UNDERSTANDING RESIDENTIAL CARE FOR CHILDREN IN CARE IN ENGLAND

ANALYSIS OF ADMINISTRATIVE DATA

May 2022

Technical report

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About the Independent Review of Children's Social Care

The Independent Review of Children's Social Care was announced in January 2021 and will report in Spring 2022. Josh MacAlister is leading the review which has a wide ranging and ambitious scope. The review is a chance to look afresh at children's social care. It will look at issues through the perspective of children and families throughout their interactions with children's social care, from having a social worker knock on the door, through to children being in care and then leaving care. What Works for Children's Social Care is supporting the review by producing and commissioning evidence summaries, rapid reviews and new analysis.

About What Works for Children's Social Care

What Works for Children's Social Care seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector. We generate, collate and make accessible the best evidence for practitioners, policy makers and practice leaders to improve children's social care and the outcomes it generates for children and families.

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CONTENTS

GLOSSARY OF TERMS

CAMHS	Child and Adolescent Mental Health Service
CCE	Child criminal exploitation
CEM	Coarsened exact matching
CiC	Children in care
CLA	Children looked after
CSE	Child sexual exploitation
DfE	Department for Education
EET	In education, employment or training
EHCP	Education, health and care plan
GCSE	General Certificate of Secondary Education
KS2	Key Stage 2 (normally known as Year 3, Year 4, Year 5 and Year 6, when the pupils are aged between 7 and 11 years.)
KS4	Key Stage 4 (normally known as Year 10 and Year 11, when pupils are aged between 14 and 16 by August 31st.)
LPM	Linear probability model
NEET	Not in education, employment or training
NICE	The National Institute for Health and Care Excellence
NPD	National Pupil Database
ONS	Office for National Statistics
PTSD	Post-traumatic stress disorder
SDQ	Strengths and Difficulties Questionnaire
SEMH	Social, emotional and mental health difficulties
SEN	Special educational needs
SEND	Special educational needs and disability
UASC	Unaccompanied asylum-seeking children

EXECUTIVE SUMMARY

This report provides descriptive analysis of the experiences of children who have had a placement in a residential children's home subject to children's homes regulations (subsequently 'residential care'). This project aimed to improve the current understanding of residential care by using routinely collected data on children in these placements.

More specifically, the project objectives were to:

- Provide an overview of the use of residential care and describe the children who experience it

- Outline the pathways of children into residential care and compare the journeys of children with different demographics

- Determine the variables that predict entry into residential care for children in care.

Methods

The analysis used individual-level, national data from the Children Looked After Dataset (SSDA903), linked with the school census data between 1998/99 and 2019/20. Please see the technical appendix for detail on how children's records were linked across datasets. Using descriptive statistics, we summarised the experiences of a snapshot of all children who were living in residential care in 2019/20 and a cohort of children who turned 18 in 2019/20 who had at least one residential care placement. We also ran regression analyses

to identify characteristics of children in care which are associated with the likelihood of experiencing a residential care placement during their first period of care.

Key findings

Who are the children living in residential care?

We described the characteristics of children who were living in residential care at some point between April 2019 and March 2020 (n=10,046). The analysis highlights that children living in residential care are not a homogeneous group and enter care at different stages of their lives or for different reasons:

- 41% enter care before the age of 11

- 40% enter care as adolescents (between the ages of 11 and 15)

- 15% of the children living in residential care entered care due to a disability or illness.

The characteristics of children living in residential care compared to all children in care within the same reporting year suggest that:

- Boys tend to be over-represented in residential care

- White children tend to be over-represented in residential care, whereas Asian[1] and Black [2] children tend to be under-represented

- 92% of children living in residential care have been recorded as receiving provision for a Special Educational Need (SEN) at some point, and over half for social, emotional or mental health (SEMH) needs.

Journeys through care

We looked at the care journeys of children who turned 18 in 2019/20 and had ever lived in residential care (n=2,913). The median total length of time spent in care among children who have experienced residential care is 3.6 years. They often experience significant placement instability: Looking over the course of their childhood, children with experience of residential care had a mean of 6.7 placements during their time in care. In comparison, the median length of time spent in care among a corresponding cohort of all children in care is 1.6 years, and this group has a mean of three placements across their time in care. We also found that residential care seems to often be used once other placement options such as foster care or kinship care have been explored.

Before entering residential care, children typically:

- Have 2.2 placements on average. This mean increases when looking at children who have lived in residential care more recently, suggesting that more placement options are explored before placing children in residential care

- Experience very high placement stability if they entered care before the age of 11. They have on average 4.6 placements before entering residential care

- Have already experienced instability at school as well, such as fixed term exclusions

- Are more likely to experience residential care if their placement has broken down or been disrupted and their carer in their first placement requested a change of placement for the child

- Some may have left and re-entered care. 22% of children who turned 18 in 2019/20 who ever experienced a residential care placement left and re-entered care before going into residential care.

Upon entering residential care, children:

- Experience a mean of 3.4 placements after their first residential care placement

- Often experience subsequent residential care placements. 32% experience two residential care placements immediately following each other and 45% experience another residential care placement at some point after their first.

Outcomes for children who have lived in residential care

Outcomes for children who have lived in residential care tend to be relatively poor compared to average outcomes for children in care. Our research presented in this report is not causal, which means that it does not tell us why outcomes tend to be poorer for children who have lived in

1   We use the term 'Asian children' to refer to children of Indian, Pakistani, Bangladeshi, Chinese heritage or 'any other Asian background' in line with the 2021 census groupings by major ethnic group.

2   We use the term 'Black children' to refer to children of Black African and Black Caribbean heritage as well as 'any other Black background' in line with the 2021 census groupings by major ethnic groups.

residential care and it does not suggest that this is a consequence of the residential care placements.

Children who turned 18 in 2019/20 and who had lived in residential care at some point in their childhood experienced, on average, the following outcomes:

- 51% have not been in education, employment or training (NEET) at age 18

- 61% have been recorded as missing from care at some point between the ages of 14-17

- 24% had at least one conviction while in care

- The educational outcomes are particularly stark. Children who have lived in residential care:

  - missed an average of 13% of all sessions during Key Stage 4 (unauthorised absence)

  - 2% have been permanently excluded during Key Stage 4

  - 31% have experienced a fixed term exclusion in Key Stage 4

  - Only 7% achieve an Attainment 8 score of at least 30 (the national average for children with special education needs (SEN), compared to 33% of all children who have been in care.

Some children have particularly poor experiences

Over three quarters of children who enter care before the age of 10 do not enter residential care until age 11 or older. This sub-group of children experience particularly high placement instability with an average of 5.2 placements before their first residential care placement and 9.3 placement moves during their whole time in care. This is well above the mean of 2.2 placements before entering residential care and 5.7 placement moves overall for all children who experience residential care.

Adolescent entrants make up a large proportion of the residential care population (40%). Relative to the time this group spends in care, they experience a higher number of placement moves. Furthermore, children in both of these groups have higher rates of being NEET at age 18, going missing from placement, being convicted, having a substance misuse problem, and fixed-term exclusions compared to all children who have experienced residential care.

BACKGROUND

Introduction

What is residential care?

Residential care is a form of care for children who, for a multitude of reasons, are unable to live with their birth family. Instead, they are cared for by a team of paid professionals in a residential setting alongside other children, such as in a children's home. Residential care is an umbrella term comprising numerous types of placement and models of care; for example the national data collated by the Department for Education (DfE) does not distinguish between secure units, children's homes or semi-independent living accommodation when discussing residential care. Residential care continues to make up a small minority of placements for children in care (CiC), with 14% placed in a form of residential care in the year ending 31 March 2021 as reported by national statistics (Department of Education, 2021a). In contrast, foster and kinship care continue to be the preferred choice, accounting for 71% of all placements (Department for Education, 2021a).

Policy, legislation and high costs are part of the explanation for the lower numbers of children living in residential care. Government policy and legislation states a preference for family-based care, such as foster or kinship care, where children live with family members, or in foster placements that more closely resemble a traditional family.[3] In addition, concerns have been raised about the experiences of children living in residential care, including the reported risk of abuse in these placements (Hart & La Valle, 2015). Residential care is frequently used for children for whom a more traditional family set-up, such as foster care, is not appropriate, often because of significant behavioural problems (Hart & La Valle, 2015). Moreover, research has shown that children who experience residential care tend to have poorer outcomes compared to other CiC (outlined in more detail below). Taken together, these concerns have led to negative attitudes towards residential care and a desire, from social work professionals and senior managers, to divert children from these types of placements, so that they are only used as a 'last resort' (Holmes et al., 2018; Narey, 2016; Thoburn, 2016).

What does existing research say so far?

Compared to CiC in other placement types, those living in residential care have poorer emotional and behavioural problems and educational outcomes, and are also more likely to have psychiatric disorders (DfE., 2014; Ford et al., 2017; Sebba et al., 2015).

Studies have shown for some time that although educational attainment gaps exist between CiC and their peers, these gaps are greatest for children who are in children's homes (Ofsted, 2021). Sebba et al. (2015) found that those in children's homes at Key

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3   Section 22c(7) of the Children Act sets out that in determining which is the most appropriate placement for a child, the local authority must "give preference" to a placement with a relative, friend or other connected person.

Stage 4 achieved significantly lower results than other placement types.

Mental health problems are more common among CiC compared to children in the general population, in large part due to early experiences of maltreatment and adversity (Engler et al., 2020). However, other experiences while in care such as placement instability and placement type are associated with more severe mental health problems (Engler et al., 2020). Specifically, research shows children living in residential care have worse mental health than children in kinship and foster care (Hillier et al., 2018; Lou et al., 2018; Xu., & Bright., 2018; Engler et al., 2020).

The increased likelihood of children placed in residential care to go missing has been well established in the literature (Bowden & Lambie, 2015; Biehal & Wade 1998, 2000; Hayden & Goodship, 2015). The most recent DfE data also illustrates this, reporting that two thirds of missing incidents reported for CiC were from 'secure units, children's homes and semi-independent living arrangements' (DfE, 2021a). There is suggestive evidence in the research that the reason for a higher number of missing episodes from residential care could be due to the older age of the young people. The Narey Review, among others, illustrates that the children living in children's homes today tend to be older and exhibit significantly more challenging behaviour with more complex needs than earlier populations, with over three-quarters aged between 14 and 17 years, and an average age of 14.6 years (Narey, 2016).

The increased risk of child sexual exploitation (CSE) occuring outside of the home for children living in residential care and the link between CSE and going missing has been highlighted for many years (Sturrock and Holmes, 2015). Shaw and Greenhow (2020) highlight the continuation of this

risk. Sturrock and Holmes (2015) note that there is less research on the increased risk of child criminal exploitation (CCE), whereby children and young people are manipulated and coerced into committing crimes such as county lines drug dealing, for children living in residential care. However, links are drawn between an increased risk of going missing and increased risk of criminal exploitation among children living in residential care (Sturrock and Holmes, 2015).

It is estimated that between 37% and 50% of children in custody are care experienced (Day, 2021) and the majority of care experienced children were living in residential homes when convicted of their first offences, or their offending increased in frequency or seriousness when living in residential homes (Day, 2019; HM Inspectorate of Probation, 2012). Furthermore, Dregan and Guildford (2012) found that residential care was associated with increased risk of adult criminal convictions. The Howard League for Penal Reform reports significant progress in reducing the criminalisation of children living in residential care; for example, formal criminalisation of these children has fallen from 15% in 2013/14 to 7% in 2018/19 (Howard League for Penal Reform, 2020). However, their recent report on CCE and residential care highlighted a number of factors which increase the likelihood of children living in residential care being exposed to CCE. One of which is the prevalence of the older age group, another is the fact that the criminal gangs are targeting these children and the placements specifically. The authors suggest that for young people who are victims of CCE, they are more likely to be criminalised for their actions under the influence of the criminals than given support. The report does also emphasise the lack of robust data in this area, due to a lack of reporting.

In England, 41% of care leavers are not in education, employment or training (NEET) at age 19-21 (DfE, 2021a). Longitudinal data shows that factors such as fewer/lower qualifications and mental ill health increase the likelihood a person will be NEET (Holmes et al., 2021). Research, as discussed above, suggests that these factors are more frequent for young people living in residential care.

Residential children's home workers have been systematically overlooked in terms of research (Parry et al., 2020), an issue which has only recently started to be addressed. A children's homes workforce literature review commissioned by the Department for Education and conducted by The RTK Ltd (2021) illustrated that evidence in this space is limited, but did highlight some important findings indicative of concern. The authors note that results from the first census to have been conducted with the English residential children's homes workforce showed that 54% of managers found it difficult to recruit staff with the appropriate level of skills and training. Of those managers, over 90% said potential candidates did not have the required experience. The demands on residential children's home workers are high, involving, among others, responsibility for safety, emotional support, and crisis management (Seti, 2008), so it is crucial to have the right staff and support in place to help the workforce to care for such vulnerable children.

Why is this work important?

It is worth noting that the needs and vulnerabilities of children living in residential care presented above are intersectional and do not exist in isolation. While evidence thus far outlines that children who experience residential care often have worse outcomes than their peers in other forms of care, to conclude that residential care leads to poor outcomes is simplistic. This sort of inference does not account for the circumstances under which children enter a residential care placement.

The potential for residential care to deliver stability may be underestimated. For some young people, residential care may be the best option and some express a preference for living in a home rather than being fostered (Narey, 2016). The recent Ofsted (2022) report highlighted that three-quarters of children in their sample were assessed as being well-matched to the home, based on inspectors' experience of meeting the children in the home, views of the children, social workers and managers, and the context of what alternative provision was available at the time. Furthermore, much of the evidence surrounding outcomes thus far has not accounted for the wider characteristics and experiences that contribute to a child entering residential care, such as previous care experience and special educational needs. Therefore, this work hopes to provide more context and understanding regarding who the children entering residential care are, and what their journeys into such placements look like, in order to inform the interpretation of their outcomes in this research and that of others.'

Furthermore, much of the literature surrounding residential care currently comes from qualitative work or government reviews which fail to provide a national picture of residential care. This is due to the nature of the data collected, such as the DfE national statistics which do not distinguish between different types of residential settings, as well as small sample sizes and missing data. The availability of national, administrative datasets means that large scale analysis of children's experiences and outcomes of children's homes specifically can be carried out and important questions can be answered. This evidence can be used to inform policy decisions which can help ensure that children's homes offer high quality support for children who often enter these settings under very challenging circumstances.

Terms used in this report

Our definition of residential care

There are a range of residential settings that CiC can reside in, such as children's homes, residential special schools registered as children's homes,[4] short-break-only children's homes,[5] and secure units.[6] Only children who had a placement in a residential children's home subject to children's homes regulations were included in our residential care population (henceforth 'residential care').[7] Other residential settings such as special schools, short-break-only homes, secure units and unregulated children's homes were excluded from our definition of residential care. The decision to look at one type of residential care placement in depth was made in order to do justice to the nuance involved in this particular setting, rather than to look at too many categories at once. Therefore, where we refer to 'residential care' for the remainder of the report, we are exclusively referring to children's homes subject to children's homes regulations. This consists of placements recorded with the code K2, and its historical equivalents H3 and H4, 'Children's Homes subject to Children's Homes Regulations', under the 'Placement Type' variable in the Children looked after (CLA) dataset. This placement type accounts for the largest share of placements among the DfE's grouping of 'residential care'. We acknowledge that even when restricting analysis to this particular type of residential setting, there is a lot of variation in the models of care provided between different children's homes that does not get captured within administrative data sets.

Our typologies

Children living in residential care placements often have the most complex needs of the population of CiC (Narey, 2016) and are placed into residential care for a variety of reasons. Children's experiences of and journeys through residential care may differ strongly. With this in mind, we explored pathways through residential care separately for a number of different groups of children to provide a nuanced overview of when or why residential care is used. Literature searches and engagement conducted prior to data analysis highlighted some factors, or characteristics of children, that may lead to particularly different experiences of residential care.

Although we do not claim the background research that informed our choice of typologies to be exhaustive, below outlines the groups of children that we considered separately and the key aspects of each that may distinguish their experiences of residential care from others. The methodology section also lists our typologies as well as how they were abstracted from the larger sample.

Unaccompanied Asylum Seeking Children

Unaccompanied Asylum Seeking Children (UASC) are young people who have applied for asylum in their own right and are

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4   Residential special schools care for some of the most vulnerable children in our society. This includes those children with complex special educational needs and/or disabilities.

5   Short-breaks-only children's homes care for disabled children to provide short breaks for their parents or carers. Most children who attend these provisions live with their parents or guardians, although some may live with foster carers.

6   Local authorities place children in secure children's homes when children are a significant risk to themselves or others, and no other type of placement can keep them safe.

7   This included the code K2, and its historical equivalents, H3 and H4 in the Placement Type variable in the CLA dataset

separated from parents and/or any other responsible adult, and are estimated to represent around 5% of the care population in the year ending 31 March 2021 (DfE, 2021a). They are a distinct group of CiC due to the experiences that have led them to becoming UASC. A systematic review of psychological distress in refugee children suggests that the separation from their primary caregiver for an unaccompanied child can be seen as a traumatic event, on top of the trauma of circumstances in the home country and the journey to seek safety (Bronstein & Montgomery, 2011). The review also found a higher prevalence of mental health difficulties for UASC in care compared to children in the general population, CiC, or refugee children living with their families. Research also highlights that UASC living in residential care had poorer educational outcomes than those in other types of placements (e.g. foster care) (O'Higgins, 2019). However, there is a significant gap in understanding the experiences of UASC living in residential care; this research speaks to this gap.

