Nottinghamshire County Council

Report to the Health and Wellbeing Board

17 April 2013

Agenda Item: 5

REPORT OF THE CORPORATE DIRECTOR, CHILDREN, FAMILIES AND CULTURAL SERVICES, AND THE DIRECTOR OF PUBLIC HEALTH

HEALTH OF VULNERABLE CHILDREN AND YOUNG PEOPLE IN NOTTINGHAMSHIRE

Purpose of the Report

1. The report describes factors that increase children and young people's vulnerability, considers the impact of vulnerabilities on health and wellbeing and outlines the Nottinghamshire multi agency response to meet the needs of vulnerable children and young people. Comment is invited on the current approach, together with consideration of potential additional developments. Members of the Health and Wellbeing Board are asked to sign up to the recently published Department of Health Pledge to improve health outcomes for children and young people, reproduced in **Appendix 1.**

2. The paper outlines a wide range of often interrelated causes of children and young people's vulnerability but in many instances, the scale, severity and impact of vulnerability cannot be measured. The Children's Commissioner for England reminds us that:

> *'Article 4* [of the UN Convention on the Rights of the Child] *says children and young people must rely on adults to protect and ensure their rights. Children and young people, especially the most vulnerable among them, are likeliest to be voiceless in a society that for all sorts of reasons takes an adult view of how life, law and policy should be*[1].

Information and Advice

Definition of vulnerability

3. This paper uses the definition of vulnerable children as described in *Healthy Children, Safer Communities* (DH 2009), which is:

> *'Those who experience multiple and complex problems which restrict their life chances and need extra attention to improve their well-being.*[2]'

Demographic information

4. There are 179,500 children and young people aged 0-19 living in Nottinghamshire. The 0-19 year old population is projected to increase by 13% across the County by 2030, with the largest growth in the 5-9 year old population (23%)[3].

What we know about children's physical and emotional health

5. The physical, mental and emotional health of a child has a fundamental impact and influence on the future of that child, and is an important outcome in its own right.

   "*Nothing can be more important than getting it right for children and young people. We know the importance of health services and healthy behaviours in childhood and teenage years in setting patterns for later life*[4] ".

6. By the age of five, early influences have already had an impact on the future outcomes for a child, be they cognitive, behavioural, social, emotional or health related. Influences include the home learning environment, mother's educational qualifications, parenting style, maternal mental health and mother's age at birth of first child, as well as demographic and family characteristics[5].

7. In 2007, a UNICEF report indicated that the wellbeing of children in the UK is poor compared to other industrialised countries[6]. More recent data shows that this county has the highest infant mortality rate in Western Europe[7] and a number of health outcomes for children and young people are poor, often linked to vulnerabilities and leading to inequalities in health which are significant and unacceptable. These can result in substantial costs to both the individual and to the state. Improving the health and wellbeing of children, young people and families is a key priority for the Nottinghamshire Children's Trust.

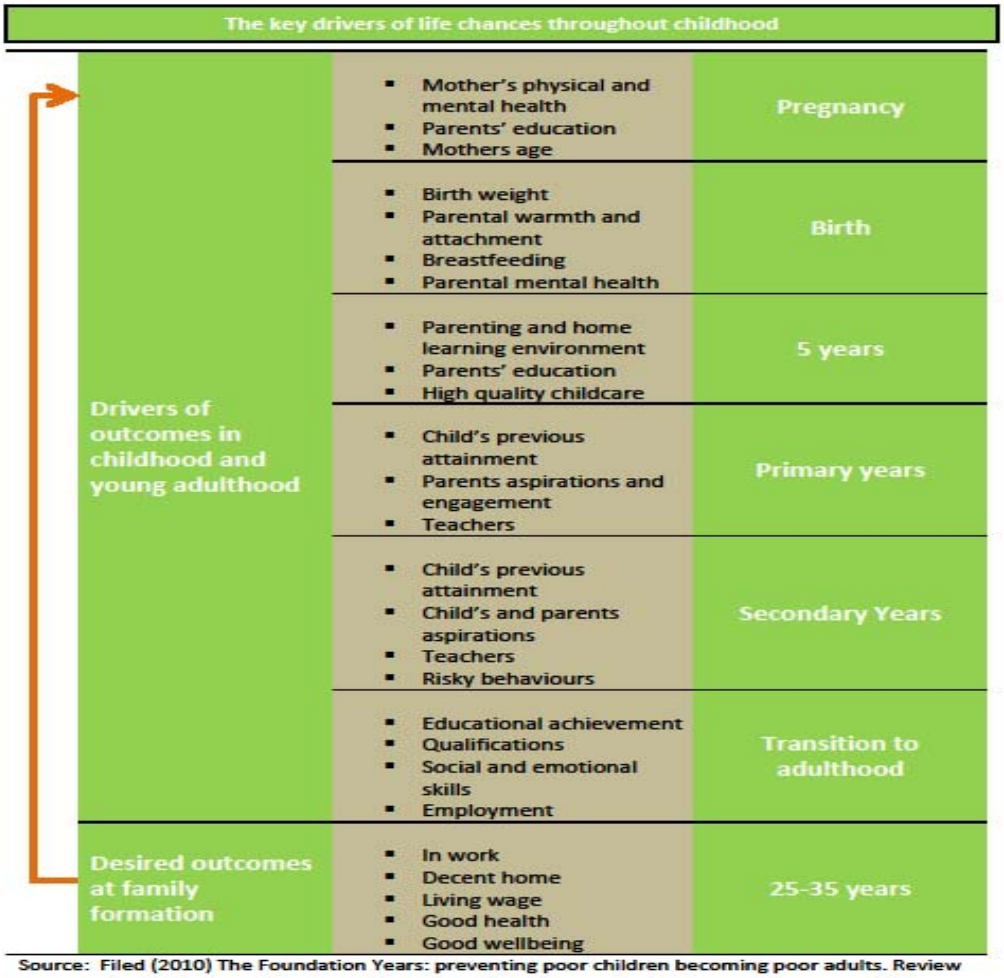
Factors that impact on children and young people's vulnerability

8. A range of factors affect the life chances and outcomes for a child or young person throughout his or her life, as shown in Figure 1[8].

Socio economic status, poverty and health inequalities

9. Children living in poverty in areas of deprivation are more commonly affected than others by a range of factors which increase their vulnerability and have a negative impact upon their health. These factors include living apart from their parents, suffering abuse, neglect or exploitation, being carers for others, suffering with physical or mental illness, having a parent in prison, being involved in the youth justice system or being marginalised as a result of learning or physical disabilities, ethnicity or cultural differences, or sexual identity and/or orientation[9].

Figure 1



Source: Filed (2010) The Foundation Years: preventing poor children becoming poor adults. Review team synthesis of research findings. The report of the Independent Review on Poverty and Life Chances.

