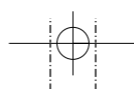
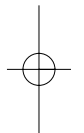
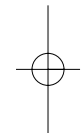
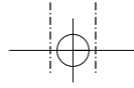




Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts





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Ministerial Foreword



Reducing England's historically high rate of teenage pregnancy is a Government priority. We have made steady progress in bringing down the under-18 conception rate – by 11.8% since the strategy started – to a point where it is now at its lowest rate for over 20 years. Last year we published *Teenage Pregnancy: Accelerating the Strategy to 2010*, which set out our plans to accelerate progress towards our target to halve the under-18 conception rate by 2010, compared to the 1998 baseline rate.

At the same time, we want to ensure that young women who do become pregnant, and decide to go ahead with their pregnancy, receive the support they need to make successful futures for themselves and their children, and avoid any subsequent pregnancies whilst still teenagers. Twenty percent of births conceived to under-18s are to young women who are already teenage mothers.

While the focus of this document is on supporting teenage parents, it is important to understand that this is part of our long-term effort to reduce future teenage pregnancies, narrow inequalities and tackle child poverty. Children born to teenage mothers are more likely to live in deprived areas, do less well at school and disengage from learning early – all of which are risk factors for teenage pregnancy and other poor outcomes. Daughters of teenage mothers are twice as likely as daughters born to older mothers to become teenage mothers themselves.

So measures to improve outcomes for teenage parents will, in turn, reduce the chances that their children become teenage parents, because their children are less likely to experience some of the factors that are known to be associated with teenage pregnancy. More immediately, supporting teenage mothers to access and use contraception effectively after the birth of their first child will also help prevent second and subsequent unplanned pregnancies.

This document therefore looks at how we improve outcomes for teenage parents in the here and now, but also has an eye to how better support for teenage parents today will help to sustain much lower rates of teenage pregnancy in the future.

In chapters 2 and 3, the document sets out the characteristics of teenage parents and provides details of the outcomes that they and their children experience. By bringing together all the

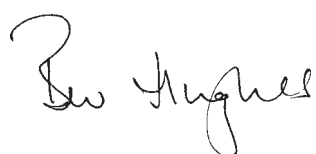
available evidence, it builds a comprehensive picture of the challenges that young parents face and helps us to identify how health, education, social care, youth support services and the voluntary and community sector need to work together to provide holistic support for young parents.

Chapter 4 presents the voice of teenage mothers and young fathers themselves, helping us to understand the practical issues that prevent them from getting the best out of the services available to them, and which hinder their efforts to build for the future. In chapter 5, we present evidence on what approaches to supporting teenage parents work – based on the learning from pilots in England and abroad.

In chapter 6, we set out our vision for what we want each local area to provide for teenage parents and what we will do nationally to support them to deliver more tailored and responsive services. It does not place new burdens on services, but looks in particular at how key mainstream services – midwifery and health visiting services, Children’s Centres, Targeted Youth Support services, Reintegration officers and Housing officers – can tailor the support they provide so that it better meets young parents’ needs. It makes the case for an integrated approach to supporting young parents, with support from different agencies brokered through a lead professional.

Chapters 7 and 8 look in particular at the needs of young fathers and at our plans for reducing the number of young lone parents who are allocated an independent tenancy, without support – which we believe contributes to the poor outcomes they and their children experience.

Providing better support for teenage parents presents many challenges. We need to find new and innovative ways of engaging the most vulnerable young parents. Agencies need to work together, recognising that teenage parents are vulnerable to a wide range of poor outcomes that no single agency can tackle on its own. And we need professionals to understand that services designed for older parents will not always be appropriate when it comes to teenage parents, remembering that teenage parents are young people too. This document sets out how we can tackle these challenges and give teenage mothers and young fathers the support they need to build successful lives for themselves and their children.



Beverley Hughes
Minister for Children, Young People and Families
Department for Children, Schools and Families

1. Introduction

- 1.1** Our ambition is that all children and young people achieve the 5 ‘Every Child Matters’ outcomes – we want them to: Be Healthy, Stay Safe, Enjoy and Achieve, Make a Positive Contribution and Achieve Economic Well-being. Currently, however, the outcomes achieved by some of our young people fall short of this aim. This is particularly true for teenage parents and their children.
- 1.2** Like all parents, teenage mothers and young fathers want the best for their children and some manage very well. But the demands of caring for a baby at a time when young people themselves are making the difficult transition from adolescence to adulthood are significant. That is why teenage mothers and young fathers need additional support – from family, partners and services – if they and their children are to avoid the poor outcomes that many of them currently experience:
- Their children have higher rates of infant mortality than children born to older mothers, are more likely to be born premature – which has serious implications for the baby’s long-term health – and have higher rates of admissions to A&E. In the longer term, children of teenage mothers experience lower educational attainment and are at higher risk of economic inactivity as adults;
 - The pressures of early parenthood result in teenage mothers experiencing high rates of poor emotional health and well-being – which impacts on their children’s behaviour and achievement; and
 - They often do not achieve the qualifications they need to progress into further education and, in some cases, have difficulties finding childcare and other support they need to participate in Education, Employment or Training (EET). Consequently, they struggle to compete in an increasingly high-skill labour market.
- 1.3** While – as chapter 2 demonstrates – teenage mothers and young fathers disproportionately come from disadvantaged backgrounds and would, therefore, be more likely to need additional support to make a successful transition to adulthood, becoming a teenage parent adds significantly to the challenges they face.

- 1.4 It is estimated that three quarters of under-18 conceptions are unplanned and around a half end in abortion. It is important, therefore, that we maintain our strong focus on preventing teenage pregnancies. We have made steady progress on reducing the under-18 conception rate, which has fallen by 11.8% (based on 2005 data) since 1998, to its lowest level for over 20 years. Within this overall reduction in conceptions, the rate of births has fallen by almost 19%, whilst the rate of abortions has fallen by almost 3%. This means that we are reducing the proportions of young women who experience early parenthood and the poor outcomes associated with it.
- 1.5 But there is less evidence that we are making similar progress on improving outcomes for teenage mothers and their children. This means that teenage parents and their children are not only facing disadvantage now, but are at risk of transmitting disadvantage down through their children to the next generation. Children of teenage parents are more likely to experience the risk factors for early parenthood and so become teenage parents themselves, creating a cycle of deprivation that is difficult to break.
- 1.6 That is why we are publishing this 'refreshed' strategy. It seeks to address more effectively the full range of issues that teenage mothers and young fathers experience, and engage all those across Government whose policies affect outcomes for teenage mothers. Rather than measuring the strategy's success only in terms of teenage mothers' engagement in education, employment or training (EET) and access to supported housing, this refreshed strategy is broader, focusing on all the issues that influence teenage mothers' ability to build successful futures for themselves and their children. The new strategy also seeks explicitly to improve outcomes for and engage more effectively with young fathers, to strengthen their relationships with their children.
- 1.7 The new strategy makes clear what we expect all areas to have in place, with a stronger focus on:
- Ensuring that midwifery and health-visiting services provide tailored support for teenage parents – both teenage mothers and young fathers (who frequently report feeling ignored by midwifery and health-visiting services) – to address problems such as late ante-natal booking by young mothers, poor levels of nutrition and high levels of smoking during pregnancy, and low rates of breastfeeding – all of which contribute to the poor health outcomes experienced by children born to teenage mothers, such as low birth weight and higher rates of infant mortality and morbidity;
 - The role of Children's Centres and other community-based children and young people's services in reaching out to the most vulnerable teenage mothers, and providing them with easy access to a broad range of support in one place;

- The role of Targeted Youth Support services in helping teenage parents to cope with the challenges of early parenthood, by providing co-ordinated support from a lead professional who can act as an advocate for the young mother and father and put them in touch with any specialist support they may need. This support will help to address the poor emotional health that leads to worse outcomes for them and their children;
- Ensuring that we offer high quality support to all mothers aged under 18, who cannot live with their own parents, in particular by seeking to avoid situations where young mothers become isolated by being placed in independent tenancies, without support;
- Making services more attractive to young fathers and recognising the implications of fatherhood when helping them to overcome barriers to engagement in education, employment and training;
- While at the same time, strengthening the focus on helping teenage mothers to re-engage in EET.

1.8 These measures will better enable us to capitalise on the strong desire of teenage mothers and young fathers to provide the best possible lives for their children. This opportunity has too often been missed, as young parents' best intentions fail to materialise because they do not get the support they need.

2. Characteristics of Teenage Mothers and Young Fathers

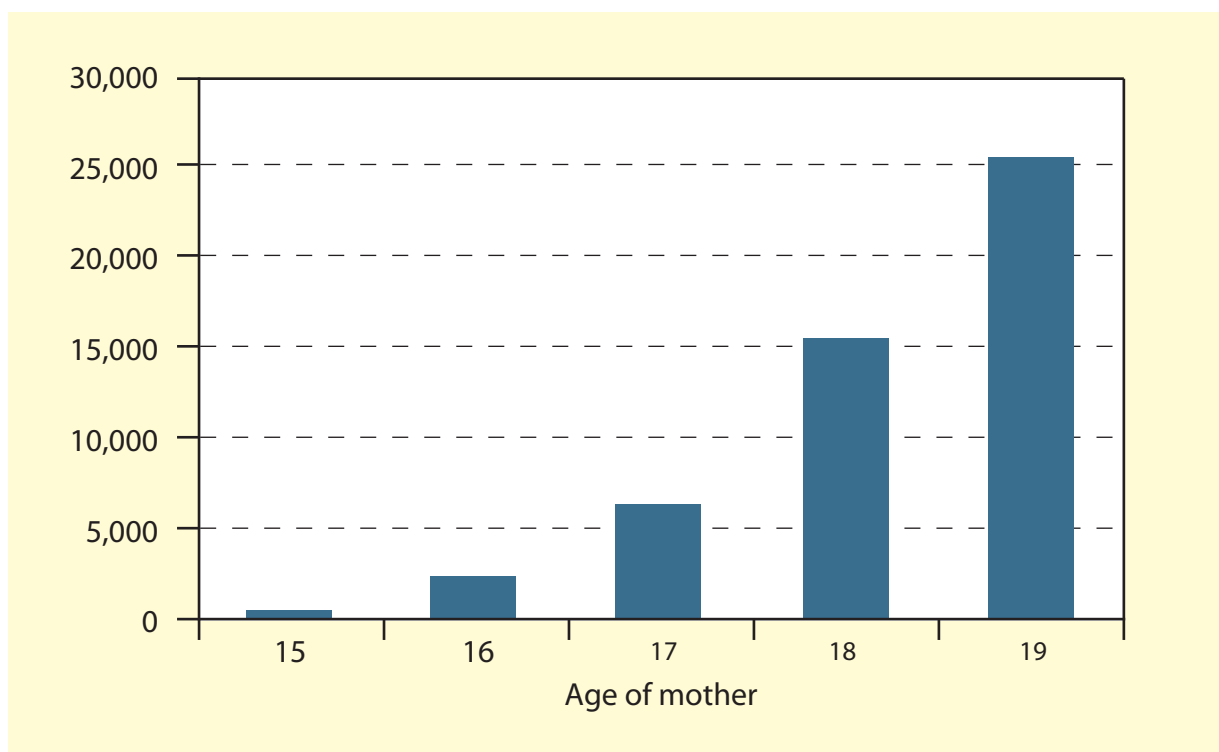
Overview

2.1 Of the estimated 50,000 mothers aged under-20 living in England in 2005, over 80% were aged 18 or 19; over 60% were lone parents; 70% were not in education, employment or training (NEET); and they were much more likely to live in deprived neighbourhoods.

