NSPCC Scotland response to the Health and Sport Committee inquiry into Teenage Pregnancy

February 2013

NSPCC Scotland believes that supporting teenagers who are struggling to cope with parenthood is one of the best ways to stop child cruelty before it starts. Intervening early gives babies the best possible chance in life and means that children need fewer support services as they get older.

NSPCC commission, 'Minding the Baby' provides intensive support to young, vulnerable, first-time mothers to enable them to care appropriately for their baby. Crucially, the programme can significantly reduce rapid subsequent childbearing[1]in some cases. Replicating the distinct, multi-displinary supervision model used in Minding the Baby within mainstream services could better support teenage parents and could contribute to a reduction in unplanned teenage pregnancy in Scotland.

About NSPCC Scotland

The NSPCC aims to end cruelty to children. Our vision is of a society where all children are loved, valued and able to fulfil their potential. We are working with partners to introduce new child protection services to help some of the most vulnerable and at-risk children in Scotland. We are testing the very best intervention models from around the world, alongside our universal services such as ChildLine[2], and the NSPCC Helpline. Based on the learning from all our services we seek to achieve cultural, social and political change – influencing legislation, policy, practice, attitudes and behaviours so that all children in Scotland have the best protection from cruelty.

NSPCC Scotland response

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

The national outcomes which will impact positively on rates of teenage pregnancy are complex and wide ranging. Due to the cross-cutting nature of the actions required to successfully deliver a reduction in teenage pregnancy, it is important that there are strong links with all other relevant policies and strategies, being pursued at UK-wide, national and local level. At a national level sexual health and reducing teenage pregnancy feeds into a range of key policies and strategies including, Respect and Responsibility: A Strategy and Action Plan for Improving Sexual Health (2005)*;* Visible, Accessible, Integrated Care (2006); Respect and Responsibility: Delivering improvements in sexual health outcomes 2008-2011[3] The Early Years Framework (2009)[4]; and The Sexual Health and Blood Borne Virus Framework 2011-2015[5].

NSPCC Scotland welcomes the key policy links that have been made to the Early Years Framework to reduce the number of vulnerable pregnancies in Scotland. However, as action is

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[1] Minding the Baby: Enhancing Mentalization in Traumatized Mothers and their Children; Slade & Sadler
[2] Until March 2012, ChildLine in Scotland will be delivered by Children 1st, on behalf of the NSPCC.
[3] Scottish Government (2008)Delivering improvements in sexual health outcomes 2008-2011, Edinburgh: Scottish Government
[4] Scottish Government, The Early Years Framework (2009) Edinburgh: Scottish Government
[5] Scottish Government, The Sexual Health and Blood Borne Virus Framework 2011-2015 (2011)Edinburgh, Scottish Government

required to deliver across a range of areas, we believe that the national policy approach to reducing teenage pregnancy must be firmly positioned within the overarching purpose of Government. Enhanced cohesion and greater interconnectedness across a range of policies spheres including; We Can and Must Do Better, (2007)[6] The Road to Recovery drugs strategy (2009)[7], Changing Scotland's Relationship with Alcohol: A Framework for Action on Alcohol (2009)[8], A Pathway of Care for Vulnerable Families (0-3) (2011)[9]; The Child Protection Guidance (2012)[10]; may go some way to reducing early parenthood in Scotland.

We welcome the inclusion of infant and early years mental health in the Mental Health Strategy for Scotland: 2012-2015 [11] which represents a concerted push by the Government to reduce health inequalities and improve outcomes at a population level. The expansion of the Family Nurse Partnership[12] also demonstrates a commitment to prioritise and invest in interventions which have sound evidence of effectiveness in improving outcomes for teenage mothers and their babies.

However, we believe that strategic reform is required across all levels of Government to reduce health and social inequalities which is likely to deliver a reduction in teenage pregnancy. Equity enhancing policies such as universal health care, benefits and services for the most vulnerable and community regeneration programmes have been shown to impact positively on levels of inequality[13]. Their maintenance should therefore be a key policy priority in local, national and UK Government strategies to reduce levels of teenage pregnancy.