10. The Joint Strategic Needs Assessment (JSNA) highlights the issue of health inequalities within Nottinghamshire, illustrating the correlation between poor health outcomes, child poverty and localities experiencing deprivation. Within the County, localities with higher levels of deprivation have higher levels of infant mortality, smoking in pregnancy, low birth weight births, childhood obesity, teenage conception and substance/alcohol misuse and low levels of breastfeeding.

11. It is well established that children growing up in poverty are more likely to suffer emotional and behavioural problems from early childhood. Socio-economic disadvantage can exacerbate chronic stress, family instabilities and parental mental health, which in turn can impair parenting. Children living in areas of deprivation are more than twice as likely to have conduct disorders than children living in more affluent areas[10].

12. In 2010 across Nottinghamshire, 27,950 children and young people aged 0-19 were identified as living in low income households, equating to 17.1% of the 0-19 population[11]. There is considerable variation in the proportion of 0-19 year olds living in poverty across Nottinghamshire's districts as follows: Ashfield 23%, Bassetlaw 18%, Broxtowe 15%, Gedling 15%, Mansfield 23%, Newark and Sherwood 16.5%, Rushcliffe 8%. All districts have at least one ward that is considered a poverty hot spot.

13. There are 1.8 million children living in workless households in the UK[12], with the UK and Ireland having the highest workless household rates in Western Europe[13]. In England, 15.2% of children live in workless households while the figure is 12.3% in the East Midlands and 12.3% in Nottinghamshire[14].

14. A high proportion of children living in low income households meet the eligibility criteria for free school meals (FSM). Nationally, FSM entitlement is used as a measure of vulnerability and is used as an indicator to focus improvements in educational attainment. Across Nottinghamshire, an average of 15.4% of children are eligible for FSM in primary and secondary schools, with higher eligibility rates in the districts of Mansfield and Ashfield (18-22% of all children) and among children attending special schools (an average of 35.7% of children).

The Nottinghamshire response

15. A range of strategic approaches and services are in place in Nottinghamshire to address childhood vulnerability and its impact on health and wellbeing. These are underpinned by the recognition that families play the most significant role in supporting children and young people who face vulnerability, while friends, schools and the voluntary sector can have important roles in supporting the health and wellbeing of children and young people. In addition, the voices of children and young people and their families are essential in determining the needs of children and young people.

16. In relation to vulnerabilities linked to socio-economic deprivation, poverty and health inequalities across the child's life course, the following strategies and plans with priorities and actions are in place:

- Health and Well Being Strategy
- Children, Young Peoples and Families Plan 2011-14
- The Child and Family Poverty Strategy
- Early Intervention and Prevention Strategy
- Closing the Gap Strategy

17. In addition to the above strategic approaches, there are a number of universal and targeted services and tools to support children, young people and families, these include:
    - **The Early Years and Early Intervention Service:** provides a range of universal and targeted services for families with children aged 0-12 years who

are in need of support. Fifty-eight children's centres across Nottinghamshire provide a Core Offer and enhanced family support services. This includes parenting programmes and 1:1 family support in relation to parenting/behaviour/emotional health and wellbeing

- **Extending free early education to the most disadvantaged two-year-olds:** in Nottinghamshire, from September 2013, 1,625 Early Education places will be offered to two year olds from lower income families. This first part of the expansion of places to target the 20% most vulnerable children will include two year olds who live in households eligible for FSM or have a looked after status. From September 2014 the expansion will increase to meet 40% of two year olds

- **Targeted Youth Support:** this service is for young people who are vulnerable but not at immediate risk of harm. Targeted Youth Support is a partnership managed by Nottinghamshire County Council, involving the Police, health services, Probation Service and the voluntary sector

- **The Common Assessment Framework (CAF)** is a holistic assessment tool that can be used by all services working with children and young people to offer Early Help. The CAF supports practitioners to work in partnership with parents/carers, children and young people to identify strengths, needs and goals

- **The Nottinghamshire County Pathway to Provision** document sets out the range of services available across the County within specific thresholds of care

18. Universal health services are commissioned to support all children, young people and families and in many instances use targeted approaches to increase engagement with the vulnerable children and their families and work to reduce health inequalities. Universal health services include:

- **General Practitioners:** often the first point of access for families with health concerns about a child. Each Clinical Commissioning Group (CCG) has identified a GP with a special interest in children and young people's health who acts as the clinical lead and champion for children and young people's health within their CCG

- **Health Visiting:** as part of the national plan, good progress is being made to increase numbers of health visitors in post in Nottinghamshire, so capacity is available to deliver the Healthy Child Programme, to provide greater support to vulnerable families and to develop local community capacity, working closely with children's centres

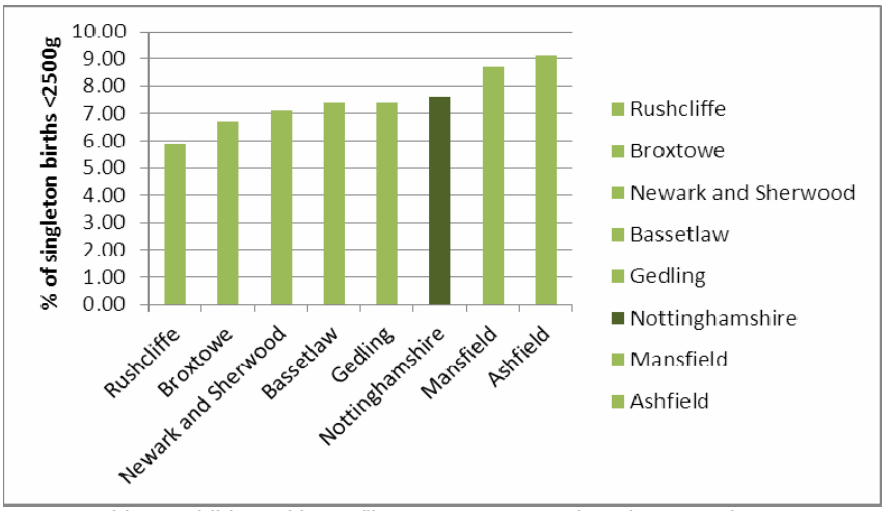
- **School Nursing:** a review of school nursing in Nottinghamshire is underway to ensure the service meets the health and wellbeing needs of children and young people across Nottinghamshire now and in the future. This includes

consideration of how the service supports vulnerable children. Findings from the review will influence future commissioning of the school nursing service.

Maternal and infant health

19. Women from poor families are more likely to have poor health and psychological problems during pregnancy. They are more likely to smoke, have poor nutrition and are more susceptible to genital infections, all significant determinants of the outcome of pregnancy, including birth weight. Birth weight in turn is an important determinant of infant health, mortality[15] and later adult health. Birth weight tends to decrease with decreasing socio economic status, a picture that is reflected in Nottinghamshire: in 2010, in England, 7.2% of all births were of babies with low birth weight, in Nottinghamshire the average was 7.1% while in Mansfield and Ashfield the figures were 9.1% and 8.5% respectively (see **Figure 2**).