Age

2.2 The media's focus on very young mothers can be misleading. In reality, over half of mothers aged under-20 in 2005 were aged 19, with only 6% aged 16 or under (figure 1).ⁱ

FIGURE 1: AGE PROFILE OF TEENAGE MOTHERS, 2005



Source: Teenage Pregnancy Unit, 2006

2.3 There are less complete data on the age profile of the fathers of children born to teenage mothers, as their details are not always included on birth registrations (see below). From the available data, however, a quarter of fathers are also aged under 20, around a further half are aged 20-25 and a further quarter are aged over 25.ⁱⁱ

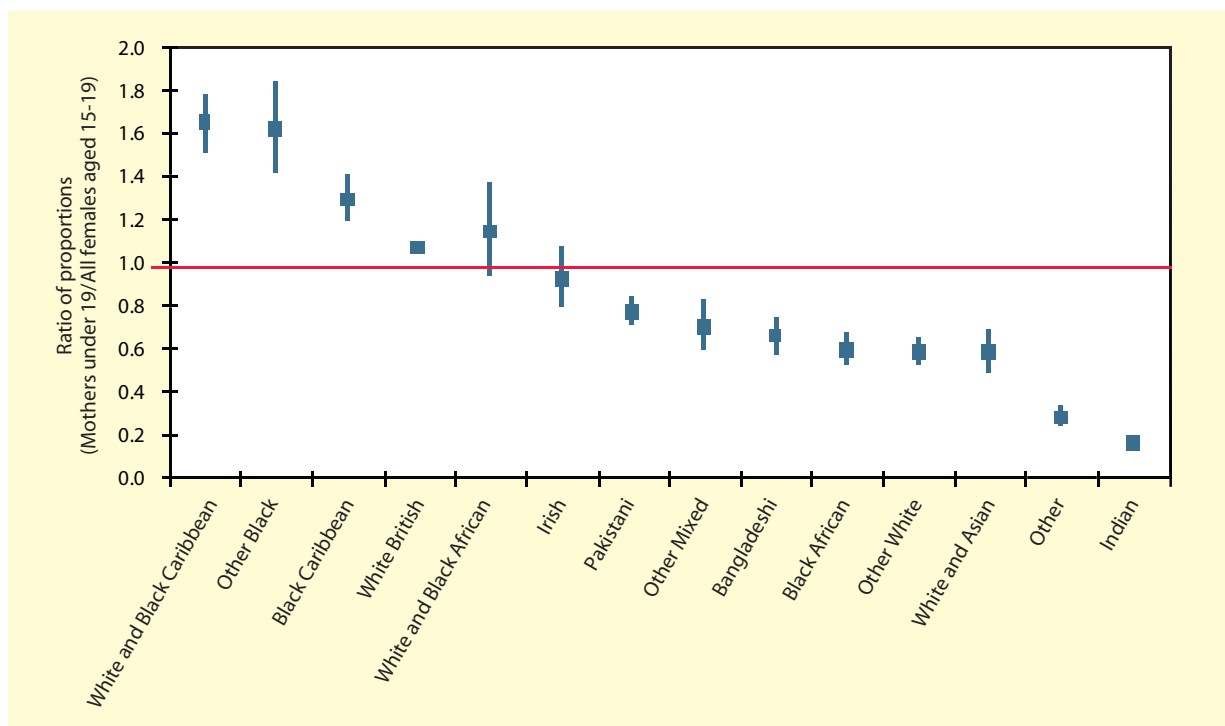
Relationship Status

2.4 The majority of teenage mothers bring up their children alone. 2001 Census data show that among mothers aged under-20, 61% were lone parents, 30% were co-habiting and 9% were married.ⁱⁱⁱ However, this pattern is not uniform across all local areas – with the proportion of teenage mothers who are married in some local authorities being over twice the England average and, in other areas, over half of teenage mothers are co-habiting. Often their relationships are volatile and lives chaotic, involving frequent moves, which makes it more difficult for services to engage them and particularly to re-engage them with learning.

Ethnicity

2.5 The vast majority (89%) of mothers aged under-19 are White British, although in local authorities with large black and minority ethnic populations the picture is different, with less than 60% of mothers in London classified as ‘White British’ and less than a third in six London Boroughs. However, the *likelihood* of teenage motherhood is higher among young women of ‘Mixed White and Black Caribbean’, ‘Other Black’, ‘Black Caribbean’ and ‘White British’ ethnicity. All Asian ethnic groups have a lower than average incidence of teenage motherhood (see Figure 2).

FIGURE 2: ETHNICITY OF MOTHERS GIVING BIRTH UNDER-19 BETWEEN 1999 AND 2001

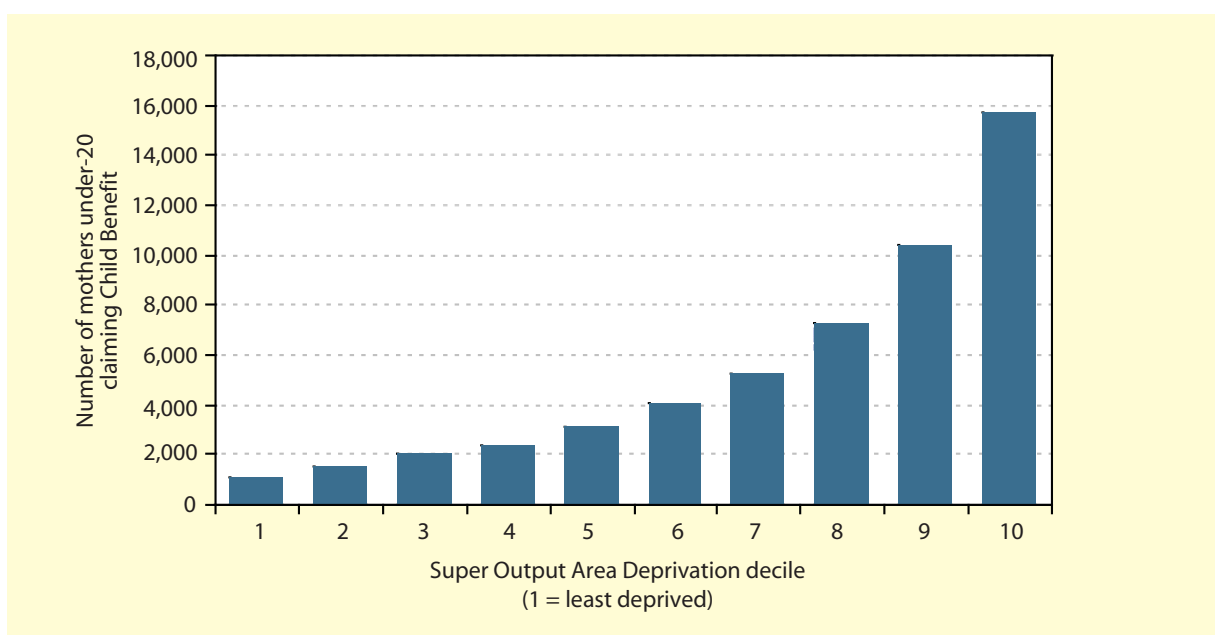


Source: 2001 census data and Teenage Pregnancy Unit (2006)

Socio-Economic Status

2.6 The prevalence of teenage motherhood is overwhelmingly concentrated in deprived local authorities, where not only are under-18 conception rates higher than average, but so are the *proportions of conceptions leading to birth, rather than abortion*. The rate of births to under-18s in the most deprived 10% of wards is nine times higher than in the 10% least deprived.^{iv} This correlation between high rates of teenage motherhood and levels of deprivation becomes even more evident when looking at smaller geographical areas, with Child Benefit data showing that 49% of teenage mothers live in the most deprived 20% of Super Output Areas (see figure 3).

FIGURE 3: NUMBER OF TEENAGE MOTHERS BY DEPRIVATION DECILES



Source: HM Revenue & Customs, 2005

Accommodation

2.7 Teenage mothers are six times as likely as other households to live in areas dominated by local authority housing. Data from the 2000 National Survey of Sexual Attitudes and Lifestyles (NATSAL) found that over half of women conceiving under-18 rented from the council or a housing association.^v

Children in Care

2.8 Teenage parents are more likely to be, or to have been, looked after children. Research has shown that, by the age of 20, a quarter of children who had been in care were young parents, and 40% were mothers.^{vi} Among girls aged under-18 and still in care, the rate of teenage motherhood is around three times higher than the rate among all girls aged under 18 in England.^{vii}

Young Fathers

2.9 Many of the characteristics of teenage mothers are also found among young fathers. Young fathers are more likely to live in deprived areas, to be unemployed and to be in receipt of benefits. Around a fifth of teenage fathers have never lived with their child, compared with 6% of older fathers.^{viii}

Young parents in custody

2.10 A high proportion of young people in custody aged 15-21 are parents. 25 per cent of young offenders in custody are estimated to be fathers, while 39 per cent of female young offenders in custody are estimated to be mothers.^{ix}