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

School-based sex education programmes have been shown to have some success in improving sexual health and averting pregnancy at a young age[14]. However, a number of recent Scottish studies indicate that explicit sex education programmes in Scottish schools have had limited effect in reducing teenage pregnancy[15]. Cultural influences and the promotion of positive relationships can have a greater impact than specific pregnancy prevention programmes[16].

Research has shown that three quarters of young people do not receive any teaching about relationships in their schools[17]. In addition, 40 per cent of young people describe school Sex and

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[6] Scottish Executive, Looked After Children and Young People: We Can and Must Do Better, 2007
[7] The Scottish Government , The Road to Recovery: *A New Approach to Tackling Scotland's Drug Problem,(2009)* Edinburgh*:* Scottish Government
[8] The Scottish Government*,* Changing Scotland's Relationship with Alcohol*: A Framework for Action (2009)*Edinburgh, Scottish Government
[9] Scottish Government, *A Pathway of Care for Vulnerable Families (0-3)* (2011) Edinburgh: Scottish Government
[10] Scottish Government, The Child Protection Guidance (2010) Edinburgh: Scottish Government
[11] The Scottish Government, National Mental Health Strategy for Scotland: 2012-2015 (2012) Edinburgh: Scottish Government
[12] http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership
[13]http://www.rcn.org.uk/__data/assets/pdf_file/0007/438838/01.12_Health_inequalities_and_the_social_determinants_of_health.pdf
[14]Asthana, S and Halliday, J. 2006. 'What works in tackling health inequalities? Pathways, policies and practice throughout the lifecourse'.
[15] Wight. D (2011) The effectiveness of school-based sex education: What do rigorous evaluations in Britain tell us?
[16] In Baker, P, Guthrie, K, Hutchinson, C, Kane, R and Wellings, K (eds) (2007) *Teenage Pregnancy and Reproductive Health*. RCOG Press: London
[17] UK Youth Parliament (June 2007) '*SRE: Are you getting it?*' London: UK Youth Parliament

Relationship Education provision as ‘poor’ or ‘very poor.’[18] Every year the NSPCC’s ChildLine service receives large numbers of calls from young people asking for information on the ‘facts of life, partner relationships. In 2011 – 12 ChildLine carried out over 27,300 counselling interactions with children and young people on these issues; facts of life and partner relationships are consistently amongst the most common issues that children and young people contact the service about. Research into calls from children and young people to the NSPCC’s ChildLine service reveals extensive contacts from children who feel under pressure from both sexual partners and peers to have sex, or lack basic knowledge about puberty, sexual health, relationships and pregnancy. Many callers state that they have not been given access to information through school. ChildLine consultations with young people stretching back across the last decade consistently see young people raising the issue of quality of SHRE and calling for meaningful input[19].

NSPCC Scotland is aware of the extent of progress in the area of SHRE and in young people’s sexual health services since the Sexual Health and Relationship Strategy in Scotland. We consider that it is every young person’s right to have access to information about sex and relationships. We are concerned that current provision remains inadequate. PSHE is best used to help children learn about pro-social and respectful relationships, including peer, partner, parenting and family relationships.

Teachers are a key part of making PSHE education a success. Despite this, many teachers are not properly trained and supported to deliver PSHE successfully and this affects the quality of the lessons delivered. Research from the NSPCC and others suggests that many teachers can feel very uncomfortable when asked to deliver SRE lessons.[20] Pupils quickly notice a teacher’s lack of knowledge or enthusiasm for the subject; they then react negatively or are simply embarrassed.[21]

For this reason, if schools are to be able to deliver these programmes effectively, they need to commit sufficient resources to enable teaching staff to deliver lessons which meet the needs of their pupils. Schools must be able to tailor the content of PSHE towards the needs of the children and communities they serve. The frameworks need to be designed in such a way that they allow schools to tailor the messages taught to meet the needs of pupils with specific needs, such as looked-after children, children with disabilities and those from different cultural backgrounds.