Figure 2: Low birth weight (% singleton births <2500g) in Nottinghamshire, 2010



Source: ChiMat Child Health Profiles. Pregnancy and Early Years from ONS 2011 Compendium of clinical and health indicators 2010 data published in 2011.

20. Linked to birth weight, all causes of neonatal death show a socio-economic gradient, with higher infant mortality rates in the most deprived groups in the population[16].

The Nottinghamshire response

21. **Universal Maternity Services**: maternity services, including community midwifery services are provided to pregnant women in Nottinghamshire by Nottingham University Hospitals (NUH), Sherwood Forest Hospitals Foundation Trust (SFHFT) and Doncaster and Bassetlaw Hospitals Foundation Trust (DBHFT). Reviews are currently underway to ensure services are of high quality and are meeting the needs of women, including more vulnerable women. Of particular relevance is the extent to which services adopt guidance published by the National Institute for Health and Clinical Excellence (NICE) in relation to supporting women who are pregnant and have complex social needs.
22. **Family Nurse Partnership (FNP) Programme**: see paragraph 72

23. **Healthy Start Programme**: this national scheme is eligible to low-income pregnant women and families on benefits and tax credits, with the aim of improving the health of mother and baby. Healthy Start provides vouchers for families to spend on milk, fresh and frozen fruit and vegetables, and infant formula milk, plus free Healthy Start Vitamins for pregnant women and for those with children under the age of four. Healthy Start is available through certain children's centres and health centres across the County.

Children and young people with a disability or special educational need

24. Disabled children and young people face multiple barriers, making it more difficult for them to fulfil their potential, to achieve the outcomes their peers expect and to succeed in education. Families with a disabled child face a range of challenges that, in addition to the disability itself, increase vulnerability. These include: a higher rate of lone parenthood, parents less likely to be in full-time work, mothers less likely to be in work[17]. Other inequalities are evident. Black and minority ethnic families with a disabled child are more likely to live in poor-quality housing and the educational attainment of disabled children is unacceptably lower than that of non-disabled children. Families with disabled children report particularly high levels of unmet needs, isolation and stress.

25. In Nottinghamshire it is estimated that between 7,000 – 12,000 children and young people experience some form of disability with more than one in five children having a Special Educational Need. The numbers with life limiting and life threatening conditions has doubled over the last decade and there has been a 60% rise in young claimants (aged 0-24 years) of Disability Living Allowance over the last decade.

26. The prevalence of severe disability is increasing because more children and babies with complex needs are surviving for longer. This, together with projected increases in the population of children in Nottinghamshire, means that the number of children with disabilities will continue to increase over the next 15 years.

The Nottinghamshire response

27. **The Children with Disability and SEN Strategy**: implementation overseen by the Integrated Commissioning Group for Children with Disability and SEN.

28. **Special Educational Needs and Disability (SEND) Pathfinder, The One Project: t**he pathfinder is testing a single planning and assessment process, which from September 2014 will replace the statutory Statements of Special Education Needs (for under 16s) and Section 139a Learning Difficulty Assessments (for over 16s). Local authorities and CCGs will be required to make arrangements to ensure that services to meet the needs of disabled children and young people, and those with Special Educational Needs (SEN) are planned and commissioned jointly. It is also intended that the process will include an offer of a personal budget for all families with an Education, Health and Care Plan as a

means of offering more freedom of choice to families (detailed in the NHS Mandate).

29. **Integrated Children and Young People's Healthcare Programme:** the aim of this programme is to enable children and young people with acute and additional heath needs, including disability and complex needs, to have their health needs met wherever they are. The programme brings together providers of services, families, Nottingham City CCG, Nottingham North and East CCG, Bassetlaw CCG, Public Health and Nottinghamshire County Council to work to improve access to and co-ordination of community healthcare services for children and young people. This work is supported by the Children with Disability and SEN Strategy.

30. More broadly, health services for children include community and acute paediatric services, provided by NUH, SFHFT and DBHFT. These medical services are commissioned to assess and treat children and young people who have acute and long term medical problems, life limiting and life threatening conditions. Community paediatric services provide a consultant led community based service for children and young people under the age of 19 (or during transition into adulthood) who are vulnerable due to disease, disability and/or disadvantage. To improve access, services are delivered in a range of community settings. The provision includes the Child Protection/ Safeguarding Service, Medical Services for Children in Care, Designated and Named Doctor and Designated Doctor for Children in Care.

Children and young people excluded from school or not attending school

31. There are a range of negative outcomes associated with school exclusion, including a negative impact on emotional wellbeing, reduction in friendship networks, mental health problems, poor educational attainment and increased engaging in risk taking behaviours. Persistent non-attenders and school excludees are at particular risk of substance misuse and are more likely to take risks with their sexual health. For example, poor attendance at school is associated with higher teenage pregnancy rates[18].

32. Children who are eligible for free school meals are approximately four times more likely to receive a permanent exclusion than children who are not eligible for free school meals[19] .

33. For Nottinghamshire, Department for Education data shows the number of persistent absences remains in line with or below the national average[20]. Permanent exclusions are slightly above the national average for primary and secondary schools, but significantly lower for specials schools[21]. Fixed term exclusions in Nottinghamshire are slightly lower for primary, slightly higher for secondary and significantly lower for special schools than the national average.

The Nottinghamshire response

34. **The Early Years and Early Intervention Service: a**s highlighted previously, services are provided for families with children aged 0-12 years, which includes children not attending school.

35. **Supporting Families Programme:** this is the name given to the local delivery of the national Troubled Families Programme, a three year programme targeted at the most difficult to engage children, young people and their families. The Programme is funded by central government on a payment by results basis, focusing on reducing crime and anti-social behaviour, improving school attendance and engaging parents in work.

36. **Targeted Youth Support**: as highlighted previously, Targeted Youth Support works closely with the Youth Justice Service, recognising that about one in ten young people will require targeted support at some time during their teenage years. Not all young people needing targeted support are at risk of offending, but most young people who offend need targeted support. Targeted Youth Support works closely with the Youth Justice Service.

Young people not engaged in education training or employment

37. In Nottinghamshire 2.5% of 16-18 year olds are not in education, employment or training (NEET). Whilst this is well below the historical figure of 4%, there has been an increase in recording of *'not known'*. During 2012-13, the percentage '*not known'* has risen above previously recorded levels, though it is still below national and regional averages. In Nottinghamshire young people with a disability and teenage mothers are less likely to engage in education, training or employment.

38. There is a need to be mindful of the significant and often long term negative impact of NEET on a young person's future. In a survey by the Ministry of Justice, 40% of newly sentenced prisoners said they had been permanently excluded from school and 46% said they left school with no qualifications[22].