Children whose main need for services arises because of their disability, illness or intrinsic condition

Many CiC have complex needs. There is a significant gap in the research concerning disabled children and their experiences, and we would like to emphasise the problematic dearth of research in this area. Jay and Gilbert (2021) found a very high proportion of children who were in care or in need during school years had Special Educational Needs (SEN) provision at some point (83% and 65%, respectively). However, children within our typology for this report represent a specific subset of children for whom their disability, illness or intrinsic condition is

the main reason for which they need care, over and above other reasons if they exist, including abuse or neglect.[8] Therefore, we expect rates of SEN to be particularly high within this group and their journey into residential care may be driven by a need for specialist support. A recent paper discussed the barriers faced in finding care for children with SEN types such as autism, one of which was the lack of understanding of the issues by residential carers (Pickles et al., 2022). Thus, the demographics of these children, as well as their journeys into, experiences of and challenges faced within residential care are likely to differ from other children and therefore it is important to consider this sub-group in more detail. It is important to note that this analysis will not capture all children living in residential settings for whom disability is a primary need, as settings such as residential care homes that provide aspects of personal, medical or nursing care or residential special schools are excluded from our definition of residential care.

Early entrants into residential care (age 10 and younger)

We identified no research on who enter residential care age 10 and younger. This lack of evidence could be because it is a very rare occurrence to enter residential care so young. DfE (2014b) reported that the average age of children in children's homes was 14.7 years, with over three quarters of children in homes aged between 14 and 17 years old. Just 7% of boys and 3% of girls in children's homes at 31 March 2014 were aged 10 and under (DfE, 2014b). As the needs and experiences of this group are likely to be specific to the journey of entering residential care so young, it was felt to be more appropriate to have a separate category to generate more knowledge about this group of children.

8   According to DfE, most children whose needs fall within this category will have a medically diagnosed condition such as cerebral palsy, autism, or Down's syndrome, and children who have been diagnosed as suffering from a psychiatric illness are included (DfE, 2015a)

Early entrant to non-residential care (enter care age 10 and younger, but do not enter residential care until age 11 or older)

As like the typology above, children within this group are aged 10 or under when they enter care. The difference is that early entrants to non-residential care are not placed into residential care until later in their journey, when aged at least 11 or older. Therefore, such children must have experienced at least one form of non-residential care before entering residential care. The Children's Commissioner (2020) reports a rise in placement moves or instability for children aged 0-11; illustrating that the number of children aged 5-11 with multiple placement moves in 2018/19 has increased by 15% from 2016 levels compared to a population rise of 6.5%. Additionally, compared to a population rise of 10%, they found that for children aged 0-11, the rate of multiple placement moves within a year is up 17%. These findings illustrate that experiencing placement instability at a young age is becoming more common. Paired with research that suggests residential care is often used as a 'last resort' option after alternative placement types have broken down (Holmes et al., 2018; Narey, 2016; Thoburn, 2016), it seems as though this is a common route into residential care. Therefore, it is important we generate more information on the children who have this experience.

Adolescent entrants to care (age 11-15)

Children in this typology first enter care between the ages of 11 and 15, and experience a residential care placement at some point during their time in care. Entering care as an adolescent could suggest a failure to give a family the right help at the right time (The Children's Commissioner, 2021). Research has found that many of these children face significant disadvantages before they come into care. The Children's Commissioner (2021)

reported that around two thirds of children who entered care between the age of 13-15 were eligible for free school meals, just over two thirds had special educational needs, and they were more likely to have faced instability in school. Furthermore, DfE (2014b) reports that children entering care aged 11 or older tend to experience a larger number of placements, a more disrupted experience of care and poorer outcomes in education. Moreover, compared to younger CiC, those aged over 13 were six times more likely to be placed in a children's home or secure unit (The Children's Commissioner, 2021). These findings highlight that this group of children have a unique journey into and through the care system by virtue of entering when they do, which leads to a distinct route into residential care.

Late entrants to care (age 16 and above)

Children in this typology first enter care aged 16 or older, and experience a residential care placement at some point during their time in care. A report by The Children's Commissioner suggests that entering care even later than age 15 suggests a series of missed opportunities where these children have often had years of interactions with health, education and other professionals, and yet that crucial opportunity was missed (The Children's Commissioner, 2021). Research suggests four main reasons young people enter care at aged 16 or older: as UASC (whom we have grouped separately); through the justice system; as a result of family breakdown and via mental health inpatient facilities (Sawhney, 2020; Sawhney, 2021). This research suggests that children who enter care aged 16 and older have distinct experiences from individuals who start to receive services earlier in life, so it is important to understand how their demographics and journeys through residential care differ.

RESEARCH OBJECTIVES

This report provides descriptive analysis of the experiences of children who had a placement in a residential children's home subject to children's homes regulations (subsequently 'residential care'). This project aimed to improve the current understanding of residential care by using routinely collected data on children in these placements.

More specifically, the project objectives were to:

- Provide an overview of the demographic characteristics of the children who experience residential care

- Outline the pathways of children before and after entering residential care and compare the journeys of children with different demographics

- Determine the characteristics of CiC that are associated with being placed in residential care.

- Describe the outcomes for children who have lived in residential care.

The analysis plan set out additional research questions that are not listed above, but can be found in the research protocol on our website.[9] Time constraints meant we had to prioritise which questions we would answer in this report, which was done according to the policy relevance of the research questions.

This analysis is limited to providing descriptive statistics and regression analysis. Our analyses establish correlations, we are not able to determine any causal effects on/of residential care.

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9   Determining whether the characteristics of children living in residential care placements vary by the type of residential care placement

METHODOLOGY

Data

The analysis used individual-level and school-level extracts from the National Pupil Database (NPD) sourced within the Office for National Statistics (ONS) Secure Research Service for the population of children in England who were ever recorded to have been in care between 1998/99 and 2019/20. Local authority returns on the population of looked after children (the Children Looked After Dataset or "SSDA903" collection) was the primary data source. The dataset contains annual records of local authorities, with children's records (within-year and across-years) linked using a unique child identifier. This dataset has been collecting annual data returns since 1992. However, between 1998 and 2003, this data collection was restricted to a one-third sample, and returned to include all CiC in 2004 (Mc Grath-Lone et al., 2016).

The Pupil Matching Reference (PMR), assigned to a child upon first entry to state-funded schooling or (if sooner) creation of an Education, Health and Care Plan (Jay et al., 2018), was primarily used as the unique child identifier. This enabled us to track a child's entire care history, as well as collect greater information by linking their records to extracts of the National Pupil Database. Where a PMR was unavailable, an alternative method was used (please see technical appendix for detail on how this was created, and the number of children affected). In absence of a PMR, no school records can be linked for a child.[10]

Data cleaning, manipulation and analysis was conducted using R version 4.0.2 in R Studio version 1.4.1717.[11]

The following extracts of the National Pupil Database were linked to the Children Looked After Dataset:

- Annual school-level and pupil-level schools' Spring Census to provide greater detail of relevant child characteristics

- Wider pupil-level data on attainment, absences and exclusions to understand a child's school history.

This work was produced using statistical data from ONS. The use of the ONS statistical data in this work does not imply the endorsement of the ONS in relation to the interpretation or analysis of the statistical data. This work uses research datasets which may not exactly reproduce National Statistics aggregates.

Samples

For the purpose of this analysis, we constructed distinct samples from the CLA national dataset to answer the research questions as precisely as possible. We conducted analysis on a 'snapshot' and a 'cohort' sample. More information about the samples that will be referred to through this report is detailed below.

First, we took a snapshot approach to obtain a sample of children who were living

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10   Please see the technical appendix for discussion on the implications of this limitation

11   More information on the packages used can be found in the technical appendix
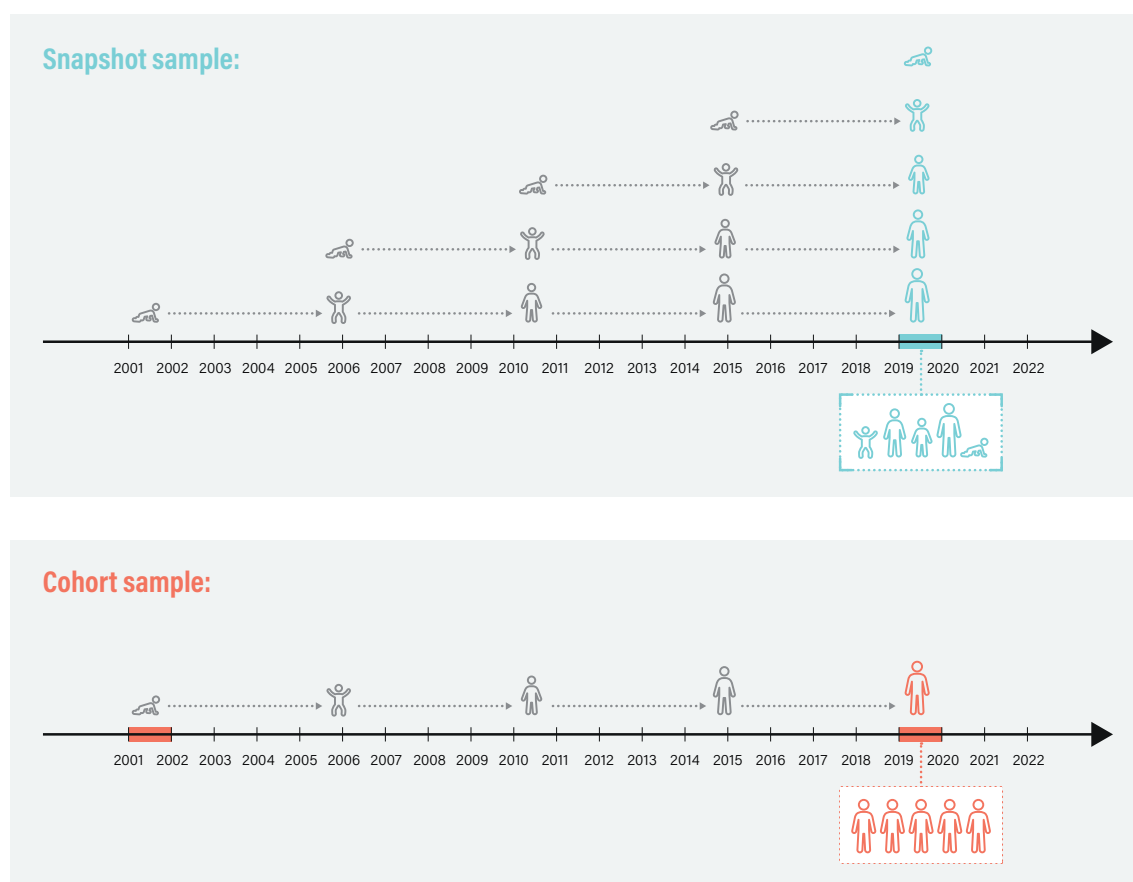
in residential care at any point during the reporting year 2019/20 (n=10,046). Hence, children in this sample were living in residential care at some point between the 1 April 2019 and 31 March 2020, allowing us to build an understanding of the characteristics of children who were living in residential care during the most recent reporting year when we requested access to the data. A corresponding sample of all children who were in care during the same year was created (n=108,552) in order to draw comparisons between the residential care sample and a sample of all CiC. The all CiC sample also includes the children living in residential care.

The snapshot approach is useful because it enables us to build an understanding

of the characteristics of children who are currently living in residential care. However, we cannot track these children's experiences and outcomes after residential care by virtue of the fact that they were living in residential care at the most recent datapoint available when we requested access to the data. Therefore, in order to build an understanding of the journeys and outcomes that children who experience residential care have, we chose a cohort approach.

The cohort approach selected a sample of children who were born between April 2001 and March 2002, hence turning 18 in the reporting year 2019/20, who have ever experienced residential care (n=2,913). A corresponding sample of children from the same birth cohort who were ever in care (in

Figure 1: Illustration of snapshot and cohort samples

any type of placement) was created (n=22,431) to enable comparisons to the sample of all CiC. The sample of all CiC also includes children who have lived in residential care.
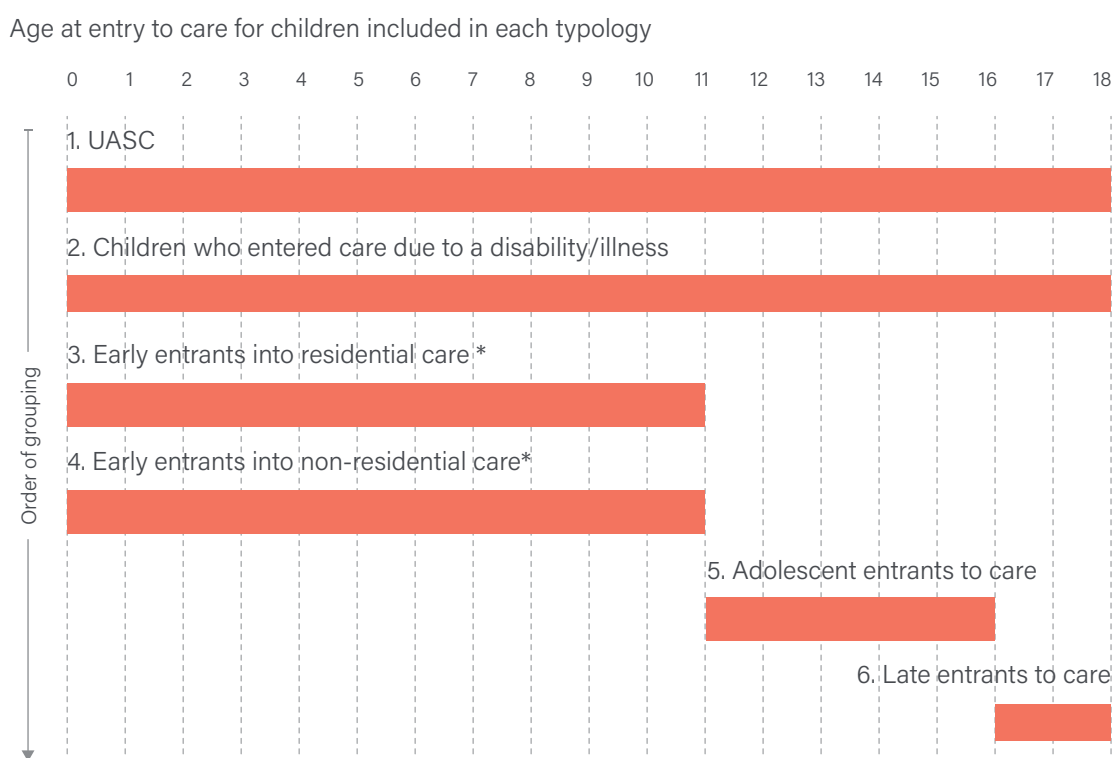
The cohort approach is useful because it enables us to track the entire care journeys of a sample of children and to analyse their outcomes at age 18, however it should be noted that results may differ for younger cohorts. The previous figure provides a visual illustration of the snapshot and cohort samples.

Typologies

As discussed in the background section, we created typologies of children within these samples which enabled us to explore the experiences of children with different characteristics separately. The typologies are mutually exclusive, encompassing every child in the residential care population and were created in the following order:

- Unaccompanied asylum-seeking children (UASC)

- Children whose main need for services arises because of their disability, illness or intrinsic condition[12]

Figure 2: Illustration of the typologies used in this report

* Early entrants into residential care enter residential care aged 0-10, while early entrants into non-residential care enter care aged 0-10 but only enter residential care aged 11 or older

12 Category of need code N2: Children and their families whose main need for services arises because of the child's disability, illness, or intrinsic condition. However, it should be noted that the guidance for recording categories of need states that when having difficulty choosing between multiple categories, the one that scores highest in the table should be selected (DfE, 2015a). Therefore, there may be children who enter care due to abuse/neglect and a disability/illness, hence given category of need N1 rather than N2, and thus do not fall within this typology. This means that this typology may not encompass all disabled children in care.

- Early entrants into residential care (age 10 and younger)

- Early entrants to non-residential care (enter care age 10 and younger, but do not enter residential care until age 11 or older)

- Adolescent entrants to care (aged 11-15)

- Late entrants to care (age 16 and above).

Overview of approach

Descriptive statistics

We created summary statistics regarding demographics of the children living in residential care, their journeys into and out of residential care care and average outcomes at age 18. These descriptive statistics were created to inform our understanding of how the characteristics, experiences and outcomes of the residential care sample compare to those of all CiC.

These statistics are presented in the form of averages, headcounts, percentages and visualisations. They do not illustrate any causal differences between groups, but rather aim to build a national picture of key themes related to residential care. The analysis of journeys into residential care is further supplemented by regression analysis, as outlined below.

Regressions

We ran multivariable analyses (regressions) to identify children's characteristics that are associated with the likelihood of experiencing a residential care placement for children who have already entered care. Inference between covariates and the outcome variable is derived from tests on each parameter measuring if there is a statistically significant difference between their estimated and predicted values, where the predicted value is 0 (null hypothesis that there is no association). Associations are reported on if they are statistically significant to at least the 5% level; this is interpreted as there being a 95% probability that there is a true difference in the likelihood of entering residential care between comparator groups. Two regressions were run to establish correlations between the characteristics of children in care and the likelihood of being placed in residential care. The two regressions used information:

- (a): Available up to the point at which a child enters care

- (b): Available at the end of a child's first placement.

More detail on the regression specifications can be found in the analysis plan[13] and in the technical report.

Statistical Disclosure Policies

To ensure that the outputs discussed in this report are safe (i.e. are non-disclosive and maintain the confidentiality of the data used), our figures went through Statistical Disclosure Control Checks from the Statistical Support Team. This means the following statistical disclosure policies have been applied:

- x indicates a cell is suppressed for values that are less than 10

- Percentages that are <0.5% have been suppressed with a "-"

- All headcounts have been rounded to the nearest 10

- All percentages have been rounded to whole numbers.

As a result of applying these policies, cells may not exactly sum to their totals and percentages may not total to 100%.

13   https://whatworks-csc.org.uk/wp-content/uploads/WWCSC_Residential_Care_Trial_Protocol_Jan2022.pdf

FINDINGS

Sample: who are the children currently living in residential care?

This section will describe the sample of children who were living in residential care in 2019/20 (using the Residential Care Snapshot sample). We focus on the snapshot sample of children living in residential care in 2019/20, rather than the cohort sample, in order to provide a current picture of the children experiencing residential care. Supplementary tables for this section are found in Appendix 1.