NSPCC Scotland considers that rather than focusing entirely on the views of adults to shape PSHE provision, schools should start by asking pupils about what they need to know. A survey of over 2,000 14 to 18-year-olds by the Brook sexual health charity found that 78% did not have the chance to influence the content of these lessons, but 72% thought they should have this opportunity.[22]

NSPCC Education Advisors have found that giving young people the opportunity to set their own learning objectives can have a positive impact on learning and engagement - NSPCC ran a successful project where our Education Advisors devised the Sex and Relationship Education curriculum based in part on what pupils felt they needed to know. Pupils were given the opportunity to request topics anonymously and topics were then addressed either as part of PSHE lessons in schools or through the use of external visitors if more specialist knowledge was

[18] ibid
[19] Wales, A and Hill, L (2011) Finding the Balance: Children’s right to confidentiality in an age of information sharing. ChildLine/ Centre for Learning in Child Protection
[20] McElerney, A; Scott, J; Adamson, G; Tracey, A; Turtle, K and McBride, O (2009) *Teaching ‘keeping safe messages in the primary school curriculum in Northern Ireland: Consulting with key stakeholders* Belfast: NSPCC
[21] Ofsted (2007) *Time for change? Personal, social and health education* London: Ofsted
[22] See: http://www.brook.org.uk/

required. The use of an anonymous ‘question box’ is a good practice example of how this could be achieved.[23]

There is evidence that cultural influences are stronger than the influence of education even when teachers are specifically trained and courses are specifically planned[24]. Research has raised concerns about the possible effects of inappropriate sexualisation on children and young people.[25] The NSPCC is keen that the risks associated with premature sexualisation are explored through the PSHE curriculum to help young people to counteract the sexualised messages they receive through the media, and to support them to avoid risks associated with sexualised behaviour[26]

A key limitation of any sex education delivered in schools is its inability to reach those outside of school, such as transient families, persistent truants or looked-after children not in receipt of formal education. These groups may be at an increased risk of exposure to particularly risky sexual behaviour[27]. The need for targeted, outreach interventions to groups and areas is clearly apparent if we are to reach children and young people most in need of support, as per Sexual Health Standard 1.4, there are targeted services for communities or individuals with specific needs.

Poorer outcomes for young parents[28] have been shown to be more adverse in the case of looked after children who become parents. This group are more likely than others to be unemployed, have more mental health problems, be expected to be independent, have little social and economic support[29] and may have limited experience of a healthy consensual relationship in practice[30]. Looked-after children are exposed to greater risk factors for teenage pregnancy than many other groups. Young people in care are recognised as being one of the principal groups to experience social isolation, a ‘key determinant of teenage pregnancy’[31].

Looked after young people are two and a half times more likely to become pregnant as teenagers[32] yet they are less able to access to good quality, consistent sources of sex and relationship education and advice than many other children and young people.

Specialist preparation and support for adults who work with looked-after children can promote earlier positive outcomes for children in their care[33]. There appears to be consistent evidence that for older children it is important that their caregivers can respond to them at their developmental age rather than their chronological age. Carers should be supported to provide non-directive pregnancy and contraception advice that is age appropriate alongside therapeutic support to promote positive sexual health and well-being[34].

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23 Martinez, A (2005) Effective learning methods: Approaches to teaching about sex and relationships within PSHE and Citizenship London: Sex Education Forum

24 In Baker, P, Guthrie, K, Hutchinson, C, Kane, R and Wellings, K (eds) (2007) Teenage Pregnancy and Reproductive Health. RCOG Press: London

25 Bailey, R (2011) Letting children be children: Report of an independent review of the commercialisation and sexualisation of childhood London: Department for Education

26 NSPCC (2011) Premature sexualisation: Understanding the risks London: NSPCC

27 Wight. D (2011) The effectiveness of school-based sex education: What do rigorous evaluations in Britain tell us?

28 SCIE Research briefing 9 (2005): Preventing teenage pregnancy in looked after children

29 Haydon D. (2003). Teenage Pregnancy and Looked After Children / Care Leavers.

30 Handy. L. (2010) Sex Education Forum at National Children’s Bureau

31 http://www.scie.org.uk/publications/briefings/files/briefing09.pdf

32 http://www.nspcc.org.uk/Inform/publications/casenotes/clcasenoteslookedafterchildren_wdf80622.pdf

33 IRISS (2012) Attachment informed practice with looked after children, Insights no. 1

34 Hallgarten.L, Misaljevich. N (2007) Reducing repeat teenage conceptions: A review of practice

NSPCC Scotland is aware of the tireless work and significant progress in developing and delivering young people's sexual health services across Scotland. *Signposting* young people to sexual health services is the day to day work of volunteers counsellors and staff at ChildLine, as well as working to enable young people to access services through information giving, confidence building etc.

