Inquiry into teenage pregnancy

Scotland's Commissioner for Children and Young People

Introduction

I welcome the opportunity to submit evidence to the Health and Sport Committee Inquiry into teenage pregnancy as Scotland has one of the highest rates of teenage pregnancy in Europe, with some geographical areas consistently higher than the Scottish average.

The United Nations Convention on the Rights of the Child (UNCRC)

In my role as Commissioner for Children and Young People, I have a statutory duty to promote and safeguard the rights of children and young people and to review relevant law, policy and practice to ensure their adequacy and effectiveness. Specific regard must be had to the UNCRC, especially requiring that the best interests of the child be a primary consideration in decision making (article 3) and that due account is taken of the views of affected children and young people (article 12). I must exercise this responsibility towards all children and young people under 18 (or under 21 if they have been looked after by a local authority or in care). Other rights relevant to this Inquiry include the right to appropriate and reliable information, including public health education (article 17), to good quality health care (article 24) and to education (article 28). There are also specific rights which relate to children in the looked - after system and those living in poverty. The principle of non - discrimination (article 2) - affording these rights to all children is also important.

The UN Committee on the Rights of the Child monitors implementation of the Convention and produces General Comments to help State Parties interpret these obligations. Two are relevant: General Comment 7[1] *'Implementing Child Rights in Early Childhood'* (2005) and General Comment 4[2] *Adolescent health and development in the context of the UNCRC (2003).* General Comment 7 makes specific recommendations around the provision of early childhood development programmes and focuses on prevention. General Comment 4 emphasises the following obligations: creating a safe and supportive environment for young people (within family, school, where they live, work and wider society); ensuring young people have access to information essential for their health and development; that health services for sexual and reproductive health are available for all young people; and that young people have the opportunity to participate in the planning for their own health and development. This General Comment also notes that health services for young people should be available, accessible and of high quality. There is a particular emphasis on young people from the most vulnerable groups.

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[1] Committee on the Rights of the Child (2005), *General Comment No.7: Implementing child rights in early childhood* (Geneva: Committee on the Rights of the Child, 2005).

[2] Committee on the Rights of the Child (2003), *General Comment No.4: Adolescent health and development in the context of the Convention on the Rights of the Child* (Geneva: Committee on the Rights of the Child, 2003).

a.) Do you have any views on the current policy direction being taken at the national level in Scotland to reduce rates of teenage pregnancy?

The Scottish Government (and previous administrations) have produced many welcome policies related to teenage pregnancy, particularly around sexual health. Scotland's first sexual health strategy *"Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* (2005), laid strong foundations and was set within a framework which promoted respect for self and others, emphasising children's rights such as involving children and young people in decisions affecting them and the right to accurate and balanced information. As part of this, NHS Quality Improvement Scotland developed appropriate standards for sexual health services provided by or secured by NHS boards, also useful benchmarks.[3]

The 2005 Strategy and the *Sexual Health and Bloodborne Virus Framework (2011) Strategy* have promoted an open view of sexual relationships and sexual wellbeing and the establishment of a group to look at 'stigma' and promote self-esteem. This aimed to de-stigmatise STIs and teenage conception. Other policy drivers include *Better Health, Better Care (2007)* and *Respect and Responsibility: Delivering Improvements in Sexual Health Outcomes 2008 - 2011, (2008)*. More recently, links have been made with alcohol and substance misuse, through *Changing Scotland's Relationship With Alcohol: A Framework for Action (2009).* The focus on supporting families and young people to make positive choices, on better education on substance misuse in schools and recognition of the value of youth work and diversionary activities, is welcome. It is likely that these policies have contributed to a small but consistent decline in teenage pregnancy rates over the last four years for under 16s and under 18s.

The 2005 Strategy underlined the crucial role of schools in fostering healthy attitudes towards relationships, sex and sexuality in young people, and an expectation that schools provide sex and relationships education (SRE). However, we do not know if all young people are in receipt of this, as limited data is available. It is worth noting that parents are keen for such education: a survey conducted by East Dunbartonshire Council in 2005[4] revealed that most parents felt that the SRE they had received from their parents and school had not prepared them for adult life and that they would not want their children to receive similar information and advice. They also felt that the responsibility for educating children and young people about sexual health was a joint responsibility between schools and parents/carers. Similar views were expressed by parents and carers across Glasgow. SRE should be available in all schools, whether they be denominational or non denominational, special or

[3] NHS Quality Improvement Scotland (2008), *Sexual Health Services: Standards – March 2008* (Edinburgh: NHS Quality Improvement Scotland, 2008).

[4] East Dunbartonshire Council (2005), *East Dunbartonshire Parents Views on Sexual Health and Relationship Education for their Children.*

mainstream, in accordance with articles 2 and 17 of the UNCRC. It must also pay particular attention to those from minority groups, such as BME communities, those with learning difficulties and LGBT young people.

