

# **Should Children in ‘Care’ be Returned to their Families of Origin? A Critical Appraisal of Recent Reunification Studies**

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## **Keywords**

Family Reunification; Child Protection; Organic Families; The ‘Care’ system; Out of home care; Service planning; Social prescribing.

## **Abstract**

UK doctors play a crucially important role in determining the services that are commissioned to meet the needs of vulnerable children. Very generous financial support is currently expended on out of home placements for children in ‘Care’, whereas by comparison, very little social and economic support is given to children at risk of abuse, neglect and developmental delay who are living with their organic families. This inequitable distribution of resources acts as a confounding variable that can bias evaluations of the two types of placements for children at risk. Further research that overcomes this element of bias needs to be conducted, to strengthen the evidence base regarding appropriate ways to address the needs of children at risk.

The out of home care system produces very poor outcomes for children, despite expensive financial cost. Cost-benefit analysis and threshold analysis is needed to test interventions that have demonstrated the potential to significantly support the welfare of children in the context of family reunification. A more diverse and cost effective menu of children’s services should be developed to address the specificity of the needs of children and their families. Entire families could potentially be rehabilitated at less financial cost than is currently expended on keeping individual children in out of home care.

## **The Role of Doctors in Child Protection**

A range of professionals, including doctors, play a role in reporting Child Protection concerns, though at times there is a reluctance to do so, because beyond surveillance, the main form of intervention involves removal of children into out of home care and there is doubt about whether this form of intervention ‘does more harm than good’ (Sankaran, Church & Mitchell, 2019). There is also considerable evidence from the *Centre for Social Justice* that Local Authorities are not responding to vulnerable children, leaving researchers outraged at the lengths that some Local Authorities are going to “withhold or restrain services from being provided”. (Eastman, 2014; Hayes, 2014). Because the main form of active intervention is expensive out of home care, demand outstrips the economic ability of Local Authorities to respond to reports of child abuse and neglect, leaving the needs of many children unmet..

Doctors play a key role in determining whether children will enter the out of home care system and whether they will subsequently return to their families of origin. Doctors participate in multidisciplinary teams that investigate child abuse, provide treatment for children in care, review care plans and determine whether children

should be reunited with their families of origin. At the level of practice, doctors select the services to be applied in ‘social prescribing’ from a menu that they themselves are able to effect.

Doctors have a vitally important role in determining the services that are commissioned to meet the needs of vulnerable children. As well as influencing the commissioning of therapeutic services that can prevent the need to take children into the out of home care system, they are able to play a key role in determining whether the services that can support family reunification will be commissioned.

There are urgent issues in commissioning that need to be addressed. For example, Local Authorities are quite outspoken in their concerns that mental health services for children are inadequate (McCardle, 2014). The role in commissioning that is played by UK doctors means that they are able to be instrumental in ensuring that mental health services, coupled with family therapy and other related services, address the needs of children. Arguably these types of targeted therapeutic services can be more efficient and effective than the current out of home care system.

### **The re-emergence of interest in re-unifying children in ‘Care’ with their families**

There has been a recent re-emergence of interest in the reunification of families separated by the removal of their children into the ‘Care’ system. In this paper, the term ‘organic family’ is used rather than the more imprecise term ‘biological family’, to describe the child’s family of origin. Reunification studies have attempted to quantify the number of children from the care system who return home as well as considering a range of questions such as which children are more likely to be reunified with their families of origin and whether contact between the children and their families during the time of separation, affects the likelihood of reunification.

Two major literature reviews have addressed the specific question of whether children in out of home care experience better outcomes if they return to their organic families or if they remain in the ‘Care’ system (Biehal, 2006; Thoburn, Robinson, & Anderson, 2012). In addressing this question across the broad spectrum of literature on reunification, there is a considerable amount of recursiveness. However, with the exception of some studies that address the issue peripherally and draw on very small numbers, the empirical evidence base from the recent UK studies on reunification basically breaks down into three sets of primary research, two of which consisted of two related consecutive studies (Farmer, 2012; Farmer & Lutman, 2010; Farmer, Sturgess & O’Neill, 2008; Wade, Biehal, Farrelly, & Sinclair, 2010; Wade, Biehal, Farrelly, & Sinclair, 2011; Sinclair, Baker, Wilson & Gibbs, 2005; Thoburn, Robinson & Anderson, 2012). The primary research is heavily loaded with the interpretations of local authority social workers with some very small-scale interviewing of children and their organic families. For example, in a study by Farmer & Lutman (2010), 138 children were followed up by means of reviews of case files and interviews with 36 social workers, team managers and leaving care workers, whereas only six interviews were conducted with parents and six with children.