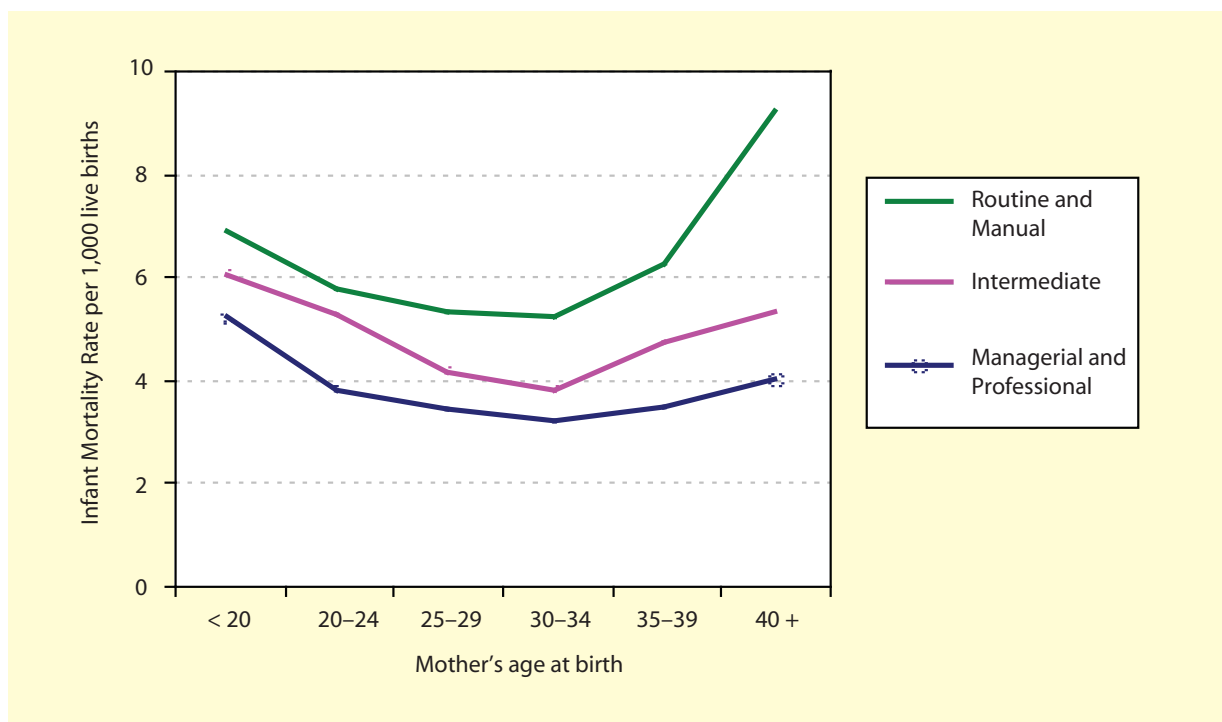
3. Poor Outcomes Experienced by Teenage Parents and their Children

- 3.1** The poor outcomes experienced by teenage mothers and their children include:
- Poorer outcomes for children born to teenage mothers, both in terms of their health, but also in regard to their behaviour, attainment and future economic well-being;
 - Poor emotional health and well being; and
 - Poor economic well-being.
- 3.2** Given the characteristics of teenage mothers (outlined in Chapter 2), the key question is the extent to which the poor outcomes they and their children experience are due specifically to teenage motherhood, or are due to other factors such as deprivation, low post-16 participation in EET, etc. This section summarises evidence that shows the problems associated with teenage motherhood are more extensive than can be explained by these wider factors alone.
- 3.3** While the actual extent to which teenage motherhood exacerbates existing problems is difficult to quantify, the evidence does point to a range of factors that increase the likelihood of poor outcomes, including: higher rates of relationship breakdown; a greater likelihood of living in a workless household and in social housing; and lower levels of emotional support.

Poor Child Health Outcomes

- 3.4** Rates of infant mortality for babies born to mothers aged under-20 are around 60% higher than rates for children born to mothers aged 20-39 years. As shown in figure 4 (below), higher infant mortality rates are seen across different socio-economic groups, indicating that the mother's age, in itself, influences mortality rates.

FIGURE 4: INFANT MORTALITY RATES BY MOTHER'S AGE AND SOCIO-ECONOMIC GROUP, 2003-05



Source: National Statistics, 2006

3.5 These poor health outcomes are reflected in the health inequalities PSA target to reduce the gap in infant mortality (IM) rates between disadvantaged groups and the rest of the population. The higher IM rates among teenage mothers were modeled for their impact on the target in the recent *Review of the Health Inequalities Infant Mortality PSA Target*. Reducing the under-18 conception rate in the routine and manual target group – in line with the teenage pregnancy strategy – will provide around a tenth of the contribution needed to narrow the gap and meet the target.

3.6 Children born to teenage mothers are also more likely to be born pre-term, with a 25% higher risk of low birth weight.^{xi} Research has shown that the age of the mother, in itself, contributes to these poorer outcomes.^{xii} However, the lifestyles and behaviour of teenage mothers also influences these outcomes, and include:

- Later booking for ante-natal care (on average at 16 weeks gestation),^{xiii}
- Higher rates of smoking throughout pregnancy, compared to older mothers, including older mothers from lower socio-economic groups,^{xiv}
- Lower rates of breastfeeding, which are around a third lower than the average for all mothers;
- Poor maternal nutrition during pregnancy.^{xv}

3.7 Smoking during pregnancy is estimated to contribute to 40% of all infant deaths.^{xvi} Teenage mothers are more likely than older mothers to have been smoking before they became pregnant and are less likely to stop smoking during their pregnancy.

Table 1: Smoking during pregnancy in England by mother's age, 2005

Mother's age	% who smoked before or during pregnancy	% who smoked throughout pregnancy	% that gave up before or during pregnancy
20 or under	68	45	34
All ages	32	17	49

Source: *Infant Feeding Survey, 2005*. DH Information Centre

3.8 Research also identifies poorer health and social outcomes for children born to teenage mothers, beyond those evident at the time of birth. For example, they have higher rates of accidents, such as falls and swallowing dangerous substances, and are more likely to experience behavioural problems, such as conduct, emotional and hyperactivity problems. Research shows the higher incidences of these problems are – at least in part – due to higher levels of poor emotional health among teenage mothers.

Poor emotional health and well being

3.9 Research shows that teenage mothers have higher rates of poor mental health after birth than older mothers, and that these higher rates are evident for up to three years after birth.^{xvii} Social isolation and high rates of relationship breakdown are key factors which contribute to this situation.

3.10 The demands of parenthood are significant even where responsibilities are shared between both parents. It can also be argued that being a parent and being a teenager are incompatible – as one report puts it, ‘while parenthood calls for responsibility, stability and predictability, adolescence is a period of exploration, spontaneity and instability’.^{xviii}

3.11 It is unsurprising, therefore, that a parent who is both young and who lives alone finds it hard to cope, unless strong support systems are put in place. 2001 Census data show that 61% of mothers under-20 giving birth in the preceding three years were lone parents. Although 66% of birth registrations for children born to teenage mothers are joint registrations, almost half of fathers are resident at a different address at the time of the child's birth. Longitudinal studies show that at age 30, 20% of men who fathered a child before age 20 had never lived with their child, compared to only 6% of men who were over 22 when their child was born.

3.12 Not being in a stable relationship at and immediately after the time of the birth also contributes to young mothers' poor emotional health and well-being. Only a third of young mothers report having a stable relationship during their pregnancy and in the following 3 years, compared to nearly 90% of older mothers.

3.13 Living in isolation, often in poor housing, further contributes to poor emotional health and well-being. That is why we are particularly keen to avoid young mothers under the age of 18 being allocated independent tenancies, without support. Our proposals for addressing this issue are set out in chapter 8.

Poor Economic Well-being

3.14 Longitudinal studies show that the factor which is most protective against poor outcomes for teenage mothers and their children in the longer-term, is being in a job which they like^{xxi}. But despite a strong desire to provide for their children, young mothers face significant hurdles to achieving economic well-being.

3.15 For very young mothers, their education is disrupted often at the most critical time, in the run-up to taking GCSEs. Even where the young woman has a child after they have left school, many have disengaged from learning early. Data from the 2001 Census show almost 40% of teenage mothers giving birth in the previous three years had no qualifications in April 2001.

3.16 Young mothers' participation in education, employment or training (EET) beyond the compulsory school leaving age is very low, with only about 30% of young women aged 16-19 being in EET, compared to about 90% of all 16-19 year olds.^{xx} While it is not surprising that participation levels are lower than average – as new mothers will, in most cases, want to spend a period of time at home with their babies before returning to EET – participation rates are unacceptably low and hinder young mothers' chances of securing jobs that will lift them out of poverty and disadvantage.

3.17 The implications of low prior attainment, coupled with low post-16 participation in EET mean that, by age 30, teenage mothers are:

- 22% more likely to be living in poverty than mothers giving birth aged 24 or over;
- 20% more likely to have no qualifications than mothers giving birth aged 24 or over;
- Much less likely to be employed or living with a partner;
- Where they do live with a partner, that partner is more likely to be unemployed and have poor qualifications.

3.18 As a consequence, children born to teenage mothers have a 63% higher risk of living in poverty, compared to babies born to mothers in their twenties.^{xx} They have lower academic attainment and are at higher risk of economic inactivity in later life.

3.19 Longitudinal studies show that men who become fathers at a young age (under age 23) are twice as likely to be unemployed at age 30 than men who became fathers aged over 23, even after taking account of deprivation.

4. What Teenage Mothers and Young Fathers Say

- 4.1** The above analysis on poor outcomes experienced by young parents and their children is drawn from a range of data sources and published research. This chapter summarises the key messages from young parents and the practitioners who support them, based on focus groups with young mothers and fathers carried out in 2007 by three voluntary organisations – YWCA, GFS Platform (formerly The Girls Friendly Society) and Working with Men – and a consultation event with practitioners who provide support for teenage mothers and young fathers.
- 4.2** It reflects young mothers' reported experience of the services provided for them – from the point at which they discovered they were pregnant, through to the advice and support they received to re-engage in EET after their child was born. It focuses in particular on the practical problems and barriers that appear to prevent them from achieving better outcomes. It also summarises young fathers' views about the extent to which they were helped to meet the responsibilities of fatherhood, as well as the extent to which services designed primarily to support mothers recognised the important role of fathers, and were inclusive.
- 4.3** We have not attempted in this chapter to assess whether the negative experiences reported by young parents were real or perceived, or the extent to which their perceptions are shaped by prior negative experiences of statutory services. Nor have we attempted to compare and contrast their experiences against those of older mothers/fathers. Rather, the aim of the chapter is to reflect the reality of young parenthood as experienced by teenage mothers and young fathers themselves.

Maternity and Health Visiting Services

- 4.4** Some of the young mothers who were consulted felt that maternity services were unresponsive to their particular needs and that sometimes midwives and other maternity staff were judgmental, which put them off attending ante-natal classes. Those who had experienced them welcomed the provision of dedicated services for young mothers – rather than all-age services.

4.5 Some practitioners reported difficulties for young mothers in accessing free pregnancy testing, particularly in rural areas. There were also problems accessing abortion services in cases where they were considering not going ahead with the pregnancy, due to the lack of local NHS-funded services. This meant travelling long distances, to places they did not know, to access an abortion. Others did not feel that young women were given the impartial advice or support they needed to make an informed decision and some young mothers were upset that they had been shown scans of the foetus in the womb early in the pregnancy, before they had decided whether or not to continue with the pregnancy.

I told him (GP) I couldn't cope. He told me to get rid of it.

The doctor just assumed I would keep it and gave me books and folic acid.

They shouldn't show you the scan automatically if you're thinking about a termination.

4.6 Experiences of the birth itself were mixed, which is probably true of many older mothers' experiences. However, it was perceived by young mothers' who had negative experiences that, in their cases, it was at least in part due to midwives' disapproval that they were having a child at a young age. Experiences were more positive where support was from a specialist teenage pregnancy midwife. Some young women reported limited support and encouragement from midwives to initiate breastfeeding.