Typologies

As outlined in the introduction, we identified the different typologies within the sample in order to consider the experiences of residential care within each group separately. Figure 3 plots the percentage share of each typology to compare their representation within the sample of children who were living in residential care in 2019/20 and the sample of all CiC in 2019/20.

The figure shows that relative to the sample of CiC, children who enter care due to a disability and adolescent entrants to care are over-represented in the residential care sample. For children with a disability, residential care may provide the facilities and specialised care required. However, it should be reiterated that residential settings with elements of medical, nursing or personal care[14] and residential special schools are excluded from our definition of residential care, meaning the over-representation of children with a disability cannot be explained

by these types of placements. Previous research has also illustrated that disabled CiC are more likely to be in a residential placement, with a high number in children's homes (Pinney, 2017), which may be because many children's homes might specialise in supporting children with disabilities even if they do not provide medical care as such. Furthermore, there may be data quality issues whereby other residential settings or, dual-registered settings, are coded as a children's home (Pinney, 2017). For adolescent entrants to care, the Children's Commissioner (2021) found that children entering care between ages 13-15 were much more likely to be placed in a children's home or other secure residential setting compared to children who entered earlier, which may be because by the time they enter care, they often have quite complex needs.

On the other hand, UASC and late entries to care are under-represented in the residential care sample relative to their shares in the sample of all CiC. This under-representation is likely explained by the tendency for children within these groups to be placed in independent living arrangements, which is excluded from our definition of residential care. According to DfE statistics, there is a higher proportion of UASC and older children living independently compared to the national average. UASC tend to be older, with 85% aged 16 or above (DfE, 2019a) and on 31 March 2019, 43% of UASC were living independently and 36% in semi-independent accommodation. Furthermore, the majority of CiC living in such placements are aged 16

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14   Placement type codes R1 (Residential Care Home) and R2 (National Health Service (NHS)/health trust or other establishment providing medical or nursing care)

Figure 3: Percentage shares of each typology among children living in residential care in 2019/20 (n=10,046) and all CiC in 2019/20 (n=108,552)

Residential Care

1%   15%   16%   40%   2%   25%

UASC

Children who entered care due to disability/illness

Early entrants to RC (10 and under)

Adolescent entrants to care (11-15)

Late entrants to care (16+)

Early entrants to non-RC

All CiC

7% 3% 2%   17%   5%   66%

Note that the "early entrant to non-residential care" group is not directly comparable between residential care and all CiC, as early entrants to residential care are a group that exclusively exists if children enter residential care.
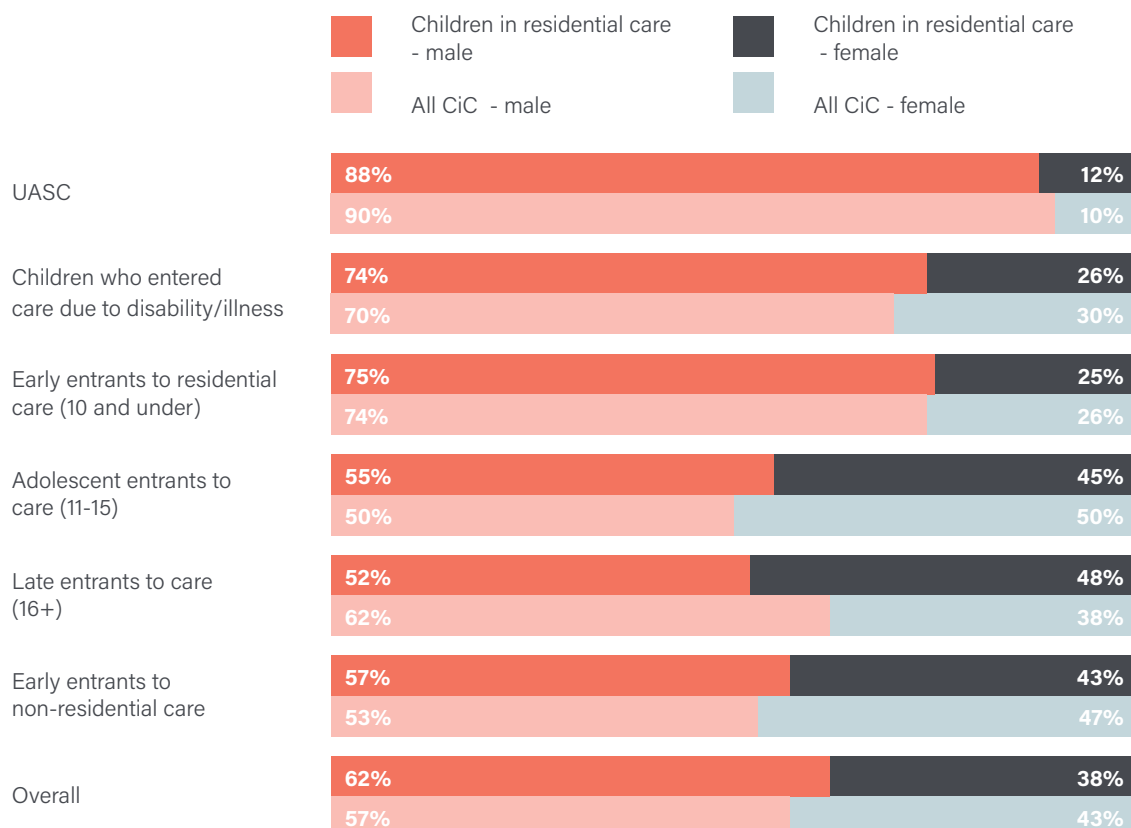
and over (99% living independently and 97% in semi-independent accommodation), with a high proportion of these children moving into these placements soon after entering care (DfE, 2020b).

Gender

The share of girls living in residential care in 2019/20 is slightly lower (38%) than their share among all CiC in 2019/20 (43%), illustrating that girls are under-represented in

Figure 4: Gender distribution within each typology among children living in residential care in 2019/20 (n=10,046) compared to all CiC in 2019/20 (n=108,552)

Children in residential care - male

All CiC - male

Children in residential care - female

All CiC - female

	male	female
UASC	88%	12%
UASC (All CiC)	90%	10%
Children who entered care due to disability/illness	74%	26%
Children who entered care due to disability/illness (All CiC)	70%	30%
Early entrants to residential care (10 and under)	75%	25%
Early entrants to residential care (10 and under) (All CiC)	74%	26%
Adolescent entrants to care (11-15)	55%	45%
Adolescent entrants to care (11-15) (All CiC)	50%	50%
Late entrants to care (16+)	52%	48%
Late entrants to care (16+) (All CiC)	62%	38%
Early entrants to non-residential care	57%	43%
Early entrants to non-residential care (All CiC)	53%	47%
Overall	62%	38%
Overall (All CiC)	57%	43%

19

residential care compared to the sample of all CiC, whereas boys are over-represented.

The patterns of over and under representation in residential care compared to the sample of all CiC by gender differed across the typologies. Girls who enter care due to a disability or illness, or enter care as adolescents, are particularly under-represented among children living in residential care, whereas girls who enter care late are over-represented. Figure 4 illustrates the percentage of girls and boys within each typology in the residential care sample compared to the all CiC sample.
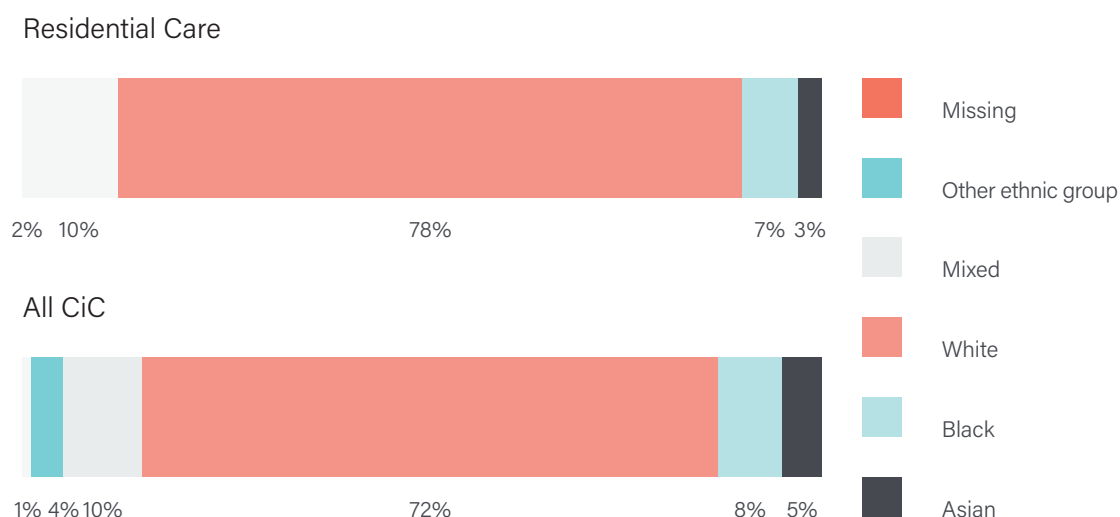
Ethnicity

Figure 5 shows the percentage share of each ethnic group within the sample of children who were living in residential care in 2019/20 compared to all CiC in 2019/20.[15] It shows that there are lower proportions of children who are Asian, Black or from an 'Other' ethnic group[16] living in residential care compared to the sample of all CiC. In contrast, children who are White are over-represented in residential care, and children who are of Mixed ethnicity are equally represented.[17]

There are a few hypotheses we can make with the data available as to why certain minority ethnic groups may be under-represented among children living in residential care compared to the sample of all CiC.

Firstly, a substantially higher proportion of children within these groups are UASC (31% Asian, 27% Black and 61% children from another ethnic group out of all CiC in 2019/20 are reported as being UASC, compared to 1% and <0.5% for children who are Mixed ethnicity or White, respectively). UASC are under-represented in residential

Figure 5: Ethnic distribution among children living in residential care in 2019/20 (n=10,046) and all CiC in 2019/20 (n=108,552)

Residential Care

2% 10%   78%   7% 3%

All CiC

1% 4% 10%   72%   8% 5%

Legend:
- Missing
- Other ethnic group
- Mixed
- White
- Black
- Asian

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15 See 2021 census groupings under https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups. This means that 'Black children' describes children of Black African and Black Caribbean heritage as well as 'any other Black background' (ONS, 2011). 'Asian children' describes children of Indian, Pakistani, Bangladeshi, Chinese or 'any other Asian background.'

16 'Other' as an ethnic group is determined by code 'OOTH' in the SSDA903 collection

17 'Mixed' as an ethnic group is determined by codes 'MWBC', 'MWBA', 'MWAS', 'MOTH' in the SSDA903 collection https://find-npd-data.education.gov.uk/en/data_elements/97d1c6c4-cb50-4708-bee4-a0ab0062f03f

care, as previously shown in Figure 1, hence the variation in proportion of children that are UASC within different ethnic groups could partially drive some patterns of under-representation.

Secondly, using the sample of all children who turned 18 in 2019/20 who were ever in care, we can determine how many children within each ethnic group were ever placed in different placement types over their whole care journey, hence where children from certain ethnic groups may be placed instead of residential care. This revealed that Black children are over-represented among those who have ever experienced a placement within a youth offenders institution or a placement grouped as 'other residential'[18] which was largely constituted by unregulated children's homes, with White children under-represented in these groups. The table breaking down the proportion of children who have ever experienced each type of placement by ethnicity is in Appendix 1.

The extent of over- and under- representation of ethnic groups in residential care compared to all CiC varies across the different typologies and is particularly pronounced among late entrants to care. Of the CiC in 2019/20, White children are particularly overrepresented in residential care among late entrants to care (accounting for 71% of children living in residential care compared to 56% of all CiC). Whereas, for example, Black late entrants to care were particularly under-represented in residential care (10% of children living in residential care compared to 17% of all CiC, respectively). The table containing these figures, broken down by ethnic group and typology, can be found in Appendix 1.

Further analysis revealed differences in general care experiences by ethnic group which could explain some of the findings. Among all CiC in 2019/20, White and Mixed ethnicity children had, on average, entered care earlier (6.3 and 5.9 years old, respectively) than Asian and Black children (10.6 and 10.3 years old, respectively). Using the sample of children who turned 18 in 2019/20 and were ever in care, we are able to determine the mean number of placement moves that children ever experienced over their whole care journey. This revealed that on average, White and Mixed ethnicity children experienced more placement moves (2.3 and 2.6 average moves, respectively) than Asian and Black children (1.2 and 1.4 average moves, respectively). These trends could underpin some patterns regarding the likelihood of experiencing, and route into, residential care for children belonging to different ethnic groups. The relevant tables can be found in Appendix 1.

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18   The 'other residential' category consists of unregulated children's homes, residential schools, and mother and baby units, with the majority (around 90%) of episodes consisting of placements in unregulated children's homes.

Intersectional analysis of ethnicity and gender

To further explore patterns of over and under representation of ethnic groups in residential care, we analysed the intersection between ethnicity and gender. Figure 6 depicts the percentage of boys and girls within each ethnic group who were living in residential care at some point in 2019/20 of all boys and girls from each ethnic group in care in this year.

The figure shows that proportionally, more Asian, Mixed ethnicity and White boys were living in residential care compared to all girls in care within the same ethnic group. Proportions of Black girls and boys living in residential care were equal, and for children belonging to an 'Other' ethnic group, the percentage of girls placed in residential care is larger than the percentage of boys,

showing that more girls in this group were living in residential care than boys.

Special Educational Needs (SEN)

SEN can affect a child or young person's ability to learn, for example by affecting their behaviour and ability to socialise, reading and writing, ability to understand concepts, concentration levels and physical ability (DfE, 2015b). Schools have a responsibility to make special education provision for children who have a learning disability or disability which significantly affects their ability to learn or use school facilities compared to the majority of children their age (DfE, 2015b). Children may have different primary SEN types recorded over different years of the schools' census if their most significant type of SEN is seen to change.

SEN were analysed in two ways. The first analysis looked at whether children had ever

Figure 6: The percentage of boys and girls from each ethnic group that were living in residential care in 2019/20 out of the number of boys and girls from the same ethnic group that were in care (in any form of care) in 2019/20
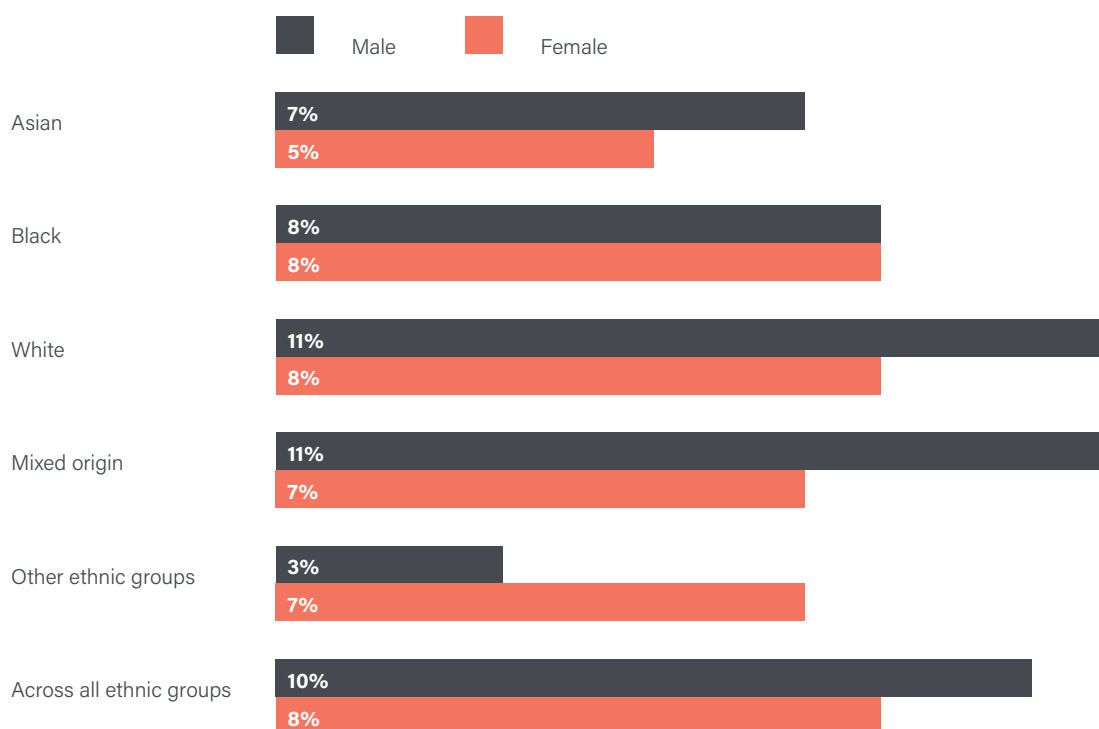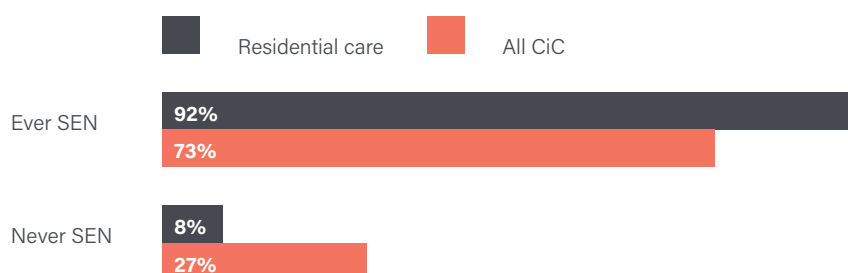
Figure 7: Children living in residential care in 2019/20 (Residential Care Snapshot, n=10,046) and all CiC in 2019/20 (All CiC Snapshot, n=108,552) by SEN status (ever)

■ Residential care　■ All CiC

Ever SEN
92%
73%

Never SEN
8%
27%

received provision for any type of SEN,[19] whereas the second analysis takes a deeper look at the type of SEN that children have received provision for. These analyses took a cumulative approach, such that information from all school census records per child is reflected. However, given that SEN statistics are reported through school data, we only have data for children who have been in school and whose records we could link to the CLA census. This meant that 2% of data was missing in the residential care sample and 27% was missing within the all CiC sample.[20] We provide figures based only on the children in each sample for whom we could match to educational data and less than 0.5% of data was missing after making this restriction.