39. There is a range of poor health outcomes for this group including an increased likelihood that young people will use substances, have poor emotional health and become teenage parents.

The Nottinghamshire response

40. **Targeted Youth Support Service, Supporting Families Programme -** see paragraphs 35 and 36

41. **Nottinghamshire Futures** offers a complete, all-age, careers and employability advice service in Nottinghamshire. This service is part of Targeted Youth Support.

42. **Child and Adolescent Health Services (CAMHS):** a range of services are commissioned to meet the needs of children with emotional and mental health problems. This includes services in each of the seven districts, Specialist

Community CAMHS, CAMHS for Looked after Children and Highly Specialist CAMHS. A CAMHS review is planned for 2013 -14 to consider how services can develop to deliver improved access to psychological therapies and meet increasing demand, particularly in relation to eating disorders and self harm. This work is underpinned by a CAMHS Strategy, with implementation overseen by the Integrated Commissioning Group.

43. A multi-agency training programme is commissioned to support universal practitioners to promote children and young people's emotional health, wellbeing and resilience, **Healthy Young Minds.** This programme offers training to promote emotional health and wellbeing and resilience in children and young people together with specific training in the management of self-harm, attachment, depression and anxiety, conduct and behavioural difficulties, bereavement and loss and other related conditions.

44. **Substance Misuse Services:** See paragraphs 67 and 68.

Black and Minority Ethnic Groups

45. Some Black and Minority Ethnic (BME) children and young people groups experience higher incidences of certain physical and mental health conditions. The link between ethnicity and health outcomes is complex and a number of inter-related factors influence this situation, including income, educational attainment, social networks, occupation and employment[9].

Gypsy, Roma and Traveller Groups

46. Gypsy, Roma and Traveller (GRT) groups experience some of the worst outcomes of any ethnic or social group including: below average educational attainment; above average rates of miscarriage, still births and neo-natal deaths; widespread discrimination and hostility. GRT groups experience the highest levels of racial abuse of any ethnic group in the UK with 63% of young Travellers bullied or attacked[23] and 35% of people admitting to racism towards GRT groups[24].

47. There is often a strong familial support network, with an emphasis on a family centred culture where mothers support their daughters. However, a number of complex social, cultural and environmental barriers prevent many GRT groups from accessing essential health services. High levels of stigma and fear in relation to mental health, mistrust of public services and a lack of awareness of what services are available mean that people do not readily use health services, despite high levels of need.

48. In Nottinghamshire, the vast majority of GRT pupils registered on roll with schools are resident in Newark and Sherwood (76%) and at least 10% of the total population that are home educated are GRT children [25].

Asylum seekers

49. There are many factors that increase the vulnerability of a child or young person seeking asylum. Illegal migrant families are most vulnerable; they often stay in overcrowded conditions, rent privately and may regularly move home. Illegal migrant children often live in poverty as their parents' status limits their access to the job market and their recourse to action when working in exploitative conditions[26].

50. Unaccompanied asylum-seeking children (UASC) may have difficulty proving their age which leads to them being treated as adults. In these circumstances, by being judged as over 18, reduces their access to appropriate protection, safeguarding and young people focused services and can result in a young person being held in immigration detention[27]. In Nottinghamshire there were 43 UASC looked after during 2009, 72% of whom were aged 16 or over, a large increase since 2005 when there were only six UASC[28]. Asylum-seeking children have unclear immunisation histories and it is thought that the immunisation rates are low within this population group.

The Nottinghamshire response

51. Support to these groups of vulnerable children and young people is provided through services already detailed and through the work of the Nottinghamshire Safeguarding Children's Board (NSCB). Other relevant strategies include the Looked After Children Strategy, the Child and Family Poverty Strategy and the Strategy to prevent and tackle youth homelessness in Nottinghamshire.

Children and Young People in Need/with a Child Protection plan

52. The impact of witnessing violence in the home and being subjected to emotional, sexual or physical abuse has a long term negative impact on children and young people. In a survey of offenders, 41% reported witnessing violence in their home as a child and 29% reported emotional, sexual or physical abuse as a child[29] .

53. In Nottinghamshire over the last two and a half years there has been an increase in the number of children requiring social care input. In June 2010, 727 children required support from a social worker as part of a Child Protection Plan (CPP), compared with 765 children in December 2012, while the number of core assessments in the previous 12 months was 1,096 in June 2010, increasing to 2,104 by December 2012, a 92% increase. Children and young people in need or with a CPP are likely to have a number of services working with them including health visitors or school nurses.

54. The most common reason children became subjects of CPPs in 2009/10 was 'neglect' (32%), followed by 'emotional and physical abuse' (20%). Over 10% of children with CPPs in 2009/10 were from a black and minority ethnic background and over a third of all children with CPPs were in the 1-4 age range. The rates of children per 10,000 population becoming subject to a CPP was lower in the East Midlands than England.

Looked After Children and Care Leavers

55. Around 60% of looked after children (LAC) have some level of emotional and mental health problem and a high proportion experience poor health, educational and social outcomes after leaving care [30]. In comparison with their peers, LAC and care leavers are four to five times more likely to attempt suicide in adulthood; they have a five-fold increased risk of developing childhood mental, emotional and behavioural problems and a six to sevenfold increased risk of developing conduct disorders[9].

56. Being looked after is an important predictor of social exclusion in adulthood. Higher than average rates of poor mental health, drug use, poor sexual health, behaviour problems and poor educational attainment reduce prospects of employment, with significant cost to the individual and the state[31].

57. There is a higher proportion of LAC in the Youth Justice System; one in three children and young people in contact with the Criminal Justice System were looked after in their childhood[32]. A substantial majority of those living in care who also committed offences had already started to offend before they became looked after[33].

58. In Nottinghamshire, over the past two years and a half years, there has been a substantial growth in the number of children and young people looked after. In June 2010, 623 children were looked after, compared with 896 in December 2012, a 44% increase. Numbers are projected to increase further over the next year.

The Nottinghamshire response

59. There has been substantial increased investment in Children's Social Care Services in Nottinghamshire over the last four years, increasing from £50m in 2008 to £85m currently, in order to meet the needs of the increasing numbers of children with a CCP or who are looked after. In addition a range of safeguarding and child protection arrangements are in place:

- **The Multi Agency Safeguarding Hub (MASH):** the MASH is designed to improve and accelerate information sharing between agencies, involving close collaboration between Police, the Local Authority, Probation and the NHS to respond to safeguarding enquiries from professionals or the public

- **Nottinghamshire Safeguarding Children Board (NSCB)**: inter-agency training enables practitioners to safeguard and promote the welfare of children in their work. The NSCB aims to deliver high quality, up to date safeguarding training to enable participants to keep safeguarding and promoting the welfare of children at the centre of their work

- **The Looked After Children's Strategy: t**his strategy sets out a range of approaches to meet the needs of Looked After Children

- **The Children in Care Nursing Service** works closely with the Community Paediatric Service and Local Authority LAC Services to ensure that the heath needs of LAC are assessed and proactively met. This includes the completion of initial medicals and regular health reviews as a statutory requirement.