*They swore at me through my labour. When the breathing got difficult, one went, 'you've been breathing all your ***** life.*

While in hospital I tried breastfeeding... she kept coming off and they wouldn't show me how to latch on, so I gave up and bottle fed her.

4.7 In a small number of cases, young mothers reported a worrying lack of post-natal support, with a young woman in one area reporting few visits from health visitors in the four months after the birth. In other cases, young women felt that the health visitors were 'checking up on them'. This again may be a common feeling among mothers of all ages, but also reflects the fact that overall teenage mothers are a vulnerable group and so health visitors may legitimately identify them as potentially needing additional support. But the perception that young mothers were being 'singled out' due to a negative preconception about their suitability to be mothers was very real among some of those consulted. This led to them being defensive, not attending appointments and consequently not getting the maximum benefit from the support available.

I've seen a health visitor once since she's been born, and she's four and a half months old.

4.8 Young fathers often reported very negative experiences of midwifery and health visiting services. They felt very strongly that they were made to feel unwelcome and were often ignored completely. This is particularly worrying given the evidence that

the fathers' involvement during the pregnancy can be a strong protective factor and influence the degree of contact with the child after the birth, even if the relationship with the mother changes.

I was active, I wanted to go to all the scans and be there at the birth, but it wasn't always as easy as that. I was at the birth, but not in the same room, I was outside, her mum was in the room with her. I didn't realise at the time I could have been in there as well, no one told me.

I went, but no one spoke to me. It felt like they were looking down their noses at us.

Relationship Support and Mediation Services

- 4.9** As the analysis in chapter 3 shows, relationships between the teenage mother and the father of the child are often fragile. In many ways this is not surprising: the transient nature of relationships made during adolescence; the fact that in the majority of cases the pregnancy is unplanned; external pressure from wider family members who were upset about the pregnancy, and their overall poor socio-economic position at the time, all contribute to this fragility.
- 4.10** At the same time, some young mothers were reluctant to talk about problems regarding their relationships with their partners, and/or families, with professionals.
- 4.11** Young mothers often reported that relationships with the father of their child were volatile. Although most had continuing contact with the father, they did not always live with them, or only did so from time to time. Most fathers provided some financial support (buying clothes and nappies), but support was sporadic and a third of the young women consulted were in disputes with the father/Child Support Agency about maintenance payments. In some areas, the majority of mothers reported that the father was unemployed, even if general unemployment rates locally were low.
- 4.12** However, consultations with young fathers paint a more balanced picture of the level of support they are providing. A number of the young fathers claimed to be the primary carer, even though they had not taken on this role formally (for example, they may not have been the recipient of the Child Benefit). In some cases this was due to the mother's poor emotional health, or drug or alcohol misuse, meaning that she was incapable of fulfilling the main caring role.
- 4.13** Despite the reported need for access to relationship support, young mothers felt that it was generally unavailable locally. Where it was available, it was generally in the context of mediation between the young mother and her family, with the aim of keeping her within the family home to avoid the need for recourse to social housing.

There should be counselling services so that we can talk but you have to pay for them.

Accessing Benefits

4.14 The confusion and difficulty over accessing benefits was reported to cause high levels of stress and be a major contributory factor to young mothers' high levels of poor emotional health and well-being. Practitioners who support young mothers also say that helping them to access benefits/housing can be extremely difficult and a major drain on their resources, diverting them away from providing more positive support, such as developing parenting skills, or providing help to find training or work.

4.15 Jobcentre Plus staff were often characterised as unhelpful and many young women said that they were given wrong information, or information that contradicted what they had been told by other Jobcentre Plus staff. This was not universally the case, however, with a minority of young women reporting that Jobcentre Plus staff were helpful, particularly where there was a named individual responsible for dealing with claims from under-18s.

Also they judge you. The way they look at you and talk to you. It stops you going back to get what you are entitled to.

4.16 Some young mothers said that they could not understand why mothers' under-18 received less benefit than those over 18, when the costs of bringing up a child were the same. Others did not feel it was fair to differentiate the amount of benefit they received on the basis of whether they were living in the parental home or living independently.

4.17 There was some lack of awareness of how the tax credit system worked (among both young women and practitioners) and also some lack of knowledge about the Healthy Start voucher scheme, to which all pregnant women aged under-18 are entitled. The lack of knowledge of the former may be acting as a disincentive to engage in work, due to concerns that they would be no better off working. In reality, tax credits, Housing Benefit 'run-ons' and other in-work support have done much to alleviate the problems of 'benefit traps', although many young women still said that they were scared to come off benefits, especially if jobs were temporary, or if they were uncertain about their ability to cope with the demands of being a working parent.

4.18 There were also felt to be perverse incentives in the benefit system that meant it was better financially for young mothers to claim benefits on their own, rather than as a couple. It was also felt to be 'safer' as there would be no disruption to the young mother's benefit claim if the relationship dissolved. But where young women claim benefits in their own right, but then co-habit, they run the risk of prosecution for benefit fraud.

We claimed separately because we got more money that way. Why would you want to claim as a couple and get less money, it makes no sense!

Engagement in Education, Employment or Training (EET)

4.19 Despite the fact that many of the young mothers had negative prior experiences of education, they generally had a strong desire to provide a positive future for their child, and recognised that their engagement in education was central to them realising those ambitions.

I'm scared because of not knowing anyone, making friends, returning to education, doing course work. Will it go well? Will it go badly? Will I miss the baby too much? It will be hard but I want [her] to be proud of me and I want to give her a better time than I've had.

4.20 A minority, however, were prepared to delay re-engagement in EET until their child was of school age, as they were keen to spend time with their children (and to be seen by others to be doing so) and/or due to higher than average levels of anxiety about using formal childcare. There was some concern about unwelcome pressure to return to EET too early after the birth of their child. This view was shared by some practitioners who argued that pushing young mothers to engage in EET before they were ready was counterproductive as many dropped out early and not finishing their courses reinforced their previous negative attitudes about education.

4.21 However, many are happy to return to EET earlier, but still felt that there were obstacles that prevented them from doing so. There was felt to be a lack of foundation-level training for those who had not gained qualifications while at school. In other cases, those that had missed out on taking GCSEs because of pregnancy reported difficulty accessing GCSE courses in post-16 institutions and said they had only been offered vocational courses.

4.22 Support from Connexions Personal Advisers to identify relevant EET options was generally felt to be good, and the Care to Learn programme was welcomed, but a number of young mothers had not heard of it and in some cases – especially in London – it did not always cover the full costs of childcare. Many, including practitioners, felt it should be extended to mothers aged 20 and above, who were more likely to have the stability in their lives that made them better placed to take advantage of the opportunities available to them.

4.23 However, there remained a number of young women – in particular those from more deprived communities – who were reluctant to use childcare not provided by family members. There were also problems identified where learning providers advertised availability of courses late, as it was difficult to arrange childcare at short notice. In particular, childcare at college nurseries or crèches was usually full by this stage.

4.24 In contrast to the overall positive feelings about Connexions and Care to Learn, accessing Education Maintenance Allowance was seen as somewhat daunting for some young parents. Some young women said that they had been given wrong information which resulted in confusion about whether they were entitled to EMA. Young mothers reported that it was frequently not made clear that students with a dependent child could apply for

EMA in their own right and that in such cases the household assessment of income only took account of their own and their partner's income and not their parents' income (even if living with their parents).

- 4.25** In addition, it was felt that EMA attendance rules were not sufficiently flexible to reflect the reality of their lives which might, for example, require them to take time off when their children were sick. This universal application of attendance rules – regardless of whether the student has a young child – meant that young mothers often did not receive the EMA bonuses.
- 4.26** Other examples of where inflexibility on the part of post-16 institutions presented obstacles for young mothers included fixed start dates, which are often tied in to the academic year, and no allowances being made when course work was late due to child illness or other factors relating to parental responsibilities.

Accessing Housing

- 4.27** Difficulties finding accommodation were reported when overcrowding in the family home, or a breakdown in the relationship between the young mother and the maternal family, meant living at home was no longer tenable. This caused a huge amount of stress and is thought to be a significant contributor to young mothers' high levels of poor emotional health and well-being.
- 4.28** The temporary accommodation offered to some young women was very poor and they reported not feeling safe where they had been placed. This sometimes led to them staying at friends' houses and becoming lost to the support services that might otherwise be in place. Some practitioners expressed concern that living in overcrowded conditions increased the likelihood that the mother would sleep in the same bed as their child, which could increase the risk of infant mortality.
- 4.29** Those who had been placed in residential units with on-site support were generally satisfied with the accommodation provided but, where 'floating support' was provided in connection with an independent tenancy, the support was sometimes of poor quality and there was little continuity of staff.

I was in a bed and breakfast. It was disgusting, it stank there were needles and drugs everywhere and it was filthy and horrible.

- 4.30** Young fathers did not usually co-habit in residential units. Usually they were living with their own parents or were homeless or in hostel accommodation where it was not suitable to take a child. This was a barrier for fathers who wanted to maintain their relationship with their children.

5. Evidence of ‘What Works’ to Improve Outcomes

- 5.1 While there is much evidence of the poor outcomes experienced by young mothers and their children, it is difficult to assess whether outcomes are improving or getting worse over time.
- 5.2 In contrast to measuring progress on *reducing* teenage pregnancies – where there are robust data on the number of under-18 conceptions, which can be disaggregated to ward level – measuring success in improving teenage mothers’ outcomes is more difficult. Data are either not available at local level, or progress is measured using less reliable survey data. Further, measuring outcomes like ‘emotional well-being’ is not straightforward.
- 5.3 Unlike conception rates – where it is relatively straightforward to compare performance between areas with similar demographics – assessing which local areas are performing better in terms of improving outcomes for teenage mothers and their children is much more difficult. Nevertheless, there are studies which help us to understand ‘what works’.

Evaluation of the Sure Start Plus pilots

- 5.4 As part of the Teenage Pregnancy Strategy, the Sure Start Plus pilots were established in 2001, in 35 Local Authorities with high rates of teenage pregnancy. The aim of the pilots was to reduce the risk of social exclusion associated with teenage pregnancy, by providing a co-ordinated package of support to help with issues such as: housing, health care, parenting skills, re-engagement in EET and childcare.
- 5.5 The evaluation concluded that having a dedicated lead professional, providing holistic support, was valued by both the young mother and professionals from specialist support services. The Sure Start Plus Adviser was able to provide the generic support role, but also provide the young mother with access to a range of specialist services, such as smoking cessation, breastfeeding, counselling services and help to re-engage in EET. Other professionals providing specialist support, such as midwives and health visitors, did not feel that the Sure Start Plus Adviser was duplicating work being done elsewhere; rather, that Sure Start Plus workers were filling a gap in provision.

