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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 26 February 2013

Session 4

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HEALTH AND SPORT COMMITTEE
6th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Paul Bradshaw (ScotCen Social Research)
Professor Lawrie Elliott (Edinburgh Napier University)
Denny Ford (Who Cares? Scotland)
Alison Hadley (University of Bedfordshire)
Anne Houston (Children 1st)
Jane Hughes (Brook)
Richard Lyle (Central Scotland) (SNP) (Committee Substitute)
Joanne Milligan (Fife Gingerbread)
Lucy Morton (NSPCC Scotland)
Dr Alastair Noble (CARE for Scotland)
Terri Ryland (Family Planning Association)
Dr Jonathan Sher (WAVE Trust)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Tuesday 26 February 2013

[The Convener *opened the meeting at 09:46*]

Subordinate Legislation

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2013 (SSI 2013/40)

The Convener (Duncan McNeil): Good morning and welcome to the sixth meeting in 2013 of the Health and Sport Committee. As usual, I remind those present to switch off all mobile phones, BlackBerrys and other wireless devices, as they can interfere with the sound system.

Our first agenda item is to consider two negative Scottish statutory instruments, the first of which is SSI 2013/40. No motion to annul the regulations has been lodged, and the Subordinate Legislation Committee has not drawn them to the attention of the Parliament.

If members have no comments to make, do we agree that the committee has no recommendations to make on the regulations?

Members *indicated agreement.*

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2013 (SSI 2013/41)

The Convener: The second instrument is SSI 2013/41. Again, no motion to annul the regulations has been lodged, and the Subordinate Legislation Committee has not drawn them to the attention of the Parliament, although it noted that the National Assistance (Assessment of Resources) Regulations 1992 have been amended 15 times.

If members have no comments to make, do we agree that the committee has no recommendations to make on the regulations?

Members *indicated agreement.*

Teenage Pregnancy Inquiry

09:48

The Convener: Agenda item 2 is a round-table evidence session in our teenage pregnancy inquiry. I welcome the contributors to the committee.

As I normally do in a round-table discussion, I intend that we should all introduce ourselves. I am the MSP for Greenock and Inverclyde and the convener of the committee.

Denny Ford (Who Cares? Scotland): I am the corporate parenting officer for Who Cares? Scotland.

Bob Doris (Glasgow) (SNP): I am a member of the Scottish Parliament for Glasgow and the deputy convener of the committee.

Anne Houston (Children 1st): I am the chief executive of Children 1st.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

Terri Ryland (Family Planning Association): I am from the Family Planning Association.

Drew Smith (Glasgow) (Lab): I am an MSP for Glasgow.

Jane Hughes (Brook): I am deputy chief executive of Brook.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Mark McDonald (North East Scotland) (SNP): I am an MSP for North East Scotland.

Lucy Morton (NSPCC Scotland): I am a service manager for NSPCC Scotland.

Richard Lyle (Central Scotland) (SNP): I am an MSP for Central Scotland.

Dr Jonathan Sher (WAVE Trust): I am the Scotland director for the WAVE Trust.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Dr Alastair Noble (CARE for Scotland): I am an education consultant for CARE for Scotland.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Joanne Milligan (Fife Gingerbread): I am the support team leader at Fife Gingerbread.

The Convener: Thank you, and welcome to you all. Richard Simpson will ask a question to start us off. Throughout the discussion, I will look to the witnesses in preference to the members.

Dr Simpson: In our previous meeting, we talked about some of the statutory services that are available. We talked about family nurse partnerships and health visiting as two of the services that exist to support young mothers. We have representatives from the third sector here today, and I am interested to hear whether they feel that they connect with the statutory services in a co-ordinated and effective way.

I ask that question partly because one of the clerks and I were down in Oldham to see a highly integrated service with social work, midwives and the Brook clinic. They work together very closely and are co-located in the centre of Oldham. Those services work together very effectively in a town in a relatively deprived area that has managed to halve its teenage pregnancy rate to below the English average. Do the witnesses believe that they are truly engaged at the local level with those other services?

Anne Houston: The situation is quite varied. For example, Bathgate has the chill-out zone—a healthy living centre—which is jointly funded by health, the local authority and ourselves. Nurses and doctors provide services within that centre, as do our own workers. The local authority also has people going in and out. That is a good example of where engagement can work extremely well.

Some services in some other local authorities do not necessarily work in quite the same way. In some places, the case loads of health visitors have, at times, militated against the possibility of that way of working. We are supportive of a lot of the other services, but co-ordination is varied.

The Convener: You said that health visitors have militated against that way of working. Can you expand on that?

Anne Houston: The problem is their case load. Our experience means that we have been concerned for a while about the ability of health visitors to continue to provide services for young mums and others who are at risk. They tend to identify and target those who are most at risk initially, and our concern is that others might fall through the gap if they are not initially identified as being high risk.

The Convener: Does anyone else want to respond to the point?

Jane Hughes: My experience in Scotland centres on our service in Highland, where we have some strong partnerships. Obviously I am familiar with the service in Oldham, and the comparison that I would draw is that, in Scotland, we tend to engage more with the sexual health services. There is more health service provision and slightly less of a link with some of the social care provision. Nonetheless, there is good partnership working. We have also established good links in schools and youth settings that enable us to make some education-type interventions and to make links with the actual service provision, which is helpful.

Terri Ryland: We have, and have had, some projects that work directly with young people, especially one that works across greater Glasgow. We have some strong links with education and youth services there, and the project has worked well.

In the past, we have worked directly with parents across Lanarkshire and Dundee to empower them to talk to their children about issues linked with sex and relationships. We have made some very good links with statutory services in that area. More recently, we have been doing some joint work with Scottish Autism on sexual health and empowerment. That work is in its early stages but the partnerships are proving to be very successful.

Joanne Milligan: Fife Gingerbread is operating three teen parent projects in Fife, with a multi-agency steering group overseeing them. We have found that to be particularly successful, as we have been able to expand services by working in partnership with other agencies and voluntary organisations.

Dr Noble: CARE has produced a resource for schools in the area of sex and relationships education, but the word “patchy” would describe our experience of uptake. We are required to make a small charge for the presentations that we offer in schools, and that has presented some schools and local authorities with a significant difficulty. We have found a degree of antipathy towards the emphasis in our sex and relationships presentation, and I can say more about that later. We have found the experience patchy, and it has been difficult to take our resource into as many schools as we would wish.

Dr Simpson: One of the things that I was most impressed with in what is a very successful project in Oldham is the fact that, once the young person has made a connection to the services, which they were able to do in a fairly unstigmatised way—that is a bit like the chill-out zone in West Lothian that I am aware of—they get an individual worker, whom the other workers support. The worker might come from the Brook, or they might be the community midwife. It might be a social work person or a third sector person.

Once that link is established, it is taken through with the young mother in a way that allows her to be supported in an unstigmatising way. There does not seem to be the level of integration here that we need for supporting young mothers. We will perhaps come back to the subject of sex

education later, but it is the support for young mothers that I wish to emphasise.

Another impressive thing in Oldham is that the number of repeated pregnancies went down significantly. The third thing that impressed me was that, because there were strong links to the schools and all the schools were aware of their own statistics, the young mothers going back into school had a profound effect on the schools concerned.

Services in Scotland are not just patchy—they are very patchy, and they are not even integrated. That applies even at Gingerbread, where there is a multi-agency steering group but not a multi-agency co-ordinated system with one-point access.

Anne Houston: In addition to the chill-out zone, we have a young mothers group working out of Edinburgh, which offers very much the kind of support that you are referring to. It is run by Children 1st, and it is financially supported by the local authority, but it works hard to make links so that the young mums can link in with other services locally.

Dr Simpson: That is interesting. We heard evidence that the young mothers group in Tayside had been stopped when FNP was introduced. I thought that that was not good news.

Anne Houston: We have very positive feedback from the young mums about the difference that it makes.

Lucy Morton: The NSPCC is working with very vulnerable families, and we provide a joined-up service with a health practitioner and a social work mental health practitioner, working jointly with families. The services are joined up at the point of the interface with the family, very much in collaboration with the local national health service.

It is important for young women, especially in cases where there are issues of trauma and particular vulnerability, for the service that they experience to be joined up; it is important that there is not a variety of different professionals around the family, asking the same questions in different ways; and it is important to build up a relationship with the families over a lengthy period of time.

Joanne Milligan: Richard Simpson mentioned a central access point. The projects that Fife Gingerbread operates have a liaison worker or project worker who takes on the referrals and acts as a link to other services. The liaison worker provides that central point and consistency for the young parents who can then be passed on to other services.

10:00

Jane Hughes: I think that what has made the Oldham project successful is that there is a commitment to partnership working among the support staff not just at operational level but at strategic level. At policy level, there was clear leadership on the need for partnership working and a commitment to the use of resources in that way. The effect of partnership working both at a strategic level and at an operational level was what made that successful. Because there was that commitment, there was also accountability. That is what has made that project work and continue to operate over a number of years.

Anne Houston: Where such services exist, it is also important that they are linked in with local communities and provide community engagement and support over and above the specific services.

It is also really important to remember the young fathers as well as the young mothers. We have done quite a lot of research—in the past and currently—into the views of young fathers, and to many it was surprising just how high a proportion of the young fathers wanted to remain involved with their children. They do not necessarily want to be involved in a permanent married or settled relationship with the mum, but they certainly want to have input into their children's lives. That aspect is sometimes missed along the way, but it is really important that we take account of it.

Dr Sher: WAVE Trust is not a service provider, so we cannot recount instances of where integration is or is not working. However, I want to make the observation that where integration is least apparent and least effective is in the area of prevention. The services that we are talking about are being provided after the fact. I think that there is too little attention, too little agreement and too little integration in preventing the things in this arena that could and should be prevented.

The Convener: That is an interesting point, which perhaps takes us on. Dr Noble mentioned that his work is not always welcomed consistently.

Dr Noble: Do you want me to speak about that?

The Convener: Yes, I think that it would be useful following the point that Dr Sher made.

Dr Noble: Let me make three points. First, our view is that the balance in the advice and content of sex and relationships education in schools gives a very mixed message. Our view—this is gathered from parents, from teachers throughout the United Kingdom and from governors in England—of the impact of sex and relationships education generally in school is that the harm-reduction emphasis somewhat overshadows the need to encourage young people to delay sexual activity

until they are within a stable relationship, which in our view would preferably be marriage.

It is hard to fault the individual content of the advice that goes to schools and of the courses that are presented, but the net effect seems to be that the harm-reduction message assumes that teenagers will be involved in sex. Therefore, there is a kind of risk compensation problem, in that we may be encouraging the very thing that we are trying to prevent.

Secondly, we have produced a series of multimedia presentations for use at various stages in schools that seek to focus on—without ignoring the harm-reduction message—the need to encourage young people to value themselves, to value relationships, to understand the value of marriage, family and stable relationships and, therefore, to encourage them to delay activity.

Thirdly, I want to make something of a plea. I think that the antipathy to what we do is sometimes related to a feeling that there is no future in an abstinence-based approach to sex and relationships education or to encouraging young people to delay. We feel that there is a need for a serious pilot study of that approach, which we think has a significantly different emphasis from the generality of approaches that are currently taken in schools. We urge the committee to give serious consideration to that. The research evidence around abstinence-based education is mixed, but there are positives in it as well as negatives, and I do not know that anyone has ever seriously developed it.