Despite some slight differences of emphasis, these recent UK primary research studies on reunification can be considered collectively because they share a common purpose in attempting to compare the outcomes for children who return home, with

those for children who remain in out of home care. The recent studies on reunification also share a common conclusion in that they have generally found that children who remain in 'Care' do better than those who reunify. I shall refer to these studies collectively as the recent studies on reunification. The view that is generally supported by these studies is that, "the majority of maltreated children who are looked after by local authorities do better in terms of wellbeing and stability than those who remain at home. Care works for these children." (Davies & Ward, 2011:14-15).

The recent studies on reunification compare the outcomes for children who remain in 'Care' with those for children who return to their families of origin. However, in order to determine whether the dependent variable in these studies (the outcomes for the children), is produced by the independent variable (whether the care for the children is out of home or home based), all other credible explanatory factors must be the same for both groups. Like must be compared with like, so that the only credible explanation for the different outcomes, is the difference said to be provided by the independent variable. In other words, the groups must be the same, except for the factor of whether the children are in out of home care or are cared for in their own homes. However, the two forms of care for children are not being fairly compared, because one is well- resourced and one is not. One receives genuine service provision and the other receives surveillance. Mr Justice Weir, of the *High Court of Justice in Northern Ireland* expressed this point clearly when he stated:

"I am often struck in these cases by the paucity of help for parents in the community, especially for parents who lack familial support. By comparison, the level of help and respite provided for foster carers seems for some reason to be very much greater...An outcome of permanent removal of children from their families is, too often, as much an indictment of a failed system as it is of inadequate parents." (*KW, EW and MW between Belfast Health & Social Care Trust v SM, 2010*).

Foster families receive generous financial and social support that is not provided, or is only negligibly provided, to families of origin (Wrennall, 2010; Staff writers 2010). Kinship carers receive very little of the support that is offered to commercial foster carers (McAndrew, 2013) and children subject to Care Orders who are looked after in their own homes, often by non-accused parents, receive little or no practical assistance (Broadhurst & Pendleton, 2007). On the other hand, foster families receive between £254-523 per child, per week in foster wages (Staff writers 2010) as well as financial support in the form of paid overseas holidays, paid loft conversions, generous gifts of toys, respite care, transportation and so on. Foster children are also more likely to receive mental health services and Special Educational Services than children who are living with their organic families (Ringeisen, Casanueva, Cross, & Urato, 2009). The monthly unit expenditure for placement types are estimated to be: "£763 for placed with parents; £1,914 for kinship care; £14,662 for residential unit; £5,951.85 for agency foster care placement within local authority area." (Ward, Holmes and Soper, 2008 cited in Hannon, Wood, & Bazalgette, 2010).

The dearth of services to families of origin is much noted in the literature (Fernandez, & Lee, 2013). However the implications of these inequalities in income and service provision have not been given appropriate weight in analysis. The unequal level of financial and social support provided to the two types of settings constitutes a major

confounding variable in evaluations of the two types of placements. The better outcomes that are reportedly achieved by children in the supported families compared to the unsupported or minimally supported families are likely to be explicable by the better levels of support, rather than by out of home placement in itself.

Such support as has been given to organic families has provided evidence-based positive outcomes (Washington State Institute for Public Policy (WSIPP) and the University of Washington Evidence-Based Practice Institute (EBPI) 2020; Guastaferrero & Lutzker, 2019; Romano *et al.* 2020; Rogers-Brown, 2020). However, research studies are needed that compare the outcomes for removed children with those for intact families at risk, *where the same, or a measurably proportionate, level of support is provided to both*, so that the best approach to children at risk is ascertained. To push the issue further- for two phenomena to be compared, a comparator is needed, that is, there needs to be a common measure by which two factors can be compared. It is precisely this type of research that has not been conducted. An appropriate basic type of comparator for example, could be the amount of money that is spent on each option. These current reunification studies do not compare like with like and do not provide a comparator.