Quote: I liked having a key worker – she can remember you, your child and provide a personal service. You can contact them in an emergency, you have their mobile number.

5.6 The pilot was particularly successful in providing crisis support in relation to family mediation, domestic violence and finding accommodation. There was also evidence of higher rates of re-integration to school among school-aged mothers – and in post-16 participation where the Sure Start Plus Advisers were based in Education. But the pilots appeared to be less successful in addressing health issues (breastfeeding, smoking cessation) and in reaching and supporting young fathers. However, the evaluation concluded that limited funding and the relatively short period during which the pilots had operated meant that the potential wider benefits of the programme may not have had enough time to become apparent.

Health-Led Parenting Programme (Nurse Family Partnership)

5.7 Studies from the USA demonstrate that intensive, strength-based interventions to support vulnerable mothers from early pregnancy and for the first two years after the birth, significantly improves outcomes for both the mother and child. The Nurse Family Partnership, developed by the University of Colorado, focuses on low income, first time unmarried teenage mothers, so the results from the programmes are particularly relevant.

5.8 Tested and evaluated over some 25 years, interventions delivered through the Nurse Family Partnership model show improved pregnancy outcomes, improved child health and improved parental economic self-sufficiency. Consistent results across the three US trials include:

- Improvements in women’s prenatal health;
- Reductions in children’s injuries;
- Fewer subsequent pregnancies;
- Greater intervals between births;
- Increases in fathers’ involvement;
- Increases in employment;
- Reductions in reliance on the benefits system;
- Improvements in school readiness; and
- Programme effects greatest among those most susceptible to poor outcomes.

- 5.9** Evidence from *Reaching Out: Think Family (2006)*, the interim analytical report of the Government's Families at Risk Review, highlights the importance of integrated services providing tailored, flexible and holistic support to vulnerable families including teenage parents. Innovative local programmes demonstrate that working with the whole family has impressive potential to tap into family strengths and engage families early. A final report from the review will be published in Autumn 2007.
- 5.10** There are, of course, many examples of innovative and promising practice in relation to issues such as smoking cessation, encouraging breastfeeding, engaging young mothers in EET and engaging young fathers, examples of which are included in the next chapter. However, these small-scale initiatives are not normally evaluated robustly in terms of their impact on outcomes.
- 5.11** There is, however, from the Sure Start Plus and Nurse Family Partnership programmes, some clear evidence that: early identification; dedicated support from a lead professional; and an appropriately skilled workforce with access to specialist support, where necessary, form the basis for an effective support package for teenage mothers. This is what we want all areas to have in place, as set out in Chapter 6.

6. Supporting Teenage Parents to Achieve Better Outcomes

- 6.1 The preceding chapters provide the underpinning data and research evidence that local areas need to take into account, when planning, commissioning and delivering services, so that they more effectively meet the needs of teenage parents and deliver better outcomes for them and their children.
- 6.2 This information will enable practitioners to understand the risks that young parents and their children face, across a broad front. For example, it allows midwives and health visitors to understand not just the increased risks that the children of young mothers face in terms of infant mortality and low birth weight, but also the mother's risk of long-term poverty and disadvantage due to their poor labour market position. As such, it is intended to increase professionals' understanding of the need to address all of the issues affecting young mothers' lives in the round. In doing so, it makes a convincing case for integrated multi-agency support, co-ordinated through a lead professional.
- 6.3 Importantly, it also provides useful user-perceptions of teenage mothers and young fathers that will help those who design and deliver services to respond better to young parents' needs.
- 6.4 There are a number of ways in which we want areas to use this information:
 - We want PCTs to look at the feasibility of having dedicated services for young mothers (rather than all age services) and to raise the awareness of staff in maternity services of the importance of proactively and positively engaging young fathers wherever possible in the pregnancy and the birth. We also want PCT staff to look critically at the arrangements that they have in place to refer pregnant young women to a lead professional who can support young mothers' wider needs during the pregnancy and after the birth, making maximum use of the guidance, *'Multi-agency working to support pregnant teenagers – a midwifery guide to partnership working with Connexions and other agencies'*, published jointly by DH, DCSF and the Royal College of Midwives;

- We want Children’s Centres and other community-based children and young people’s services to further embed the findings from the Sure Start Plus pilots in the services they are offering. In particular they should review the extent to which the services they are providing are tailored to the needs of teenage mothers, young fathers and their children and are reaching the most vulnerable mothers who are the least likely to access ante-natal and other services;
 - We want Children’s Trusts to ‘design-in’ teenage parents into their developing Targeted Youth Support services, so that systems are put in place which identify young mothers early, and provide them with ongoing, holistic support through a lead professional;
 - We want Housing and Jobcentre plus staff to understand the vulnerability of young parents and to deal with them sympathetically during a time when they face the significant challenge of coping with a new baby, while possibly also dealing with the pressures of living independently for the first time; and
 - We want all of the above services to consider how they can work together better – for example through Local Area Agreements – to address all of the issues that young parents face, which result in the poor outcomes that they and their children experience.
- 6.5** It is the responsibility of the local Director of Children’s Services, working with senior staff in the Primary Care Trust, to ensure that sufficient strategic importance is placed on the need to reduce teenage pregnancy while at the same time ensuring that teenage parents and their children are supported to achieve the best possible outcomes. The delivery chain that will ensure that effective support is forthcoming includes a wide range of agencies and services. Directors of Children’s Services will, therefore, need to ensure that Teenage Pregnancy Co-ordinators and other key staff have the resources and support they need to ensure this strategy is successful. Local Strategic Partnerships (LSPs) will also want to consider how improving outcomes for teenage parents and their children can support their efforts to meet LSP targets in relation to health inequalities, education and worklessness.
- 6.6** This co-ordinated approach can most effectively be achieved if all local agencies acknowledge the priority that should be given to supporting teenage parents in their local Children and Young People’s Plan and Local Area Agreement and ensure that the appropriate actions are included and outcomes rigorously monitored. It is particularly important at the local level to identify ‘hotspots’ in terms of particular communities and localities where additional support is most needed.
- 6.7** This document does not put new duties or burdens on local authorities and PCTs. Rather, it helps them understand the challenge they face in effectively supporting teenage parents and the need for an integrated package of support to be in place – co-ordinated by a single lead professional, drawing on specialist support, as necessary. It provides evidence of best practice – both in terms of the evaluated programmes summarised in chapter 5 and the case studies in this chapter.

6.8 The remainder of this chapter summarises the underpinning infrastructure that is in place to support delivery of better outcomes for teenage parents and their children and, for each of the specific problems identified earlier in the document, it sets out our vision of what should be provided locally and what action will be taken by central Government to support local delivery.

Delivery Chain

6.9 Over and above the support provided by midwives and health visitors, there are two further mainstream channels through which ongoing support for teenage mothers and young fathers will be delivered – Children’s Centres and other community-based children and young people’s services and Targeted Youth Support services – complemented by work undertaken by the voluntary and community sector. In the 10 local areas where the Health Led Parenting Programme is being piloted, service delivery exists alongside the integrated service offered by Children’s Centres. Participating families are encouraged to make active use of community resources and to involve themselves in activities such as parenting groups and educational opportunities, including dedicated services for young parents.

6.10 These are the services that pregnant young women should be referred to as soon as they are identified in ante-natal services. A lead professional in the Children’s Centre or Targeted Youth Support service can then assess the support they will need during the pregnancy and after the child is born, including any specialist support that the lead professional may need to help them to access.

CHILDREN’S CENTRES AND OTHER COMMUNITY-BASED CHILDREN’S SERVICES

6.11 Through Children’s Centres and other community-based children and young people’s services, teenage parents can access a broad range of support in one place, including childcare, parenting support and health-related information, advice and treatment. When providing services, Children’s Centres are required to focus in particular on reaching vulnerable families, including teenage parents – and have a specific performance indicator on the percentage of 16-19 year old mothers in Education, Employment and Training. *The Children’s Centres Practice Guidance* (2006) also stresses the importance of involving fathers in their children’s care, learning and development, including advice on how to provide effective services for young fathers.

6.12 The Practice Guidance includes advice on how to deliver services effectively to teenage parents, which draws heavily on the findings from the Sure Start Plus pilots mentioned in chapter 5 above. It recommends that: a) each teenage mother should have a personal adviser; b) delivering services on a drop-in, rather than an appointments basis; c) providing services focused on teenage parents rather than parents of all ages (which is likely to encourage greater take-up); d) young mothers and fathers should be involved in service

development through consultation, peer research or feedback and evaluation of services; and e) staff should take a flexible approach to reconfiguring services in response.

Case Study: Children's Centre multi-disciplinary team (Plymouth)

Following the Sure Start Plus pilot, Plymouth teenage pregnancy partnership has continued to fund a support worker who works in partnership with a range of service providers to coordinate support to teenage mothers.

Resources are targeted at pregnant teenagers and teenage mothers who have additional support needs.

The support work is provided within a multi-disciplinary context – the Sure Start Plus worker liaising with other members of the 'virtual' team, referring young women on to specialist workers where appropriate.

The 'virtual' team includes staff from Plymouth's education centre for school age parents based at a children's centre, a Connexions adviser, a midwife and the Sure Start Plus worker. Each member of the team spends dedicated time at the centre. In addition, health visitors, social care staff and the school nurse work in collaboration with the 'virtual' team.

Childcare is provided on site at the children's centre and the childcare workers are integral to the ongoing support offered to the young women.

Support workers cover a range of issues including building positive relationships, advice on domestic violence, housing, benefits, health and healthy eating. When necessary referrals are made to relevant specialist services: substance misuse and alcohol team; supported housing/mother and baby unit; smoking cessation support; and contraception and sexual health services.

Because the support is part of a wider partnership approach, young women do not have to keep building relationships from scratch with each adviser they meet – and can develop a positive relationship with one member of the team. The workers are able to work to their strengths and areas of specialism; communication is enhanced and they are able to minimise the duplication of effort. This coordinated approach helps to ensure all the needs of the young mothers are met.

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TARGETED YOUTH SUPPORT

6.13 By April 2008, all areas are expected to have reformed the support services available for vulnerable and at risk young people. The principles that underpin these reforms include:

- A stronger emphasis on early identification and prevention to avoid problems escalating to a point where intensive support is necessary;

- Provision of multi-agency support, co-ordinated by a lead professional who acts as the main point of contact for the young person, co-ordinating referrals to specialist support services, as necessary;
- Common processes for assessing need and joint protocols for information sharing between agencies.

6.14 All teenage parents should have access to multi-agency support, brokered through a lead professional. This function *could* be taken on by a practitioner working in a Children's Centre where that makes sense, but would otherwise be picked up as part of the local Targeted Youth Support arrangements (or family nurse in the Health-led Parenting Programme pilots). Key to ensuring that all young mothers receive the ongoing support they need is early referral from ante-natal services, so that a proper assessment of their longer-term support needs can be made. This assessment will determine what support needs to be provided by, or accessed through, the lead professional.