The Convener: Are there any comments on the last two contributions?

Lucy Morton: Over the past year, more than 27,000 children and young people have phoned our ChildLine service to seek advice on sexual health and relationships issues. Those children felt that the service that they were receiving through their educational establishments was not sufficient because they were not getting the kind of information that they needed. Therefore, there is perhaps a wider question about the general effectiveness of an educational approach in thinking about tackling the causes of young pregnancy and other issues related to general vulnerability and health inequalities.

The level of cultural messages that children get are significant, and an important thing that the ChildLine service does, in addition to providing individual counselling, is to signpost vulnerable children and young people to other effective services that can offer a more personalised approach to the issues.

Denny Ford: In discussing education in schools, we should also consider the experience of looked-after children. Quite often, looked-after children will come into care at a point of crisis in the family home and might then be moved around quite a lot, with different placements while they are in care. That can mean that their education is disrupted, or they might go to many different schools. That has an impact on their opportunity to receive the consistent messages that their peers get.

Educational outcomes for looked-after children are much worse than for their non-looked-after peers. In 2010, 56 per cent of the non-looked-after population left school with five standard grades or more, whereas that was true of only 4.7 per cent of looked-after children away from home and of 0.5 per cent of looked-after children who were at home with their parents. The difference in educational outcomes is huge.

The difference in health outcomes is also huge. That is possibly due to inconsistency in the information that they receive due to their moving around and lacking consistent relationships with adults. In terms of processing information, if you are working with the same adults consistently, you are more likely to have a working relationship with them.

Terri Ryland: Denny Ford has said some of what I was going to say, but I also think that the information that young people receive should be appropriate to their age. There is a need for consistent messages, whether the young people access those messages from the education system or from youth services. It is important that young people have the opportunity to get the correct information and know where to go to for advice on sexual health and relationships.

Anne Houston: One difficulty is that we tend to look for an answer, but I do not think that there is one answer.

There is a complex range of reasons why young people become pregnant. For some, alcohol or drug misuse may be a contributory factor in an accidental pregnancy, which was unintended but just happened. Other young people might be ambivalent about having, or proactively wish to have, a child. Certainly among the young people whom I have worked with over the years, some young women have talked about having no other aspirations at that point in time. They were unsure of their identity and had no sense of achievement. Sometimes, they just hope that a baby will love them and that they can love it and that that will fill a bit of a gap. Therefore, I think that we need to look at very different responses to those two groups.

There are also issues of abuse for some young people, and pregnancies can result from abuse. It can either be an adult abusing a child or peer-to-peer abuse. Unfortunately, some of the research

around young women's views of themselves, their sense of self-esteem and what they can expect of sexual and other relationships shows that they are often negative and that young women often find themselves in abusive relationships. There are so many reasons and contributing factors and no one simple answer, so a range of issues lies behind young women's pregnancies.

The Convener: Do other panel members want to contribute?

Jane Hughes: At Brook, we provide both sexual health services and education and support services. Young people consistently tell us that the sex and relationships education that they receive is too little, too late and too biological. What they ask for is education support that equips them with the language and skills to manage their relationships effectively, understand appropriate and inappropriate behaviour, and enable them to resist peer pressure. They tell us that they often do not receive that type of education, although it is what they need. As Terri Ryland said previously, the education should be age appropriate and provided throughout their years of education.

The Convener: As no other panel members want to comment at this time, I bring in Bob Doris.

Bob Doris: I want to ask Dr Noble briefly about some of the challenging comments he has made to the committee, and then explore them a bit further—I had hoped to ask a supplementary question earlier.

Dr Noble, you referred to the benefit of an abstinence-based programme in schools. The language that I have tended to hear is that of informed choice in schools. I would be worried about a programme that was based just on abstinence. I suggest that a more nuanced approach would be to include abstinence as one of a number of options for young people.

I do not want to get the wrong impression from your evidence to the committee, so can you clarify whether you advocate a solely abstinence-based approach? You also referred to not getting access to some schools. I certainly believe that abstinence should be presented to young people as an option for informed choice. I think that it is reasonable to ask whether your organisation or the schools should present that option. However, some clarity around that would be useful for the committee.

Dr Noble: I used the word "abstinence", with inverted commas around it, simply because it is a common term. I know that it is a bit confusing because it sounds like celibacy, which is not at all what we are talking about. I think that it is better to talk about encouraging young people to delay sexual activity until they are in a stable relationship, which we would say would preferably be marriage. I use the term "abstinence" because it is in the literature and it refers to the emphasis on encouraging young people to delay.

The point that I wanted to make was that I think that there are mixed research messages around abstinence that include some positive messages. I do not mean to suggest that we should encourage only abstinence. I was trying to say that our view is that the balance of sex education in schools too often tips towards harm reduction and contraception. We need a higher profile for the message that there is value in delaying sexual activity, valuing relationships and anticipating relationships for the future. It is a mix, but I am simply saying that I think that the balance has tipped too far in the direction of harm reduction and assuming that teenagers will be involved in sex, which perhaps inadvertently encourages the very thing that we are trying to prevent.

Bob Doris: I think that you have clarified your position. However, using the word "encouraging" could be interpreted as preaching to young people. If the evidence shows anything, it is that preaching to young people can have a negative impact. As I said, the language that I have heard refers to informed choice.

We have heard, including at last week's committee meeting, that some of the dynamics around why young girls are sexually active relate to a lack of empowerment, self-esteem and self-worth issues, and low aspirations. They do not manifest themselves only when young people become sexually active. I suggest that they manifest themselves in primary school and possibly even pre-school.

My question to the witnesses is: as part of a strategy to reduce unplanned teenage pregnancies, are we doing enough to get the basics right in primary school and pre-school to empower not just young women but all young people? Young men also have to think about what the future would be for their daughters if they have daughters. Young people need to be empowered early. Can anyone point to any good work that is being done or raise any issues that show that there is a gap in such provision?

10:15

Dr Noble: Can I just make a further point on that?

The Convener: Yes.

Dr Noble: I have clearly given the wrong impression. The materials that we have developed for schools tackle that very point. It is about raising people's self-esteem, showing them how to resist peer pressure, and stressing the value of the individual and the importance of their decisions. I

think that I gave the wrong impression by using the word “abstinence”.

In doing the very thing that Bob Doris is talking about, we raise the possibility of young people thinking seriously about whether they wish to be involved in sex and to consider delaying it. We do not have a lot of empirical data on that, but we do have some. In the schools in which we have been working, there is some evidence that young people have considered those decisions more carefully than they might have done previously.

Bob Doris: My apologies for not giving you the chance to respond to a comment that I just left sitting there.

Dr Noble: I was happy to do so.

Bob Doris: Are there any good examples of empowering and informing young people and raising their aspirations in primary school and pre-school? Is enough being done?

Terri Ryland: Some projects or education emphasise sex and relationships, which are, of course, important, but a lot of the work is around resilience and empowering young people. FPA has a number of projects—and I am well aware that Brook also has a number of projects—and when we are working with young people, one of our key activities is to talk about resilience, self-esteem and respect, as well as key messages about consent. Sex and relationships issues are built into that work.

The other key point is about healthy and positive relationships. It is important to say that a lot of programmes emphasise that.

Anne Houston: To pick up on Bob Doris’s point, in Scotland we are talking a lot about early years and I do not think that it is ever too early to start thinking about self-esteem and confidence, and all the other things that children begin to develop at a young age. I guess that some of that will be about working with young parents, as well as ensuring that our early years provision is in place. I am on the early years task force so I am aware of what is being looked at, but we must continue to push that work and see that, in time, it helps with the problem that we are discussing.

We have talked about raising the issue in schools and at pre-school level. We in Scotland are not at all good at talking about sex in general. If children are going to learn about it at a very young age, it needs to be something that we talk about in everyday language when it comes up and we have to deal with it. We need to help children at all stages learn how to engage in relationships because, ultimately, relationships underpin everything to do with sex. Yes, they need information about contraception and choices, but they also need to know how to build relationships, and that should start at the very youngest age.

Dr Sher: I would like to bring to the fore one of the issues that WAVE covered in its submission to the committee. There should be some consideration of what society as a whole and the committee in particular is trying to prevent, and what is the focus of the committee’s inquiry. My understanding is that the inquiry is not about teenage sexual behaviour or teenage relationships, important though such issues are. It is rather an inquiry about teenage pregnancy, which is only an occasional result of teenage sexual behaviour. It is not that the other is unimportant, but some clarity is needed about what is being examined and what you are trying to prevent.

I hope that the committee will be clear about that, because there seem to be a couple of presumptions that are not supported by much evidence. One is the presumption that sexual behaviour among teenagers can be prevented. There is not much evidence in history that will support that goal, however desirable one might think it is.

The amount of sexual behaviour is also being exaggerated. It is useful for teenagers, as well as society, to understand that it is not the case that all teenagers are having sexual relationships. Part of informed choice for a particular teenager is understanding that he or she is not the last person in town who is not having sex but that, whether by choice or not, that is the reality for many teenagers.

There also seems to be an assumption that teenage pregnancy is inherently and always a bad thing. I encourage the committee not to take that view because there is no evidence to encourage the belief that it is always a bad thing. There are absolutely times, circumstances and situations in which it is disadvantageous to the young mother, the young father and the child they will have. That is where prevention needs to come in, but the starting point should not be that it is always a bad thing and should always be prevented.

Bob Doris: You make a valid point, Dr Sher. For clarity, do you agree that—to go back to the idea of informed choice—it is not about making a moral judgment about whether young people should or should not have sex, because that will happen, but about whether it happens with appropriate consent, in a pressured environment, without taking precautions or because of drug or alcohol abuse? I put it to you that it is about the context in which young people are sexually active.

Do you accept that many of the core skills that young people need are not about sexual behaviour, although it is important to have safe

sex, but, in the early and pre-teen years, about having self-esteem, valuing themselves and having aspirations—not as a moral judgment—because that means that, when young people decide that they want to start a family, they and their children are far more likely to have positive life outcomes?

I totally accept everything that you said, but do you still believe that it is important to do much of that work in the early years?

Dr Sher: There is no question about it. In fact, one of the WAVE Trust's claims to fame is that the organisation was largely responsible for bringing initiatives such as the roots of empathy programme to the UK from Canada. In that programme, babies are brought into primary schools. Just so that there is no misunderstanding, I clarify that the idea is not to encourage primary school students to have babies. It is about the roots of empathy and helping people—even at a very early age—to gain an understanding of what the empathetic relationship between a baby and a parent looks like as a way of encouraging their own understanding of child development and a way of understanding their own relationships. It gives a positive role model.

Absolutely—early intervention is good. In our submission, we suggest a variety of things that are entirely worthy of being prevented. However, those comments are about preventing conception in certain circumstances that we outlined. We also need to prevent a situation in which pregnancy and having a baby seem like the only viable option. That is not just a sexual health issue; it goes much broader than that. One thing that we as a society absolutely need to prevent is the notion that having a baby is the answer to the universal quest to have a meaningful life and a place in the community and to be taken seriously as an adult. We are in trouble if we create a society in which people believe that that is their only way of transitioning to adulthood and of having meaning in their lives. Having a baby as part of a meaningful life is a choice that I and I am sure many of you have made; however, it was not the only choice that I had. The issue perfectly exemplifies why this inquiry needs to go beyond sexual health and to take in the broader context of what we are trying to prevent and why we are trying to prevent it.