There are examples of good practice around school - based delivery of education in Scotland and good collaboration between the NHS and education authorities allowing for quality SRE in primary and secondary schools. NHS Greater Glasgow and Clyde was recently commended for its rolling training programme, skills audits and cross-agency partnership training in the recent NHS Review[5]. There are also good examples of CPD for teachers who deliver SRE and probationer teacher training programmes. In principle, I would welcome further work around consulting with children and young people on the delivery and provision of SRE (in school and out of school settings). Engaging pupils in SRE will help to ensure that such programmes will be effective, but it requires an in -depth approach. Research conducted by the MRC Social and Public Health Sciences Unit illustrates: that very few young teenagers can anticipate the negotiation skills they'll need and that they will be unaware of the various options available for delivering sex education (including those shown to be most effective). Moreover, they are more likely to opt for the least embarrassing or demanding approach which might in fact be the least effective.[6]

However, I would urge caution in attaching too much importance to SRE in schools education. Clearly all young people should be in receipt of good SRE, but the focus should now move to early interventions and structural interventions that shape young women's life chances. Work should be focused around prevention and addressing the wider influences of poverty and a lack of aspiration amongst our young people. I would also like to see more of a focus on structured youth development programmes and harnessing the interests of those most disengaged and disadvantaged.

A key part of prevention is investing in the early years and early intervention, which are priorities for the Scottish Government. There are encouraging developments in Scotland with initiatives such as "Roots for Empathy" and 'Family Nurse Partnerships' (FNPs).

FNP's focus both on supporting parenting - laying the foundations for the long term health and wellbeing of mother and child is essential. One of the key success factors identified by nurses and clients was the strength and nature of the therapeutic relationships that family nurses develop with clients, which allows them to share their issues, particularly around mental health and

[5] Healthcare Improvement Scotland (2011), *Sexual Health Services Local Report: NHS Greater Glasgow and Clyde* (Edinburgh: Healthcare Improvement Scotland, 2011).

[6] Wight, D, and Stephenson, J, School-based sex education: evaluating teacher-delivered (SHARE) and peer-delivered (RIPPLE) programmes in *Teenage pregnancy and reproductive health* ed. by Philip Baker et al (London: Royal College of Obstetrics and Gynaecologists), 2007, pp. 263 - 272.

emotional wellbeing.[7] The NHS Lothian evaluation points to success in confidence building, economic self - sufficiency and improved wellbeing. The family nurses also felt the programme was impacting positively by allowing clients to reflect on their life goals and work through a plan to achieve these, with support from the nurse.[8] One aim of FNP was to reduce subsequent unintended teenage pregnancies. The evidence of this is less obvious. A view from the NHS Lothian, Edinburgh FNP team was that there was scope for further work within FNP nationally (UK or Scotland-level) around further pregnancies and the challenges/opportunities these bring for FNP teams. I would support this. Other interventions such as Mellow Bumps or Enhanced Triple P are also worth considering. I understand that these are currently being evaluated and look forward to the results.

b.) **Do you have any views on the action being taken at the local level by health boards, local authorities and other relevant organisations to reduce teenage pregnancy, particularly in the under 16 age group**?

There is much good work being done at local level across Scotland. For example, the engagement of young people and effective multi-agency work can be seen in 'The Healthy Communities Collaborative' (HCC) in Dundee, an evaluated and evidenced - based community action model which works with communities and partnership agencies to develop sustainable interventions. I understand that every secondary school in Tayside operates a health drop-in, which provides pupils with information and advice on sexual health, relationships and well-being and signposts to local services. Community pharmacies also provide young people access to free condoms, pregnancy testing and Emergency Hormonal Contraception. The 'Health Buddies peer-led education programme'[9] operates in four secondary schools in Dundee. I am aware of the recent evaluation (2012) and was impressed by the feedback from guidance teachers, parents and particularly from the young people who spoke about how their confidence and understanding had improved as a result.

We can also learn from the UK's teenage pregnancy strategy (1999). This provided an evidence-based approach to the prevention of unintended teenage pregnancy, prioritising the identification of risk and appropriate interventions - identifying young women and their partners and providing broad interventions, especially for those disengaging with school or looked after young people. By 2010, England had the lowest under-18 conception rate for over 20 years. Essential to its success was investing in a skilled workforce able to identify those at risk and provide the right interventions. *Early Intervention: Securing good outcomes for all children and young people*

[7] Ormston, R and McConville, S (2012), *Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland: 3rd report – infancy* (Edinburgh: Scottish Government Social Research, 2012), pp ii.
[8] ibid., p.31.
[9] NHS Tayside (2010), *Health buddies report: report of a peer-led pilot programme in Dundee - 2010*.