Case Study: An integrated support service for young parents (South Tyneside)

The South Tyneside Teenage Pregnancy Team takes a multi agency approach to providing holistic support for pregnant young women, their partners, and their children. The aim is to provide support, starting with pregnancy decisions through to parenthood.

First stop is the Options Adviser who provides information on pregnancy options and supports young women through their decisions. The Options Adviser also discusses contraception and co-ordinates the post-natal contraceptive service to reduce the rate of further unintended pregnancies.

The Young Women's Pregnancy Service provides complete maternity provision, including ante-natal and post-natal care, a nutrition programme and infant feeding classes.

Sure Start Plus (SSP) Young Parents Support advises pregnant young women, young parents and professionals on health, education, parenting, childcare, housing and benefits. A SSP Adviser is also currently facilitating a parenting programme along with the dedicated health visitor for teenage parents. The course is currently delivered from a local Children's Centre.

The Teenage Parent Health Visitor facilitates and delivers the accredited Young Mums To Be course with the SSP adviser as well as working with mainstream health visitors and professionals.

The Reintegration service provides for the education and social inclusion of pupils who are pregnant and school age parents who are of compulsory school age.

The Team also works in partnership with the Youth Support Service which assists with the facilitation of the Young Mum's To Be course and also provides a drop-in service for young parents which is funded by Connexions Tyne and Wear. Two Connexions PAs work very closely with the Team, ensuring progression pathways are in place for individuals.

Additionally, all services from the statutory and voluntary sector working to support young parents meet regularly to share information and good practice in order to provide the best opportunities for the client group and prevent duplication of work.

Support for young parents has more recently been complemented by the inception of the Common Assessment Framework (CAF) and has also been integrated into the Targeted Youth Support programme for which South Tyneside is a pathfinder.

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6.15 Targeted Youth Support services also provide the vehicle for supporting young fathers, both in relation to their role as a parent, but also to address wider issues affecting their lives, where necessary. It is important that the process used to assess vulnerable young men's needs (the Common Assessment Framework) identifies whether or not the young man is a young father and recognises that any action agreed with the young man takes account of his responsibilities as a parent.

CHILDREN IN CARE AND CARE LEAVERS

6.16 Children in care and care leavers are at much higher risk of early pregnancy than their peers. Because of their negative life experiences, they and their children are particularly vulnerable to poor outcomes. We have therefore made clear in *Care Matters: Time for Change* that it is vital that the specific needs of pregnant teenagers and teenage parents, in care or leaving care, are fully met. The comprehensive package of support, coordinated by a lead professional, should include:

- Unbiased advice on pregnancy options and support in deciding what to do about the pregnancy;
- If they choose to have the baby, advocacy and support during the pregnancy, and after the child is born, with healthcare, benefits, educational opportunities and childcare;
- Access to a trusted adult who they can confide in, so that any difficulties they have can be identified and addressed early; and
- Advice on contraception, to minimise the risk of repeat pregnancies.

6.17 As a further commitment of *Care Matters: Time for Change*, we will also be developing the skills and competencies of foster carers to provide high quality care for teenage parents. This will build on the Foster Care Training, Support and Development Standards, published by the Children's Workforce Development Council.

HEALTH-LED PARENTING PILOTS

- 6.18** The Health Led Parenting Pilot Project began in April 2007 and focuses on first time mothers up to and including the age of 20, from the sixteenth week of pregnancy until the child is two years old. The programme involves a structured programme of home visits by health visitors. The pilots are based on the US Nurse Family Partnership model described in chapter 5 and will run in 10 local areas.
- 6.19** Ante-natal visits occur once a week for the first four weeks after enrolment, usually between sixteen and twenty eight weeks into the pregnancy, then every other week for the rest of the pregnancy. After the baby is born, visits are increased again to once a week for the first six weeks, then level out at every other week until the child is twenty one months old. Visits then continue once a month until the child's second birthday. Each visit is expected to last from one to one and a half hours. The family nurse acts as a lead professional for the young mother. Family Nurses are provided with tailored training in use of the model's guidelines and materials, as well as skills in building a therapeutic relationship, motivational interviewing, attachment theory and behaviour change.
- 6.20** Fathers are actively encouraged to engage in the programme and, if the mother is not agreeable, the nurse advocates for the father to be involved. Parents can be referred to mediation and other relationship services when necessary. Evaluation from the USA shows that the intervention does promote more sustained involvement from the father with both mother and child.
- 6.21** If the father is, or becomes, the child's primary carer they will be enrolled in the programme. As the focus is on the well being of the child, and recruitment takes place in early pregnancy the primary enrolment is with the mother because of the direct impact she has on the developing child.
- 6.22** The 10 areas piloting the intervention are Barnsley, Derby City, County Durham and Darlington, Manchester, Slough, Somerset, Southend, Southwark, Tower Hamlets and Walsall.
- 6.23** The Pilot Project is being evaluated by Birkbeck College, University of London, to identify short term impacts on maternal and child health, assess implementation, deliverability, take-up and costs. More widely the evaluation can inform the future commissioning of health led early intervention and prevention programmes as part of the progressive universal model of child and family health.

Improving Child Health Outcomes

PREGNANCY TESTING

- 6.24** Given that the majority of teenage pregnancies are unplanned, it is crucial that young people have non-judgemental, neutral advice about their options. Most young women report 'shock' at discovering they are pregnant and need help and support to decide

whether or not to go ahead with the pregnancy. If they decide to go ahead with the pregnancy, they should be referred as quickly as possible to ante-natal services. If they choose to have an abortion, referral should be organised at the earliest opportunity and counselling should be provided, as necessary. If the pregnancy test reveals that they are not, in fact, pregnant they still need to be provided with advice on contraception to avoid an unplanned pregnancy.

6.25 Pregnancy testing services should be confidential, non-judgemental, free at point of use and available in a range of young-people friendly health and other community-based settings that meet the DH 'You're Welcome' quality criteria. Delaying confirmation of the pregnancy can reduce the options open to a young person and problems with the pregnancy can go undetected.

6.26 Local services should be configured so that:

- In line with the 'You're Welcome' quality criteria and DH good practice standards for sexual health services, all areas should provide free pregnancy testing in locations and at times which young people find easy to access (in particular after school and college hours and on Saturdays). Attention needs to be paid to access for those most at risk of early pregnancy and for young people in rural areas where lack of public transport may be a barrier;
- These pregnancy testing services should be well publicised to young people and to professionals working with them. Young people who are pregnant should also have easy access to free and unbiased advice and information about their pregnancy options and swift referral to ante-natal care or NHS funded abortion services;
- Pregnancy scans while the young woman is considering her options, should be in line with the Royal College of Obstetricians and Gynaecologist's guideline – *Care of Women Requesting Induced Abortion* – and be conducted with sensitivity and with the screen not visible.

6.27 To support local areas, Government will:

- Issue best practice guidance in Autumn 2007 on sexual and reproductive health services, which will include expected standards on the provision of free pregnancy testing, pregnancy advice and counselling and pregnancy scanning.

ACTION TO TACKLE SECOND AND SUBSEQUENT PREGNANCIES

6.28 Around 20% of births conceived to under 18s are to young women who are already teenage mothers. It is clear from discussion with young mothers, that many are unaware of how easy it is to become pregnant after having a baby, are ill informed about the range of contraception available – often through missing out on school sex and relationships education – and are not actively supported to access contraception. Compounding this are the pressures and demands post-natally when organising a visit to a contraceptive

service may seem a low priority. Proactive support – including home visits – for young mothers to choose and use contraception effectively is therefore essential to help them avoid repeat pregnancies.

6.29 Local services should ensure that:

- Support for young mothers – and their partners – to prevent repeat pregnancies is included as an integral part of the coordinated package of support, starting in the ante-natal period – with clear arrangements concerning who is responsible for ensuring young parents receive the support they need;
- Information about contraception – in an accessible and young people friendly format – is given to teenage mothers so that they are aware of the range of methods available and can choose the most suitable method. Information should also be provided to young fathers so they also have accurate and up to date information about contraception and can support their partner in using their chosen method effectively;
- Clear messages about the risks of pregnancy after birth are prominently displayed in ante-natal and post-natal settings, including in General Practice and Children’s Centres, as recommended in the *Sure Start Children’s Centres Practice Guidance*;
- Negotiate with local hospital trusts to share data on repeat pregnancies conceived to under-18s, to monitor the issue and inform planning.

6.30 To support local areas, Government will:

- Make available – to maternity units, Children’s Centres, community contraceptive clinics and pharmacies – posters alerting teenage parents to the risk of repeat pregnancy and clear information booklets for health professionals to talk to young parents about the range of contraception available, particularly long acting reversible methods of contraception (LARC).
- Include expected standards on access to free contraception after birth and abortion in the best practice guidance on sexual and reproductive health services, as mentioned in 7.27;
- Identify effective practice in supporting young parents to avoid repeat pregnancies, through the four Teenage Health Demonstration Sites, and share this through the ECM website and the National Service Framework practice database;
- As part of the Teenage Pregnancy Data Collection and Information Sharing Toolkit, provide guidance to areas on collecting local data on repeat conceptions, both births and abortions.

Case Study: Preventing repeat pregnancies (Wigan)

In Wigan, teenagers receive normal midwifery care with extra support from the part time teenage pregnancy midwife who is also a family planning nurse. She can issue contraception under Patient Group Directions (PGD) within the family planning service. At her first contact with a young pregnant woman (when the young woman attends her 16 or 18 week scan) the midwife checks if any contraception has been used and ensures that the young woman understands why the method used may have failed. She then discusses future contraception, with a general explanation of all methods and, if the young woman has already made a choice, a detailed discussion of this method and how to access it locally. She discusses sexually transmitted infections, demonstrates condom use and gives the young woman a supply of condoms. Contraception is raised again whenever the midwife sees the young woman (usually at 30 weeks). She does one post-natal home visit to under 16s and again discusses contraception, provides condoms and gives information on local young mums groups and services.

The teenage pregnancy midwife runs teenage parent craft classes at the local Connexions service. At the contraception session she leads a discussion and passes around samples of different contraceptive methods. She advises the young people on how alcohol and drugs can lead to contraceptive failure (e.g. incorrect condom technique), and uses “beer goggles” to illustrate how alcohol affects perception. The contraception session was originally a session on its own, but has been incorporated into a tour of the hospital delivery suite as this has been found to maximise attendance.

There is good uptake of contraception, but the teenage pregnancy midwife role may in the future be extended to enable the midwife to provide contraception and fit long-acting reversible contraceptives (LARC), to reduce the consequences of young women not returning for appointments.