Child Sexual Exploitation (CSE)

60. A recent report by the Office of Children's Commissioner found that thousands of children are sexually abused by gangs and groups in England each year[34]. The report says that there were 2,409 victims in the 14 months to October 2011; it is likely that the true number is far higher. The report also identifies 16,500 children who were at "high risk of sexual exploitation" in 2010-11. A 'warning signs and vulnerabilities checklist' has been developed as a result of this work (Annex 1).

61. The inquiry informing the report received evidence of the devastating impact of the violent nature of CSE in gangs and groups. Areas of particular concern included: children going missing as a result of sexual exploitation; the health of victims (particularly drug and alcohol problems, self-harming and mental health; offending by victims either as part of the process of being exploited or as a consequence of it). 85% of the sexually-exploited young people interviewed had either self-harmed or attempted suicide as a result of CSE.

62. In Nottinghamshire, 1012 children and young people were reported missing in 2009. Of these, 25% went missing more than once. The highest numbers went missing in Mansfield (199), Ashfield (176), Bassetlaw (163) and Newark & Sherwood (162)[35].

The Nottinghamshire response

63. The Child Sexual Exploitation Cross Authority Group (CSECAG) is composed of representatives from statutory and third sector organisations in the City and County. The group is led by a senior police officer and is delivering work outlined in an action plan including: mapping to help identify the scale and nature of the problem; development of effective communication channels between the Local Safeguarding Children Boards (LSCBs) and partner agencies regarding CSE; development of a programme to enable engagement with young people regarding CSE; consideration as to how to minimise CSE risks to children and young people in children's homes.

64. This work is also underpinned by the NSCB Child Sexual Exploitation Strategy and Action Plan.

Young People using drugs and/or alcohol

65. Children and young people experiencing increased vulnerability (for example homeless young people, young people who have been sexually exploited, children looked after, teenage mothers and young people not in education, employment or training) have an increased risk of problematic substance use.

66. Those who smoke regularly, drink alcohol and experiment with drugs have an increased risk of starting sex under-16 (men and women) and teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience[36]. In Nottinghamshire, there were a total of 500 young people in specialist substance misuse treatment across the year (2008/09) – an increase of 15% from the previous year[37].

The Nottinghamshire response

67. **Substance Misuse Services:** there is a range of services available for young people in Nottinghamshire, commissioned by Targeted Youth Support Services and provided though Nottinghamshire Healthcare Trust. These include including What About Me (WAM), a service for children and young people affected by parental substance misuse.

68. This work is underpinned by the Young People's Substance Use Strategy and the Nottinghamshire Strategic Tobacco Alliance Plan.

Teenage parents and their children

69. Evidence is very clear that having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Teenage mothers are three times more likely to smoke during pregnancy, 50% less likely to breastfeed than older mothers and have a 63% increased risk of living in poverty compared to mothers in their twenties. Teenage mothers are three times more likely than older mothers to suffer postnatal depression and experience mental health problems in the first three years of their child's life[38]. Teenage mothers also have an increased risk of domestic abuse during the period just after giving birth[39].

70. The impact on the infant and child is seen in an increased rate of low birth weight babies born to teenager and infant mortality rates 60% higher than for babies born to older mothers. Children born to teenagers are more likely to experience a range of negative outcomes in later life; they are up to three times more likely to become a teenage parent themselves, to leave school at 16 with no qualifications, to experience domestic violence, to smoke and to experience poor mental health. Children of teenage mothers are more likely to have accidents and behavioural problems. A significant proportion of teenage mothers have more than one child whilst still a teenager. Nationally, around 20% of births conceived under-18 are second or subsequent births[40].

71. In Nottinghamshire the under-18 conception rate in 2010 was 32.9 conceptions per 1000 young women (461 conceptions with 44% of these resulting in termination). This is a reduction of 4.9% on 2009, and compares with an East Midlands average of 34.5 conceptions, and a national average of 35.5. The reduction in teenage conception rates in Nottinghamshire from 1998 is 29.1%, compared with a regional reduction of 29.3%, and a national reduction of 24.6 %. At district level there are marked variations in rates, with Mansfield and Ashfield having the highest teenage conception rates[41] and 'hot spot' wards within districts

where the rates are relatively high; these form the focus of continuing teenage pregnancy reduction activity.

The Nottinghamshire response

72. **Family Nurse Partnership (FNP) Programme**: this national evidence based programme has been commissioned jointly by Nottinghamshire County Council and Nottinghamshire CCGs and is now up and running. It focuses on vulnerable first time pregnant teenage women and has been shown to significantly improve health, social and economic outcomes for mothers and babies.

73. **Sexual Health and Contraception Services: t**here is a range of services across Nottinghamshire including a number of dedicated young people's services in localities of greatest need.

74. **C-Card condom scheme** is a condom distribution scheme for young people aged 13-19 years, offered in a range of settings including youth clubs, children's centres, health centres, colleges and schools.

75. **Teenage Pregnancy Training** is offered to the workforce across Nottinghamshire. The training aims to increase the skills and confidence of practitioners working in a range of settings to contribute to reductions in teenage pregnancies and to support teenage parents and their children to improve their outcomes.

Young People involved in Offending Behaviours

76. There are a number of adverse risk factors that disproportionately affect young people in contact with the Criminal Justice System[42]. These include:

- approximately 50% have problems with peer and family relationships
- 75% have a history of temporary or permanent school exclusion
- 66% come from a background where family structure has broken down
- 33% have been looked after by the Local Authority
- 33% have severe or complex mental health problems
- 25% have a learning disability or a physical disability
- over 50% have communication, speech and language and literacy problems
- many have histories that include high levels of smoking, alcohol and substance misuse
- high levels of dental health problems, sexually transmitted infections, asthma, blood borne virus infections such as Hepatitis B and C.

77. In many cases, children and young people in contact with the youth justice system have been exposed to multiple risk factors and traditionally they do not access universal preventive services[43].

78. The negative impact on mental health and wellbeing of using drugs and alcohol has been referred to in paragraphs 65 and 66 There are often direct links between heavy use of cannabis and alcohol and offending behaviour, with a

young person either offending to fund the habit or offending as a result of being under the influence of substances. In Nottinghamshire during 2012, young people in contact with the Youth Justice System reported a high use of substances, particularly tobacco, cannabis and alcohol. The use of class 'A' drugs (for example Heroin) had a very low incidence however. **Table 3** shows the percentage of young people in local settings who reported recently using substances.