Denny Ford: As research in England has suggested, teenage pregnancy can sometimes be a positive thing for the individuals concerned. I am sure that everyone in the room agrees with the concept of striving to give your children a better life.

One societal problem is the stereotype associated with being a teenage mother or father, which has had a particular impact on the looked-after population who, in many cases, have already been stereotyped by society as problem kids and for whom being pregnant simply adds another stigma on top of what they already have to face.

Perhaps we should approach the problem as we would approach a garden hose that has been left running and is swinging about by the back door. It is sometimes easier to turn these things off at source and, if we are to address the various societal and cultural problems in Scotland and the UK, we need to recognise that there are disadvantaged groups everywhere and start to deal with educational and health outcomes, the places where young people are being sent to live and so on. Until we address the many socioeconomic difficulties that are out there, we will find it quite difficult to move forward.

Lucy Morton: Dr Sher is absolutely right that not all teenage pregnancies are necessarily a bad thing, but we need to focus on vulnerability and think about what works and what we know works with vulnerable groups. If people are having babies because they think that it will give meaning to their lives, we have to think about what we are passing on to the next generation and the role that those babies are being asked to fulfil in those families.

When we work with the most excluded and vulnerable young women and families who are having children, we find that there may not be an understanding of a baby as a separate individual and as a creature with needs and wants of its own. The notion of the baby as an extension of the young person and as fulfilling something for the parents is potentially quite dangerous for it and some of the techniques in our minding the baby programme, which very much builds on the theoretical basis of family nurse partnerships, focus on working with vulnerable young people who have limited resources and often have experienced trauma themselves, trying to get them to think of the baby as a separate individual and ensuring that we do not start another cycle of attachment difficulties that will carry on to the next generation.

Dr Sher: I could not agree more with your point about the potential harm to children if people who become parents have unhealthy and unhelpful ideas about who the children they have created are. Unfortunately, however, the problem of having children for reasons that have nothing to do with the child's wellbeing, which can sometimes lead to maltreatment, is not age-dependent. It is not peculiar to teenagers but goes across age groups.

10:30

The Convener: The committee has arrived at this point now, but everything that we have

discussed in the past hour or so was discussed a number of years ago. At that time the strategies that you have supported since then were worked out, and an objective was set to reduce the number of unintended teenage pregnancies. However, that has not worked. What do we do now to improve the situation?

Do we broaden the objective so that it relates not simply to reducing the number of pregnancies? Do we measure the incidence of sexually transmitted diseases rather than just pregnancies or terminations? Where are we now, and what should we do? What are the issues? Dr Sher was right to say that we need to be clear on that. Have the issues changed since we set the objective and supported those strategies? If they have not changed, should they?

You have the opportunity now not just to confirm from your evidence what many of us already know, but to tell us what we should do next. Do we just continue to support the strategies as they are?

Lucy Morton: My plea is that you should look at the evidence for what we know works, which forms the basis of the services that the NSPCC provides free at the point of delivery across the board in various communities in Scotland. We have a robust evaluation programme for everything that we do so that we can try to understand the impact.

We are trying to understand how the minding the baby programme, which emphasises parental as well as infant mental health, changes the parental relationship with the baby to make things better and improve attachment. That has been the result in America, where the programme was developed, and where it has been found to reduce subsequent pregnancies for young vulnerable women who may still be teenagers. That is something that family nurse partnerships have been working on in Scotland.

We need to focus on the evidence and on vulnerability. Education issues are not our area of expertise; we need to think about children who are at most risk of harm and the next generation of children.

The Convener: The objective that was set for the strategies was not to look after young mothers more effectively—although that was a subsequent issue—but to reduce the number of pregnancies. I presume that Governments and professionals at that time decided that, in the majority of cases, it is not a good idea for a 16-year-old to have a child. I do not know whether anyone here would recommend it for their own children; I think that they probably would not.

Dr Noble: At the risk of sounding a little smug, we are dismayed that, as the convener says, the current strategies do not appear to be working, and we urge the committee to take a fundamental look at the emphasis of those programmes, particularly with regard to sex and relationship education in schools. Our suggestion, as I said earlier, is that the overall emphasis may be wrong and we need to address that.

One issue that concerns us, although I may exaggerate a little, is that parents are somewhat marginalised. We need to listen to what parents feel and what they have to say about the issues. I do not know whether there is a great deal of evidence on what parents think about sex education in schools, but in 2004 or 2005 the Scottish Catholic Media Office carried out a survey. It found that almost 70 per cent of parents were in favour of the type of emphasis that I have described, which involves encouraging "abstinence" and delay, as well as building self-esteem and understanding how to handle peer pressure. We should listen to what parents have to say and engage them more actively in the process and in the specific schools programmes. I know that that is in the guidance, but the extent to which it is not happening gives us some concerns.

I do not have a glib, easy answer; I am simply saying, in response to the convener's comment that current approaches do not appear to be working, that we suggest a fundamental review of sex education in schools.

Joanne Milligan: I will detail what we do in Levenmouth, which is working. We started to work with teenage parents over three years ago. We have found that, by raising the aspirations and skills of teenage parents, they are able to give appropriate peer support to other teenagers in the area, and we have seen a reduction in the number of first pregnancies and subsequent pregnancies. There is definitely a connection between supporting parents and their being able to change the culture in their local areas. We have supported nearly 250 parents, including dads, and more than 200 children have been supported. We are working with the children of those parents in early interventions and, by working with the parents, I hope that we are raising the bar for the future of the children.

We also have the gateway project, in which there is work with families in schools. We identified that there was a barrier to engagement, so our team works with families in schools. Family learning is looked at, and sexual health will eventually be looked at. We are getting the message to both parents and children, and we are raising aspirations and relationships.

I wanted to highlight that that approach is certainly working.

Anne Houston: When the convener asked his question, I struggled for a moment, because it takes us back to what I said earlier. It is not a

matter of one size fitting all; we need to do a lot of different things. I mentioned the early years work. It is a matter of getting in there early and working with young or older parents on their relationships with their children, how we build self-esteem, and how we build the ability to talk about things as people get older so that relationships are established and issues that, as I said, we in Scotland are not very good at talking about can be discussed.

Over and above that, there is the community level. We have to involve communities much more in supporting young parents and, indeed, young people, because quite a number of young people are quite alienated from their communities. We have to do a lot of work there. We have to work with young people and young parents where and when they want to be worked with so that they engage with the services. A lot of work must be done around what healthy relationships look like at all the different ages and stages.

I return to Richard Simpson's point about whether we are really applying the getting it right for every child approach and working together to get the best for children, whatever age they are. We can do more, but the reality is that, as young people get older, there are issues to do with their aspirations, training, employment and poverty that we cannot duck and which are absolutely relevant to some of the things that Jonathan Sher, I think, eloquently described in respect of why young people sometimes become pregnant in a much more intended way. That can be a way to find some identity for themselves. There are issues such as young people's use of alcohol. All sorts of strategies are being looked at to deal with such issues. That contributes to the situation as well.

There is a specific and small question that might be helpful. I know that, once there is a pregnancy, the mother is asked at the point of booking a midwife whether they have ever experienced domestic abuse. They should specifically be asked whether they have ever experienced sexual abuse. Many years ago, research was done in England by Dr Rhoda Oppenheimer, who routinely asked every woman who attended a women's clinic whether she had ever been sexually abused. Quite a significant number of women said that they had been. They could not have raised that issue themselves, but they were asked that question specifically. Asking that question would perhaps give people who have experienced abuse the opportunity to get additional support and to be able to remove themselves from abusive relationships. That is just one tiny, specific example. The other questions are much bigger, and I do not think that they are either/or questions. That is part of why the issue is so difficult.

Denny Ford: Listening to and actually hearing young people is crucial to the process. Recently, we did a consultation with some young people for the proposed children and young people bill, and it came across—this has been a recurring theme over the years in our consultations—that young people feel that care is something that is done to them rather than with them. That is particularly felt by looked-after young people. If you take evidence directly from young people, you will get a real expert view and a powerful testimony. We can get better at listening, hearing and acting on what we hear.

The Convener: We have a couple of sessions planned for next week at which we will deal with young people directly.

Jane Hughes: I support much of what the previous speakers have said. Going back to your original question, convener, I think that it is important that there is a strategy. If the powers are delegated to local authorities, it is important that they are held accountable and that support and guidance are provided on commissioning appropriate services to deliver against the strategy. It is critical that SRE is made statutory in the curriculum so that it is not patchy and there is a consistent approach for all young people.

It is key that any strategy specifically on teenage pregnancy is tied in closely to the other strategies that we have discussed, such as those on drug and alcohol use, and that they are not treated separately. The issues that we have discussed this morning demonstrate the links between the social issues that impact on teenage pregnancy.

Dr Sher: I appreciate your bringing us back to the point of the inquiry, convener. In WAVE's submission, we suggest seven specific things that we encourage the committee to take seriously as what is to be prevented. Part of the problem comes when there is only one measure. The criterion that launched the committee's inquiry was the fact that, in comparing the overall teenage pregnancy rate in X year and the rate now, although we could see that the rate had come down, the target was missed by a wee bit. If the committee remains wedded to the overall teenage pregnancy rate being the only way in which the problem is defined, I am not sure that you will get to new, different and better places.

I am suggesting—particularly following Anne Houston's comment that, when it is a problem, it is not a single problem with a single solution—that the problem needs to be disaggregated in terms of what you are trying to prevent. I suggest that a prime target for prevention is to deal with the reality that more than half of pregnancies now end in terminations. They are pregnancies not of people who are keen to have children—for reasons good, bad or indifferent—but of people for

whom it was unintended and undesired, and the consequence is a termination. That is not a cost-free reality for any of the people involved. Doing what is possible to prevent pregnancies that will inevitably end in terminations is a good place in which to start focusing on prevention, because in those situations there is not a good outcome for anyone.

The other thing that I suggest concerns two other factors that are within the Health and Sport Committee's remit. One is that we continue to have an unhealthy relationship with alcohol. It is still the reality that more than a few, and more than a small percentage, of teen pregnancies were not only unintentional but alcohol fuelled. Focusing on what can be done not just on the sexual health side but to increase healthy relationships with alcohol would have the side effect of reducing teen pregnancies, so it is also important to focus on that other health issue.

10:45

The other factor, which is also in the committee's remit, is mental health. I do not have the facts and figures—because, to the best of my knowledge, they do not exist—but, anecdotally, I have been around long enough to know that it is not uncommon for some young women who get pregnant to have underlying mental health issues, such as addiction, learning disabilities or other problems that have not been addressed properly as mental health issues. As with alcohol, the consequence is a pregnancy that is not intended and that is neither healthy nor desired. Part of the solution to the problem part of teenage pregnancy is to deal more effectively with adolescent mental health issues. However, unfortunately, that continues to be one of the weaker spots in Scotland's overall health provision.