Figure 7 above shows the percentages of children in the sample of children in residential care in 2019/20 and all CiC in 2019/20 that had ever been recorded as receiving provision for SEN out of all children in each sample that we had data for. It shows that based on this, 92% of children in the residential care sample have been recorded as receiving SEN provision at some point, compared to 73% in the all CiC sample. To

put these figures into context, Jay and Gilbert (2021) illustrated that 37% of children who were not in care or in need had SEN provision at some point, highlighting that rates of SEN are higher in the sample of all CiC, and strikingly high in the residential care sample.

All types of SEN other than Speech, Language and Communication Needs were more commonly reported among the residential care sample compared to that of all CiC. The most common type of SEN that children who were living in residential care placements in 2019/20 have received provision for is Social, Emotional and Mental Health Difficulties (SEMH). This was also the most common need for all CiC, in line with previous research illustrating that the largest category of SEN for both Children in Need and CiC is SEMH (Berridge et al., 2020). However, the rates were much higher in the residential care sample (57%) compared to among all CiC (39%). Therefore, it seems as though SEMH is a particularly prevalent need among CiC, particularly among those living in residential care.
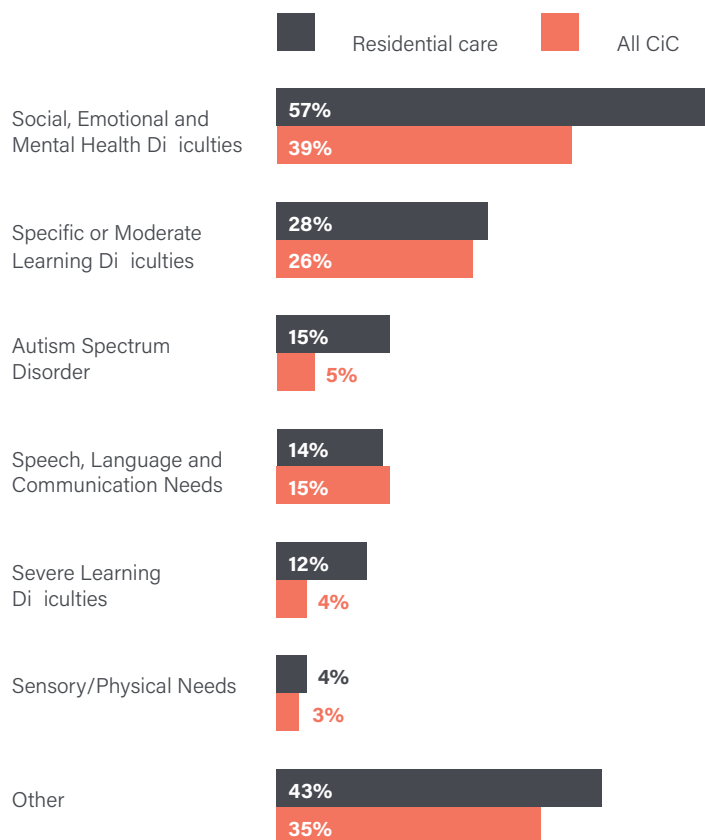
Figure 8 below shows the percentage of children in the residential care and all CiC

19　As defined by ever having a SEN statement or Educational, Health and Care plan, or receiving a school/ early years' action/action plus or SEN support (DfE, 2015b).

20　A table breaking down the percentage of children and resulting sample sizes across typologies is provided in Appendix 1.

Figure 8: Proportions of children who were living in residential care in 2019/20 (Residential Care Snapshot, n=10,046) and all CiC in 2019/20 (All CiC Snapshot, n=108,552) who have been recorded as receiving provision for each type of SEN

Legend: Residential care | All CiC

SEN type	Residential care	All CiC
Social, Emotional and Mental Health Difficulties	57%	39%
Specific or Moderate Learning Difficulties	28%	26%
Autism Spectrum Disorder	15%	5%
Speech, Language and Communication Needs	14%	15%
Severe Learning Difficulties	12%	4%
Sensory/Physical Needs	4%	3%
Other	43%	35%

samples who have ever been recorded as receiving provision for each type of SEN, out of all children for whom SEN data was not missing. A child's most significant need as recorded by the Schools' Spring Census commonly varies over time; we report every primary SEN type a child has ever been assessed for, therefore a child may be included in the percentages for multiple categories.

Across the typologies, there were particularly high rates of SEMH among early entrants to residential care and early entrants to non-residential care who went on to experience residential care later in their care journey, with around 70% of these children being reported to have this need. A table breaking down rates of ever receiving provision for any SEN and broken down by SEN types across typologies is in Appendix 1.

Journeys into residential care

To describe the journeys of children through residential care, we focus the descriptive statistics on the cohort of young people who turned 18 in 2019/20 who experienced residential care at some point in their care journey. This decision was made because it enables us to track the children's entire care history and thus journeys into, during and after residential care (whereas the snapshot sample includes all children of all ages living in residential care in 2019/20, and is limited to information up to and including that placement). Supplementary tables related to journeys into residential care are found in Appendix 2. Appendix 3 contains further information related to journeys upon entering residential care.

Descriptive statistics
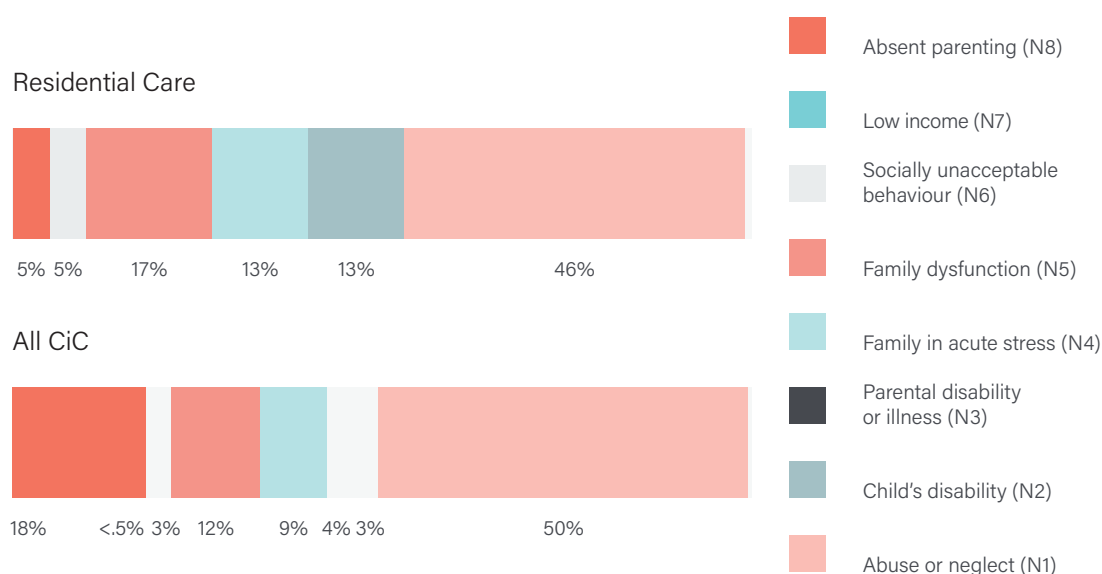
Reason for entering care

When a child enters care, a category of need is recorded to indicate the main reason why

they started to receive services. We present here on the categories of need that children were reported as having when they first ever entered care.

Overall, almost half of all children who have lived in residential care first entered care because of abuse or neglect (46%), followed by family dysfunction (17%). However, compared to the categories of need within the All CiC Cohort, child's disability, family in acute stress and family dysfunction are more common among children who were placed in residential care, whereas abuse or neglect, parental disability, and absent parenting were less common. Figure 9 below illustrates the percentages of children in both samples who were registered as having each category of need.

There were also notable differences in the categories of need reported between typologies in the Residential Care Cohort. Entering care because of abuse or neglect was particularly common among early entrants to residential care (69%) and early

Figure 9: Percentage of registered reason for entering care (category of need) for the cohort of children who turned 18 in 2019/20 and had ever experienced residential care (Residential Care Cohort, n=2,913) and the same cohort of children who had ever been in care (All CiC cohort, n=22,431)

Residential Care

5% 5% 17% 13% 13% 46%

All CiC

18% <.5% 3% 12% 9% 4% 3% 50%

Legend:
- Absent parenting (N8)
- Low income (N7)
- Socially unacceptable behaviour (N6)
- Family dysfunction (N5)
- Family in acute stress (N4)
- Parental disability or illness (N3)
- Child's disability (N2)
- Abuse or neglect (N1)

Note, where values were suppressed due to statistical disclosure, they have not been included in the figure.

entrants to non-residential care (64%) compared to the mean overall (46%). Whereas, family dysfunction and family in acute stress were more common categories of need among adolescent entrants to care (22% and 17%, respectively), compared to these means overall (17% and 13%, respectively). The full table broken down by typology can be found in Appendix 2.

However, it is important to note that the categories of need are designed to identify the kinds of pressures placed on social services rather than having diagnostic value for the children themselves (DfE, 2015a). There is considerable variation in how they are used across local authorities and they are subjective to the judgement of the individual reporting them. Furthermore, children are likely to have multiple, complex, needs for services and categorising each child into one category of need may be a simplistic reduction of their circumstances (Farmer et al., 2004; Hood et al., 2020; Ofsted, 2022). The guidance for practitioners from the DfE states that when having difficulty choosing between categories, the one that scores highest in the table should be selected (DfE, 2015a), which may lead to the chosen code being somewhat arbitrary.

Age at entry

On average, children who turned 18 in 2019/20 and ever experienced residential care first entered care at age 11.4, later than the sample of all CiC during 2019/20 (mean age of 9.7 years).

Furthermore, the children were on average 13.6 years old when they entered residential care for the first time, with an average duration of 2.2 years between entering care and being placed in residential care.

Number of placements and periods of care before entering residential care

In the Children Looked After Dataset, an episode of care describes a period of time in which a child is continuously in care, physically in the same placement with the same placement provider, and under the same legal status. The analysis differs in that it does not consider changes in legal status and reports a child's care experience through placements; periods of time in which a child is continuously in care, and physically in the same placement with the same placement provider. A placement move as referred to in this report therefore represents a change

Figure 10: Percentage of children who turned 18 in 2019/20 and ever experience residential care (Residential Care Cohort, n=2,913) by the number of placements they had before first entering residential care

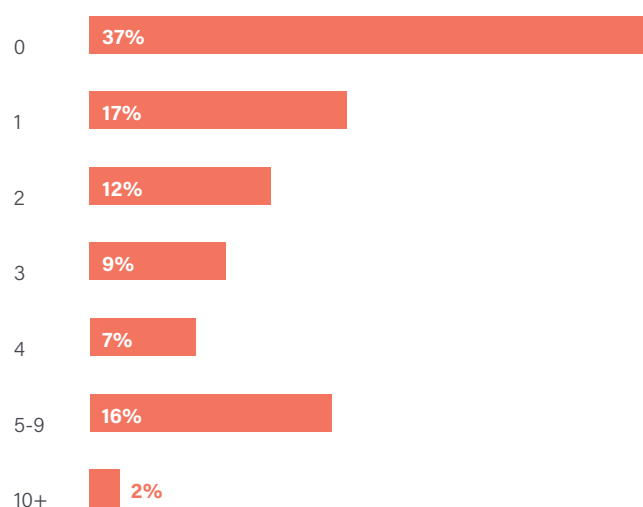| Number of placements	Percentage
0	37%
1	17%
2	12%
3	9%
4	7%
5-9	16%
10+	2%

Table 1: Summary of key information regarding the number of placements and periods of care experienced before the first residential care placement for the sample of children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort, n=2,913)

Typology	Mean length of time between entering care and residential care (in years)	Mean number of placements before entering residential care	Percentage of children who experienced 3 or more placements before residential care	Percentage of children who enter residential care within their first period of care
UASC	0.25	0.88	17% (20)	x
Children who entered care due to disability/illness	0.67	0.47	5% (20)	93% (340)
Early entrants to residential care (10 and under)	1.91	2.48	40% (80)	81% (160)
Adolescent entrants to care (11-15)	0.65	1.70	26% (380)	80% (1,190)
Late entrants to care (16+)	0.05	0.70	8% (10)	x
Early entrants to non-residential care	7.93	5.23	81% (490)	53% (320)
Overall	2.21	2.25	34% (1,000)	78% (2,260)

in a child's physical environment, through a different placement or placement provider.

A period of care is defined as a period during which a child is continuously looked after for a duration of 24 hours or more by a local authority and can consist of one or more placements. Periods of care can consist of multiple placements. Periods of care end when a child ceases to be looked after, for example due to returning to the care of their parents/guardian, starting to live independently or transferring to the care of adult services (DfE, 2019b). This means that for a child to have two periods of care, they must have entered care, left, and re-entered at a later stage.

Figure 10 above shows the percentage of children who turned 18 in 2019/20 and ever experienced residential care by the number of placements they had before first entering residential care. It shows that the majority of children who have lived in residential care experienced multiple placements before entering residential care.

Among the cohort of children who turned 18 in 2019/20 and had ever experienced residential care, 37% entered residential care as their first care placement. This was most common among children who entered due to disability/illness (80%), followed by UASC (68%) and late entrants (66%), and much less common among the other typologies.

The mean number of placements before entering residential care was 2.2 and there is a substantial proportion of children who experience many (7% with 4 and 16% with 5-9). This again illustrates how varied journeys into residential care can be. Furthermore, the mean number of placements beforehand increases when looking at children who have lived in residential care more recently, suggesting that more placement options are explored before placing children in residential care.[21]

Care histories prior to entering a residential care placement vary across typologies, with some groups of children experiencing more time and instability before their first residential care placement than others. Table 1 above summarises some key information about care histories before entering care across the typologies and overall:

Mean length of time spent between entering care and entering residential care

- Mean number of placements experienced

- Percentage of children who experienced more than 3 placements beforehand

- Percentage of children who entered residential care within their first period of care.

The table shows that overall, children spent an average of 2.2 years between entering care and entering residential care and experienced 2.2 placements within this time, with over a third (34%) having three or more placements. Furthermore, less than a quarter (22%) of children experienced their first residential care placement after re-entering care, i.e. in a second or subsequent period of care. However, these figures differed immensely across typologies, as outlined below.

Early entrants to non-residential care experience the most time between entering care and entering residential care (7.9 years), the most placement moves prior to entering residential care (5.2), the highest proportion of children who have three or more placements beforehand (81%) and almost half (47%) not entering residential care within their first period of care - i.e. leaving and re-entering care at least once before their first residential care placement. The longer and more unstable care journey into residential care is due (at least in part) to the definition of this group.[22] More tables outlining the care histories of children within each typology before entering residential care can be found in the Appendix 2.

Types of placements experienced before residential care

Overall, 63% of children who turned 18 in 2019/20 and ever experienced residential care had experienced a different type of placement before entering residential care (1,820 of 2,913 children in the sample).
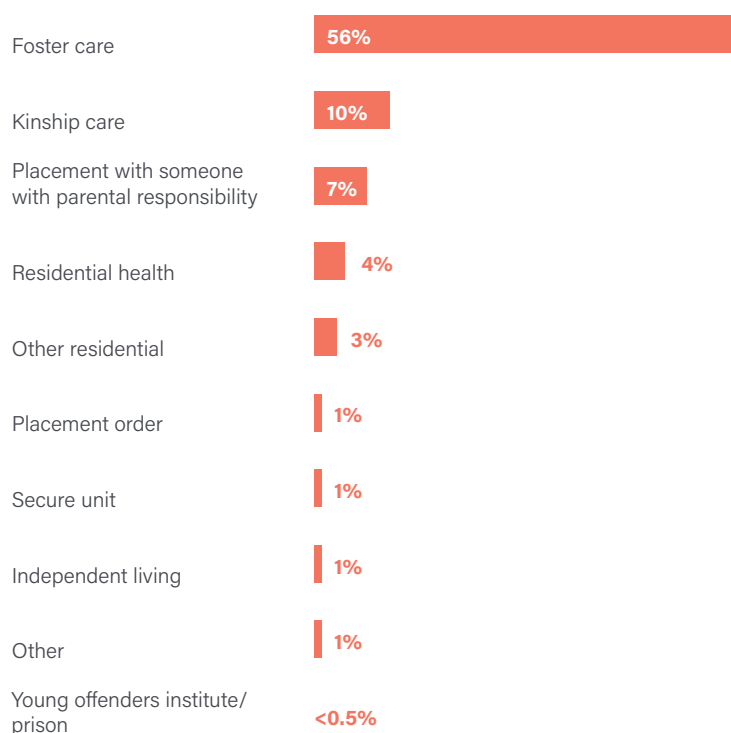
Figure 11 below shows the percentage of children in the residential care sample who experienced each placement type at some point before their first residential care placement. The most common placement type experienced before residential care was foster care, followed by kinship care (with 56% and 10% of all children who turned 18 in 2019/20 and ever experienced residential care having these placements at some point beforehand, respectively).

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21 For children who were living in residential care in 2019/20 (Residential Care Snapshot, n=10,046). For these children, only 19% had residential care as their first placement, with an average of 3.9 placements beforehand, and 27% having their first residential care placement after leaving and re-entering care at least once. This could suggest that in recent years it has become more common to exhaust all other options before placing a child into residential care.

22 This typology must enter a non-residential care placement age 10 or under, and enter residential care age 11 or older, meaning they must have experienced at least one placement breakdown before entering residential care.