Confidentiality is the key issue for young people when accessing sexual health services, yet many children and young people are often unaware of their right to confidential services[35]. The confidence of professionals in delivering services in the best interests of young people and clear information about confidentiality for young people are paramount issues. Tensions in respecting young people's rights to confidentiality whilst serving information sharing agenda have recently been documented, but must be continually re-visited and explored in order to ensure young people access the help, support and protection they need from sexual health services. Recent evidence around abortion figures and use of contraception at first sexual experience underline the need for us to consistently address core access issues such as confidentiality.

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

Teenage parents are often from deprived and/or socially excluded backgrounds[36]. Teenage mothers are more likely to have experienced separation, divorce, step-parents, and the early transition to motherhood can cause stress on adolescent relationships, compromise antenatal health and affect educational attainment and longer-term opportunities, often resulting in poorer outcomes and long-term poverty[37]

While teenage pregnancy is strongly associated with socio-economic disadvantage, the relationship is even more pronounced for early motherhood. Several studies have shown that young women in areas that are socially deprived are less likely to use abortion to terminate an unplanned pregnancy than their counterparts in wealthier areas[38].

Teenage pregnancy has been associated with prenatal depression and anxiety, risks that reflect both cumulative life course exposure to stressors and current circumstances. Forty three per cent of teenage mothers have an episode of depression within one year of childbirth[39] and postnatal depression may be up to three times as common in teenage mothers as their older counterparts.

Financial hardship has been identified as a source of pressure for low income mothers throughout the perinatal period. Loss of income and social provisions may compound the social isolation of vulnerable young mothers and can contribute to, and exacerbate, the impact of antenatal and post natal depression[40]

High quality healthcare during pregnancy makes a crucially important contribution to the reduction of health inequalities at birth, in infancy, throughout childhood and across the whole of an individual's life course[41]. However, little research has been carried out on the content, quality and accessibility of antenatal classes in Scotland. A key issue is the degree to which parents living in

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[35] Freake, H., Barley, V., & Kent, G. (2007) 'Adolescents' views of helping professionals: a review of the literature', Journal of Adolescence 30, 639-653.
[36] http://www.nice.org.uk/nicemedia/documents/teenpreg_evidence_briefing.pdf
[37] Chevalier and Viitanen, 2003; Swann et al., 2003
[38] Lee et al, 2004; Social Exclusion Unit, 1999
[39] Botting et al.,1998 Teenage mothers and the health of their children
[40] http://www.family-action.org.uk/uploads/documents/Against%20All%20Odds%20-%20Mind%20the%20Gap%20Report%20FINAL.rtf%20-%2020120514181626.pdf
[41] Scottish Government Reducing Antenatal Health Inequalities(2011) Scottish Government: Edinburgh

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disadvantaged areas are able to access the support they require, and whether the support that is available meets their specific needs.

The GUS study found that, in terms of attendance at antenatal classes, there was marked variation by socio-economic group and by maternal age at birth:

- Around two thirds of those aged under 20 did not attend any classes; three quarters of those aged 30-39 went to most or all classes
- Women from non-white ethnic groups were less likely than women from white ethnic groups to have attended classes.
- Women with lower levels of educational attainment were less likely to attend classes than those with higher qualifications (mothers who had a degree were six times more likely to attend classes than those with no qualifications) (GUS, 2007)

Improving access to antenatal care and the quality of the care received by young mother must be seen as priority in improving outcomes for both teenage mothers and their infants. The content of antenatal classes should incorporate and reflect the distinct social, emotional, health and developmental needs of teenagers and should be accessible and non-stigmatizing. Focus on topics around ante- and intrapartum care is valuable, however, issues of child care/child health, and postpartum events should also be addressed. Information on sexual health and contraception is also vital as it may prevent future unintended pregnancies and give teenagers knowledge and confidence about their bodies, which can improve child/parent mental health and general wellbeing[42]

Improving access to quality antenatal care will improve outcomes for teenage mothers and their babies. Current economic constraints dictate that strategic reform is required to reduce health and social inequalities at a UK level. Increasing access to quality universal health care can play an important role in improving outcomes for young mothers and their babies.