Table 3: Recent use of substance in Nottinghamshire Youth Offending Service (YOS) and Clayfields Secure Children's Home

	Self-report recent use of…		
	Tobacco	**Cannabis**	**Alcohol**
Nottinghamshire Youth Offending Service (YOS)	76%	47%	65%
Clayfields House Secure Children's Home	69%	69%	52%

Source: Unpublished data 2012 Health Needs Assessment in YOS and Clayfields House SCH

79. Data collected at Clayfields House Secure Children's Home (SCH) shows that 54% of young people reported that substance use had a noticeable detrimental effect on their education, relationships and daily functioning, with an association between substance use and offending in 82% of cases[44].

The Nottinghamshire response

80. **Youth Offending Health Assessment Service:** a specialist nurse practitioner works within the Youth Offending Service (YOS), providing a screening health assessment and sign posting services to first time young offenders.

81. **The Nottinghamshire Strategic Tobacco Alliance Plan: a**ction to reduce the prevalence of smoking within this is group and young people more widely is lead by the group overseeing this plan.

82. **Clayfields House Secure Children's Home** - is a mixed gender secure residential children's home with 18 places available for children up to the age of 17, managed by Nottinghamshire County Council. From April 2013, Nottinghamshire Healthcare Trust (NHT) will act as the lead provider of health services, delivering a range of in-reach primary healthcare, CAMHS and substance misuse assessment, intervention and detoxification services to young people in Clayfields House.

Children affected by parental mental health, parental substance use, parental alcohol misuse and domestic violence

83. **Parental Mental Health** - households with a chronically ill person are among those with the highest levels of deprivation[45]. Children and young people

commonly undertake the role of a carer for a parent with mental health problems, with resulting negative impact on their own health[46].

84. **Parental Substance Misuse** - The Advisory Council on the Misuse of Drugs has estimated that there are between 200,000 and 300,000 children in England and Wales whose parent or parents have serious drug problems[47]. Those with a childhood history of abuse, neglect, trauma or poverty are disproportionately more likely to be affected by substance or alcohol misuse. In turn, the children of those dependent on drugs have to cope with the impact on their own lives and some may end up in local authority care[48] . It is estimated that up to 4,266 (2.7%) children and young people are affected by parents' illicit drug use in Nottinghamshire[49].

85. **Parental alcohol misuse** - parental alcohol and substance misuse is strongly correlated with family conflict, domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences. The Children's Commissioner reported that the number of children who are affected by or living with parental alcohol misuse is largely unknown but estimates that parental alcohol misuse is far more prevalent than parental drug misuse and there is a need for greater emphasis on parental alcohol misuse as distinct from other substance misuse[50].

86. Different patterns of consumption such as binge drinking, and not just dependency on alcohol, affect children and it cannot be assumed that higher levels of consumption equates to greater harm. Children living with problematic parental alcohol misuse come to the attention of services later than children living with parental drug misuse. Boys are less likely than girls to seek help, coming to the attention of services as a result of their behaviour or through Youth Offending Services, than for the harm they are experiencing.

87. In Nottinghamshire it is estimated that between 13,271 and 21,565 children (7.3 - 12%) are affected by parental problematic alcohol use.

Domestic Violence

88. The Health and Wellbeing Board received an in depth paper on domestic violence in January 2013, outlining the scale and impact of domestic violence in Nottinghamshire, together with information on the Nottinghamshire response. Suffice to say that approximately 75% of children living in households where domestic violence occurs are exposed to actual incidents. This group of children have an increased risk of developing acute and long term physical and emotional health problems[51], many are traumatised by what they witness and also at an increased risk themselves of abuse, death and serious injury[52] .

Young carers

89. The 2001 census identified 175,000 young carers in England. The impact of being a young carer varies according to the child's age and the extent of caring responsibilities deemed to be inappropriate. Younger children are more likely to

miss school and experience developmental delays, while older children may be more affected through feeling isolated or themselves misusing substances[53].

90. Children and young people frequently take on the role of carer when there is parental substance and alcohol misuse, experiencing emotional stress associated with feeling responsible for their parent's and other family members' welfare. Young carers most affected by such stress are those living with parental substance misuse or mental health problems [54].

91. In 2010, the BBC surveyed more than 4,000 secondary school pupils and found an "invisible army", 8% of those surveyed, taking on caring roles, including helping someone dress, bathe or shower. From the number of young carers based on the 2001 census, which was probably completed by parents, it had been estimated that only 2% of children were carers[55]. Professor Saul Becker, from Nottingham University's School of Sociology, said:

"The figures are a wake-up call to governments, carers' organisations, civil society as a whole, that in our midst are many children who are providing care to family members, often at the expense of their own childhood. Is this a situation that we can tolerate in our society that children are giving up to a large extent, their childhood?"

92. The true number of young carers aged 5 – 24 years in Nottinghamshire is unknown, but it is recognised that the number is significantly under-reported by the agencies working with them, due to the difficulty in identifying children and young people with inappropriate caring responsibilities. Applying 2001 census data to Nottinghamshire suggests that there are at least 3,100 young carers across the County. In Nottinghamshire, approximately 400 young carers are currently known to the Young Carers Service.

The Nottinghamshire response

93. **Young Carers Service:** the service works with a range of statutory, voluntary and independent sector partners to support young carers through assessing the needs of young carers, delivering tailored support directly to young carers, including positive activities, and providing training and advice to other professionals working with young carers. In order to ensure a continuing focus on support for young carers, a longer term strategy has been developed, the Nottinghamshire Young Carers Strategy.

Impact of changing family structures and vulnerability of children

94. Evidence suggests that children tend to enjoy better life outcomes when the same two parents are able to give them support and protection throughout their childhood[56]. Nationally, 28% of children in lone parent families live in poverty, compared with 17% for couple families[57] . In Nottinghamshire, 6.5% of families are described as one parent with dependent children, as compared to 7.1% for England. The percentage is slightly higher in Ashfield and Mansfield, at 7.9% and 7.4% respectively[58] .

Children and young people affected by poor housing conditions and/or homelessness

95. The relationship between poor housing and poor health for children and young people affected is well established, specifically in relation to fuel poverty, overcrowding, poor housing stock condition, affordability of housing, home security, fire safety and indoor pollutants.

96. Young people who are or have experienced homelessness are more likely than other groups to suffer a range of social, physical and mental health problems: they are twice as likely to suffer from psychiatric disorders; over a third have experienced physical or sexual violence; over a half have been bullied; levels of sexual activity tend to be high, leading to high levels of sexually transmitted infections and pregnancy, with up to 25% of homeless young women becoming pregnant within a year[59]. Research has also shown that young people living in supported housing can struggle to access a healthy diet due to gaps in their early health education and an inability to afford fresh healthy food.