Gil Paterson: I need to take us back a bit, as my questions are on peer pressure. I will ask two questions, if that is okay. Are we doing enough with young men on peer pressure? I understand that male-on-male peer pressure is considerable, but more important is the pressure of the power of males over females. Is work being done in schools in that regard?

My second question—which is related—is about the evidence that we have heard about there being insufficient expertise in some schools. I do not believe that that applies across the board. Is there reluctance on the part of teachers or the system because of pressure from outwith the school, from parents? A teacher might be very good at such work, but feel reluctant to deliver it properly because of things in the outside world, one of which might be pressure from parents not to be explicit.

Anne Houston: My answer to the first question is that we are not doing enough. On your question about schools doing work on that, we provide services in schools that are broadly about raising awareness on domestic abuse, for children in primary school or in the transition between primary and secondary school. Obviously, those programmes come at the issue in a gentle way. The purpose is to raise awareness of domestic abuse and relationships between parents. More generally, they look at how young people relate to each other in relationships. Our experience is that that is extremely well received in a number of schools and it is evaluated highly in terms of the difference that it makes to young people's attitudes by the end of the programme, and in terms of how useful it is outwith the programme.

I have to say, however, that some schools are reticent about allowing that kind of discussion. I suppose that that goes back to my earlier point that we do not find it easy to talk about sex. In some places, a variety of methods for raising the more difficult issues are not well accepted. Certainly, we are welcomed with open arms more in some schools than we are in others. That is a real loss for the young people in those other schools. We need to address those issues.

Jane Hughes: Anne Houston is right about the variation between schools and that some are more receptive to that type of approach, which is why there is value in external agencies working alongside schools to provide that support. Joanne Milligan mentioned work on peer education and peer mentoring. From our experience, that can be valuable as it engages and supports young women and men, in particular through work on reducing peer pressure and on learning how to respond to such pressure and to make informed choices and decisions. There is real value in services working together on that. A number of third sector organisations in particular have some really good programmes for working with schools—and, indeed, in informal education settings—to provide such support and input.

Terri Ryland: I would echo what Jane Hughes said, particularly on peer pressure and working with young men. Some services work directly with young women and some work directly with young men. Some of our experience has shown that working with young men and young women together is beneficial. That is particularly the case with work on peer pressure and with work on relationships and domestic abuse, because part of the problem is the level of understanding and acceptance among some young people, who will say, "It's all right for my partner to just slap me." When we talk with young people about whether that really is okay, we can get back-and-forth discussion between the young men and the young women. That is a key area that needs to be

considered. Many life skills are key elements of sex and relationships education. Sometimes, we talk about life skills—skills that everyone needs—and we can then build the sex and relationships on top of that.

Gil Paterson: We know that there is good practice in certain schools and that it is not happening elsewhere, so can you identify—without naming schools; I do not mean that you should do that—such a model? Is it found in a particular type of area or is it to do with the heidie—the headteacher—having a particular ethos? Is it found in non-denominational or denominational schools? Is there something that will predict for us that the good practice will happen, or is it something we cannot predict at all?

Anne Houston: Good practice can be because of the heidie, who has a lot of power. It depends to some extent on how forward-looking and open the headteacher is.

We have experience that has to do with, I guess, a certain belief base. I do not want to characterise it totally as being to do with non-denominational or denominational schools, but there have been occasions when we have had more difficulties in some of the denominational schools—I will put it like that—although that is not exclusively the case.

Jane Hughes: There are number of factors; for example, school governors can also have an influence. It depends where the priorities lie.

Earlier Dr Simpson mentioned the example of a project in Oldham. At one point, all the schools there were involved in such activity and the driver for that was competition. When the schools were provided with information about the number of teenage pregnancies among their pupils—either while the young women were in school or within a year after leaving school—they wanted to compete with their peer schools, bring services in and provide training for their staff to enable such support to be provided to young people. That work focused very much on self-esteem rather than specifically on SRE. There was targeted work with young men and separate targeted work with young women. Peer education was used as one of the strands to support that.

Denny Ford: I echo that. One of the things that has come across from the young people with whom we have worked in the past is that learning in school—even if it is "informal"—can sometimes still be quite a formal setting for young people. The environment in which such education takes place can make it unsuccessful.

As Anne Houston said earlier, working in the young people's communities with youth workers would sometimes be a good way to go. There are many cases of that, but there are budgetary restraints on youth work services in Scotland and throughout the UK, which is another problem.

Lucy Morton: If we focus on schools too much, there is a danger that we do not focus on the most excluded groups and on the most vulnerable young people, who either attend school sporadically or find it difficult to engage in that type of educational setting and do not have the back-up from their parents that would reinforce the positive messages. On Jonathan Sher's points about what we want to achieve in relation to the pregnancies that are the most harmful and which have most implications for the next generation, we should think about how we target the most vulnerable young people.

Drew Smith: This will possibly—but possibly not—follow on from that. I do not want to caricature what Anne Houston said, but she seemed to characterise three groups—I understand that they are not exclusive, and that they overlap. One group is young women who become pregnant accidentally, for a range of reasons, including abuse. There is another very complicated group who are ambivalent about becoming pregnant, if I can describe it that way. Dr Sher took the issue a bit further when he spoke about breaking down the national targets around reducing the number of pregnancies. Essentially, the national target does not reflect the picture that sits underneath it. How can we genuinely make policy differently around those groups, instead of just saying at national level that we want to reduce the problem, when all the people who are charged with doing that are saying that the landscape is much more complicated than that, and that we will end up—as the convener said—just having to repeat the exercise in five or 10 years, as we have done before?

I was struck by Dr Sher's view that it might be possible to make most progress with girls and young women who become accidentally or unintentionally pregnant and then choose not to proceed with their pregnancy. However, there seems to be a tension there. Is society's driver not actually a reduction in the number of teen pregnancies, but concern about young mums, and is the reason why we do not focus on that group—you seem to be saying that we could make more progress there—that we are concerned about the number of children who are growing up with one or more young parents? Is that a bigger tension that we need to solve at societal and policy-making levels before we can make a real difference? I am sorry if that is a very broad-brush question.

Dr Sher: I would respond in two ways. One is to say that WAVE's role is to suggest possibilities to the committee; it is the committee's responsibility to decide what its priorities are and what it is keen

to prevent. However, I wanted to present the committee with alternatives, rather than just one idea, to think about.

The other way in which I would respond is to acknowledge that there is a concern about young parents, but to say also that we need to do a better job by seeing young parents not as a problem but as a reality. There have been, there are now and there will continue to be young parents, so the smartest thing that society can do in relation to them is to ensure that they have whatever support and assistance they need in order to be successful young parents, for their own benefit and for the benefit of their children. To take as a starting point that young parents are a problem is not as strong or healthy a starting point as accepting that they are a reality and asking how we can help them to succeed in parenting and in creating good lives for the children whom they have created. That is a different approach, which I think would have a lot more success.

11:00

Drew Smith: That leads us to understand that we need to take a different approach. If our concern—which is driven by society—focuses on whether young people are sexually active, we are not addressing the three broad groups that we have been talking about.

I will ask one more specific question. As the witnesses will all be aware, the committee has received written evidence about access to sexual health services in schools, which has understandably been picked up in the media's coverage of our work. Our evidence sessions with health professionals and educationists last week raised the question of our understanding of what young people want in school. I am interested in hearing from the witnesses today about the experiences of the people with whom they work.

Last week we heard completely differing views. Some young people want, if it is appropriate, contraception or other sexual health services at school because that is the place that is most convenient for them, but for other groups of young people school would be the last place that they would want to go for those services. However, it seems that answering the question in that way makes it easier for us as policy makers to ignore the question whether we should do more in schools. I am interested to know how we can find out more from young people about where they would access services—whether that would be in schools or not—and how we can genuinely understand their needs and wants in that regard, rather than thinking simply about our needs and wants as service providers.

Anne Houston: We have talked to many young people over the years about their experiences in schools, on which they have clear views. They do not want a teacher who is very embarrassed about the subject when he or she tries to talk about the practicalities of sex education rather than the health or relationships aspects. Sometimes, the sex education takes place in fairly large groups and the young people and the teacher are embarrassed, and the whole thing is a bit of a disaster. We hear on a fairly regular basis that that is really not what young people want.

I mentioned our chill-out zone—a drop-in healthy living centre—which attracts a lot of young people who otherwise have not engaged with, or would not engage with, some of the more formal settings for their health and relationships education. They say that they need a place where it is safe to talk about things, where people will not laugh at them, where the group is not so big that they feel embarrassed to talk, and where people whom they trust genuinely engage with them, are honest with them and are not embarrassed to talk about the whole subject and whatever else the young people want to talk about, so that they have an opportunity to ask questions. There needs to be consistency so that young people can build up that level of trust with one person or two people—whoever is working with them—and build up to ask the more difficult questions that they would certainly not ask elsewhere.

Such things make a difference, as we hear very clearly from young people. We are currently doing some reality-simulating work in the chill-out zone—for example, we have a pregnancy suit that young men and women can wear so that they understand the reality of what pregnancy feels like. We also have realistic dolls that they can take away, which cry and keep them awake for half the night, if they are really thinking about pregnancy.

Some of those things are very resource intensive, which is a difficulty, but we work with vulnerable young people who often do not engage with more formalised methods. They say that those approaches shift their attitudes quite significantly and enable them to begin to talk to each other in their own relationships, as young women and young men, about what they might want.

Denny Ford: I want to follow up Anne Houston's point. Over the past couple of years, Who Cares? Scotland has worked on a national training programme on corporate parenting for elected members and NHS board directors. As part of the training films that we have been making, we have been fortunate enough to interview young people in every local authority. One thing that has come across is that young people are quite happy to sit and talk about their

accommodation experiences, their education experiences, their experiences accessing leisure, and their hopes and fears for the future in terms of their care background, but getting them to talk about health is sometimes—pardon the pun—like drawing teeth. Among the looked-after young people whom we work with, health can sometimes be a low priority and getting them to engage on any level can be a challenge.

Jane Hughes: I support what Anne Houston and Denny Ford have said. At Brook, when we establish new services we always consult young people—those who have been service users and those who have not. That is a critical point.

That perhaps goes back to the earlier point that young people have different views, so what they need is choice. Therefore, as well as services that are provided in schools and colleges, there is a need for services out in the community. It is crucial that young people be made aware that those services are available, that the services are well publicised and that the young people feel that they can access them. They need to be able to feel comfortable when they visit services, so the staff need to have the right attitude and approach.

That is where education can play a part; if people from those services go out into communities, schools or other youth settings, that starts to build up a link between the service and the young people. Very often, young people may feel more comfortable with a worker out in the community or an education worker; that can help to overcome some of the barriers and fears about accessing more clinical services. Therefore, I think that the issue is about providing that choice and a broader approach.

On how you find out whether you are going in the right direction, it is really important that the young people are given a voice, such as by hearing from them as the committee will do next week.

Lucy Morton: I agree with the last three witnesses on the need to think about how we meet the individual needs of vulnerable young people in particular. Denny Ford mentioned that vulnerable young people are reluctant to talk about health issues, but that is not borne out by calls to ChildLine, in which young people are keen to talk about relationships and sex and health. Certainly, there is a point about confidentiality and trust. When young people start to talk about sex and what has happened to them that might not be safe, they worry about what will happen to that information. We have to take that worry seriously. Our ChildLine service's work bears out the point that young people want to talk about these things, but they value the confidentiality that our service provides.