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

Current levels of inequality and increasingly limited resources represent significant challenges to reducing levels of teenage pregnancy. Local authorities are making difficult decisions against a backdrop of changes in staffing and budgets. Also, professionals working with families across universal and targeted services do not always have the confidence and capacity to be able to identify those most at risk and ensure that those in need access the right provision.

Alongside training and development, there is a need for more data and longitudinal evidence to ensure early identification, targeting and support of young people at risk of teenage pregnancy, and assess the impact and cost effectiveness of interventions in Scotland. Further research to allow for comparisons across a range of issues and interventions would be usefull. Strategic leadership requires an understanding of what each partner agency contributes to delivering sex and relationship education and contraception/sexual health advice as well as good use of local data to reach those most at risk. Local people and frontline services should also consult and involve young people to find solutions.

[42] Rozette et al, 2000

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

As outlined above, universal healthcare has a pivotal role to play in assessing health and social needs of teenage parents and ensuring appropriate pathways of care, including multiagency and multidisciplinary pathways of care are in place[43]. Home visiting has been identified as an important intervention for tackling health inequalities from an intergenerational perspective, and is capable of producing improvements in parenting, child behavioural problems, cognitive developments in high-risk groups, a reduction in accidental injuries to children and improved detection and management of postnatal depression[44]

In spite of this, NSPCC Scotland evidence indicates that, in universal services, staff who work with infants and parents are stretched to the limit. Between 2009 and 2010 health visitor numbers fell in 7 out of 14 Health Boards.[45] In NHS Lothian numbers declined by 25%, reflecting a shift towards public health nursing.[46] Concerns about excessive health visitor caseloads continue to be highlighted.[47] The 2008 review of the health visiting workforce in NHS Greater Glasgow reported capacity overwhelmed by the scale of need, measured in levels of child vulnerability.[48]

Capacity issues are not just about staffing levels, but also the service model and status of the profession, the nature of its role and relationship to others, and the level of skill and qualification, which have all seen major change – and major uncertainty - over the past decade.

A good indicator of these capacity issues is the actual coverage, or reach, of child health surveillance, which is a universal service. Recent research shows that the actual take-up of child health reviews is variable, declines with child age, and is lowest amongst the most deprived groups with the highest needs. Amongst the most deprived families take-up of the 39-42 month review was just 78%.[49]The remedy to the 'Inverse Care Law' [50]operating here is resource intensive: it requires 'robust efforts…to assess their (the children's) needs and engage them and their families with appropriate and sensitive services.'[51]

The aim should be to provide the best care to all parents through a supportive, highly skilled and well trained workforce, with a higher level of support for the most vulnerable parents. To achieve this requires a significant investment in health visiting in Scotland, both in numbers and skills, to fine tune our universal service delivery ('progressive universalism').

- The health visitor workforce must be expanded, in a planned programme of increased recruitment and training, to achieve caseload levels optimal for the support of vulnerable children.

[43] Scottish Government Reducing Antenatal Health Inequalities(2011) Scottish Government: Edinburgh
[44] Bull et al, 2004
[45] http://www.isdscotland.org/workforce/
[46] Care concerns as health visitor numbers fall by 25% in Lothians'. Scotsman, 3 March 2011.
[47] Scottish Parliament Finance Committee Scrutiny of Draft Budget 2012-13. Submission from Dr Philip Wilson, Dr Colin Brown, Dr Kerry Milligan and Dr Anne Mullin. Available at: http://www.scottish.parliament.uk/S4_FinanceCommittee/Dr_Phillip_Wilson.pdf
[48] NHS GGC (2008), Mind the Gaps: Improving Service for Vulnerable Children (Glasgow: NHS GGC).
[49] Scottish Parliament Finance Committee Scrutiny of Draft Budget 2012-13. Submission from Dr Philip Wilson, Dr Colin Brown, Dr Kerry Milligan and Dr Anne Mullin. Available at: http://www.scottish.parliament.uk/S4_FinanceCommittee/Dr_Phillip_Wilson.pdf
[50] Tudor Hart, J, (1971), The Inverse Care Law. The Lancet. 1(7696): 405-412.
[51] Wood, R, et al. (2012) Trends in the coverage of 'universal' child health reviews: observational study using routinely available data. British Medical Journal Open 2012; 2:e000759

- We need to enrich the skills of health visitors, equipping them with skills to assess parenting needs in the community, together with an understanding of attachment and interventions to promote it.
- Accompanying this should be a framework of regular clinical supervision for health visitors working with high risk families.