Figure 11: The percentage of children who turned 18 in 2019/20 and ever experienced residential care (n=2,913) who had experienced each placement type at some point before their first residential care placement

Placement type	Percentage
Foster care	56%
Kinship care	10%
Placement with someone with parental responsibility	7%
Residential health	4%
Other residential	3%
Placement order	1%
Secure unit	1%
Independent living	1%
Other	1%
Young offenders institute/prison	<0.5%

Note that some placement types are not listed here due to the small number of children experiencing these types of placements. The placement types that are not listed are: Residential Employment, In Refuge, Temporary Accommodation and Whereabouts Unknown. Residential care is not listed as this is only showing types of placements before entering residential care.

Furthermore, when restricting to the children who had placements before entering residential care (n=1,820, 63% of the full sample), 89% of them had been placed in foster care and 16% in kinship care at some point beforehand. In fact, among the children who had placements before entering residential care, 77% were in foster care directly before entering residential care, followed by kinship care (6%). This is in line with research and policy indicating that these types of placements are the preferred choice (DfE, 2021a, Ofsted, 2022), and suggests that residential care is utilised as an option when such placements break down.

There were also large differences across typologies in terms of the types of placements children had experienced before their first residential care placement. Almost all (96%) of early entrants to non-residential care had been in foster care beforehand, whereas only 14% of children who entered due to disability/illness and 19% of late entrants to care had this experience. These figures highlight how varied the journey into residential care can be for different groups of children. Tables illustrating the breakdown of placement types experienced before residential care across typologies are in Appendix 2.

Regression analysis 1:
What predicts entry into residential care using information available up to the start of care entry?

We conducted binary logistic regression to identify factors associated with experiencing a residential care placement in a child's first period of care, using information which is available as they enter care for the first time. Regression was performed on the sample of children who turned 18 in 2019/20; the reported probability of having a residential care placement in the first period of care therefore applies to children who are already in care.

The outcome variable was a binary indicator for whether a child had a residential care placement in their first period of care, where 'residential care' was defined by children's homes subject to Children's Homes Regulations.[23] The main specification included the following covariates:

- Gender

- Major ethnicity group

- Age at entry to care

- Primary need for services upon entering care

- Indicator for UASC status

- IDACI in the most recent school census prior to care entry

- Primary SEN type in the most recent school census prior to care entry

- Indicator for if a child was ever eligible for free school meals prior to care entry

- Unauthorised absences at KS2

- Indicator for if a child was ever fixed term excluded at KS2

- Indicator for if a child was ever permanently excluded at KS2.

Table 2 shows regression results for this report's main specification: regression analysis run on the sample of children who turned 18 in 2019/20 who have ever been in care, and control variables including demographic characteristics, children's social care history and school-related factors known at a child's first entry to care.[24] The odds ratio, calculated by exponentiating the beta value, provides an interpretable insight: where the odds ratio is greater than one, the outcome variable is more likely to equal one if the covariate value increases; where the odds ratio is less than one, the outcome variable is less likely to less than one if the covariate value increases. Additional specifications can be found in the technical appendix, which use alternative samples and control variables.

Holding all other covariates constant, girls are significantly less likely than boys to be placed in residential care in their first period of care; our findings estimate that girls are 21% less likely to enter residential care, statistically significant at the 0.1% level.[25] This aligns with findings from the descriptive statistics.

Children from some minority ethnic groups are significantly less likely to enter residential care in their first period of care than White children. This aligns with the findings from the descriptive statistics. Holding other covariates constant, Asian children are an estimated 26% less likely than White children to enter residential care in their first period

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23 SSDA903 code K2, and its historic equivalents of H3 and H4.

24 Please see the technical appendix for details on how variable values were imputed when a child entered care for the first time before any particular variable could be measured.

25 Assuming gender has no impact on the likelihood of a child in care entering residential care, there is a <0.1% probability the observed effect size in Table 2 would have been found for our sample.

of care, and Black children are estimated 29% less likely than White children to enter residential care. Of children who turned 18 in 2019/20 and were ever in care, these results support that isolated from other correlating variables such as UASC status or age at first entry to care, children from some minority ethnic groups are significantly less likely to enter residential care. This does not include potential correlations between different residential settings, such as independent living, which are excluded from our definition of residential care. Children from Mixed or 'Other' ethnic groups are not significantly more or less likely to enter residential care in their first period of care than White children.

There is no robust linear association between the age at first entry to care and the likelihood of a child entering residential care in their first period of care. There is, however, a statistically significant positive association between a child's age at first care entry and likelihood of residential care when restricting the sample to children who entered care for the first time when they were in at least school Year 7 (see technical appendix for regression table). This could suggest a nonlinear relationship between age and care placement type, where services or young people's preferences influencing the likelihood of residential care are only material for older children and adolescents.

When a child enters care, their category of need is recorded to indicate the main reason why they started to receive services. Children's needs are complex and nuanced therefore this variable is limited in the insight it provides to explain why a child may enter

residential care; nonetheless, trends are reported. Children whose need arises due to their disability[26] are significantly more likely to enter a residential care home in their first period of care than a child whose primary need for services is abuse/neglect (the most commonly used placement code), holding all else constant. This reflects the specialist care that children who have disabilities may need in order to be fully supported by the social care system which some residential care homes may provide.[27] Primary SEN type provides greater insight to the needs of children who are more likely to enter residential care; children who have received provision for Autism Spectrum Disorder, moderate learning difficulties, severe learning difficulties, social, emotional or mental health difficulties, or speech, language & communication needs are all significantly more likely to enter residential care than children who have never been assessed as having SEN prior to entering care. Only children whose primary SEN is due to a sensory/physical need are similarly likely to enter a residential care home than a child who has never been identified as having SEN; this could be attributed to our definition of residential care which excludes residential health settings which provide medical care.

Children whose primary need for services arises from a parent's disability are estimated as 64% less likely to enter residential care in their first period of care than a child whose primary need arises from abuse or neglect, statistically significant at the 0.1% level. Children whose primary need is due to acute familial stress are however statistically more likely to enter residential care; acute

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26 Category of need code N2: Children and families whose main need for services arises because of their child's disability, illness or intrinsic condition

27 However, our definition of residential care excludes settings with elements of medica, nursing or personal care (placement type codes R1 (Residential Care Home) and R2 (National Health Service (NHS)/health trust or other establishment providing medical or nursing care). Therefore, this finding cannot be explained by children with a disability entering residential healthcare settings.

familial stress is typically characterised by 'temporary crisis' (DfE, 2021b), therefore this result could be attributed to a sudden emergency need for accommodation which may be most accessible through residential care.[28] Children whose primary need for services arises for any other reason are not significantly more likely to enter residential care than children whose primary need arises from abuse or neglect.

UASC status is not shown to be a significant predictor of entry to residential care in Table 2. Specifications included in Appendix 2 which exclude school-related variables show that UASC are significantly less likely to enter residential care in their first period of care. Availability of school data for UASC is very poor (79% missing), therefore introducing these variables into the regression specification may reduce the precision of estimated results, and could mean specifications excluding school-related variables are more informative. A significant negative association could be attributed to UASC entering other residential settings such as independent or semi-independent living where there is a greater proportion of UASC (DfE, 2020b), because UASC typically enter care when they are older (averaging 15.4 years old at first care entry for UASC in care in 2019/20).

Children who have ever been recorded in the schools' Spring Census as eligible for free school meals prior to entering care for the first time are less likely to enter a residential care placement in their first period of care than children who have never been recorded as eligible for free school meals, statistically significant at the 5% level. The level of within-

LA and between-LA deprivation is positively associated with the incidence of CiC (Bywaters, 2016), however this correlation implies an inverse likelihood among the population of CiC who enter residential care. Similarly, children who live in a less deprived local area, as measured by their most recent IDACI[29] prior to entering care, are also significantly more likely to enter residential care in their first period of care when restricting the sample to children who entered care for the first time in at least Reception class. This implies that children suffering from less income deprivation are more likely to enter residential care in their first period of care. Children from more affluent families reportedly experience higher thresholds for intervention by social services (Bernard, 2018), therefore this finding could be attributed to more affluent children who do enter care having more specialist needs, and therefore enter residential care.

Children who ever had a fixed term exclusion in KS2 are statistically more likely to enter residential care in their first period of care, significant at the 0.01% level; this indicates that children who have school disruption at a young age are more likely to enter residential care later in their childhood.

The rate of unauthorised absences at KS2 and permanent exclusions at KS2 do not seem to be significantly associated with the likelihood of children entering residential care.

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28 Alternative specifications shown in the technical appendix also show children whose primary need for services is due to socially unacceptable behaviour are statistically more likely to enter residential care in their first period of care.

29 IDACI measures the prevalence of income deprivation in a child's local area by calculating the percentage of families who are low-income within a super-output area (Gorard, 2012); a higher IDACI indicates a local area is more deprived.

Table 2: Logistic regression predicting the likelihood of entering residential care in a child's first period of care out of all children from the birth cohort who have ever entered care

Covariate	**Outcome variable:** entry to a residential home subject to Children's Homes Regulations in the first period of care		
	Beta	**Standard Error**	**Odds Ratio**
Female (v. male)	-0.241**	0.057	0.786
Ethnicity (v. White)			
Asian	-0.300**	0.108	0.741
Black	-0.346***	0.102	0.708
Mixed	0.083	0.092	1.087
Other ethnic origin	-0.277	0.146	0.758
Age at entry to care	-0.046	0.054	0.955
Primary need for services (v. abuse/neglect)			
Child's disability or illness	1.57***	0.126	4.807
Parent's disability or illness	-1.031***	0.237	0.357
Acute stress	0.198*	0.084	1.219
Family dysfunction	0.063	0.076	1.065
Socially unacceptable behaviour	0.242	0.133	1.274
Low income	-1.124	0.811	0.325
Absent parenting	-0.235	0.138	0.791
Child is UASC (v. not UASC)	-0.323	0.165	0.724
IDACI	-0.068	0.039	0.934
Primary SEN type (v. no SEN)			
Autism Spectrum Disorder	1.207***	0.143	3.343
Moderate learning difficulties	0.289**	0.100	1.335
Severe learning difficulties	1.863***	0.172	6.443
No specialist action	0.312**	0.108	1.366
Other	0.625**	0.231	1.868
Physical	0.439	0.260	1.551
Social, emotional or mental health	0.813***	0.079	2.255
Social, learning, or communications needs	0.543***	0.157	1.721
Rate of unauthorised absences at KS2	-0.765	0.847	0.465
Ever eligible for free school meals prior to care entry (v. never eligible)	-0.192**	0.072	0.825
Ever experienced a permanent exclusion at KS2 (v. never experienced a permanent exclusion)	0.460	0.277	1.584
Ever experienced a fixed term exclusion at KS2 (v. never experienced a fixed term exclusion)	0.763***	0.083	2.145

Stars indicate significance level: *p<0.05, **p<0.01, ***p<0.001. Sample size: 22,431.

Regression analysis 2: What predicts entry into residential care (information from first placement)?

We conducted binary logistic regression analysis to identify what information available as a child leaves their first ever care placement could predict having a residential care placement during their first period of care. Regression was run on the sample of children who turned 18 in 2019/20 who had at least one placement move in their first period of care and whose first placement was not in residential care. Prior to regression, coarsened exact matching was applied to create statistically equivalent groups by adjusting the sample on the following variables:

- Primary SEN type

- Major ethnic group

- Category of need upon care entry

- Age at entry to care

- UASC status

- IDACI at most recent school census

- Ever eligible for free school meals up to the most recent census prior to entering care

- Fixed exclusions at KS2.

The following variables were controlled for in regression:

- Gender

- Length of first placement episode[30] (in days)

- Type of first placement (e.g. in a residential care home, foster placement)

- Whether the first placement was in or outside of the local authority (0=inside LA boundary, 1=outside LA boundary)

- Reason for placement change.

Only information about why there was a change in placement was significantly associated with the likelihood of the child moving into residential care at some point during their first period of care; children whose first placement ends because their carer(s) requests it are significantly more likely to have a later placement in residential care. The result is significant both when the carer requests a change in placement due to the child's behaviour or due to other reasons. All other information available at the end of a child's first placement is not significantly associated with the likelihood of a child entering residential care.

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30 An episode of care forms part of a period of care that consists of one or more episodes of care. A new episode of care is started when a child becomes looked-after, when there is a change of legal status, when there is a change of placement, or when the placement provider changes, although we will not count changes solely due to a change in legal status as a change of placement. More information can be found under: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974676/Children_looked-after_by_local_authorities_in_England_2020_to_2021.pdf

Table 3: Logistic regression predicting the likelihood of entering residential care within a child's first period of care, when their first placement was not in residential care

Covariate	**Outcome variable:** entry to a residential home subject to Children's Homes Regulations in the first period of care, in a second or subsequent care placement		
	Beta	**Standard Error**	**Odds Ratio**
Female (v. male)	-0.263	0.151	0.768
First placement type (v. non-kin foster care)			
Independent living	0.428	0.479	1.534
Kinship foster care	-0.088	0.281	0.916
Residential healthcare	0.657	0.461	1.929
Other residential	0.484	0.376	1.623
Placed with someone who has parental responsibility	0.514	0.266	1.672
Secure unit	0.745	0.657	2.106
Young offenders' institute or prison	0.503	1.126	1.654
Other	-1.458*	0.712	0.233
First placement outside the LA boundary (v. inside)	0.054	0.129	1.055
Reason the child moved from the first placement			
Carer requested change because of child's behaviour	0.908***	0.186	2.479
Carer requested change because of reason other than child's behaviour	0.803**	0.305	2.232
Child requested placement change	-0.306	0.439	0.736
LA requested change	1.322	0.707	3.751
Length of first placement in days	0.000	0.000	1.000

Stars indicate significance level: *p<0.05, **p<0.01, ***p<0.001. Sample size: 8,343.

Journeys after entering residential care[31]

Duration of placements

Of the sample of children who turned 18 in 2019/20, those who were ever placed into residential care spent an average of 388 days in their first residential care placement.

The mean length of all residential care placements experienced by these children was 322 days, compared to 220 for non-residential care placements. This illustrates that for children who have experienced residential care, their residential care placements are on average longer than their other types of placements. This could reflect the multiple breakdowns of alternative placement types often experienced prior to entering residential care, resulting in the mean length of non-residential care placements being shorter.

Across all typologies other than UASC, the residential care placements were longer than non-residential care placements, however the extent of this difference varied.[32] For early-entrants to residential care and early entrants to non-residential care (who both enter care below 10, but the former experience residential care before turning 11 and the latter did not until later in their care journeys), the mean length of non-residential care placements was similar (291 and 304 days respectively). However, the mean length of residential care placements was much longer for early entrants to residential care (476 days) compared to for early entrants to non-residential care (353 days). This indicates that for children who enter the care system early, those who are placed in residential care earlier experience longer, more stable, residential care placements compared to those who end up in residential care later on, often after multiple placement breakdowns, as outlined earlier.

Overall time spent in care

Among children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort, n=2,913), the median length of time spent in care, encompassing all residential and non-residential placements, is 3.6 years. This means that half of children in the residential care sample spend longer than 3.6 years in care. This is considerably higher than the median for all CiC from the birth cohort (1.6 years), despite the earlier finding that children who experience residential care, on average, enter care later. See Appendix 3 for a breakdown across typologies.

Overall number of placement moves

Within the overall time spent in care, children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort, n=2,913) experienced 5.7 placement moves on average, compared to 2.0 moves for the same birth cohort for all CiC (All CiC Cohort, n=22,431). This finding suggests that children who experience residential care experience much more placement instability during their care journey compared to the all CiC population. The number of placement moves is higher in the residential care sample compared to the all CiC sample across all typologies, with some larger differences than others.

For children who entered due to disability/illness, the mean total number of placement moves was only slightly higher for the residential care sample (2.7) than in the all CiC sample (2.1). In contrast, for early entrants to non-residential care, the mean total number of placement moves was much higher in the sample of children who went on to experience residential care (9.3) compared to those that did not (2.3). This finding suggests that the experience of entering care

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31   Supplementary tables for this section are found in Appendix 3.

32   A table illustrating summary statistics for the length of residential and non-residential placements across typologies is in Appendix 3.

early and going on to experience residential care some time after leads to a particularly unstable care journey.

Number of placements and periods of care after residential care

For approximately one in five (20%, n=590) children within the cohort who turned 18 in 2019/20 and ever experienced residential care, the first residential care placement is their last placement in care. The largest share of these cases (37%, n=220) are a result of ageing out of care, as opposed to other reasons such as returning home without going on to re-enter care later. In fact, from the whole residential care sample, 12% (n=360 of 2,913 children) returned home to live with someone with parental responsibility after their first residential care placement, but only half of these children do not re-enter care. This suggests that 50% of the reunifications that occur immediately after a child's first residential care placement are successful.

Most children tend to experience additional placements after their first residential care placement. On average, children in the cohort experience 3.4 additional placements after their first residential care placement. Figure 12 below shows the percentage of children who turned 18 in 2019/20 and ever experienced residential care by the number of placements they had after first entering

residential care. It shows quite a large distribution, for example, 20% of children have no further placements and 19% have five to nine additional placements after their first residential care placement.

Early entrants to non-residential care, early entrants to residential care and adolescent entrants to care experience the highest rates of placement instability after their residential care placements - 58% of early entrants to non-residential care, 52% of early entrants to residential care and 52% of adolescent entrants experience three or more placements after residential care. On average, early entrants to residential care experience almost five additional placements after their residential care placement (4.8 average placements per child), while adolescent entrants and early entrants to non-residential care experience approximately four additional placements (3.6 and 4.1 placements, respectively).

Around 14% of children leave care at some point after the first residential care placement and come back into care at a later point. Adolescent entrants to care in particular tend to leave and return to care more frequently, with 19% leaving and returning to care at some point after their first residential care placement.

Table 4 outlines some key information about the number of placements and periods experienced after entering residential care.