(DCSF, 2010) highlights good practice in reducing teenage pregnancies, supporting teenagers to access contraception, identified those at risk and provided sexual health advice and specialist support.

A workforce able to identify those at risk of teenage pregnancy and provide the right interventions is essential. Experience in England illustrates that this is achievable with the right leadership and clear partnership arrangements. Community Planning and Children's Services are the right vehicles for such work to be taken forward in Scotland. As with effective strategies to reduce teenage pregnancy, improved outcomes for teenage mothers, young fathers and their children need an effective multiagency approach. This demands identification in the antenatal period and sustained support from a lead professional who can coordinate and draw in specialist support if needed. Clear referral pathways and on-going support to prevent teenage mothers and young fathers slipping through the gaps are required, to minimise the chance of non-engagement.

c.) What are your views on the relationship between high levels of teenage pregnancy and socio-economic inequality?

There is a clear correlation between high levels of teenage pregnancy and socio economic inequality. In their most recent concluding observations of 2008, the UN Committee raised concerns at the high rate of teenage pregnancies, particularly among girls from a lower socio economic background and recommended that…."*the State Party intensify its efforts in order to provide adolescents with appropriate reproductive health services, including reproductive health'.* Providing such services are only part of the solution.

Evidence shows that teenage parents and their children are at increased risk of poverty. They are also at increased risk of the biggest causes of poverty; worklessness and low pay, whilst under 5s make up 44% of all children in poverty[10] like teenage pregnancy, poverty follows intergenerational cycles. Children born into poverty are at increased risk of teenage pregnancy, especially young women living in workless households when aged 11-15[11] . Pregnant teenagers are also more likely to drop out of school resulting in low educational attainment which can lead to low-paid jobs. Disengagement from school is often evident well before the teenager becomes pregnant so intervention strategies are essential as well as skilled professionals able to identify risk at an early stage. Essentially, success in reducing teenage pregnancy will depend on how we tackle the underlying structural factors.

Although numbers have fallen, Scotland still has some of the highest rates of teen pregnancy across Europe. Whilst figures vary across the country, those in

[10] Department for Work and Pensions (2008), *Ending child poverty: everybody's business* (London: HM Treasury, 2008), p.14.
[11] Ermisch, J., Francesconi, M and Pevalin, D. J. (2001), *Outcomes for children of poverty, Research Report 158* (Leeds: Department for Work and Pensions, 2011), p.83.

poorer areas under 20 are 10 times more likely to have a child and 2 times more likely to have an abortion than those who are better off[12]. The abortion rate clearly illustrates how teenage births are highly shaped by socio-economic factors. While there is a very clear social class gradient in teenage pregnancies, the gradient is much steeper, in the opposite direction, for abortions. Thus proportionately far more deprived young women become pregnant than affluent young women. But of those that conceive, affluent young women are far more likely to have an abortion than deprived young women[13].

Offering appropriate support to young people experiencing these underlying risk factors will help to build resilience and raise aspirations, thereby limiting poor outcomes - including teenage pregnancy. These risk factors are also found more often in the looked after population than among children and young people not in care and these young people are at greater risk of early pregnancy than other groups. The prevention of teenage pregnancy amongst these children needs careful consideration - they may need more intensive and tailored SRE and contraceptive advice as well as additional support to build resilience and educational attainment. Targeted interventions are potentially stigmatising and needs to be taken into account in the approach adopted.

d.) What are the barriers and challenges to making progress in achieving positive change in communities that might lead to reductions in the levels of teenage pregnancy?

The major challenge is to have a society in which young people's life chances are far more equal. A further challenge will be limited resources. Decisions are being made by local authorities against a backdrop of changes in staffing and budgets. Moreover, professionals working with families across universal and targeted services do not always have the knowledge and skills to be able to identify those most at risk and ensure that those in need access the right provision. Alongside skills development, there is a need for more hard data and longitudinal evidence to ensure early identification, targeting and support of young people at risk of teenage pregnancy, and assess the impact and cost effectiveness of interventions in Scotland. Further research to allow for comparisons across a range of issues and interventions would be useful.

To feel respected and valued, young people need to have confidence in health and other professionals. We know that confidentiality is important, but to do this in practice can be challenging. Many young people comment on not feeling respected and having their right to confidentiality infringed, with those under 16 in particular finding it hard to approach health professionals because of these fears. Without understanding confidentiality, trust between a young person and a professional is compromised.

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[12] ISD NHS National Services Scotland (2012), *Teenage pregnancy: year ending 31st December 2010* (Edinburgh: National Statistics Publication for Scotland, 2012), p.7.
[13] ibid.