The 2005 Framework highlighted that, in addition to competencies, time for staff to support new parents and babies is an important factor in achieving desired outcomes. More recently, the 2011 National Guidance on Reducing Antenatal Health Inequalities recognises that staff need support, supervision, time and resources to enable them to work effectively with women who have multiple and complex health and social care needs[52].

New models of working are required that prioritise the needs of high risk groups, with more integrated and multi-disciplinary models of working between health and social work professionals.

The supervision model used in two of the NSPCC's services – the home visiting programme Minding the Baby and the Glasgow Infant and Family Team (GIFT – part of the New Orleans Intervention Model) – could be replicated within mainstream services. In both these cases an infant mental health service is delivered by multi-disciplinary health and social care professionals.

Delivering a higher level of support to the most vulnerable parents requires attention to service design, to ensure that support is attuned to the realities of life for parents and communities, and that it really reaches those that it should. The needs and views of parents and the realities of their lives as service users must inform service design. In developing community programmes we need to think about mobilising the whole community in providing a nurturing environment for young mothers and their babies[53].

f. **Are there specific initiatives that you would wish to highlight to the Health and Sport Committee that you consider indicate good practice with regard to reducing teenage pregnancy rates in Scotland, either in the public sector, voluntary sector or in partnership?**
g. **Are there specific approaches to reducing teenage pregnancy that are not currently getting sufficient attention in order to affect positive change for children and young people?**
h. **Do you have any comments on any other aspect of teenage pregnancy policy or examples of good practice that you wish to raise with the Committee?**

Minding the baby

The Scottish Government's commitment to the expansion of the Family Nurse Partnership[54] demonstrates a commitment to prioritise and invest in interventions which have sound evidence of effectiveness in improving outcomes for teenage mothers and their babies. NSPCC Scotland is building on this evidence by funding and delivering the 'Minding the baby' programme to vulnerable parents and families across Scotland.

Minding the baby builds on the existing evidence base and adds a strong mental health and social work component. MTB is a rigorously developed and intensive home visiting programme for high risk first time pregnant women and their families. The programme was developed in the

[52] Galloway. S. NSPCC Scotland response to the consultation: A Mental Health Strategy for Scotland 2011 – 2015
[53] Galloway. S. NSPCC Scotland response to the consultation: A Mental Health Strategy for Scotland 2011 – 2015
[54] http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership

USA, contains health and social work support and is delivered in the home from the third trimester of pregnancy until the baby reaches the age of two.

Unlike Family Nurse Partnership, Minding the baby is delivered by a multidisciplinary team including a specialist children nurse and an NSPCC registered social worker. It aims to promote positive physical health, mental health, life course and attachment outcomes in babies, mothers and their families. Minding the baby is based on theoretical frameworks drawn from attachment theory and current understanding of infant brain development and places particular emphasis on encouraging maternal reflective capacity i.e. the mother's ability to conceptualise and respond to the needs of her baby.

Service Delivery

Minding the baby focuses on the families who need the most help. It is currently being offered to first-time mothers aged under 25, who are struggling with problems such as depression, homelessness, poverty and violent relationships. The mums may also have suffered trauma, poor parenting abuse or neglect in their own childhood. Home visits are made biweekly to provide an intensive level of support and ensure difficulties are effectively addressed.

NSPCC Scotland's multidisciplinary team works directly with mothers and across whole family systems to including fathers and other family members to prevent infants suffering abuse or neglect. Families are offered the service by their GP or midwife, and the parents choose whether they wish to join. NSPCC staff will work with other relevant local organisations like local health services and Sure Start Children's Centres.

The intervention teams have protected caseloads and are offered intensive support and supervision from specialist supervisors who have expertise in areas of child attachment and parent/child relationship interventions.