97. For young offenders, having suitable accommodation arrangements significantly reduces the risk of re-offending. Young people released from custody have a wide range of needs and ensuring that they have access to suitable, stable accommodation is described by the Youth Justice Board as 'critical' if they are to engage or benefit from programmes crucial for effective rehabilitation[60]. A case worker in the secure estate shared that:

'If young people do not have somewhere safe to go they depend on others for accommodation which brings with it a lifestyle cost and makes them vulnerable[61].'

98. Homelessness in the East Midlands has increased by 24% in the last two years, with nearly 3,800 households accepted as homeless by local authorities in the region during 2011-12[62].

The Nottinghamshire response

99. **Targeted Youth Support**: as highlighted previously, the service works to support young people who are vulnerable, providing a range of services and interventions.

100. A number of existing strategies incorporate action to reduce family and youth homelessness including the **Child and Family Poverty Strategy** and the **Strategy to prevent and tackle youth homelessness in Nottinghamshire.**

101. **The Nottinghamshire County Pathway to Provision**, referred to previously, sets out clear thresholds for services available across the County. Environmental factors, including those relating to poor housing or homelessness can identify children and young people in need of targeted or specialist services.

Commissioning arrangements for children and young people's health services

102. From 1 April 2013, commissioning responsibilities for children and young people's health services are distributed across a number of commissioning organisations as shown below. There is a serious risk of fragmentation of service provision for children as a result of these changes:

- universal services 0-5 years (Health Visiting, Family Nurse Partnership) and immunisations and screening - NHS Commissioning Board (NCB) Area Teams
- universal services 5-19 years (School Nursing) - Public Health within the Local Authority
- CAMHS, community and secondary care paediatrics and therapy services (paediatric speech and language therapy, paediatric occupational therapy, paediatric physiotherapy), children's community nursing and Children Looked After nursing services, named and designated Safeguarding and Children Looked After doctors, termination of pregnancy services - Clinical Commissioning Groups (CCGs)
- Specialised children's health services, offender health (including Secure Children's Homes), HIV Treatment – NHS Commissioning Board Regional and National Teams

103. Following discussion with senior representatives of Nottinghamshire CCGs, the NCB Area Teams, Public Health and the Nottinghamshire Children's Trust, agreement has been reached to develop an integrated commissioning function/unit, which will have delegated commissioning responsibilities on behalf of CCGs, Public Health and Children, Families and Cultural Services for children's health services. The function/unit will report to the Children's Trust Board and ensure a multi-agency response to meeting the health needs of children.

104. Table 4 details the rationale for establishing an Integrated Commissioning Function. The agreed scope and areas for commissioning are shown in **Appendix 2.**

Table 4

Rationale for integrated commissioning for children's services:
▪ Whole system approach to planning and commissioning
▪ Maximise the quality of services for children and their families
▪ Focus on outcomes
▪ Reduce silo working and duplication
▪ Clear processes for engaging with children and families to inform commissioning
▪ Opportunity to integrate approaches to prevention
▪ Added value, greater savings, best use of available resources
▪ Clearer accountability
▪ Clearer links with recommendations from the JSNA and other in depth needs assessments to inform commissioning decisions
▪ In line with the Government's focus on better health outcomes for children

The Government's Pledge to improve outcomes for children and young people

105. On 19 February 2013, the Department of Health launched **Better health outcomes for children and young people: Our pledge** as part of the Government's response to the Children and Young People's Health Outcomes Forum. The Pledge has been developed in recognition of the fact that, nationally, outcomes for children and young people are poor in a number of areas, with marked room for improvement. System wide changes are required and the opportunity now exists in the new health and care system to focus on outcomes for children and young people, from conception through to adulthood.

106. The Pledge commits signatories to improving the health outcomes of children and young people so that they become amongst the best in the world, with a focus on five specific shared ambitions (see **Appendix 1**). The Department of Health is asking organisations who have the power to make a difference to sign up alongside the Government and do everything they can to improve the care that children and young people receive and reduce avoidable deaths. Many national organisations have already done so.

107. The Health and Wellbeing Board brings together all key players across the health and care system in Nottinghamshire and is thus in a position to improve health outcomes for children and young people. For this reason, the Board is asked to sign up to the Pledge.

Other Options Considered

108. No other options have been considered.

Reason/s for Recommendation/s

109. To ensure that the Health and Wellbeing Board has a full appreciation of the issues affecting vulnerable children and incorporates these into the Health and Wellbeing Strategy, to raise awareness of the developing arrangements for joint commissioning of services for children and young people. Lastly, to demonstrate commitment to the Government's pledge to improve the health and wellbeing of children.

Statutory and Policy Implications

110. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

That the Health and Wellbeing Board:

1) is invited to comment on the current approach summarised in this paper to improving the health and wellbeing of vulnerable children and young people in Nottinghamshire.
2) considers what additional developments should be considered to reduce vulnerability and the impact on the health and wellbeing of children and young people in Nottinghamshire.
3) considers the health and wellbeing of vulnerable children, young people and families when developing the Health and Wellbeing Strategy for Nottinghamshire, recognising the importance of proactively identifying and target services to those children and young people who are most vulnerable whilst reducing contributory health inequality factors.
4) signs up to the Department of Health Pledge to improve health outcomes for children and young people, attached as **Appendix 1**.
5) endorses the establishment and scope of work of an Integrated Commissioning Function, as set out in **Appendix 2**.

Anthony May
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Constitutional Comments (LM 05/03/13)

111. The recommendations in the report are within the remit of the Health and Wellbeing Board.

Financial Comments (KLA 04/04/13)

112. There are no financial implications arising directly from this report.

Background Papers

Background papers comprise reference documents as listed on pages 24-26.

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Electoral Division(s) and Member(s) Affected

All.