Figure 12: Percentage of children who turned 18 in 2019/20 and ever experienced residential care (n=2,913) by the number of placements they had after first entering residential care
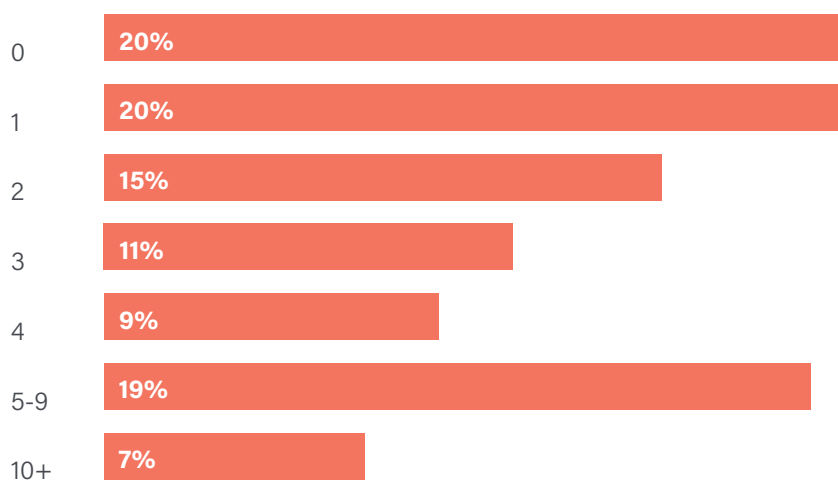
Table 4: Summary of key information regarding the number of placements and periods of care experienced after the first residential care placement for the sample of children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort, n=2,913)

Typology	Mean number of placements after the first residential care placement	Number of children who had 3 or more placements after their first residential care placement	Share of children who left and re-entered care at some point after their first residential care placement
UASC	2.02	28% (30)	x
Children who entered care due to disability/illness	2.27	13% (50)	11% (40)
Early entrants to residential care (10 and under)	4.76	52% (100)	15% (30)
Adolescent entrants to care (11-15)	3.63	52% (770)	19% (280)
Late entrants to care (16+)	1.07	12% (20)	x
Early entrants to non-residential care	4.09	58% (350)	6% (40)
All children in the residential care sample	3.44	45% (1,320)	14% (400)

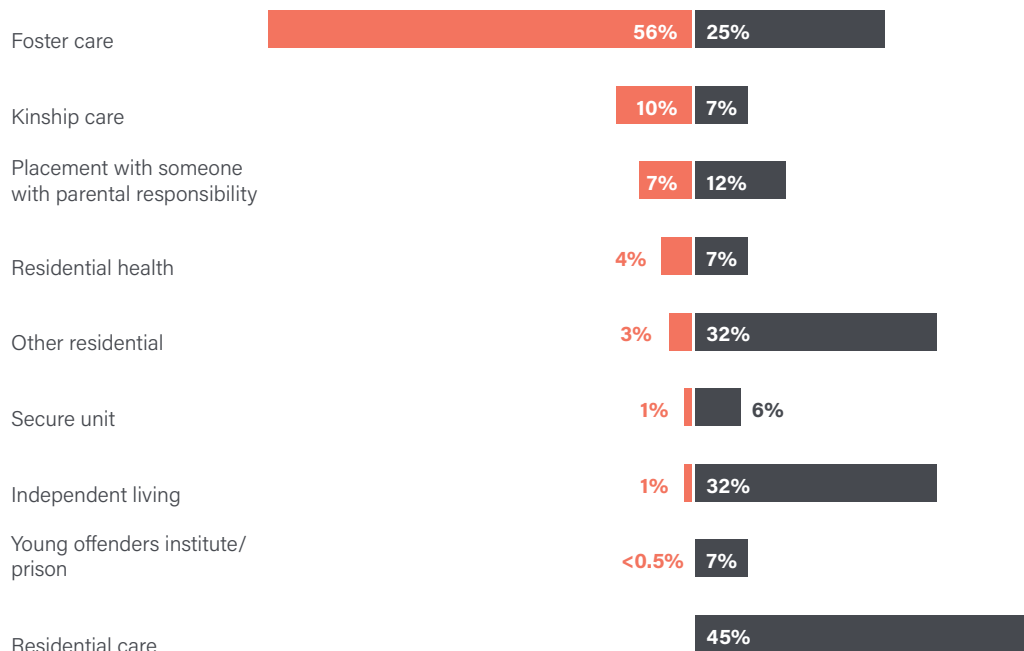### Types of placements experienced after residential care

Since it is common for children to have multiple placements after the first residential care placement, with 80% (2,320 of 2,913) of children having at least one other, it is important to establish which kind of placements were experienced afterwards.

Foster and kinship care placement options seem to be explored more before children are placed in residential care. Placement instability once placed into residential care is common, with children often going on to experience multiple residential care placements, independent living, or a form of 'other' residential[33] (largely constituted by unregulated children's homes).

33 The 'other residential' category consists of unregulated children's homes, residential schools, and mother and baby units, with the large majority of episodes (around 90%) being placements in unregulated children's homes.

Figure 13: The percentage of children who experienced each type of placement before and after entering residential care for the first time, out of all children who ever experienced residential care before turning 18 in 2019/20 (n=2,913)

Placement type		
Foster care	56%	25%
Kinship care	10%	7%
Placement with someone with parental responsibility	7%	12%
Residential health	4%	7%
Other residential	3%	32%
Secure unit	1%	6%
Independent living	1%	32%
Young offenders institute/ prison	<0.5%	7%
Residential care		45%

Note that some placement types are not listed here due to the small number of children experiencing these types of placements. The placement types that are not listed are: Residential Employment, In Refuge, Temporary Accommodation, Whereabouts Unknown, Placed for adoption and Other.

Some of these patterns could be explained by age dynamics. Children are older after their first residential care placement, and independent living arrangements and unregulated children's homes tend to be used for older children (DfE, 2020b). It also speaks to the notion of residential care as a 'last resort' used after foster care and kinship care placements break down, and it appears that once children are placed in residential care, they are moved around different residential placements or unsupervised accommodation, such as unregulated children's homes or independent living.
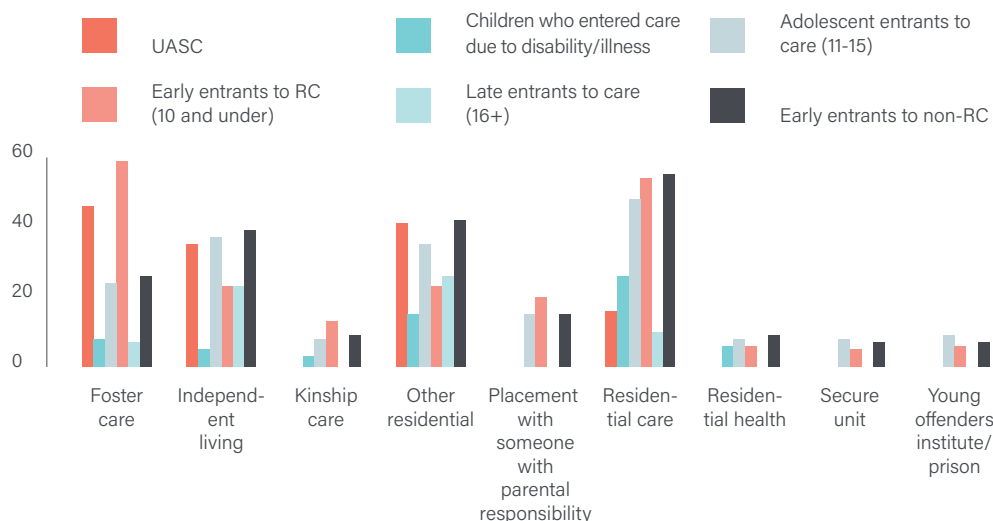
Figure 13 illustrates the percentage of children who turned 18 in 2019/20 and ever experienced residential care who experienced different placement types before and after their first residential care placement.

Almost half of all children (45%) go on to experience at least one more residential care placement at some point after their first residential care placement. The next most common placement type to ever experience at some point after residential care is a placement classified as 'other residential'[34] (32%) and independent living (32%), followed by foster care (25%). In fact, when restricting only to children who had a further episode

34   The 'other residential' category consists of unregulated children's homes, residential schools, and mother and baby units, with the majority of observations (around 90%) consisting of placements in unregulated children's homes.

Figure 14: Percentage of children within each typology in the sample of children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort, n=2,913) who experienced the different placement types at some point after their first residential care placement

Note that some placement types are not listed here due to the small number of children experiencing these types of placements. Among the typologies, where numbers were suppressed in the table (Appendix 3) due to statistical disclosure policies, they have not been included in the figure.

of care (n=2,320, 80% of the full sample) and looking at the next placement type that follows the first residential care placement, we find that 40% (n=930) went into another residential care placement immediately following their first residential care placement. A significant share of children (22%, n=520) transitioned from their first residential placement to a foster care placement.

The proportion of children that experienced different placement types at some point after residential care varied across the typologies, as shown in Figure 14.

Experiencing a further residential care placement was most common among early entrants to residential care (54%), early entrants to non-residential care (55%), and adolescent entrants to care (48%). Over 40%

of UASC and early entrants to non-residential care also experienced 'other residential'[35] care placements', which includes primarily unregulated children's homes.

Rates of being placed in foster care at some point after the first residential care placement were higher for early entrants to residential care (59%) and UASC (46%). For early entrants to residential care, rates of kinship care and placement with someone with parental responsibility were also higher than the mean. This trend could suggest that for younger children, there is more commitment to try a return to a family-like setting after residential care.

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35 The 'other residential' category consists of unregulated children's homes, residential schools, and mother and baby units, with the majority of observations (around 90%) consisting of placements in unregulated children's homes.

Outcomes for children who have lived in residential care

This section will describe the average outcomes at age 18 for children that have experienced residential care at some point. The analysis is descriptive and does not suggest that these outcomes are a result of having experienced residential care, nor do they imply causality in any way.

For the purpose of this section, we are limited to only using the cohort samples. This is because, unlike for the snapshot, the birth cohort turned 18 between April 2019 and March 2020 and thus there is data available to analyse relevant outcomes at this age. Moreover, since children within the birth cohort are the same age, comparison of outcomes is more appropriate than for a sample of children who are of different ages (which is the case in the snapshot sample). Supplementary tables for this section are found in Appendix 4.

Suitability of accommodation at age 18

Data about the suitability of accommodation is collected for children once they leave care and reflects their accommodation after leaving care. However, the value of this information is limited by missing data; for those who turned 18 in 2019/20 and ever experienced residential care, data is missing for 19% of the sample, and for the same cohort of all CiC, 52% is missing. The missing data is due to the restrictions on the children for whom this information is collected for. Suitability of accommodation is collected only for children who left care and who were previously looked after for at least 13 weeks after their 14th birthday, including some time after their 16th birthday.[36] We therefore restrict analysis of suitability of accommodation at

age 18 to children who qualify as a care leaver under the DfE definition, and among these children, less than 1% of data is missing.

Furthermore, the variable used to measure this outcome ('Accommodation' in the SSDA903 data) groups the suitability of accommodation into a binary category of 'suitable' or 'unsuitable.' Therefore, there will be complexity associated with each individual case that becomes lost, and the decision is down to the subjective judgement of the individual reporting the case. Accommodation is to be regarded as suitable if it provides safe, secure and affordable provision for young people (DfE, 2019b). Accommodation that clearly exposes the person to risk of harm or social exclusion by reason of its location or other factors should be coded as 'unsuitable.' (DfE, 2019b). This definition highlights the subjectivity and lack of nuance involved in the binary judgement of 'suitability.' Indeed, where the individual reporting the case might consider that accommodation which is safe, secure and affordable to be suitable for these young people, it is probably not the only things we wish for their homes to be.

As Table 5 shows below, of the children who turned 18 in 2019/20, ever experienced residential care and qualify as care leavers under the DfE's definition (n=2,360, 81% of the full sample), the large majority (92%) lived in accommodation that was deemed 'suitable' at age 18. This figure is marginally worse than the corresponding sample of all CiC (94%).

Within the residential care sample, suitability was highest among UASC (99%) and lowest among adolescent entrants to care (90%) and late entrants (91%). The rate of living in suitable accommodation at age 18 by each typology within the residential care sample and all CiC samples is in Appendix 4.

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36   A table breaking down the percentage of children who were classed as a care leaver and the resulting sample size per typology can be found in Appendix 4.

Table 5: The number and percentage of children who are care leavers among the sample of children who turned 18 in 2019/20 and had ever been in residential care and the corresponding birth cohort sample of all CiC whose accommodation at age 18 was deemed to be suitable, unsuitable or where this data was missing

Suitability of accommodation	Residential Care Cohort	All CiC Cohort
Unknown due to missing data	- (10)	- (70)
Suitable	92% (2,170)	94% (10,140)
Unsuitable	8% (180)	5% (540)

Due to the restrictions on the children classed as 'care leavers' by the DfE, the rates of the suitability of accommodation within the Residential Care Cohort were based on 2,360 children (81% of the 2,913 children in the full sample). The All CiC Cohort rates were based on 10,750 children (48% of the 22,431 in the full sample).

NEET status at age 18

The 'Activity' variable in the SSDA903 dataset provides information regarding whether an individual is not in education, employment or training (NEET) or in education, employment or training (EET) at age 18. Similar to the suitability of accommodation, the analysis of young people's NEET status at age 18 is also limited by missing data because the same restrictions in who this data is collected for apply. This means that 19% of data is missing for the residential care sample and 52% is missing in the all CiC sample. When considering only children that fall under the DfE's definition of a care leaver and thus occur in the care leaver dataset, the amount of missing data is very low at less than 1%.

Table 6: The number and percentage of children who are classified as a 'care leaver' among the sample of children who turned 18 in 2019/20 and had ever been in residential care and the corresponding birth cohort sample of all CiC by their NEET status at age 18

NEET status	Residential Care Cohort	All CiC Cohort
Unknown due to missing data	- (20)	- (90)
EET	48% (1,130)	67% (7,230)
NEET	51% (1,210)	32% (3,430)
Of which are NEET due to:		
NEET due to disability/illness[37]	15% (180)	11% (390)
NEET due to pregnancy/parenting[38]	8% (100)	9% (310)
NEET due to other circumstances[39]	77% (930)	80% (2,740)

Due to the restrictions on the children classed as 'care leavers by the DfE, the Residential Care Cohort NEET rates were based on 2,360 children (81% of the 2,913 children in the full sample). The All CiC Cohort rates were based on 10,750 children (48% of the 22,431 in the full sample).

37 CLA Activity code G4: Young person not in education, employment or training because of illness or

38 CLA Activity code G6: Young person parenting not in education, employment or training due to pregnancy or parenting

39 CLA Activity code G5: Young person not in education, employment or training: other circumstances

Of the children who turned 18 in 2019/20, ever experienced residential care and qualify as care leavers under the DfE's definition (n=2,360, 81% of the full sample), 51% are NEET at age 18. This is a strikingly high rate and is much higher than the NEET rate among all children who have been in any type of care from this birth cohort (32%). Table 6 outlines this information.

Of the children who were reported as being NEET at 18 in the residential care sample, 8% of cases were reported as being due to pregnancy/parenting, and 15% due to disability/illness. The majority (77%) are coded as NEET owing to other circumstances.

Across the typologies within the residential care sample for the children we have data for, the NEET rate is highest among adolescent entrants to care (58%), followed by late entrants to care (54%) and early entrants to non-residential care (54%). The table breaking down NEET rates by typology can be found in Appendix 4.

Going missing[40]

The way that LAs record missing episodes changed from 2015 onwards to require that when children were missing from placement without authorisation for any length of time this must be recorded, whereas previously information had been collected for those who were missing for at least 24 hours. Therefore, this section is limited to cases where children went missing for any length of time from 2015 onwards, meaning since our cohort was aged around 14 and above and restricted to children who were still in care. This means that children who left care

by 2015 will have been counted as no missing episodes since 2015, limiting the informational value of this statistic. Furthermore, missing episodes reported here are not necessarily cases of going missing from a residential care placement, rather instances where children who have ever experienced residential care have gone missing from any type of placement since 2015.

61% of children who turned 18 in 2019/20 and ever experienced residential care went missing at some point (from any placement type) after 2015, compared to 23% for the same cohort of all CiC. Within the residential care sample, the rate was highest among adolescent entrants to care (75%) and early entrants to non-residential care (70%). Of the children who had ever gone missing, the mean number of missing episodes was 27 in the residential care sample and 15 in the all CiC sample, indicating that it is common for children to repeatedly go missing from their placement, especially for children who experience residential care.

The official statistics caution that they believe missing episodes are over reported by about 13% (DfE, 2021a). DfE outlines that missing incidents were reported for 1 in 10 CiC in the year ending 31 March 2021, which is much lower than the rates at which children living in residential care have been recorded as missing since 2015, even when taking into account the different time frames. It was also reported that two thirds of missing incidents in the year ending 31 March 2021 from 'secure units, children's homes and semi-independent living arrangements'. These settings are all grouped as residential care by DfE meaning that missing episodes from children's homes specifically cannot be identified. Furthermore,

40 Our definition of going missing includes children who, at some point, have been coded as : 'Missing from care: a looked after child who is not at their placement or the place they are expected to be (for example school) and their whereabouts is not known'. It excludes cases only coded as: 'Away from placement without authorisation : a looked after child whose whereabouts is known but who is not at their placement or place they are expected to be and the carer has concerns or the incident has been notified to the local authority or the police'.

the missing episodes in our results are not necessarily from residential care placements, just relating to children that have experienced residential care at some point.