### **Comparing the outcomes of family reunification and remaining in out of home care**

In the recent reunification studies, one of the main criteria for judging the outcomes of reunification was whether the child was assessed by the Local Authority as needing to be returned into the 'Care' system after reunification. Placement stability is rightly considered to be important. However when these recent studies on reunification are compared with studies that assess a broader range of factors than re-entry into 'Care' subsequent to reunification, the picture becomes more complex. In a study by Taussig *et al* (2001), reunified youth showed more problems in internalizing behaviors, total behavior problems and lower total competence compared to children who remained in 'Care', whereas there "were no statistically significant differences between the groups on delinquency, sexual behaviors, pregnancy, suspensions, or externalizing behaviors". However, Lawrence *et al* (2006) found that children in foster care, "showed higher levels of internalizing problems compared with children reared by maltreating caregivers." Their findings suggest that, "outcomes related to foster care may vary with type of care and beyond the effects associated with maltreatment history, baseline adaptation, and socioeconomic status." (Lawrence *et al*, 2006). Poor outcomes for children in 'Care' are reported across a broad range of adverse impacts, including medical endangerment, teenage pregnancy, dental neglect, substance misuse, poor educational achievement and serious psychological impairments (Polnay & Ward, 2000; Richardson & Lelliott, 2003).

Lest it be thought that the poor outcomes for children coming through the 'Care' system are wholly attributable to their experiences prior to 'Care', Lloyd & Barth (2011) analysed multiply-sourced data suggesting that, "long-term foster care is unhealthy for children's development even when poverty is relieved, more skilled caregivers are provided, and perhaps even when placement stability is enhanced." Noting that observers in this field have often asserted that the effects of maltreatment and the effects of the 'Care' system are confounded, Lloyd & Barth ensure that this is not the case in their analyses, "maltreatment type and severity were controlled for

independently.” They are able to state categorically that the negative effects of foster care, “are specific to foster care, not maltreatment.” (Lloyd & Barth, 2011).

Further evidence contradicting the studies that oppose reunification comes from Pecora *et al* (2005) who report that only 26% of their foster care alumni, “demonstrated positive outcomes in terms of good mental health, education achievements, employment, or personal income.” Children on the margin of foster care placement have better employment, delinquency, and teen motherhood outcomes when they remain at home (Doyle, 2007) but are two to three times more likely to enter the criminal justice system as adults if they were placed in foster care (Doyle, 2008). On a broad range of factors, the *Department for Education* (2007) concluded that children in out of home care had poor outcomes, despite significant increases in expenditure as part of the *Quality Protects* programme. The department reports that, “Between 2000-01 and 2004-05 total expenditure increased by around £230 million for children in residential care and by around £330 million for those in foster care, representing real terms increases of 20% and 44% respectively, while the care population only rose by 3% during that time.” Yet these significant increases in expenditure on out of home care did not leverage commensurate positive outcomes for children.

Furthermore, the criterion of whether the child needed to be returned into ‘Care’ after reunification, is far from being objective. The threshold for taking children into the ‘Care’ system, responds to a range of economic factors, including the availability of economic resources (Commons Select Committee 2011; Pickles, 2006; Pemberton, 2013). The current reunification studies assume that the decisions about whether to take, or return, children into ‘Care’ are rationally based, whereas in reality, these types of decisions are likely to be influenced by several economic factors that occlude the best interests of the child (Wrennall, 2007). There is a wide diversity, one might say a postcode lottery, governing whether children are likely to be taken into out of home care. The ‘Care map’ produced by the *Department for Education & Skills* and the *Department for Constitutional Affairs* (2006), shows that the proportion of all children in an area aged under 18 who are taken into ‘Care’ can vary by 300%. To some extent this wide variation is likely to be explicable in terms of conflicts of interest (Wrennall, 2013).

Even more disturbing is the evidence of error, untruthfulness, manipulation and other misconduct in Child Protection assessments. For example, a sampling of cases in a broader and more deeply troubling trend includes a case in which The Honourable Mr Justice Keehan reported in *X County Council v M & Ors [2014] EWHC 2262 (Fam)* that before he went into court his clerk, “received an email from one of the mother’s treating consultant psychiatrists Dr Z, setting out that his professional opinion and views had been mis-represented by the local authority in the application for a care order and in the social worker’s statement filed in support of the same.” In one case, a child was subjected to forced adoption because it was wrongly believed that her sibling had drowned due to their Mother’s drunkenness and intoxication, despite the fact that the mother was in possession of blood test evidence proving that she was not intoxicated, nor under the influence of any drugs at the time (Davies, 2011). In *Re X (Emergency Protection Orders) [2006] EWHC 510 (Fam)* Mr Justice Macfarlane found that every single one of the cited “elements of the team manager's evidence was misleading or incomplete or wrong.” In another case a social worker covered up