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EARLY BOOKING FOR ANTE-NATAL CARE

- 6.31** Late booking and poor attendance at ante-natal sessions contributes to the health problems teenage mothers experience in pregnancy, as well as the poor health outcomes for the child. They can be in denial or fearful about the pregnancy – which they may be trying to conceal from parents, their school or their peers – or they may not be fully aware of the health risks to themselves or their child of delaying going to ante-natal services.
- 6.32** The DH and DfES *National Service Framework for Children, Young People & Families* (NSF) standard on maternity, emphasises that teenage parents and their children face higher risks of poor maternity outcomes than older parents, due to low uptake of ante-natal and post-natal support. However, once engaged with services, there is evidence that the risk of poor outcomes is significantly reduced.

6.33 Local services need to ensure that:

- In line with the NSF, and NICE guidelines, PCTs should commission ante-natal services that pro-actively and positively encourage teenage mothers to book early and to use these services throughout their pregnancy. This means providing young mothers with access to midwives in a variety of locations, and making clear that these services: welcome young mothers and their partners; are non-judgemental and confidential; and meet the 'You're Welcome' quality criteria. Where possible, they should provide classes or sessions specifically for young parents;
- Written information about what to expect during ante-natal appointments and classes, what happens during pregnancy and what to do to prepare for the arrival of the baby should be provided in an easily accessible format.

6.34 To support local delivery, we will:

- As part of the development of Public Service Agreements, explore introducing a specific indicator for maternity services based on early access and choice, to improve the outcomes of all women including expectant teenage mothers;
- Drive forward the commitment in *'Maternity Matters: Choice, access and continuity of care in a safe service'* – published by Department of Health in April 2007 – which guarantees that by the end of 2009 women (including teenagers) will have a choice of how to access maternity care when they first learn that they are pregnant. Women and their partners will be able to go straight to a midwife if they wish, or to their General Practitioner. Self-referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services;
- publish an implementation plan to help deliver the recommendations of the health inequalities infant mortality review [DH, 2007], including the recommendations on reducing infant mortality among babies born to teenage mothers.

USING ANTE-NATAL SERVICES THROUGHOUT PREGNANCY

6.35 As well as booking late, teenage mothers often do not attend ante-natal sessions regularly or drop out of going to them. In one survey in the North East of England, 83% of pregnant teenagers did not attend ante-natal classes and many had limited understanding of the progress of their pregnancies. Health practitioners are sometimes seen as unsympathetic, not fully understanding of teenage mothers' needs and perceived as judging them negatively.

6.36 Teenage fathers can also feel discouraged about attending ante-natal sessions with them. They report being ignored by receptionists and health professionals and not being made to feel welcome. This can also impact negatively on the women's attendance. Father's Direct have recently drawn attention to this issue in their publication *Including New Fathers: A Guide for Maternity Professionals*, for which DH provided funding.

6.37 Local areas should ensure that:

- The locations where ante-natal services are provided should be places that teenage parents are happy to access and these should be established through consultation with young parents locally and a needs assessment of what works. Children's Centres may well play a crucial role in this, where they have been established locally. The revised Sure Start Children's Centre Practice Guidance (2006) emphasises the need to personalise services for teenage parents. In some cases this may mean co-locating ante-natal classes in a service already valued and trusted by young people;
- Ante-natal support should be provided in a way that engages young mothers and young fathers – focusing initially on the immediate concerns of the young parent and establishing a trusting relationship to help to ensure sustained contact;
- A lead midwife for teenage parents (if not a specialist post) should be identified, to ensure that the needs of teenage parents are met. This should include ongoing training, support and supervision of maternity staff, including receptionists, on the specific needs of teenage parents and the importance of not deterring their attendance at services through perceived judgmental or stigmatising attitudes and behaviours;
- A clear pathway of referral is developed between maternity services and on-going support services, in line with the guidance – *Multi-agency working to support pregnant teenagers* – published jointly by DH, DfES and Royal College of Midwives (RCM).

6.38 Government will support local areas by:

- Publishing a revised and updated version of the joint DH, DfES and RCM publication *Teenage Parents: who cares? A guide to commissioning and delivering maternity services for young parents*. This will include recent good practice on ante-natal care, based on the experience of the teenage pregnancy midwifery network, as well as best practice on engaging with young fathers;
- Developing a booklet for all practising midwives and maternity support workers, to raise awareness of the needs and concerns of expectant teenage parents and help improve the universal provision of services;
- Promoting *'Delivering health services through Sure Start Children's Centres'*, published by DH in June 2007, which explains how health services can work with Children's Centres to improve child health outcomes.

Case Study: Specialist maternity care for teenage parents (West London)

Queen Charlotte's and Chelsea Hospital in London run a Young Mums' one-to-one midwifery programme that aims to reduce health inequalities and social exclusion among teenage mothers and babies. Continuity of care is central to the scheme, with each young woman having her own midwife who carries out most of her ante-natal and post-natal care. The same midwife, or her partner who the young woman also gets to know, will usually be there for the birth. Midwives work in pairs so they can provide 24-hour on-call cover for their clients, using text messaging to keep in touch between appointments.

Each of the young mothers' midwives carries a caseload of around 34 young women per year. The midwives build up a strong relationship with each of their young clients and this enables them to assess needs, and to offer individualised care. The care provided is community based, with the young person deciding the location of care – which can be at home. The midwives also engage with the young woman's family, friends and partner, and make referrals to a wide range of support services.

Young women are encouraged to take an active role in learning about their pregnancy and preparing for parenthood. They are offered ante-natal classes and access to a post-natal support group specifically for young people, which brings opportunities to network with other young people in a similar situation. Breastfeeding is promoted during ante-natal classes and home visits and young women who are breastfeeding are encouraged to 'buddy up' with others for support and advice.

The one-to-one midwifery scheme has seen a trend towards earlier booking for ante-natal care and a dramatic improvement in attendance for ante-natal care through a combination of text message reminders and follow-up home visits. Rates of premature birth and low birthweight are lower than the national average. Rates of post-natal depression are also lower than average, and rates of breastfeeding are much higher, with 74% initiating breastfeeding.

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Case Study: Specialist maternity care for teenage parents (West Hertfordshire)

In West Hertfordshire, pregnant teenagers receive normal ante-natal care plus additional support from two teenage pregnancy midwives. These midwives aim to optimise the physical and emotional wellbeing of young mothers and their babies and also to reduce social exclusion. They provide holistic care through a multi-agency and multi-disciplinary approach to pregnancy. They offer ante-natal and post-natal support groups for young people, peer support, peer counselling and peer education, a 'buddying-up' process, and contraceptive implants. Transport is provided to make group work accessible to the young women. The confidence building and group work has been found to assist the young women to develop their self-efficacy and parenting skills, as well as providing them with social networks. The midwives use their understanding of risk-taking among teenagers to develop effective age-relevant health promotion advice.

The teenage pregnancy midwives have developed a wide range of partnerships to facilitate young women's access to other services. They liaise with health visitors, school nurses, sexual health staff, education welfare officers, social workers, family planning nurses, the local council housing department, housing associations, Connexions, the Money Advice Unit, the Citizen's Advice Bureau, youth services, the child protection team, smoking cessation and drug and alcohol services. They also work with young women's parents and partners and support these relationships. They achieve high rates of breastfeeding and low rates of smoking among their clients, and a high proportion of young mothers selecting post-natal contraception, especially long-acting contraception. The midwives also play a positive role in re-engaging clients with education or employment.

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SMOKING CESSATION AND ALCOHOL/SUBSTANCE MISUSE

- 6.39** 45% of all teenage mothers smoke throughout their pregnancy compared to 17% of older mothers. Smoking during pregnancy is the single most important factor in the poor health outcomes of teenage mothers and their children. It certainly contributes to the higher chance of a low birth weight baby (25% higher than older mothers), and possibly to Sudden Unexpected Infant Deaths (SUIDs).
- 6.40** Their propensity to smoke during pregnancy may also be compounding their stigmatisation as it creates negative perceptions of them by services and other service users, particularly in ante-natal services.
- 6.41** There is clear evidence that excess alcohol or use of drugs has an adverse effect on the foetus. Teenage parents need to be aware of this, in particular because they may have been drinking or using drugs recreationally prior to pregnancy. Some may have a specific pre-existing problem with alcohol or substance misuse which will require specialist help to address.

6.42 We want local services to ensure that:

- For expectant mothers (and their partners), pregnancy is seen as an opportunity to stop smoking. Maternity staff should be trained and supported to harness the strong desire of young parents to do their best for their baby and to promote smoking cessation programmes. Midwives should establish when a teenage mother books with her, whether she smokes and if she does, give her information about and encourage her to access help with smoking cessation including nicotine replacement therapy (NRT) – which is recognised as the most effective form of smoking cessation;
- Local smoking cessation programmes should develop a protocol with midwifery services on providing NRT under Patient Group Directions (PGDs), enabling midwives or family nurses to offer NRT as part of maternity care;
- Local areas should know how many pregnant women are smoking and should develop targets for reducing levels in line with the 'Smoking Kills' target (to reduce the percentage of women who smoke during pregnancy from 23% to 15% by 2010), with a particular focus on reducing the numbers of teenage mothers who smoke through their pregnancy;
- Maternity staff should take a similar approach to supporting young mothers to stop drinking alcohol or using drugs as early as possible in the pregnancy. Teenage mothers and young fathers should be provided with clear, non-judgemental messages about the effects of alcohol on the foetus and offered practical tips on how to reduce their intake. Local protocols should be developed with specialist services to enable swift referrals of young mothers who have a specific alcohol problem.

Case Study: Smoking cessation with pregnant young women and their families (Doncaster)

An intensive smoking cessation project in Doncaster has been achieving impressive quit rates of 60-65 per cent amongst young pregnant women and their families. The work was initially delivered through Sure Start Plus, which provided intensive one-to-one support to young expectant mothers to be and their families. Now it has been integrated into mainstream services.

The initial work was carried out in young women's homes, to promote both smoking cessation and to encourage a smoke free environment.

Now that the Sure Start Plus pilot programme has ended, Doncaster Primary Care Trust has maintained the strong referral pathways set up under the pilot and is now delivering smoking cessation through mainstream provision. The Smoke Free team for maternity services is offering a service with a focus on teenagers.

The referral pathways were set up from midwifery booking-in, but also from multi-agency referral. Originally, the Sure Start Plus worker carried out a cessation programme of around six to 10 weeks, but this could be extended. There was at least one visit a week, with additional telephone support if needed. The Sure Start Plus assistant worked closely with the Smoke free pregnancy midwife to get nicotine replacement therapy prescribed for the under-18s.

The programme benefited from very strong marketing and from lots of promotions which were an incentive to quit. Rewards were offered at various stages of quitting, including a piggy bank to encourage women to put their cigarette money into savings for their baby, mugs with the phone number of the smoking support workers, a teddy bear, plus clothing and accessories for the baby such as vests, bibs and a hooded towel – all branded with the smoke free logo. If the expectant mothers or their partners or families reached the 4-week quit time they got an extra reward package.