Dr Sher: One thing that would perhaps be agreed on, and understood by, everyone around the table is the role that child maltreatment—child abuse, child neglect and witnessing domestic violence—plays in all this. Reluctance to talk about these issues is partly because the young people are required to confront some of the harm that they may have experienced in their lives. Child maltreatment is an undercurrent here, and preventing child maltreatment is absolutely essential to dealing with teenage pregnancy.

Child maltreatment may result in a self-image and a set of behaviours that lead to misuse of alcohol or drugs. It may result in an unhealthy idea about what appropriate relationships are between men and women because of the young person's experience of what those relationships look like up close and personal. It may result in mental health problems, such as depression or anxiety. It may result in a sense of isolation and a sense that pregnancy is one's only chance to have a loving relationship with somebody. The effects of child maltreatment manifest themselves in many different ways, but the underlying commonality is that, for too many people who are part of the teenage pregnancy equation, the child maltreatment that they have experienced is an underlying root cause.

The lesson for the committee is that giving priority to preventing maltreatment whenever possible, or to dealing as quickly and effectively as possible with it after it has occurred, will have the side effect of reducing some of the motivations and pressures that end up leading to teen pregnancy. If we understand it partly as a consequence or symptom of not having addressed the prevention of child maltreatment, we will be on the right road.

Nanette Milne: In the course of a scoping exercise for our health inequalities inquiry, research suggested that a continuation of what were described as "downstream solutions" was not really going to work. I am referring to anti-smoking campaigns and so on. It was suggested that we need to look much more upstream. It strikes me that there are tremendous similarities here, and that what is being done now has not been successful in reducing the rate of teenage pregnancy; it is almost that the solution has come too late. The main focus should be, as witnesses have said, on the early years—the prenatal stage and the first few years of life—if we are thinking into the future. Obviously we must continue with on-going things, but perhaps the real solution lies in work at a really early stage.

Terri Ryland: In relation to access to services, I emphasise the importance of listening to young people. There is also a key thing around times when services are open, which is a big part of

accessibility. Furthermore, we must not forget the role that parents and/or carers play in caring for young people. I say "parents and/or carers", because young people are looked after by many different people. It is a matter of educating parents and carers, too. Young people do want to hear from their parents and carers about sex and relationships, or to have the discussions at home—which so often does not happen.

Mark McDonald: My understanding from the earlier evidence is that although the target for reducing teenage pregnancy was not achieved, there has still been a reduction. The direction of travel is correct—it is just that the reduction has not reached the target that was set at national level.

I take on board the point that teenage pregnancy is not always necessarily a bad thing. I had a message from a constituent who said that she had her first kid when she was 19. She is now 28, and she and her partner have two more children. She asked, "Am I part of a problem because I had a kid at 19?" The answer is that she is not, but it is difficult to get that message across sometimes. There is perhaps a stigma, and we need to think about how we discuss the issue.

We have spoken a lot about the roles of the public sector, the health service, schools and the third sector. There is a bigger role: that of the family, whether it is the biological family or the family in a looked-after setting. The influence that the family has on a child's behaviour and development is absolutely critical.

There are some targeted interventions for young people—in particular for those who might be defined as being more at risk, whether because of their socioeconomic background or other things. I noted that young people in the lowest socioeconomic group are most likely to become pregnant and most likely to carry the child to full term, as teenagers.

What kind of support is given in the family sense? The family has two roles, the first being in the development of the child and in getting the right kind of message across to the child about behaviour and so on. The second role is after the event.

We are not going to get the pregnancy rate down to zero—teenagers will get pregnant and we should be honest with ourselves about that—but there is a role for the family in supporting the young person and including the father when that is appropriate. Evidence that we heard earlier shows that some young fathers who want to be interested and involved find that difficult because the young mother's family does not want them to have any further involvement, which goes back to the point about stigma. What can be done to ensure that there is family support in advance that builds on the prevention work, and after the event to ensure that the young person and their child get the best possible chances in life?

11:15

Terri Ryland: Again, I go back to my earlier point about working directly with parents and carers. The FPA runs a programme called speakeasy, which is intended to empower parents and carers to talk to their children about sex and relationships. When we are working with parents, they sometimes tell us that they do not need the programme because they know all about it, but when we do the work, they come to understand that they do not know all about it. When they then start having the informal conversations with their children, perhaps over dinner or during a television programme that has sparked a conversation, they can talk about the issue to their children. The programme is a group work programme over six to eight weeks, so parents and carers can come back to the groups and discuss their conversations with other parents. Parents and carers often do not have the confidence to talk about sex and relationships because it is a difficult conversation to have.

Lucy Morton: On the point about accepting the reality when a young person gets pregnant, and other points about child maltreatment, we cannot always assume that the family is going to be a benign influence. The most vulnerable young women often come from families in which there have been abuse and neglect, which might be on-going. There therefore needs to be a detailed understanding of the dynamics within that family and an assessment made of whether it is safe for that young person to have and bring up a baby within that environment.

We also need to make sure that family members get the support that they need. If they are going to be involved in the baby's care, we need to ensure that they are also receiving services.

It is interesting when young teenage women get pregnant because they would normally, at that developmental stage, be trying to separate from their family and make their own way in the world. If they get pregnant, they sometimes feel that they are again dependent on their family, which can introduce more tensions into the family relationships. We have to consider the potential for violence and the safety of young people and babies in such circumstances.

The Convener: As there are no further points and no further questions from committee members, it just remains for me to thank you all for your participation and for the evidence that you have given this morning and in writing. I

encourage you to follow the inquiry and to continue your input. If you strongly agree or disagree with any evidence that you see coming into the committee, stay in contact.

11:19

Meeting suspended.

11:26

On resuming—

The Convener: We continue with agenda item 2, which is the second evidence session in our inquiry into teenage pregnancy. I am pleased to welcome to the committee Alison Hadley, director of the teenage pregnancy knowledge exchange at the University of Bedfordshire and previously head of the UK Government teenage pregnancy unit; Paul Bradshaw, senior research director at ScotCen Social Research; and Professor Lawrie Elliott, research professor at Edinburgh Napier University.

I am not expecting any statements, so we will go directly to Bob Doris for our first question.

Bob Doris: My question is for all three witnesses, but principally for Alison Hadley. Your submission states that the UK Government took what it believed to be an evidence-led approach to tackling the issues surrounding teenage pregnancy, which—importantly—seemed to be very centralised.

That is not a criticism, Ms Hadley, but perhaps you can outline whether there was a centralised approach, and whether local discretion was necessary depending on regional variations. I do not know whether you have looked at the Scottish situation, but I would like to know whether you think that there is appropriate local discretion in Scotland or a strong enough centralised approach. I was struck by the close monitoring from the centre in England, which meant that the 21 poorest-performing local authorities or regions in England were called in for analysis of their performance. It seemed that they were not adhering to or implementing the national strategy in the way that was intended, and when that issue was addressed they started to perform much better.

I hope that I have shown a reasonable understanding of what happened in England, but I am curious about the downsides. Is that what happened, and are there downsides to that approach? Does it perhaps not allow enough local discretion?

Alison Hadley (University of Bedfordshire): That is a really interesting question. The original strategy for England aimed to halve the under-18 conception rate and produce a steady decline in the under-16 conception rate—so we focused on a slightly different age cohort—and to support and improve outcomes for young parents. There was a national-local balance, so there was a national target for a 50 per cent reduction and every local authority area was given its own specific reduction target. The high-rate areas had a 60 per cent target, the average areas a 50 per cent target and the low-rate areas a 40 per cent target. If the authorities collectively met those targets, we would meet the national ambition.

The 50 per cent rate was set in order to bring down the UK's rate to the rates of comparable western European countries, so there was a rationale behind it. The timescale was perhaps not quite so rational, because it was fairly short at 10 years, which in retrospect we felt was quite ambitious.

On the balance between national and local, we gave everyone a local implementation grant, with the condition that a local teenage pregnancy co-ordinator be appointed and a local teenage pregnancy partnership board set up. As mentioned in the previous session with regard to the position in Oldham, the board allowed all the local partners to take forward the strategy.

11:30

We set out guidance on developing local strategies, which set out a framework on the evidence base. Broadly, the framework was about improving sex and relationships education in schools, and out of schools through youth services, social workers and so on, and improving access to contraceptive services; another arm supported teenage parents. We set out the framework, then left it to local discretion to develop the local strategy according to communities' needs.

Midway through the strategy, we found that some areas were doing much better than others in reducing their rates. We gave them a few years in which to do the work, then we looked and found clear differences, in that similarly deprived areas showed different progress in reducing their rates. We did some deep-dive reviews and found that the areas that were making the fastest progress were implementing what they had been asked to implement and had all the jigsaw pieces in place. The areas that were making less progress had a teenage pregnancy co-ordinator, but they had left it up to them to do some good work somewhere in the area; there might have been a fantastic project in the local area, but there was no whole-systems approach.

We then took a much more hands-on approach and had more prescriptive guidance, which was

not statutory, and a self-assessment toolkit that looked at exactly what everybody should be doing and how to monitor the implementation. As has been mentioned, ministers decided to focus particularly on the 21 areas with high and increasing rates. We knew that if all areas had performed as well as the top quartile did, we would have doubled our progress nationally. Senior people from the 21 areas met ministers; I think that that turned things round, because it became a strategic and senior leadership conversation and it made things happen locally. I think that it also gave people the feeling that it could be done, and they got a lot of support to improve their performance. Interestingly, a few years after that, the rates in those areas started to come down.

If we could rely on everybody giving the strategy equal priority and doing exactly what they should do, we would not need such a strong hand at the top. However, our experience was that national performance management was quite critical in getting local leadership to take charge of the strategy.

I am sorry that that was a long answer, but I wanted to set out the position for the committee.

Bob Doris: Do you mind if I clarify what you said? I was looking through some of the suggested national guidelines, such as access to contraception, targeted interventions for vulnerable groups, well-resourced youth services, broadening horizons and aspirations, and good-quality personal, social and health education in schools. We have heard that all those things are happening in Scotland, but we do not know whether they are happening consistently across the country. We will ask the minister about this next week when we have him along to the committee. Is the difference that the poorer-performing areas were asked—in a supportive way, I hope—to explain why they were not performing and that improvement programmes were then put in place? Is that the key aspect in driving change?

Alison Hadley: Some of the areas that were not performing well felt that high rates were inevitable, because it was part of the local culture and always had been. Some of them had focused more on improving support for young parents than on prevention, because they thought that they could not do much on prevention. Only when we reflected back to them that similarly deprived areas had made big progress on prevention did they start to think that there was something that they could do.

The attitude of, "It's just like that round here," was quite a challenge. However, those areas then learned from other areas that had put things in place, so there was a lot of sharing of effective practice around PSHE and sex and relationships education programmes in schools, through to workforce training of youth workers, social workers and foster carers. They started putting everything in place and having a performance monitoring system to measure what they were doing. I think that that made the difference.

