care provision is both non-discriminatory and culturally sensitive. All services need to embed effective approaches to eradicate racist and discriminatory practices. Evidence supporting such practice with families (see e.g. Waddell et al. 2022), and within the child welfare system (Miller et al. 2013), needs to be embedded into policy and practice.

The findings relating to the differing effects of risks in different populations are also important. They build on the work of Webb et al. (2020) which found that area-level deprivation had less of an impact in some ethnic minoritized populations. Our findings were similar: the odds ratios

for area deprivation were greatest for the White population and lower for all the other ethnic groups. For the Black group, they were not significant. However, we have also looked at the intersection of ethnicity with other risk factors and found startling differences in the effects of the risk factors in different ethnic minority populations. Particularly, notable is the significantly stronger impact that adult alcohol and anxiety variables have on the odds of care for Asian children. The finding about alcohol could be related to Hurcombe, Bayley, and Goodman's (2010) finding that alcohol abstinence is particularly high amongst South Asians, but Pakistani men who drink do so more heavily than other non-White minority ethnic groups and Muslim men who drink do so more than those from other religious groups. However, more research, and particularly qualitative studies, may be needed to be confident of this explanation. The findings relating to the lack of the effects of most risk factors on the population of Black children are also important. We could only find evidence of two risk factors being related to the likelihood of children from the Black population entering care—the child's SEN and the number of adults in the household. Some of this may be due to the relatively smaller number of Black children in the data which meant that findings were less likely to be significant compared to the majority White population. It would be useful if this analysis could be repeated in an area with a larger population of Black children to be confident of such effects. Notwithstanding this, there were 3,238 Black children in the data and all the risk factors were present in at least some of their households. The fact that some of the relatively prevalent risks, such as like anxiety and depression, did not predict care entry seems to indicate that Black children are entering care for different reasons to children from other ethnic groups.

## Limitations

All administrative data contain small errors and the data used in the study were no exception to this. However, these errors will have been off-set by the large population-level data. In relation to some of the ethnic minoritized populations, particularly the Black and Other categories, the population in Wales is not particularly high. This meant that we cannot tell whether some of our results that were not significant would have been significant with a larger population. The study was carried out in Wales because the facilities provided by the SAIL databank mean that it is possible to link data about children in the population to primary and secondary health care data for the adults living in their households. As similar data become available in other areas of the UK, with higher minority ethnic populations, it would be useful to repeat this to see if there are similar effects. The relatively small ethnic minority population of

Wales meant that we did not have sufficient data to use the eleven classifications of ethnic group. This would have provided a greater granularity of understanding.

Evidence suggests that diagnosis and reporting of health issues may vary by ethnic group (Faber et al. 2023; Knipe et al. 2024). As we could only control for the risk factors as recorded in administrative data, residual confounding may still have affected our findings. If this is the case, it might mean that the measurements of risk factors are reporting slightly different, or more or less severe, conditions in different populations. Further research would be needed to understand these differences in reporting and how they might impact on the findings.

## Conclusion

By using linked administrative data, we have been able to examine the intersection of ethnicity and parental risk factors. This has provided us with some important findings. It has shown that when parental risk factors are taken into account, Asian children are in fact more likely to enter care than the majority White population, not less likely as shown in Government statistics. This is a concerning finding, which may be indicative of bias that needs to be taken seriously by policy makers and practitioners. This study has also shown that some of the factors associated with the majority White population of children entering care do not have the same impact on the likelihood of care for Black children. Conversely, alcohol misuse, though less common in the households of Asian children, where it does occur, has a significantly bigger impact on the likelihood of children entering care. This highlights the urgent need to carry out work to ensure that social care provision is non-discriminatory and culturally sensitive.

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## Supplementary data

Supplementary data are available at *British Journal of Social Work* online.

*Conflicts of interest.* None declared.

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