Notwithstanding these caveats, official statistics generally support our finding that missing episodes are more common for the residential care sample compared to that of all CiC.
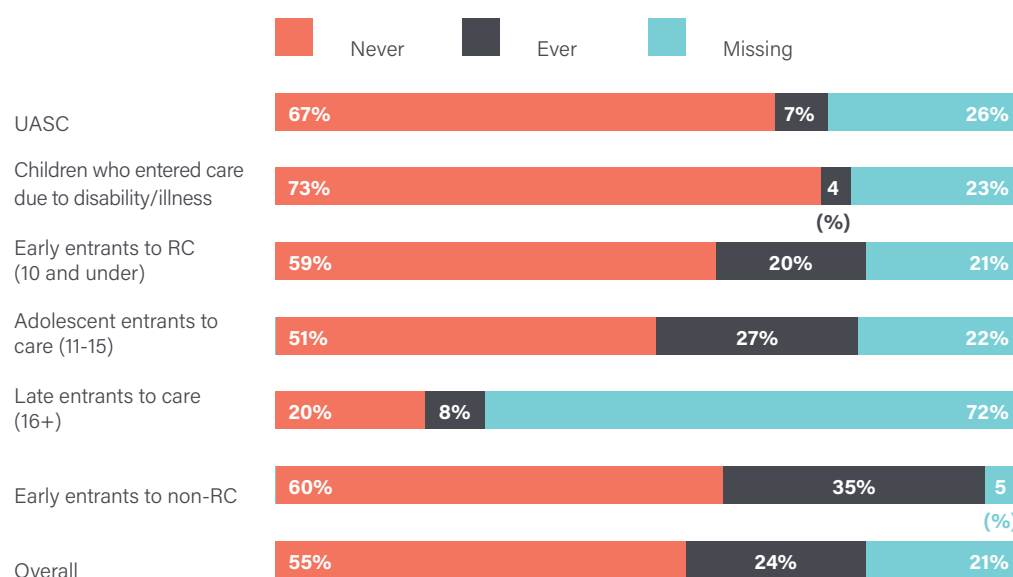
Convictions

Data on whether a child was convicted or subject to a youth caution are reported only for young people in our sample who were convicted during their time in care and specifically during a period of being looked after for at least a year.[41] For our analyses, the annual conviction indicator was aggregated across years to make an indicator determining whether each child had ever been convicted while in care. Therefore, the conviction did not necessarily occur during a child's time living in residential care.

At least 24% of the children who turned 18 in 2019/20 and who experienced residential care have been convicted at some point during their care journey. This potentially underestimates the conviction rate given the limitations of the data discussed above and that we are missing information for 21% of our cohort. The large share of missing data also limits comparison to the cohort of all CiC. Due to the high rate of missing data (63% for the All CiC cohort) we refrain from discussing any direct comparisons between these two cohorts.

The percentage of children who have ever been convicted varied across typologies among the residential care sample, as shown below in Figure 15. Early entrants to non-residential care had the highest rates of conviction (35% ever convicted), followed by adolescent entrants to care (27% ever convicted). Although differences in the share of missing data limits comparisons between

Figure 15: The percentages of children who have never been convicted, ever been convicted and missing data in the sample of children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort, n=2,913) broken down by typology and provided overall

Legend: Never | Ever | Missing

Typology	Never	Ever	Missing
UASC	67%	7%	26%
Children who entered care due to disability/illness	73%	4 (%)	23%
Early entrants to RC (10 and under)	59%	20%	21%
Adolescent entrants to care (11-15)	51%	27%	22%
Late entrants to care (16+)	20%	8%	72%
Early entrants to non-RC	60%	35%	5 (%)
Overall	55%	24%	21%

41   Information is collected annually for all children aged 10 or over who have been looked after continuously for at least a year. Data is recorded to indicate whether a child was convicted or subject to a youth caution (including a youth conditional caution) under the Crime and Disorder Act 1998 for an offence committed while being looked after (DfE, 2019b).

groups, rates of convictions remain highest in these typologies when calculating rates based only on children for whom data is not missing.

The results illustrate that conviction rates are high among children who have experienced residential care, with substantial numbers of children being convicted during their time in care. Potentially, these findings could be linked to the previous results regarding going missing. Rates of convictions are highest among groups where going missing is more common (i.e. early entrants to non-residential care and adolescent entrants to care). Sturrock and Holmes (2017) discuss the links between gang involvement and going missing from residential care, particularly highlighting the issues around being placed a long way from home and the resulting feelings of isolation which can increase the likelihood of risk-taking behaviours. However, we reiterate that the missing episodes and convictions outlined in this report did not necessarily occur during children's time in residential care. In fact, the recent Ofsted (2022) report highlighted that going missing and criminal exploitation were among common risks leading to a child entering a children's home.

Substance misuse

Substance misuse is defined as 'intoxication (or regular excessive consumption and/or dependence on) of psychoactive substances, leading to social, psychological, physical or legal problems' (DfE, 2019b). It includes problematic use of both legal and illegal drugs, including alcohol when used in combination with other substances (DfE, 2019b).

Similar to convictions, data on substance misuse are reported only for young people in our sample who were identified as having a substance misuse problem during their time in care, and specifically during a period of being looked after for at least a year. For our analyses, the annual substance misuse indicator was aggregated across years to provide an indicator determining whether each child had ever been identified as having a substance misuse problem while in care. Therefore, the substance misuse problem did not necessarily occur during the child's time living in residential care.

Of the children who turned 18 in 2019/20 and ever experienced residential care, 24% were reported as having a substance misuse problem at some point and 21% of data was missing, likely owing to the restrictions on whom this data is collected for as outlined above.

Rates of having a substance misuse problem varied across the typologies, and were highest among early entrants to non-residential care (35%) and adolescent entrants to care (28%), and remain highest in these typologies when calculating rates based only on children for whom data is not missing. Paired with the previous findings regarding going missing and being convicted, early entrants to non-residential care and adolescent entrants to care who experienced residential care are more likely to have poorer outcomes around convictions, substance misuse and going missing while in care. The tables outlining rates by typology are in Appendix 4.

SDQ scores at 16

The Strengths and Difficulties Questionnaire (SDQ) is a short behavioural screening questionnaire widely used to measure children's social and emotional well-being. The SDQ Total Difficulties Questionnaire is scored out of 40, with higher scores indicative of more social and emotional difficulties. SDQ scores are recorded for children aged 4 to 16 years old who have been in care for 12 months or more and should be completed by the child's main carer (DfE, 2019b). This, alongside other reasons for missing data, means that data is missing for 50% of the residential care sample and 74% of the sample of all CiC. Due to this, we do not compare figures between the different samples. Instead, the results for the all CiC sample can be found in Appendix 4.

Table 7 below shows that for children who experienced residential care at some point before turning 18 and for whom we have data, the mean SDQ score at age 16 is 17. However, this varies across the typologies.

According to Goodman (1997), a score of 0-13 is considered 'normal', 14-16 is 'borderline', and 17-40 is a 'cause for concern'. In keeping with this classification, the mean SDQ score among children in the residential care sample and particularly among some groups is concerning.

However, while the SDQ is an extremely widely used screening tool and provides an easy way of monitoring well-being (Luke et al., 2014), there are limitations to this measurement. The tool is narrow and is more effective at 'screening' for some disorders, e.g. conduct issues, than others, such as depression. Moreover, it is often used to set thresholds for access to CAMHS services, which lacks nuance, invites bias and may lead to young people being excluded from desperately needed services given the high levels of complexity involved (Wright et al., 2019). As an example, for some specific sub-groups or typologies of CiC such as UASC, the SDQ has been found to be insufficient in recognising PTSD symptoms (NICE, 2021).

Table 7: Mean SDQ scores at 16 and missing data for the sample of children who turned 18 in 2019/20 and ever experienced residential care, broken down by typology and provided overall

Typology	Mean SDQ score at age 16	Number of observations	Missing data
UASC	Not reported due to the high share of missing data*		
Children who entered care due to disability/illness	17.4	190	49%
Early entrants to residential care (10 and under)	17.3	130	35%
Adolescent entrants to care (11-15)	16.8	840	44%
Late entrants to care (16+)	Not reported due to the high share of missing data*		
Early entrants to non-residential care	17.1	490	21%
Overall	16.8	1,710	41%

*There was too much missing data to report SDQ scores at 16 for late entrants. This is due to late entrants only entering care at age 16, and SDQ scores only being reported for children aged 4 to 16 years old who have been in care for 12 months or more. The results for UASC have been suppressed to avoid statistical disclosure of the results for late entrants.

There are also biases in the measure, with some children more likely to score higher than others. DfE (2020a) reported that among CiC, scores varied by gender, with 40% of boys having a score which was a cause for concern compared to 33% of girls. Therefore, while these findings generally suggest social and emotional difficulties among children who experience residential care and particularly within some groups of children, the results should be interpreted in light of data availability (we only have data for around half of the sample) and the limitations of the measurement.

Educational outcomes

The educational outcomes reported below are reported for all children who have ever lived in residential care, regardless of whether they are living in residential care at the time of the measurement. We report on educational attainment as a measure associated with long-term life outcomes (O'Higgins et al., 2021), and absences and exclusions as outcomes which provide insight to a child's participation in secondary education and which are important levers of policy to target improving educational attainment (Liu et al, 2021; Thompson et al., 2021).

Educational outcomes are not available for all children. We are restricted to report outcomes for the sample of children for whom records could be linked to extracts of the National Pupil Database (NPD). The variable used to link a child's records between the Children Looked After Dataset and the NPD is called the Pupil Matching Reference (PMR) and is assigned when a child enters state-funded education for the first time (or upon the creation of an Education, Health and Care Plan if this is sooner) (Jay et al., 2018). Therefore, records cannot be linked if a child left care for the final time before this happened. This is predominantly explained by children entering and leaving care for the final time before they

are of mandatory school age. Outcomes are also unavailable where a matching record cannot be identified in particular extracts of the NPD for other reasons.

Overall, we were able to link educational data for 95% (n=2,770 of 2,913) of children in the residential care sample and 65% (14,510 of 22,431) of children in the sample of all CiC, and hence our analysis in this section is only based on these children. However, there were different levels of missing data related to specific educational outcomes at KS4, thus the amount of missing data related to each outcome has been outlined in the relevant section.

Furthermore, the rate of missing data as a result of being unable to link records to the school data differed across the typologies. UASC had the highest rate of missing school data which is likely a result of many UASC arriving later and not being enrolled into school (O'Higgins, 2019). A full table breaking down the percentage of children for whomwe were able to link to a PMR by typology is in Appendix 4.
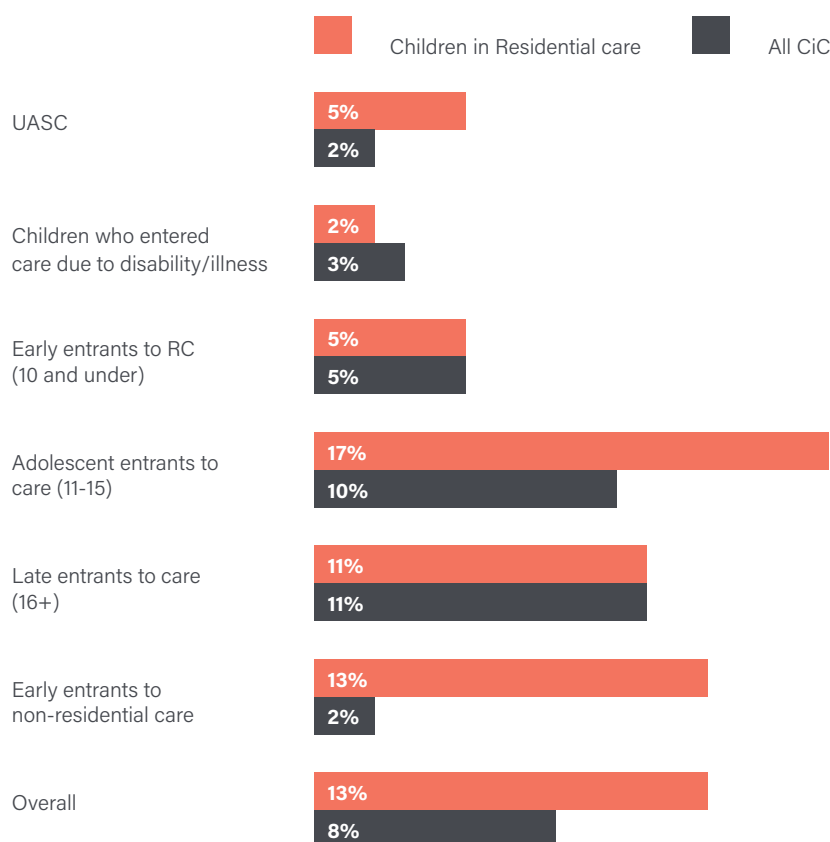
Unauthorised absences

We measure attendance as the number of sessions missed due to unauthorised absences relative to the total possible sessions a child could have attended. We report unauthorised absences for children at Key Stage 4 (KS4) which aggregates attendance across Year 10 and Year 11. Figures refer to all children who have ever lived in residential care compared to all children who have ever been in any type of care, even if some of the children may have already left (residential) care or have not entered care yet at KS4.

Figure 16 below illustrates that at Key Stage 4 (KS4), on average, children in the residential care sample have higher rates

Figure 16: Mean rate of unauthorised absences in KS4[42] for children who turned 18 in 2019/20 and ever experienced residential care and the corresponding cohort of all CiC broken down by typology and provided overall

Legend: Children in Residential care | All CiC

Category	Children in Residential care	All CiC
UASC	5%	2%
Children who entered care due to disability/illness	2%	3%
Early entrants to RC (10 and under)	5%	5%
Adolescent entrants to care (11-15)	17%	10%
Late entrants to care (16+)	11%	11%
Early entrants to non-residential care	13%	2%
Overall	13%	8%

Note: There was additional missing data related to absences at KS4. The overall mean rate of absences for the Residential Care Cohort was based on 2,000 observations, as 31% of the total sample was missing. The overall mean rate of absences for the All CiC Cohort was based on 12,670 observations as 44% of the total sample was missing.

of unauthorised absences (13% overall) compared to all CiC (8% overall). Within the residential care sample, adolescent entrants have the highest share of unauthorised absences (an average of 17% of sessions missed in KS4), followed by early entrants to non-residential care and late entrants to care. Early entrants to residential care, UASC and children who entered care due to disability/ illness had the least unauthorised absences in KS4. Where sufficient data was available, there were no large differences in the mean unauthorised absences depending on whether the children were still in care or had left care by KS4.

To contextualise these findings more, in the last year before entering residential care, adolescent and late entrants had the highest rates of unauthorised absence (12% each). The higher absence rate may be related to the age at which these two groups enter care, hence the absence measure covers a later academic year as these two groups of children enter care the latest. Overall, the rate of unauthorised absences was higher in KS4 (13%) compared to in the year before entering residential care (9%).

42   Rate of unauthorised absences was measured as the number of sessions missed due to unauthorised absences relative to the total possible sessions a child could have attended in KS4. The mean rate across children was calculated to form the average rate of unauthorised absences per typology and overall.

Exclusions

This section covers permanent exclusions and fixed term exclusions for children at KS4. Fixed-term exclusions are defined periods of time in which a child cannot enter the grounds of a school they have been excluded from; this can be for a cumulative maximum of 45 days within an academic year from all schools a child is excluded from (The School Discipline (Pupil Exclusions and Reviews) (England) Regulations, 2012). A permanent exclusion means a child is permanently expelled from a school for severe or persistent breaches of policy; statutory guidance requires headteachers to avoid "as far as possible" permanently excluding any looked after child because CiC may be particularly vulnerable to its consequences (DfE, 2017). Data available

does not include "informal exclusions", whereby schools temporarily transfer students to alternative provision to improve their behaviour (DfE, 2013; Malcolm, 2018).

A child will have a record in the exclusions extract of the NPD for any academic year in which they have any reported fixed term or permanent exclusion. Many children do not have exclusions (and thus do not appear in the exclusions NPD extract), therefore we estimate the prevalence of exclusions at KS4 among children who live in residential care from the sample size of children for whom we have educational data.

Out of all children turning 18 in 2019/20 who have ever lived in residential care, 2% have been permanently excluded in KS4. Late

Table 8: Number and percentage of children in the Residential Care Cohort who ever had a permanent or fixed-term exclusion in KS4 out of all children who can be linked to educational data, broken down by typology and provided overall[43]

Typology	Ever permanently excluded in KS4	Ever had a fixed term exclusion in KS4	Average number of fixed term exclusions if ever fixed excluded in KS4
UASC	x	x	x
Children who entered care due to disability/illness	x	6% (20)	2.35
Early entrants to residential care (10 and under)	x	18% (30)	3.24
Adolescent entrants to care (11-15)	3% (40)	39% (570)	3.67
Late entrants to care (16+)	8% (10)	33% (40)	4.23
Early entrants to non-residential care	x	35% (210)	3.53
Overall in the Residential Care Cohort	2% (50)	31% (860)	3.61
Overall in the All CiC Cohort	2% (260)	28% (4,130)	3.21

Note: As children are only recorded in the exclusions dataset if they have had an exclusion, the specific amount of missing data for this outcome cannot be determined. These rates are based on the children within the samples who can be linked to educational data (95% of the Residential Care Cohort and 65% of the All CiC Cohort).

43   In line with Statistical Disclosure Control policies, "x" is used in cells to avoid disclosing values based on headcounts less than 10

entrants are much more likely to have been permanently excluded in KS4 compared to other groups, with approximately 8 percent having been permanently excluded in KS4. Since children in this group do not enter care until age 16, most might not have entered care or won't have been in care for very long at this point.

Fixed term exclusions in KS4 are slightly more common among the residential care sample (with 31% of children experiencing at least one fixed term exclusion during KS4) compared to the sample of all CiC (28%). Adolescent entrants to care have the highest rate of fixed term exclusions in KS4 with 39% followed by early entrants to non-residential care, where 35% have experienced a fixed term exclusion in KS4. Table 8 below illustrates findings related to permanent and fixed-term exclusions.

To put the findings relating to permanent exclusions into context, the average permanent exclusion rate in England in the 2015/16 and 2016/17 academic years (when our cohort of children would have been in KS4) was 0.1% (DfE, 2021d). This is lower than the overall rate of 2% for our residential care sample, despite statutory guidance stating that permanent exclusions for CiC and children with an Education Health and Care plan (which many of our children will have due to the high rates of SEN outlined earlier) should be avoided (DfE, 2017). Furthermore, the rate of permanent exclusions for late entrants is particularly high (8%), which could be because many of these children were not yet in care so the statutory guidance relating to CiC would not have applied to them during KS4.