C0211

List of References

[1] Children's Commissioner (2012) Dr Maggie Atkinson, Children's Commissioner for England: Address at the Inaugural Lecture of The Nottingham Children and Childhood Network - "Childhood in Adversity" Nottingham University - 27th June 2012
[2] DH (2009) Healthy Children, Safer Communities
[3] JSNA (2010) Nottinghamshire County Demographic profile. Key messages
[4] DH (2010) 'Achieving equity and excellence for children – how liberating the NHS will help us meet the needs of children and young people'
[5] Washbrook E (2010) Early Environments and Child Outcomes: An Analysis Commission for the Independent Review on Poverty and Life Chances
[6] Unicef (2007) An overview of child wellbeing in rich countries. A comprehensive assessment of the lives and well-being of children and adolescents in economically advanced countries.
[7] INED (2012) Infant mortality rate (per 1,000 live births) in 2011. Accessed 17.02.2013 http://www.ined.fr/en/pop_figures/developed_countries/birth_and_death_rates_infant_mortality_rate/
[8] Field (2010) The Foundation Years: preventing poor children becoming poor adults.
[9] Children's Commissioner (2012) Inequalities in health outcomes and how they might be addressed.
[10] Green el at (2005) cited in Children's Commissioner (2012) Inequalities in health outcomes and how they might be addressed.
[11] Nottinghamshire Child Poverty Needs Assessment 2011. Nottinghamshire.gov.uk/caring/childrenstrust/developemntwork/childpverty/childpovertyneedsassessment.
[12] DWP (2012) Social Justice Transforming Lives
[13] Association for young people's health (2011) Key data on adolescents
[14] ONS (2009) Information Centre Indicator Portal
[15] M S Kramer, L Séguin, J Lydon and L Goulet (200) 'Socioeconomic Disparities in Pregnancy Outcome: why do the poor fare so poorly?', Paediatric and Perinatal Epidemiology 14, 2000, pp194-210
[16] DH (2007) Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide.
[17] Barnardo's 2002 Still Missing Out
[18] National Statistics (2004) *Census 2001 table: C0069 Mothers under 19 at birth* (Commissioned by Teenage Pregnancy Unit, DfES)
[19] Department for Education, 2011, Permanent and Fixed Period Exclusions from Schools in England 2009/10 cited in Social Injustice. Transforming Lives DWP 2012.suse.
[20] Department for Educations (2012) Statistical First Release Permanent and fixed term exclusions from schools and exclusion appeals in England 2010-11. Published 25.07.2012. Statistical First Release Pupil Absence in Schools in England Autumn Term 2011 and Spring Term 2012. Published 17.10.2012
[21] Department for Educations (2012) Statistical First Release Permanent and fixed term exclusions from schools and exclusion appeals in England 2010-11. Published 25.07.2012. Statistical First Release Pupil Absence in Schools in England Autumn Term 2011 and Spring Term 2012. Published 17.10.2012
[22] Ministry of Justice, 2008, The Problems and Needs of Newly Sentenced Prisoners cited in Social Injustice. Transforming Lives DWP 2012.
[23] Children's Society Report (2007) cited FFT (2010) in Fair access for all.
[24] Profiles of Prejudice Mori & Stonewall (2003)cited FFT (2010) in Fair access for all.
[25] Nottinghamshire JSNA (2010) Chapter 1 Section 4.6 p 203-307
[26] NSPCCC (2012) A summary of findings on irregular migrant children and unaccompanied asylum seeking children
[27] Children's Commissioner (2012) The fact of age.
[28] Nottinghamshire JSNA (2010) Chapter 1 section 3.4 p 177-187
[29] Ministry of Justice (2010) Compendium of reoffending statistics cited in Social Justice Transforming Lives. DWP 2012

[30] DCSF (2009) cited in Children's Commissioner (2012) Inequalities in health outcomes and how they might be addressed.
[31] NICE & SCIE (2010) Promoting the quality of life of looked-after children and young people
[32] DCSF (2009) cited Children's Commissioner (2012) Inequalities in health outcomes and how they might be addressed.
[33] Darker *et al* (2008) and NICE Guidance on Looked After Children cited in Children's Commissioner (2012) Inequalities in health outcomes and how they might be addressed.
[34] Children's Commissioner (2012) "I thought I was the only one. The only one in the world" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups Interim report November 2012
[35] Nottinghamshire JSNA (2010) Chapter 1, 3.3 p 172-176
[36] Alcohol Concern (2002) Alcohol & Teenage Pregnancy. London: Alcohol Concern
[37] JSNA (2010) Nottinghamshire County. Be Healthy Chapter 2.10
[38] Ermisch. (2003) Does a 'Teen-Birth' Have Longer-Term Impacts on the Mother? Suggestive evidence from the British Household Panel Survey. Colchester: Institute for Social and Economic Research.
[39] Harrykissoon SD, Vaughn IR, Wiemann CM (2002) (2002) Prevalence and patterns of intimate partner violence among adolescent mothers during the postpartum period. Archives of Paediatrics and Adolescent Medicine 156: 325-30.
[40] Spencer (2008) Health Consequences of Poverty for Children. End Child Poverty.
[41] JSNA (2010) Nottinghamshire County Be Healthy 2.11
[42] DH (2009) Healthy lives, brighter futures. The strategy for children and young people's health. Section 5.45
[43] Hobcraft J (1998) *Intergenerational and life-course transmission of social exclusion: Influences of childhood poverty, family disruption and contact with the police.* CASE paper 15, LSE
[44] Asset is a structured assessment tool to be used by Youth Offending Teams in England and Wales on all young offenders who come into contact with the criminal justice system].
[45] Joseph Rowntree Foundation (2000P) Poverty and Social Exclusion in Britain,
[46] Supporting Disabled Parents Working Panel Survey (2009)
[47] Advisory Council on the Misuse of Drugs (2003) Hidden Harm – Responding to the needs of children of problem drug users, Inquiry by the Advisory Council on the Misuse of Drugs cited in Social Injustice. Transforming Lives. DWP 2012
[48] HM Government (2010)'Drug Strategy; Reducing demand, restricting supply, building recovery: supporting people to live a drug free life
[49] Nottinghamshire JSNA (2010) Chapter 1 section 2.10 p 117 -125
[50] Children's Commissioner (2012) Silent Voices. Supporting children and young people affected by parental alcohol misuse.
[51] Royal College of Psychiatrists (2004) Domestic Violence: its effects on children, Factsheet for parents and teachers [online]. Available from www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/domesticviolence.aspx
[52] DH (2009) Improving safety, reducing harm: children, young people and Domestic Violence. A practical toolkit for front-line practitioners.
[53] McInnes and Newman (2005) cited in Children's Commissioner (2012) Silent Voices. Supporting children and young people affected by parental alcohol misuse.
[54] Christie (2011) PhD Thesis cited Children's Commissioner (2012) Silent Voices. Supporting children and young people affected by parental alcohol misuse.
[55] BBC Young Carers Survey (2010) accessed on 13.02.2013 - http://www.bbc.co.uk/news/education-11757907
[56] Coleman, L and Glenn, F, (2009) When Couples Part: Understanding the Consequences for Adults and Children, One Plus One cited in Social Justice. Transforming Lives. DWP 2012.
[57] Department for Work and Pensions (2011) Households Below Average Income: An analysis of the income distribution 1994/95 – 2009/10 cited in Social Justice. Transforming Lives. DWP 2012
[58] ONS (2011) Census 2011 - Household Composition (KS105EW)

[59] Lewis E (2006) Promoting the Health and Well-being of Young People in Supported Housing - A practical guide for providers of supported housing and health services. National Children's Bureau
[60] Youth Justice Board (2006) Suitable, sustainable, supported: A strategy to ensure provision of accommodation for children and young people who offend. YJB, London cited in Barnardos (2011) No fixed abode. The housing struggle for young people leaving custody in England.
[61] Barnardos (2011) No fixed abode. The housing struggle for young people leaving custody in England.
[62] Communities and Local Government (CLG) statistics (2010, 2011 and 2012)