Bob Doris: That is very interesting. To be fair to the other witnesses whom we have heard from over the weeks, in the local authorities that see high levels of teenage pregnancy, whether that be Dundee or Fife, there appears to be a real focus on addressing that. Do the other witnesses believe that there is a consistent approach to implementing a national teenage pregnancy strategy in Scotland?

Professor Lawrie Elliott (Edinburgh Napier University): I do not really know the answer to that. It was interesting to sit in on the previous evidence session. What is happening across Scotland is probably patchy.

In the research that we carried out on healthy respect, we had a comparison area and we know that it was not delivering sex education to the same standard as the healthy respect area was. People in that area did not have the same access to the young people's sexual health services that was available in the healthy respect area. On the basis of that research and other research that has been published by NHS Health Scotland, there seems to be a patchiness in the approach. That is inevitable, given that people are given the resources and left to take their own approach.

If I have one plea to make after listening to the evidence that was given earlier, I would like the committee to consider the link between evidence and practice. Science has some answers, although it does not have all the answers to the problems, but there are some things going on in the world that people are not aware of. They were mentioned during the earlier evidence session and I will talk about them later.

In answer to Bob Doris's question, the approach that is taken in Scotland is likely to be patchy; that was shown in our experience.

Paul Bradshaw (ScotCen Social Research): Like Professor Elliott, I do not have a lot of knowledge about the services that are being delivered at local authority level. However, through the project that I am involved with, we have become involved in various discussions and processes to set up the early years collaborative, which is expected to be delivered by local authorities with a lot of centralised, co-ordinated discussion to bring together representatives from local authorities to share best practice and talk about what they think might work locally and what could be transferred elsewhere.

That is not too dissimilar from the experience that Alison Hadley described. Local authorities are left to deliver their own programmes, but they do it with evidence and support from a central source.

Dr Simpson: The system that I looked at in Oldham had some problems initially, but then it got to grips with the issue. I was impressed by a number of things in the programme. First, there was a ministerial visit to Oldham; I was told that the person in charge was called in, which makes it sound quite serious. They were asked why they were not performing and what could be done to assist them to perform.

The other thing that impressed me was that the data collection was not two years out of date. The programme data were collected locally. The toolkit that the programme used—either we do not have it in Scotland, or we are not using it—was not just one strand; it took the whole-system approach that Alison Hadley mentioned. It covered every measure, including terminations, repeat terminations, long-acting contraception, the provision and use of condoms, and the signposting. Every possible measure that could be taken was listed and used to show how the programme was performing. Beyond that, the data were broken down by postcode, by ward for the councillors, and by school so that the level of competition could be seen.

Are any of our witnesses aware of the sort of data collection system that we have? Are such systems prescribed nationally in Scotland? Does Scotland have a toolkit that works?

Professor Elliott: There are national data systems, and information on teenage pregnancies is collected through the Information Services Division. Some very good surveys have been conducted regularly in schools, which give some indication of the sexual attitudes and knowledge of schoolchildren, mainly at secondary school. As you are probably aware, some fantastic longitudinal studies have been conducted or are beginning to be conducted in Scotland, and they have considered health and social outcomes among young people and their families.

There are databases and data that are collected routinely by health boards and councils. Those data have been gathered nationally, too, including routine databases that are starting to be linked electronically. There are a number of different resources around, but they are not all co-ordinated, so there is no single unit, person or government body that co-ordinates all those data to give you, the committee, a flavour of what might be happening with young people's health, including sexual health, across Scotland.

To be fair to NHS Health Scotland, ISD and other bodies, that question is being addressed. For instance, the linking of routine health data to big national surveys is currently in the remit of the Government and the civil service, which is working behind the scenes to help that happen.

Paul Bradshaw: In the study that I manage—the growing up in Scotland study—we are actively undertaking that linkage. We are matching the data that have been collected via our survey on parents and their children to routine administrative data, concerning not just health but education—we are linking to school records.

We are pretty good in Scotland at linking the central databases that we have, but lots of the data that would be useful, particularly for local authorities in determining whether what they are doing is making a difference, are not available at local authority level. We have fantastic, very detailed data from ISD, but as far as the survey data for our own project are concerned, we cannot produce local authority statistics. Most of the surveys that are run in schools or elsewhere do not have the capacity. There is still a gap when it comes to local authority level data, although that is being addressed and discussed, and the data are being improved upon.

Alison Hadley: The local self-assessment tool is a really important issue. The Scottish Parliament information centre briefing referred to the Learning and Teaching Scotland publication, "Reducing teenage pregnancy: Guidance and self-assessment tool". I am afraid that I did not have time to look at that, and I do not know what the self-assessment tool refers to and whether it contains a data set that can be applied locally.

Ward data and data from schools were examined, and the ingredients of protection that had been implemented were monitored. For local areas, it was a matter of checking how many of their youth workers, social workers and foster carers had been through the desired training programmes. It was a matter of putting things into the pot as well as measuring the outputs. That was an effective way of demonstrating why an area was not doing so well and needed to prioritise something over the next six months or year. That linked to the outcome data on conceptions—including repeat conceptions—abortions and maternity.

I can send the self-assessment toolkit to the committee so that you can have a look at it. Some people found it quite big and cumbersome to begin with, and they did not want to get bogged down sitting in a room filling it in while they should have been getting on with their work. We slimlined it into a two-page version, which I will also send you. It really helped to focus the mind, and information sharing was possible, so that people could get data from hospital maternity services and abortion clinics without having to wait for the national data

set. That gave them a sense of what they were doing. Your point is very well made, Dr Simpson.

Dr Simpson: ISD is very good, but the problem is that the data come out a year, 18 months or two years after the event. It is very difficult for local people to know what they are going to do and how they are improving. I think that is the point that Alison Hadley is making.

11:45

Alison Hadley: The sex education forum is an umbrella organisation for about 63 different organisations that are involved in sex education, which we supported through the strategy. They provided an interesting SRE audit toolkit for schools to ask pupils to evaluate the SRE that they were receiving so that there could be a little improvement cycle in each school. The pupils could tell the school what was good and what was not so good, and what the current issues were that should be included in the SRE. There was a rolling programme of asking pupils whether the SRE was meeting their needs. We try to understand what young people are facing, but they are the only ones who hear the issues being discussed in their peer groups.

That toolkit was not a statutory requirement, and some schools have used it really well while others have not. However, it is another example of local monitoring that gets closer and closer to young people's experiences.

Mark McDonald: I have an initial question for each of the witnesses and then I might have follow-ups, depending on what they say.

My first question is for Alison Hadley. I read through your submission, and one of the things that leapt out at me was on page 13, where you say:

"However, the ten year timescale for the necessary shift in culture to tackle historically high rates may have been too ambitious. At a local level, in some very high rate areas, the challenge of halving rates seemed impossible and either demoralised or de-motivated leaders and practitioners."

Is that a problem that comes from taking a centrally focused approach as opposed to working more closely with local organisations and practitioners? How do you ensure that that does not happen? Setting targets is obviously laudable and there is a reason for it, but how do you ensure that we get local buy-in and do not effectively disenfranchise or demotivate the people whom you are entrusting to help you to achieve that target?

Alison Hadley: All the local areas signed up to the target, although it was not a statutory requirement to do so. I think that, at the time, everyone thought that 10 years was quite a long way off but it is not that long a period in which to effect the kind of changes that we wanted.

I do not think that we took a top-down approach, because we had a lot of support for local areas. It was not a case of there being a diktat followed by nothing happening to support those areas. There was a regional structure and a lot of support for local areas.

These are my reflections. Perhaps we should have had a 10-year target set at a slightly lower level of 35 per cent and a 15-year target of 50 per cent. If a target is set too far into the future, people think, "I won't be in my post by then so I don't need to bother," and the target can seem too remote. However, I think that the original target might have been a bit ambitious for 10 years.

However, ambition was really important. We had to change the situation. Why should England be so out of line with other western European countries? That was not fair to the young people. We really had to tackle the issue and not just meddle around the edges, so the high level of ambition was very important, as were the local targets. However, on reflection, we could have made the targets slightly lower and more achievable, although they had to be aspirational too. The problem lies with getting that balance right.

The 2011 data have come out today. I gather that they show another quite big drop, so perhaps our ambition was not so far off. However, it was challenging for a lot of local areas.

Mark McDonald: The committee is about to launch a major inquiry into health inequalities. Some of the evidence that is coming through on the topic of teenage pregnancy shows that the issues that feed into health inequalities are much bigger and wider than perhaps we had previously credited. Was enough done to look at the wider cultural factors that influence the teenage pregnancy rate, rather than simply viewing it as a sexual health issue, when so much else lies beyond it and feeds into it?

Alison Hadley: I do not think that we viewed it just as a sexual health issue. The difference between the current strategy and previous attempts in England under the health of the nation target for under-16s, which was very much a health approach, is that this strategy is the first to have examined things very broadly, including the underlying issues affecting young people's decision making and their abilities to make informed choices. This has absolutely not been a single-agency approach. We have always described the strategy as everybody's business. We asked areas to consider closely their high-rate wards and to try and narrow the gaps between the

rates in their higher-rate wards and the average for the local authority.

The targeted work that we strongly recommended was for young people in care, young people who were starting to get disengaged from school and young people in the criminal justice system. The work with that group was targeted and intensive, and aimed to narrow the inequalities. The lesson from the evidence was that no one agency can solve the problem, and that a collective approach is required, backed by senior leadership. Addressing inequalities lay at the centre of the strategy. The support for teenage parents—the strategy covered the support element for the first time—very much aimed to narrow the inequalities among them and among their children, as the next generation.

Mark McDonald: I note from your submission that you mentioned the media message and the importance of ensuring that the media were on board with the work that was being done. Some of the coverage that the committee has received recently has erred towards the idea that all children will get free contraception handed out to them in schools, which perhaps does not reflect some of the work that is being done. Is it your experience south of the border that the media are receptive to the issue if you approach it in the right way?

Alison Hadley: They are. The debate has changed a lot over the past 10 years. Occasionally, there might still be a "Sex lessons for five-year-olds" headline somewhere, but the coverage is nothing like what it used to be. We probably should have been bolder and taken a more proactive approach by getting some key, high-profile journalists and media representatives onside from the beginning, making an effort to have a calm debate right from the start.

Scandalous headlines affect local delivery. If a school is starting to deliver some really good sex education programmes or is setting up a school-based clinic, one bad headline like "Condoms for 11-year-olds" makes everyone very nervous, and it stops the delivery of good practice. Perhaps we could have been bolder from the start. A calm debate requires leadership from the top.

The discussion that we had earlier was interesting. The attempt to make PSHE a statutory part of the curriculum failed in April 2010, despite the consensus to have it, but during the build-up to that we found a huge consensus among parents, young people and stakeholders: once they understood what sex and relationships education was, and once they realised that it did not mean sex lessons for five-year-olds, they said, "Of course that's what children need."

That consensus exists, but it needs to be much more visible and it needs to be articulated by very senior people. That would support the work that is being done locally and it would support young people, who get confused about whether they are meant to discuss such things and ask for advice, approach services and so on. We need to make it the normal and responsible thing for people who have questions to ask for advice. A calm national debate would help with that.

Mark McDonald: I have a question for you, Professor Elliott. I can see that you want to respond to what Alison Hadley has just said—perhaps you can build that into your answer.