To contextualise the findings relating to fixed term exclusions, adolescent entrants and early entrants into non-residential care also had the highest rates of fixed term exclusions in the year preceding residential care (49% and 44% of children having at

least one fixed term exclusion, respectively). This indicates that while the exclusion rate is still high in KS4, it has reduced compared to their rate before these children went into residential care. Furthermore, the overall rate of fixed term exclusions is lower in KS4 (31%) compared to in the year preceding a child's first residential care placement (38%). The corresponding table for exclusions in the year preceding residential care is in Appendix 4.

Attainment

This outcome focuses on Attainment 8 and Progress 8 scores as measures for educational attainment. Attainment 8 measures the achievement of a pupil across 8 qualifications, including English and Maths GCSEs, 3 GCSE subjects which contribute to the English Baccalaureate (excluding English and Maths), and 3 additional GCSEs or non-GCSE equivalent subjects approved by the Department for Education (DfE, 2016). Progress 8 aims to capture a pupil's progress from the end of primary school to the end of secondary school relative to their peers by grouping a child into 1 of 34 prior attainment groups using their Key Stage 2 (KS2) score, and taking the net value of their Attainment 8 score against the average Attainment 8 score for their prior attainment group (DfE, 2020c).

Attainment 8 scores are zero for at least half of the children who turned 18 in 2019/20 and ever experienced residential care (indicated by the median score being zero). Attainment 8 is calculated from a child's grade score in each subject selected for the Attainment 8 (e.g. in the reformed GCSEs, grade 4 in a single weighted DfE-approved subject adds 4 points to a child's Attainment 8); a score of 0 indicates a child did not achieve higher than Ungradeable in subjects which contribute to the Attainment 8. The finding that at least half of children who have experienced residential care obtain an Attainment 8

Table 9: Summary statistics for Attainment 8 scores for children who turned 18 in 2019/20 and ever experienced residential care (Residential Care Cohort) broken down by typology and provided overall. The last row depicts the summary statistics overall in the All CiC Cohort.

Typology	Median Attainment 8 score	Mean Attainment 8 score
UASC	Not enough observations to publish Attainment 8 data[44]	
Children who entered care due to disability/illness	0	1.66
Early entrants to residential care (10 and under)	2	9.94
Adolescent entrants to care (11-15)	1.75	7.8
Late entrants to care (16+)	6	13.1
Early entrants to non-residential care	0.5	6.5
Overall in the Residential Care Cohort	0	7.04
Overall in the All CiC Cohort	17.75	20.91

Note: There was additional missing data related to Attainment 8 scores at KS4. The overall mean Attainment 8 score within the Residential Care Cohort was based on 2,450 observations, as 16% of data for the total sample was missing. The overall mean Attainment 8 scores for the All CiC Cohort was based on 13,220 observations, as 41% of data for the total sample was missing.

score of zero could be explained by schools not entering children for examination in applicable subjects; if a child does not have an examination result for a particular slot of the Attainment 8, they receive zero points. Attainment 8 is considered to be more stringent in selecting applicable subjects than the previous headline school accountability metric measuring grade A*- C achievement in GCSE subjects including English and Maths (Burgess & Thompson, 2020), which could contribute to subject slots not being filled. Further explanations could be derived in children not sitting the exams which the school has entered them for, or children sitting exams but not being graded higher than Ungradeable.

Over the entire distribution for the sample, scores are very low compared to the mean Attainment 8 scores for all pupils in England and to the overall care population. Table 9 shows the summary statistics for Attainment 8 scores across the samples. The mean Attainment 8 score in the residential care sample was 7.04, compared to 20.91 in the sample of all CiC. Within the residential care sample, late entrants have the highest mean Attainment 8 scores, followed by early entrants to residential care.

The average Attainment 8 score for pupils in England in the 2019-2020 academic year was 50.2 (DfE, 2021c). In the sample of children who turned 18 in 2019/20 and ever experienced residential care for whom we have Attainment 8 data, just 1% (30 children)

44   Note: the large majority of data is missing for UASC which is likely a result of this data being recorded through schools, since many UASC arrive later and are not enrolled into school (O'Higgins, 2019). Our cohort of children who turned 18 in 2019/20 will have taken their GCSEs in the academic year of 2017-2018 rather than 2019-2020. In this year, the average Attainment 8 scores were slightly lower, at 44.4 across all pupils and 27.2 for those with SEN (DfE, 2019c)

Figure 17: Percentage of children in the Residential Care Cohort for whom we have Attainment 8 data (n=2,450, 84% of the full sample) who achieved an Attainment 8 score within/between certain thresholds.

93%	6% 1%

- <30
- 30-50
- >50

achieved a score of 50 or higher. The average Attainment 8 score among pupils in England who have any SEN in the same academic year was 30.7 (DfE, 2021c). Within the residential care sample, 7% (180 children) achieved a score of 30 or above.

As discussed previously, the mean number of placement moves within the residential care cohort sample is 5.7. Among children who achieved an Attainment 8 score of 30 or higher, the mean number of moves is 3.9, and reduces further to 3.4 when restricting to children who achieved a score of 50 or higher. These findings suggest a potential link between placement instability and educational attainment within our sample.

The Progress 8 score is negative for over 75% of the residential care cohort. This means that a child who experiences residential care has less than average attainment at KS4 compared to peers who had similar attainment to them at KS2. Around one in seven children experience an intervention from children's services at any point between school Years 1–11, only 13% of whom enter care at their highest level of intervention (Berridge et al., 2020). Progress 8 for a child in our sample is therefore calculated by comparing their Attainment 8 to the scores of a prior attainment group which is dominated in volume by children who never experienced intervention by children's services; CiC are commonly exposed to adverse experiences before entering or whilst in care which provides a barrier to school development (O'Higgins, Luke & Strand, 2021), and could explain why the majority of our sample make less progress than their peers.[45] The full breakdown of Progress 8 Scores by typology can be found in Appendix 4.

45 These results can be contextualised through the Attainment 8 scores identified above: if an individual achieved an Attainment 8 score of 0 (the minimum possible value - scored by the majority of the residential care cohort), and were included in the Progress 8 measure, the maximum possible Progress 8 score they could have would be 0 if their entire prior attainment group also had an Attainment 8 score of 0. If however anyone within the prior attainment group scored an Attainment 8 higher than 0, the individual's maximum Progress 8 score is strictly less than 0; given there are only 34 prior attainment groups in which a child can be allocated, the likelihood of this event is considerable

DISCUSSION

The findings detailed in this report underline very poor outcomes and high placement instability of children who have experience of residential care. Children have often experienced multiple placement breakdowns before entering residential care. Whilst this analysis cannot tell us if these outcomes are a result of the residential placement or children's experiences before (and after), policy makers, commissioners and researchers should consider how the current system can be improved to meet children's needs.

Limitations

There are limitations to this study, and it is important to consider the findings in light of these.

Firstly, this study excludes many types of residential settings from its definition of residential care and focuses purely on children's homes. This decision was purposefully made in order to do justice to the nuance involved in this particular setting rather than to look at too many categories at once. However, this inclusion criteria means that findings from this report should not be extrapolated beyond this type of residential setting.

Secondly, there are limitations involved with the administrative datasets used to obtain these findings. We acknowledge that even when restricting to children's homes alone, there is an abundance of variation across homes that does not get captured within administrative datasets. Furthermore, the

annual data returns collected and submitted by local authorities will inevitably contain some erroneous information due to the sheer volume of data recorded and variation in interpretations, such as category of need or going missing from placement. Moreover, restrictions on the children for whom certain information is required, such as being in care for a minimum length of time or leaving care after a certain age, results in large amounts of missing data. This has particularly influenced the amount of data available for the outcomes of all CiC, which limits the informational value of these figures. Combined with the fact that the all CiC sample also contains the residential care sample within it, the ability to compare results between these samples is further limited and differences between the samples may be under-estimated.

Thirdly, as previously stated, this study is limited to descriptive findings and does not offer any causational results. Hence, the findings do not illustrate any causal differences between children living in residential care compared to all CiC or between groups of children who experience residential care, nor do they indicate whether outcomes are driven by the experience of residential care or other factors. Instead, they are limited to descriptive findings and we recommend that these results are considered in tandem to build an overall picture of the characteristics, care journeys, and outcomes of children who experience residential care.

Lastly, outcomes are compared for all children who have ever experienced a residential care placement, rather than those

currently in a residential care placement. This was done intentionally to provide a picture of all children who experienced residential care at some point while being in care. However, the outcomes may differ between children who have not yet entered residential care, children who have already left residential care, and children who are still in a residential care placement at the time of measurement, which our results cannot speak to.

Summary and implication of findings

The findings from this report can be summarised into three broad topics; the demographic characteristics, care journeys and outcomes of children who experience residential care. The key findings and recommendations for policy and future research from each of these topics are highlighted below.

Demographic characteristics:

It is clear that the children who are placed into residential care have high levels of need, with 92% reported as receiving provision for SEN at some point and children who enter care due to disability/illness being over-represented in residential care compared to all CiC. The regression confirmed the finding that children with SEN are significantly more likely to enter residential care.

There are also other patterns of over and under representation of certain demographics among children living in residential care compared to all CiC that warrant further consideration. Girls are significantly less likely to enter residential care placements, but the level of under and over representation of girls living in residential care compared to all CiC varied across the typologies. Girls who enter care due to a disability or illness, or enter care as adolescents, are particularly under-

represented in residential care, whereas girls who enter care late are over-represented. Additional research is needed to understand why these variations exist.

It is notable that Asian and Black children were under-represented in residential care compared to the population of all CiC and the regression confirmed that children of minority ethnic backgrounds are significantly less likely to enter residential care. In contrast, our analysis of the whole CiC cohort found that Black children were over-represented among children who have ever experienced a placement classed as 'other residential', which is largely constituted by unregulated accommodation. We urgently need more research to understand these children's journeys, how placements are chosen for them and if these are appropriate to meet their needs.

Care Journeys:

Data analysis cannot tell us why children are placed in residential care rather than other types of placement, but our findings do appear to confirm the narrative that residential care is increasingly used as a 'last resort' after family models such as kinship care or foster care placements break down. Children are significantly more likely to enter residential care where the reason for their first placement change were reported as the carer requesting placement end (both cases where this was due to child's behaviour or for reasons other than the child's behaviour). Furthermore, the findings also speak to the notion that once children are placed in residential care, they move between different residential placements or unsupervised accommodation, such as unregulated children's homes or independent living.

The majority of children do not experience residential care as their first placement,[46] and experience an average of 2.2 placements beforehand (which varies greatly across the typologies, with early entrants to non-residential care having 5.2 placement beforehand, on average), highlighting the adversity faced before children even enter residential care.

Our findings also suggest that children often have very poor experiences outside of their care history before entering residential care. For instance, children who have experienced a fixed term exclusion in KS2 are more likely to enter residential care.

The current heterogeneity of children living in residential care and the different points at which they enter residential care suggests that policy makers and commissioners need to consider carefully what the purpose of residential care is. A shared understanding of this would help ensure placements can meet the needs of children and young people. Once children enter residential care, a clearer sense of the purpose of this placement would help ensure that residential placements can provide the support young people need. Future research could aim to understand whether staff have the skills, experience and support to work effectively with these vulnerable children and young people who have significant needs (e.g. high levels of SEN and multiple care placement breakdowns). In addition, research should examine whether current qualifications are appropriate for the demands of the role, especially in light of wider research indicating that managers struggle to recruit children's homes staff with the appropriate level of skills and training (Thornton et al., 2015; RTK Ltd, 2021).

Overall, placement instability, which may be an important factor associated with poor outcomes, is a clear feature of the journeys of most children who have experienced a residential care placement (both before and after their first residential placement). Alongside the Children's Commissioner's Stability Index (2020) which reported a rise in the experience of placement instability at a young age, this may suggest that a lack of stability is becoming a more prevalent feature of children's care journeys. Policy makers should consider the current placement matching process as well as support given to children after a placement move to help ensure greater placement stability for these young people. Further research should look at what helps to improve placement stability for children in both residential, foster and kinship care, a research topic that has also been recommended by the National Institute for Health and Care Excellence (2021).

Outcomes:

This report adds to the literature showing that children who experience residential care tend to have worse outcomes compared to their peers in other forms of care on a wide range of measures. However, this report has also provided more context on who the children who experience residential care are and the nature of their care journeys. Additionally, the report has shone a light on the heterogeneity of the characteristics, care journeys and outcomes of children who experience residential care in order to inform the established finding that children living in residential care have poorer experiences than their peers in care.

Although outcomes in general are poorer among the children who have experienced

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46   The number of children who experience residential care as their first placement decreases when looking at children who were in residential care in 2019/20, suggesting that it is becoming even more common to exhaust all other options before residential care.

residential care, they vary substantially across different groups of children, as demonstrated with our analysis of typologies. We repeatedly find that early entrants to non-residential care (those who enter care age 10 and under, but do not enter residential care until age 11 and older) and adolescent entrants to care (who enter the care system age 11-15) tend to have the poorest outcomes relative to all children who have lived in residential care. They are more likely to be NEET at age 18, have gone missing, have been convicted, have had a substance misuse problem, and to have been fixed-term excluded both in the year before entering residential care and during KS4. Therefore, it is crucial to understand why children who enter residential care during their teenage years fare so poorly and how they can be better supported.

With regards to the characteristics of children in this group, we see that within the sample of children who were living in residential care in 2019/20, 93% of early entrants to non-residential care and 86% of adolescent entrants to care had been reported to receive provision for SEN (the rate across the whole residential care sample is 92%). Furthermore, almost half of children in these groups had a fixed term exclusion from school in the year before they entered residential placement.

Secondly, when examining care journeys, we see that early entrants to non-residential care and adolescent entrants to care experience more instability during their time in care, particularly among the former group. Although some of this instability is due to how we defined early entrants to non-residential care (as they must have experienced at least some time in a non-residential care placement before first entering residential care), the level of instability is still striking. On average, early entrants to non-residential care spend 7.9 years between entering care and entering residential care, and have 5.2 placements in

this time. Almost half (47%) of the children in this group have left and re-entered care before they are placed in residential care and almost all (96%) have experienced a foster placement breakdown before their first residential care placement. These results highlight the adversity these children have already faced priority to their first residential care placement. After their first residential care placement, early entrants to non-residential care have an average of 4.1 additional placements and adolescent entrants to care have 3.6, which is high given both groups of children do not enter their first residential care placement until at least age 11. Rates of being placed in another residential care placement, in independent living and in a form of 'other' residential placement, largely constituted by unregulated children's homes, are also higher among this group compared to the average in the residential care sample, and common among adolescent entrants to care.

When considering how unstable care journeys might underpin some of the poor outcomes for the early entrants to non-residential care typology, it is interesting to compare this group to that of early entrants to residential care. Both categories entered care within the same age threshold (age 10 and under) and their mean age at entry are very similar (5.8 years for early entrants to non-residential care, compared to 5.6 for early entrants to residential care). However, children in the former group were not placed into residential care until later on (age 11 and older), whereas the latter was placed into residential care before turning 11. Although outcomes for the whole residential care sample and across all typologies were generally poor, compared to early entrants to non-residential care, those who enter residential care earlier have better educational outcomes at KS4; lower rates of unauthorised absences and fixed-term exclusions, and higher Attainment 8 scores.

This could imply a benefit of children entering residential care earlier with less instability already faced (mean number of placement moves beforehand was 2.5 compared to 5.2). It could also be due to the placements experienced after the first residential care placement, as early entrants to residential care are more likely to transition from residential care into foster care or kinship care placements compared to early entrants to non-residential care.

Looking wider to the overall residential care sample, notwithstanding the caveat around missing data, our finding that over half of children classified as care leavers in the residential care cohort are NEET at 18 suggests that care leavers require urgent additional support at this stage. Staying Close, an adaptation of Staying Put for children in foster care, has been piloted through the Innovation Programme. Under this scheme, care leavers who have lived in residential care live independently in accommodation close to their previous children's home and continue to have support from their key worker and the chance to visit the home frequently. Staying Close should be expanded to ensure young people have the opportunity to benefit from this additional support. This expansion should include impact and implementation evaluations so we can generate high quality evidence about this intervention and how it could best be implemented in a full roll out of the programme.

Given the poor educational attainment of children and young people who have experienced residential care, policy makers and researchers should look at what educational support is currently in place for children who are living in residential care (including the role of the Virtual Schools Head) both within mainstream education and alternative provision. This should help to improve the current evidence base and inform what further interventions are needed to improve outcomes for these children.

When considering the findings related to outcomes, we reiterate that this report does not identify the factors that cause worse outcomes for children who experience residential care. The findings show that children who experience residential care have high rates of SEN and unstable care journeys. The results also show that rates of SEN and levels of instability are higher among groups of children with particularly poor outcomes. While we cannot say for certain that these factors drive poor outcomes among children who experience residential care, we argue that they are important considerations to make when interpreting findings (both in this report and in the wider literature) relating to the outcomes for this population of children.

CONCLUSION

Children living in residential children's homes subject to children's homes regulations make up 9% of all children in care in 2019/20. Our analysis suggests that this group of children experience higher levels of placement instability and poorer outcomes at age 16 and 18 than children who have been looked after in other placements. While this analysis does not answer the question as to why experiences for children living in residential care are different, it raises questions as to how these children can be supported better at an earlier age. The analysis also reveals stark differences between the experiences of different groups of children who entered residential care at different ages or for different reasons. Children who enter care between age 11-15 and children who enter care before the age of 11, but only enter residential care several years later tend to experience particularly high placement instability and poor outcomes. Going forward, more work is needed to explore how children living in residential care can be supported best, both before going into residential care and beyond.

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