allegations of sexual abuse in foster care (Dyer, 2003) and another faked an assessment interview with a child (McGregor, 2014). Even more seriously, a social worker who had been found guilty of conspiracy to murder, was found to have orchestrated lies in a Child Protection case (*Bath & North East Somerset Council v A Mother & Ors [2009]*). In another case, a social worker confessed to having made a false accusation of sexual abuse (Prynne, 2014). More generally, Baldwin (2005) found that narratives that were not underpinned by fact could nevertheless persuasively influence courts, due to a series of narrative techniques and processes. There is also evidence that families are ‘set up to fail’ (San Diego County Grand Jury 1991-2; Banks, 1995) so that children can be retained in, and returned to, highly profitable out of home care. Such misconduct is thought to result from conflicts of interest (Wrennall, 2013).

Given that these current reunification studies did not include a control group which has experienced appropriate Family Support without child removal or who have experienced family reunification involving the same level of intensive support provided to Foster families, or some other meaningful comparator, the conclusions of these studies, namely that children are better off in the ‘Care’ system than with their natural families, are not valid.

### **Cost Comparison Research: What research is needed?**

Evaluating outcomes from different social policies by way of a common economic comparator, intuitively makes good sense. Taxpayers are entitled to information on whether their compulsorily obtained contributions to social policy are well spent and therefore using financial costs as a comparator between different options for public expenditure is justified. Cost comparison research is needed to evaluate the various options for children who are presently in out of home care.

The methodology that is required is cost-benefit analysis together with threshold analysis, to test interventions that have demonstrated the potential to significantly support the welfare of children in the context of family reunification. Cost-benefit analysis can compare the outcomes from residential care with the outcomes from the care of children in their own homes for each unit of expenditure. This can then be done for different types of interventions within the context of home based care, where the alternatives are sufficiently promising to suggest that testing them is worthwhile. As shown above, the outcomes from out of home care are not so positive that automatic deployment of out of home care ought to be assumed as an appropriate response to child abuse and neglect. The ethical problems associated with offering different approaches to children would need to be addressed, however, they should be no more complex than any study which compares treatment modalities. It would be unethical to deny children the opportunity to explore approaches that could be more beneficial to them.

### **Conclusion**

A major significant problem with the recent reunification studies is that the comparison being made is of an ‘all or nothing’ nature. Either children are in the ‘Care’ system with enormous economic resources being applied to their situation (*Department for Education, 2012; Williams, 2012*) or as Mr Justice Weir pointed out,

they are at home with their families receiving virtually no genuine support (*KW, EW and MW between Belfast Health & Social Care Trust v SM [2010] NIFam*).

Rather than the 'Black and White' thinking that is expressed in the reunification studies, what is needed is consideration of a continuum of options that includes diverse therapeutic services and economic policies. Family therapy, Cognitive Behavioural Therapy, individual psychotherapy, negotiation and conflict resolution strategies, poverty reduction, job creation, specialist bodyguards, Day Care/ 24 Hour Care, parenting classes, Nurse Family Partnerships, housework training and support, Nurture Groups, 'Incredible Years' Family Support and youth workers in schools are among the options that provide alternatives to this 'all or nothing' type of thinking. Entire families could potentially be rehabilitated at less financial cost than is currently expended on keeping individual children in out of home care.

The question of whether children in 'Care' should be returned to their natural families needs to ultimately be examined in the context of a serious rethinking of how resources in Child Protection are allocated. The research agenda needs to address questions about how the available resources can most efficiently be deployed to secure the most positive outcomes for children. How can positive outcomes be achieved for the largest number of children? What outcomes do we want? For which children? Which services are most likely to achieve these outcomes? The menu of items from which multi-agency teams currently make their decisions is meagre. We need to stop assuming that a one size fits all 'Care' system can meet the needs of a nation's children and develop a continuum of diverse appropriate services for children. Doctors in the UK are in a position to influence commissioning in the direction of more appropriate services to meet the needs of vulnerable children.

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