In your submission you conclude that it is important to focus on the early years. That is certainly the direction in which the Government is trying to go. I was interested in your comment that

"generic aspects of parenting are more important than communication about sexual matters."

Could you develop that point and explain your thinking?

Professor Elliott: I will come back to that. First, I will say something about sexual health inequalities. We have worked on the healthy respect project and other programmes and there is a raft of research about such prevention programmes being limited. That does not mean, however, that we should get rid of them—to do so would be a grave mistake. There is evidence from our research to suggest that, when programmes are not delivered in the way in which they are meant to be delivered, there is a deterioration in attitudes towards condom use and so on. It is important to acknowledge that the prevention programmes are limited in that they must be delivered properly, but we should not get rid of them. Otherwise, a couple of years down the line, we could be faced with a very big problem.

In our research, we addressed the question whether such programmes have an impact on health inequalities. As far as we were concerned, they certainly did not. That left us pondering what should come next—and this relates to your question about how we move forward from the big generic health programmes.

There is an emerging evidence base that suggests that we should be moving towards earlier intervention and there are a number of programmes involved in that. A really good review was published by the Medical Research Council in 2011—the "Scottish Collaboration for Public Health Research and Policy". I will give you a couple of examples of projects that have been fairly well researched. One is the Seattle social development project, which is geared towards teenagers and aims to improve young people's social competence. It covers all the things that you

heard about in the previous evidence session, including life skills and making people better citizens. It is important that it involves parents—we found that parents were not really engaged in the healthy respect project. Even in the projects that I am talking about, only about 43 per cent of parents have been engaging in them, so there are problems with some of them.

The Seattle social development project will have long-term impacts. I refer to the recent research on sexual activity and sexual risk and even things such as heavy drinking, which is important. The new generic programmes tend to target an array of health outcomes. They do not all do all the same things. For instance, there is not one single programme that will reduce drug use, sexual health problems and problems with alcohol and smoking. Some of them have different effects across those outcomes. There is, however, very promising evidence.

Another project is health for life, which was also developed in the United States. The gatehouse project in Australia worked not with young people but with teachers. It involved teachers tackling risks, which they identified through school surveys, so there is a feedback mechanism involved in that. Closer to home, members are familiar with the family nurse partnership, which targets young mums; support is delivered while the child is at the pre-school stage. Some of the other projects that I have mentioned are delivered in primary schools. The 15-year outcome suggests that the children who were exposed to such programmes had fewer sexual partners and consumed less alcohol than people who were not exposed to them.

I emphasise that there is good, emerging evidence that is really promising: if we adopt generic measures at a younger stage, we get effects on young people's health. The important thing to note is that none of the programmes focuses on a single health thing. They do not discuss sexual health per se—they focus on developing and strengthening family relationships; they direct people into the welfare and educational systems; and they prepare young people for school. They are focusing on all that kind of stuff, which I think is very interesting.

There are limitations with the programmes. They do not do all things for every person. Some outcomes will be affected and some will not. They are not a magic bullet. Therefore, when the committee comes to sum up the evidence and perhaps make recommendations for a strategy, it will be important to think about which part of the strategy will tackle which health, educational or social outcome and then link that back to the evidence that is available in Scotland, to trace such things over time.

There are limits to all those things. I would say to any agency that is operating, whether we are talking about the NHS, local authorities or other agencies, "Know your limitations. Know where you are likely to have an impact and assess your goals accordingly; don't go chasing rainbows."

12:00

Mark McDonald: Mr Bradshaw, you said in the conclusion to your submission:

"Teenage parents are more wary of formal support services and"

have

"more reluctance to use them than older mothers. These trends have significant implications for the delivery of parenting support for young mothers."

The evidence that Professor Elliott talked about suggested that we should focus on generic parenting support, but your evidence indicates that it is difficult to deliver that through traditional models. Where do you recommend that we look for best practice or alternative approaches?

Paul Bradshaw: We certainly find that there are quite distinct attitudes among the youngest groups of parents on how they prefer to receive support and advice and what sources they use in that regard, whether they are seeking general information and advice about parenting or specific advice about their child's health or behaviour. Some of our strongest finds have been around antenatal education. Young mums are significantly less likely, by quite a large margin, to attend antenatal classes. When we asked them why, they said that they do not like the class and group format—indeed, they do not particularly like that format for any aspect of parenting support.

As Lawrie Elliott said, a wide range of programmes is available. Programmes can be delivered in different ways, meeting different needs and using different resources. They can be delivered one to one or in small groups. It is important that we recognise that one size does not fit all, including for parents under 20. The family nurse partnership, for example, will not be the solution for all our young mums.

If the committee wants to be pointed in the direction of evidence that exists, the MRC paper that Lawrie Elliott mentioned is a good starting point. Work has been undertaken on effective interventions through the early years taskforce subgroups, and I think that Health Scotland produced a paper that looked at a range of parenting programmes—some of the programmes focus on addressing social, emotional and behavioural development, but addressing such issues is likely to have an impact on other aspects of children's lives, probably including their risk of teenage pregnancy at a later stage.

Alison Hadley: I am not suggesting that Paul Bradshaw was implying this, but there is a danger that people are still looking for the single, silver-bullet solution and thinking that somewhere in the world there is something that will do what needs to be done. There is always learning to be had and to be built on, but we must not forget that we have not yet implemented the bits that need to be implemented universally. That is certainly true in England, where we do not have statutory PSHE and young people consistently say that they do not get what they need in schools.

We know that midwives just do not get it right with young parents. There is something about the environment into which they receive them, and they seem to portray a slightly judgmental approach, even though they might not want to do so. The same can be said for health visitors. They might not offer a chair to the young father, for example. There are some basic things that we need to get right in universal mainstream services that could make quite a difference. Targeted interventions for very vulnerable young people need to be overlaid on top of that.

The danger sometimes is that we forget that we do not have in place the main building blocks for all young people in the universal system on prevention or support. We must not forget that that is the big question, so that everyone gets what they need. The targeted work is done on top of that. Otherwise, we are in danger of chasing the thing that will make the difference in the end, which I am not sure that we will ever find.

There are fantastic examples of teenage parent specialist midwives, who have got really good engagement from young parents in antenatal care and from young fathers. In England, children's centres are trying to get everything in a one-stop shop—that is a bit like the Oldham model. Antenatal care is done in them; young parents meet there; education and training people come along; and social workers, counsellors and mental health people are there. Everything is in one place, and young parents trust the centres and are confident about using them.

That is not rocket science—to use a term that I do not like very much. We need to concentrate on getting the basics right and then look for the learning on the work with the most vulnerable young people to add to that.

The Convener: I suppose that there is a challenge for the committee—it is a rhetorical question for you. Although we have not met the target for lowering the teenage pregnancy rate, we recognise that much progress has been made. In some groups, not as much progress has been made. We know that the response has been patchy and that the number of teenage pregnancies in one deprived area can be double that in another deprived area. We are moving on now to invest a lot of money in the early years. Everybody gives the caveat that that is not a silver bullet, but we talk about it as if it were the solution.

The challenge is how we move to the other ideas. Where is the evidence for that when the first part of the job has not been completed, at least within the inquiry's limits? Should we agree to shift money away from work that is incomplete to work that is—at this stage—not evidence based and which, on the limited evidence, requires intensive investment of money over a long period to achieve results? Should we change strategy or should we adopt Alison Hadley's caution and say that there is a job still to complete before we invest heavily in other areas?

Alison Hadley: I was saying that a twin-track approach is needed. I know that money is—

The Convener: In politics, budgets are not twin track. In reality, not everything can be done.

Alison Hadley: Of course. It is difficult to invest in upstream prevention when we must deal with the reality of the situation now. However, not doing the universal provision is not an option, because the universal provision protects all young people from all sorts of things—not just pregnancy but other sexual health aspects—and, I hope, gives them the ability to make positive and informed choices about their relationships. That is not a deficit model; it gives young people the protective ingredients. That is an entitlement that all young people need as they grow up.

The budget point is interesting. The deprived areas that did well under the strategy were not given more money than the deprived areas that did not do as well, so that was not just a question of financial investment. The workforce training programme for youth workers and social workers to ensure that the whole-systems approach was in place was not very costly, but it was an essential way of joining the dots. Areas were not necessarily investing in high-cost programmes.

A mainstream and fairly low-cost provision is needed, as well as targeted work for very vulnerable young people, which looks quite expensive. That is the reality that you must face—I do not think that one or the other option can be chosen.

The Convener: I may have misunderstood, but we have heard evidence that we do not have universality in sex education and support. Before we can even consider its quality, we must acknowledge that it is not available. School nurses are not universally available. Projects that we have visited that support young mothers in cities such as Glasgow and Dundee are exceptional and facilities are not available for all young mothers in those cities.

From the evidence that we have had and the general point that you make, the challenge is that there is a lot still to be done in providing universal services. It will require significant commitment and investment at a time when there is significant investment in such things as the family nurse partnership and the early years agenda.

Professor Elliott: Everything in life comes with a price tag; we all know that. One of the areas in which the evidence is lacking is how cost effective interventions are, including the more generic ones that are coming over the horizon. They seem very intensive—the Seattle social development project is quite intensive and would cost quite a lot of money. Some evidence suggests that they are cost effective and that you get more benefits per pound spent, but they are fairly expensive. Given that we are in a recession and under severe budgetary constraints, there will always be a question about where resources are allocated. That is a big question, and it is probably a political one.

However, Alison Hadley is right: things can be done at local area level to make things work better. Earlier we debated partnership working. Some of our research suggests that when partnerships get going there are mutual benefits and some logistic benefits. Referring young people to specialist sexual health services is one of them, as is working better with young people, and so forth. Some of that need not have a big price ticket. Some of that is about getting people to work better together and breaking down the barriers to working together. When that happens, you can see some benefits.

The ultimate question is how we make all young people more middle class in life. That is about redistributing wealth and changing fundamental aspects of society. That is outside the gift of NHS services and local authorities. It is probably the big question and it lies more at a parliamentary, UK and European level.

There are resource issues and I agree that it is not easy, but Alison Hadley is right that there are things that can be done to make things work better—if that is what you want to do—at a more local level and get the minimum that needs to be there. If possible, the more expensive interventions can be built on. The family nurse partnership is being rolled out across Scotland and the evidence suggests that that is a reasonably good thing to do. However, that is time and money intensive.

I do not have the answer to what you should be doing. That would be governed politically. The evidence is not there to support you, I am afraid; it will come down to arguing for resources in any forum that has that clout.

The Convener: Alison Hadley told us that local government can address inequalities in a specific way. Universal provision plus targeting will reduce inequalities and those affected by them when early pregnancies or second pregnancies are prevented. We have heard that inequalities are being tackled at local government level.

Professor Elliott: I do not see the evidence for that, although Alison Hadley may be able to quote some studies. The evidence that I have mentioned today comes not just from our own work but from reviews—

The Convener: There are small projects, apparently.

12:15

Professor Elliott: Worldwide, there is no evidence—including in our own work—that such prevention programmes have any impact on sexual health inequalities.