Strategic leadership requires an understanding of what each partner agency contributes to delivering SRE and contraception/sexual health advice as well as good use of local data to reach those most at risk. Local people and frontline services should also consult and involve young people to find solutions.

e.) What are your views on the current support services available to young parents / young mothers, e.g. range of services, focus of services and whether services are being delivered in the most appropriate settings?

See answer to a)

f.) Are there specific initiatives that you would wish to highlight to the Health and Sport Committee that you consider indicate good practice with regard to reducing teenage pregnancy rates in Scotland, either in the public sector, voluntary sector or in partnership?

See answer to a) and b) and further examples provided below.

The Young Parents Support Base (YPSB) at Smithycroft School in Glasgow provides an example of engagement with young people, with a particular emphasis on continued education. This multi-agency scheme takes a rights-based approach and supports young women to maintain and/or return to education during their pregnancy and after the birth of the baby. Support includes developing parent-child interaction, exploring sexual health and relationship choices and providing guidance on giving up smoking and alcohol use. Advice and information on childcare and benefits is also provided which helps young people to think through their options, giving them some control over their lives. The emphasis is on a flexible approach; for example adapting the young woman's timetable and/or accessing continued educational support during the time she is absent for the birth of the child.

Initiatives which allow young people the opportunity to talk openly about their sexual feelings, "based around respect and strong relationships" are important, especially if parents find it difficult to talk about this. One example is the ccard in Angus, which helps to raise awareness of sexual health and wellbeing and increases access to condoms for young people under 25. Young people can talk in confidence about health concerns with professionals who can help them make informed sexual health choices. I have also been impressed by efforts made to encourage parents to talk to their children around these issues, such as the Talk 2 initiative, NHS Greater Glasgow and Clyde[14]:

[14] Fullerton, D and Burtney, E (2009), *Talk 2: feedback from parents, final report*, (Dunblane: Insights).

Brook, the young people's sexual health charity, takes a rights-based approach and provides clarity around confidentiality, consent and child protection; of understanding sexual consent is key to healthy relationships and preventing sexual violence. Their 'Education for Choice' promotes choice and aims to de-stigmatise all pregnancy options. The underlying point is that high-quality SRE should be delivered in a balanced and sensitive way by trained professionals who can complement the role of parents and carers as educators of children and young people.

g.) Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?

It is important to consider the role of young fathers. When young people give birth and become parents, this should be seen positively and they should be supported in the best possible way to parent their child. Children 1st research[15] illustrates that some young men have been galvanised by the pregnancy and birth to change their behaviour or way of life and to take on parental responsibilities. They note that young men are often ignored or portrayed negatively in public discourse and in interactions with support services and recommend a more nuanced approach which includes portrayals of the more positive end of the spectrum, where young men are highly participative and committed as partners and or parents. I support this view.

h.) Do you have any comments on any other aspect of teenage pregnancy policy or examples of good practice that you wish to raise with the Committee?

There are many reasons why teenagers become pregnant. I am interested in the findings from the Dundee qualitative study[16] which stressed the need to tailor interventions to the young person's readiness to prevent pregnancy and must take account of how young people feel about pregnancy and parenthood. Some will be positively inclined towards pregnancy, others ambivalent, whilst others are motivated to avoid pregnancy. They call for different prevention strategies when working with young people in different stages of readiness to prevent pregnancy, rather than assuming that one intervention will suit all people. (i.e. if a young person has positive attitudes towards pregnancy, improving knowledge about contraception is no use). They call for a targeted approach, i.e. focusing on those who are ambivalent rather than targeting adolescents actively seeking pregnancy might not be the best course of action. The point is also made that little qualitative evidence exists in Scotland in relation to teenage pregnancy and how young people

[15] Ross, N., Church, S., Hill, M., Seaman, P and Roberts, T (2010), *The fathers of children born to teenage mothers: a study of processes within changing family information practices*, (Edinburgh: Children 1st, 2010), p.9.
[16] Petcu, O., Eriksen, A., Swanson, V and Power, K (2011), *Perspectives on teenage pregnancy in Dundee: a qualitative study* (Dundee: NHS Tayside, 2011).

(particularly young men) view primary pregnancy prevention. I support further research in this area.

The reasons for high rates of teenage pregnancy are complex and varied. Effective responses will depend primarily on recognition of the underlying socio-economic and historical factors along with an understanding of the motivations of teenage mothers. Teenage pregnancy is both a consequence of deprivation as it is a cause and a failure to address the wider social and cultural influences on teenage pregnancy will impede progress. By and large our reproductive health services are working well. Our approach to improvement should be to: consider the evidence available on what works; make universal provision as effective as possible; and be prepared to complement this with targeted provision where appropriate.

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Commissioner for Children and Young People

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