Why are we doing it?

Babies are most vulnerable in the first few months of their life. Research shows that babies are more likely to be abused or neglected if their main carers have poor mental health and fail to bond with them well.

Almost half of all investigations into serious abuse involve a child aged under one. Babies are much more likely than older children to be killed, and the risk from parents and carers is greatest in the first three months of a baby's life.

The impact of poor attachment also has negative implications for children across the life course in areas such as relationship stability, educational attainment, addiction, employment and mental health.

Supporting young mothers and fathers who are struggling to cope with parenthood is one of the best ways to stop child cruelty before it starts. Intervening early gives babies the best possible chance in life and means children need fewer support services as they get older.

How this makes a difference

Getting help to parents and babies early can make a big difference to their lives - and to society as a whole. 'Minding the baby' will be the first service in the UK to combine support from social workers, nurses and mental health experts. The programme in the USA has shown promising early findings, including better bonding between mother and child.

We will know 'Minding the baby' is successful in the areas we're working, when we see:

- Fewer cases of reported abuse and neglect
- Better bonds between mother and baby
- More parents caring effectively for their baby
- Healthy child development

We will evaluate this intervention using measures which reflect these outcome goals and share our learning with government and we would ultimately want to roll out the programme with other organisations so that more babies get the best start in life.

This service fits well alongside mainstream provision, delivering additional intensive services to those with the most complex needs. Practitioners working on MTB can be relied upon to collaborate closely with other agencies in the best interests of their clients

This is a highly innovative and intensive intervention. It focuses on families with complex intergenerational histories and multiple problems. It works over the course of 27 months at a key stage in family development and formation, when the baby is at greatest risk. The scale of the service has been carefully designed in order to balance rigorous and high quality implementation against the need for a large sample size for efficacy testing in the evaluation.

The programme uses experienced, masters level clinicians and supervisors qualified to doctoral level. There are 2 teams in each site in Scotland, each comprising one registered social worker, one paediatric nurse and a clinical supervisor. Specialist training on the specific intervention components has been commissioned from Yale University.

Costs data is currently being gathered to describe the costs of administering the programme and to articulate the benefits of the programme in terms of its benefits compared with the costs of treatment as usual and the economic implications of improved outcomes across the lifespan for the most vulnerable children.

Conclusion

Teenagers who become parents are known to experience greater educational, health, social and economic difficulties than young people who are not parents, and their children may be exposed to the consequences of greater social deprivation and disadvantage[55]

Due to the cross-cutting nature of the actions required to successfully deliver a reduction in teenage pregnancy, it is important that there are strong links with all other relevant policies and strategies, being pursued at a UK-wide, national and local level. Equity enhancing policies to strengthen access to high-quality therapeutic health care should feature as a key policy in strategies to reduce levels of teenage pregnancy.

Cultural influences and the promotion of positive relationships can have a greater impact than specific pregnancy prevention programmes[56] in reducing levels teenage pregnancy. Targeted services for communities or individuals with specific needs should be strengthened and where early pregnancy does occur, targeted parenting programmes and universal antenatal care programmes can be effective in improving outcomes for both teenage mothers and their infants.

NSPCC commission, 'Minding the Baby' provides intensive support to young, poor, first-time mothers to enable them to care appropriately for their baby. Crucially, the programme can

[55] SCIE Research briefing 9 (2005): Preventing teenage pregnancy in looked after children
[56] In Baker, P, Guthrie, K, Hutchinson, C, Kane, R and Wellings, K (eds) (2007) *Teenage Pregnancy and Reproductive Health*. RCOG Press: London. Pp. 263-74.

significantly reduce rapid subsequent childbearing[57]. Replicating the distinct, multi-disciplinary supervision model used in Minding the Baby within mainstream services could better support teenage parents and could contribute to a reduction in unplanned teenage pregnancy in Scotland.

NSPCC Scotland would welcome the opportunity to discuss the issues raised in this paper with the committee.

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[57] Minding The Baby: Enhancing Mentalization in Traumatized Mothers and Their Children()Arietta Slade, Ph.D. & Lois Sadler, Ph.D., PNP

NSPCC registered charity numbers 216401 and SC037717