Alison Hadley: Interestingly, progress has been made on the conception rate, which the 2010 data showed was 25 per cent down overall—in other words, there were 25 per cent fewer teenage pregnancies. However, there was a steeper decline, of 35 per cent, in pregnancies leading to birth. Given that those who take their pregnancies through to maternity tend to be young people from more deprived areas, we were making faster progress on births than we were overall. That is interesting, because that is a narrowing of inequalities.

An interesting thing about what happens in local areas, as I am sure Dr Simpson found in his visit to Oldham, is that there is some really good, targeted work. In schools and in out-of-school settings, young people are assessed—not overtly—by the practitioner as to whether they may need a little bit more support. It may be that a young person is starting to disengage from school, or is in the looked-after care system or has other things happening in their life that make them vulnerable, so they are offered one-to-one targeted support. There is a very good example in Blackpool, where a huge reduction in the number of conceptions among a very vulnerable group has been achieved over 18 months following the implementation of such a one-to-one programme.

Such examples will not be included in the evidence base because they need a proper review. There is a tension there. I am not at all disputing the need for quality evidence, but in establishing a link between evidence and practice we also need to be realistic about how we learn things. I think that there is a lot of local learning. I can certainly put the committee in touch with some of those targeted programmes, such as those in Blackpool and Stoke, where a concerted effort has

been made to take out the young people causing most concern so that they can be given more intensive prevention work, which seems to have been effective.

Support for teenage parents is critical in narrowing inequalities, so that needs to be part of the next steps. With FNP plus—given that FNP is voluntary and for first-time mums only, it will not reach everyone—we need to make the universal services very accessible and youth friendly. That will narrow inequalities for the next generation as well as for the young parents themselves.

There is learning there to be shared, plus more to come out of reviews and evidence from across the world. However, rather than wait for those, we should get on with what we know.

Paul Bradshaw: I want to make two related points. To pick up on what Lawrie Elliott said, these interventions are very successful in improving support for parents and addressing some specific concerns, but our evidence suggests that, without addressing the underlying structural inequalities—of income, of employment and, in particular, of education—the level of support that is given to parents will have only a limited impact on their children's outcomes over the long term.

A related point is that using the health budget to deliver a health-based intervention designed to reduce teenage pregnancies may lead to a measurable improvement not only in the teenage pregnancy figures but in other indicators, such as the qualification rates among those young people and the number of positive transitions from school. There will be multiple benefits and cost savings by delivering that intervention, which will have come out of a specific budget. The point that I am trying to make is that, although the initial money might come out of the budget of a single portfolio, over the long term savings will be made across different portfolios and departments.

If we can improve the relationship between parents and children at a very early stage, the children's social and emotional behavioural development will be better from an earlier point. That means that their cognitive development is likely to be better, which means that their school experience, their educational performance, their qualifications and their transition to employment and a positive future will be better over the long term. It is therefore necessary to take that much broader view when we talk about these issues.

The Convener: I remind you that we deal with the health portfolio and not the others, although at least the health portfolio has a top target for reducing inequalities. I take your point that that approach is not always reflected in other portfolios.

We are looking at teenage pregnancy, and will look at health inequalities in a broader sense. However, we are aware even from the evidence that we have heard so far that such work is rather limited in the Government's other portfolios and priorities.

Professor Elliott: The evidence that I am talking about is the peer-reviewed evidence that is there in the scientific journals. It is based on research evidence and not on anything else. What I have said today is firmly based on that.

The Convener: They are small projects that involve small numbers of people in America and Australia.

Professor Elliott: No. Some of the research that I quoted is based on thousands of people. The research that we undertook on healthy respect included 5,000 young people, and the studies that I quoted on family nurse partnership programmes included thousands of people. They were big, randomised control trials or quasi-experimental trials. That is the best kind of evidence that we can get to suggest whether something is working, or shows some promise. I firmly say to the committee that that is the evidence that I am drawing on in what I am saying here.

The Convener: I accept that, of course, but you said that there were signs of good practice. I forget the precise words that you used, but you mentioned indicators.

Professor Elliott: Yes. They are promising. I say that because the studies have not been on the go for all that long compared with, say, sex education studies that have been going for the past 20 years. Because they are so large, they are not funded to the same extent. We get one or two popping up in each country, and more in America because the funding is a lot better there. They are based on fairly large randomised control trials and they are in the peer-reviewed academic journals. The evidence base is not too bad, where it exists, but the effects are limited.

I just wanted to clarify that. Sorry.

The Convener: No, no. That is quite right. Are there any other questions or comments?

Alison Hadley: May I make a point? We need both the broad-brush, universal approach and the intensive, targeted approach. I know that there are budget constraints, but when you are working with someone who is really vulnerable and has few aspirations, there is an awful lot of work to do to build their personal development plan. If they are having sex, which they may well be, there is a real need for intensive prevention, contraception and SRE, because you want to prevent them from becoming pregnant in the next three months while

you are building up their aspirations and their personal development plan.

It is not a question of saying, "We will just do the aspirations." Aspirations are great. A common phrase that is used is, "Ambition is the best form of contraception," but it is not a method of contraception. We must remember that both things need to be in place. We need really good SRE and access to contraception, and for the most vulnerable we need the aspiration-building programmes as well. There is always a slight risk in thinking that, if we get the underbelly of everything sorted out, we will reach where we want to get to. We need to take a twin-track approach.

There is a particular issue around sex in Britain. We do not find it easy to talk about things. Young people still say that it feels stigmatising to go and ask for sexual health advice and that they are not sure whether they should do that. Sometimes, they say that they do not go to services because they are not sure whether they will be judged for doing that.

There is therefore a cultural backdrop that we need to change. We want to say, "You shouldn't have sex until you feel ready and you are making a positive choice to have sex"—the point about delaying sexual activity that came up earlier—"but when you feel ready, the right and responsible thing to do is to go and get contraception, even if you are under 16, and we are there to help you." Changing the backdrop will make it much easier for young people to get the advice that they need.

The culture needs to be tackled alongside all the other intervention programmes. It is about the wallpaper around young people's lives. We started to do a little bit of that in the last gasp of the strategy with the "Sex. Worth talking about" national advertising campaign, when advertisements on television, on the radio and in cinemas showed parents talking to their children about contraception and chlamydia in an ordinary, everyday way. The adverts were shown on the television in the living room before the watershed, which was a huge cultural step forward. The campaign stopped because there was a change of Government and all the campaigns stopped, but such campaigns form the backdrop to young people's lives and will make it easier for them to start talking about things more openly. We should not forget that.

The issue is particular to English-speaking countries—that is a PhD in itself, I am sure—and we have not quite got there. There is still a lot of Benny Hill and Graham Norton-type humour around and there is plenty of explicit stuff on television, but people still find it difficult to go to a sexual health clinic or a general practitioner and ask for advice. We have to crack that, somehow.

Nanette Milne: How much emphasis is put on the legal issue? I am thinking about the age of consent and the fact that people might be criminalising themselves by indulging in sex when they are under 16.

Alison Hadley: Good sex and relationships education programmes should cover the legal aspects of sexual activity. In focus groups, a lot of young men have said that they do not understand the law and sex; no one has taught them about that. The age of consent is an important debating issue and it is possible to have a really good SRE class about it. It comes down to people understanding the positive reasons for entering a sexual relationship, as opposed to passive or coercive relationships.

The critical point is that we do not want to stop people who are under 16 coming to services. We can draw a line in the sand around the age of consent, but we need to make it clear that young people are entitled to confidential services and support. If we do not do that, young people will continue to have sex but not get the advice that they need.

It is a fine balance. I do not know how recently this has been done, because I have not seen a very recent survey, but when young people have been asked what they think about the age of consent, most have said, "I think I'd quite like it to stay at 16." That is a line in the sand. Even young people under 16 who might be having sex want the age of consent to remain at 16. They certainly do not say, "Don't have one." The age of consent seems to offer them a bit of a gauge.

It is about getting the balance right and not putting young people off seeking advice if they need it. The important point, which was made earlier, is that most young people under 16—probably about two thirds—are not having sex. However, if we ask 14 and 15-year-olds, they will say that two thirds are having sex. A sort of social-norms distortion puts more pressure on young people. It also puts pressure on parents, who say, "If everyone's doing it, that's maybe just a sign of the times and there's nothing I can do about it." The assertion of social norms is quite important if we are to take pressure off young people.

Dr Simpson: That is a very important point.

Professor Elliott: I agree absolutely. Roughly 70 per cent of young people do not have sex; the other statistic to bear in mind is that of the people who do have sex, 70 per cent are using condoms and other contraceptives. We are talking about a small number who are engaging in risky behaviour.

On the question about underage sex, we can have sexual health clinics in schools. Another good approach is the chill-out zone in West

Lothian, which has a health clinic to which people can turn up to talk about sex and so forth. There is good guidance from the Scottish Government for healthcare staff who operate in such clinics around reporting behaviour—or rather, not reporting behaviour that is not a problem.

I agree with what Alison Hadley said about making sexual health services more widely available and more youth friendly. The youth-friendly bit encapsulates what is needed.

12:30

Dr Simpson: I have a quick supplementary. Are you aware of the very interesting research into alcohol and social norms? Researchers ask people in schools or colleges what they think is happening, then they go to people and find out what is actually happening, as Alison Hadley just said. That information is then fed back and the researchers look at the changes in attitudes, which they find to be significant.

Have we done the same thing for sexual health, or have we just accepted that there is a massive discrepancy between the reality and the myth?

Professor Elliott: Are you asking about using such research as a health promotion tool?

Dr Simpson: Absolutely. I am talking about research on social norms that has been carried out by the University of the West of Scotland.

Professor Elliott: I mentioned the gatehouse project in Australia, which did that with teachers. Young people were surveyed and the results were fed back to teachers. The teachers then came up with an action plan to address any health issue that had been raised, including sexual health. The technique has been used by that project—I think that the results were published in 2010-11.

Dr Simpson: Can we get a link to that?

Professor Elliott: Yes.

Alison Hadley: There is also an organisation called Gencia, which has done a lot of work with schools on social norms. It asked year 8 pupils what percentage of year 10 pupils they thought were having sex, then it asked the year 10s, whose answers they reflected back to the year 8s. Of course, the year 8 pupils were way out. Gencia used some of those techniques to feed back to the school. In some areas—such as Swindon, I think—it has started to put the messages out to the local community as well, so there is a sort of community social-norm assertion.

I can give you the details about that organisation, which has some particular programmes—

Dr Simpson: That would be helpful.

Professor Elliott: The National Institute of Health Research is funding a new trial in Scotland in which I am a co-collaborator. The trial, which is being led by the Medical Research Council social and public health sciences unit in Glasgow, uses a gatehouse-type initiative to improve young people's mental and social wellbeing. I can give you a link to that project, as well. It has just started and will not report for a couple of years—unfortunately, research has that lag; it is one of the downsides.

The Convener: There are no other questions. If witnesses would like to put on record anything about areas that have not been covered this morning, we have time to do that now. Obviously, we encourage you to keep an eye on the inquiry's progress and we would appreciate your feedback if you strongly disagree with anything or feel that you need to make a point.

Are there any other important issues that you would like to leave with the committee to consider before it writes its final report? It seems not, so I thank you for giving us your precious time and your evidence.

Meeting closed at 12:33.

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