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6.43 At a national level:

- From 1 October 2007, it will be illegal to sell tobacco products to 16 and 17 year olds which will affect many young mothers and others under 18 who smoke. As part of the publicity campaign about this change, Government will publish a poster, developed with young people, aimed at pregnant teenagers and their partners, encouraging them to stop smoking – emphasising what services are available and that they are safe to use and free of charge;
- Changes relating to the sale of cigarettes will also mean visual images on packets of cigarettes that emphasise the dangers of smoking during pregnancy, which should have particular resonance with young people;
- To coincide with the change in legislation on smoking in public places, which came into force on 1 July 2007, the Government is considering a campaign to reduce smoking among health practitioners, including nursing and maternity staff;
- Government will explore how the Healthcare Commission will measure reductions in smoking, including among expectant mothers, as part of the performance management of the Smoking Kills target ;
- Government will develop a poster, with young parents, warning of the risks of alcohol in pregnancy with signposting to relevant helplines.

MATERNAL NUTRITION DURING PREGNANCY

- 6.44** Good maternal nutrition is critically important, because the foetus competes with the mother for nutrients. This is particularly the case with younger mothers, who may not have stopped growing themselves and are likely to have additional need for nutrients. Some teenagers are nutritionally vulnerable and could, therefore, start their pregnancies in a compromised state.
- 6.45** We want all pregnant teenagers to have access to adequate food and good nutrition for themselves and for their children, and to have the economic means to consume a healthy balanced diet, as well as the skills to prepare food, purchase healthy foods and to know how to prepare them.
- 6.46** The Government's key initiative for improving the nutrition of expectant mothers and their children once they are born is the Healthy Start voucher scheme, which all pregnant women under-18 years old are eligible to apply for, even if not receiving the qualifying tax credits or benefits that are a condition of receipt for older mothers. Mothers aged under-18 will be able to receive support from the scheme until the baby is born – even if they turn 18 at a later point in the pregnancy. Once the baby is born, this support will continue if the qualifying tax credits/benefits are claimed.
- 6.47** However, from April 2009 all pregnant women, including all teenage mothers, will be entitled to the Health in Pregnancy Grant (HiPG) – the additional financial support announced in the Pre-Budget Report 2006. The intention is that HiPG, which will be worth around £200, will help all pregnant women to afford a healthy diet, especially during the last 12 weeks of their pregnancy. HiPG will be paid in addition to the voucher scheme and all other benefits.
- 6.48** We want all local areas to ensure that:
- Application forms for Healthy Start are readily available in appropriate locations – such as maternity units, Children's Centres and General Practice – and that pregnant teenagers have access to information about the scheme, support in making an application, as well as receiving high quality advice about breastfeeding and a healthy diet to help them make the most of the scheme;
 - Staff working directly with pregnant teenagers signpost the scheme effectively to their clients, encourage them to apply as soon as they become eligible (from the 10th week of pregnancy) and make sure that they understand that any application must be countersigned by a health visitor, midwife or doctor before it is sent off;
 - Staff know about, and promote the local PCT's arrangements for distributing free vitamin supplements through the scheme;
 - In line with the NICE guideline for routine ante-natal care – and the forthcoming guidance on Maternal and Child Nutrition – all women are offered information about the pregnancy care services and options available, lifestyle considerations, including

dietary information and screening tests at their first contact visit with midwifery services. If the first booking appointment is missed, midwives must ensure that these issues are addressed whenever the teenage mother makes contact with the service;

- Effective links are made with PCTs to ensure that local positive parenting initiatives for young pregnant women – which include advice on parenting, healthy eating and lifestyles – are effectively promoted by health visitors and midwives.

Case Study: Healthy living for teenage parents (Ipswich)

Teenage parents in Ipswich are benefiting from a package of innovative measures to give them and their babies a healthy start in life. The teenage pregnancy team get to know the young parents-to-be at the popular 'Baby'n'me' ante-natal sessions, and they encourage them to return after the birth to join the 'Sunflowers' group.

Based in a children's centre in Ipswich, Sunflowers provides good safe play facilities, with the opportunity for messy activities, crafts and outside play. It also enables both young mothers and fathers to make new friends and provide support for each other. There has been a midwifery health link with the teenage pregnancy team and a monthly visit from the health visitor. Between 12 and 18 young parents regularly take part, including young fathers.

The group go swimming on a weekly basis, which encourages physical activity and socialisation for both parents and children. This also helps address issues of body image post delivery and helps the mothers get back into shape.

Partnership work has been done with the Women's Institute, who provided a six week cooking course in which the mothers learned to cook nutritious dishes which were then eaten by the whole group together. Sunflower members are also taking a "confidence building" course provided by Sure Start and want to build up their practical parenting skills.

Sunflowers has its own constitution and committee of young mums and dads who voted for a member of the teenage pregnancy team to act as chair for the first year. In April 2007 independent funding was secured which enabled the group to have their own facilitator, herself a young mother. She draws up activities with the young mothers and plans local trips to parks and libraries, giving the group a learning focus.

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6.49 At a national level, we will:

- Publish information about Healthy Start, including on how to access the Healthy Start website at www.healthystart.nhs.uk.
- Publish supporting materials aimed at health professionals working with pregnant women and families to help them promote the scheme and provide nutritional advice;

- Evaluate the impact and effectiveness of Healthy Start over time, to ensure it continues to adequately support the nutritional needs of the most vulnerable pregnant women and young children.

BREASTFEEDING

6.50 There is compelling evidence that breastfeeding has important advantages for both baby and mother. Babies fed on formula milk are at greater risk both of immediate health risks such as gastro-intestinal infections, eczema and asthma and of longer term problems including cardiovascular disease in later life. Importantly, breastfeeding also protects against childhood obesity. It is therefore a key concern that teenage mothers have 50% lower rates of breastfeeding and, if they do initiate breastfeeding, are much less likely to continue than older mothers. Sensitive encouragement and intensive support on breastfeeding is critical to improving child health outcomes.

6.51 Locally we want to ensure that:

- Maternity and child health services encourage and support all teenage mothers to breastfeed, in line with the NICE guideline on post-natal care and the WHO/UNICEF 'Baby Friendly Initiative'; providing intensive support to overcome initial problems and continuing support through community midwives, family nurses, health visitors and peer support;
- Commissioners are considering how services can be incentivised to encourage breastfeeding. This could be through contractual arrangements, with financial incentives agreed for achieving set levels of breastfeeding generally, and amongst teenage mothers in particular;
- Family members, partners and peers are made aware of the positive effects of breastfeeding and supported to encourage the young mother to start and continue breastfeeding.

6.52 At the national level we will:

- Through the Public Service Agreement (PSA) on improving children's and young people's health, explore including a performance indicator at PCT level on continuation of breastfeeding for six weeks after birth;
- Provide positive images of young mothers breastfeeding for display in ante-natal, post-natal and community settings, including General Practice and Children's Centres.

Case Study: Encouraging breastfeeding in teenage mothers (Birmingham)

Specialist teenage pregnancy midwives at the Birmingham Heartlands Hospital devote a lot of time to the issue of breastfeeding in the weekly ante-natal classes in a bid to improve breastfeeding rates.

Their aim is to challenge and change negative perceptions around breastfeeding, with particular emphasis on getting young mums to at least be prepared to try to breastfeed, especially straight after birth.

Discussions about breastfeeding begin at the ante-natal clinic at the booking-in visit with the community midwife. One of the specialist teenage pregnancy midwives then makes contact by text, inviting the expectant mother along to the weekly drop-in ante-natal sessions specifically for teenage mums.

When they first come to the group the initial hurdle is to get them to explore their feelings about breasts and breastfeeding, and to tackle perceptions and stereotypes. The specialist midwife uses video clips about breastfeeding from popular television programmes to kick-start debate and discussion, and to bring some humour to the sessions.

Often the group starts by dealing with the negative aspects of breastfeeding, getting them all written up on a clipboard, before the teenage mums themselves start coming up with the positive reasons to do it. They then cover all the benefits of breastfeeding, ranging from the financial savings, the health of the baby and mother, and the convenience. They also demonstrate that breastfeeding can be done very discreetly.

The specialist midwife will challenge the expectant mother about her view on breastfeeding but will also build the support of partners and parents who attend the group with the mother-to-be. Getting the young fathers to understand the importance of breastfeeding has been found to be a major contributory factor to improving breastfeeding rates.

When possible, the team brings in young breastfeeding mothers to show the group how it is done, and to talk to the expectant mothers. Some of the young women have never actually seen breastfeeding being done before.

After delivery, breastfeeding support workers are available in the post-natal wards. The hospital runs a drop-in breastfeeding clinic every Friday afternoon to encourage young mothers to continue breastfeeding for as long as possible.

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Improving teenage mothers emotional health and well-being

- 6.53** Young mothers are three times more likely to suffer post-natal depression than older mothers and to suffer mental health problems for up to three years after the birth. Poor emotional health not only affects the well being of the young mother but also affects her ability to be an attentive and nurturing parent, which can lead to an increased risk of accidents and behavioural difficulties for her child. Some young mothers may have pre-existing poor emotional health but this is exacerbated by the demands of parenthood, particularly when they lack family support, are in conflict with their partner, or are isolated in poor quality housing.
- 6.54** There is compelling evidence that strong social and emotional skills help to shape young people's level of self-awareness and self esteem, their ability to build warm relationships and empathise with others, and their levels of motivation and confidence in taking control of their lives. This in turn has a positive impact not only on young people's learning and educational attainment but also on their emotional and mental health.
- 6.55** The value of positive activities in building social and emotional skills is also compelling. Evidence shows that involvement in structured leisure time activities increases resilience and motivation and reduces rates of depression.
- 6.56** We have signalled the priority of improving all young people's social and emotional skills through: including emotional health and well being as one of the four criteria for becoming a Healthy School; rolling out the SEAL programme (Social Emotional Aspects of Learning) to secondary schools; increasing the number of Children's Centres with specific support for teenage parents; providing additional resources to promote the delivery of a comprehensive Child and Adolescent Mental Health (CAMH) service in all areas, which includes services for 16 and 17 year olds; and placing a new statutory duty on local authorities to provide positive activities for young people.
- 6.57** However, while our vision is that all young people acquire these skills, it is clear that disadvantaged young people, including many teenage parents, are more likely to lack these skills and will need greater support to build resilience. Early identification and appropriate support for teenage mothers and young fathers with poor mental and emotional health is therefore critical in improving outcomes for them and their children.
- 6.58** Locally we want to ensure early identification and support for young mothers with poor mental and emotional health, through:
- Adherence to the recommendations in the NICE guideline for routine post-natal care, which states that all women should be asked about their emotional well-being at every post-natal contact with health services and encouraged to inform their health care professional about any changes in mood, emotional state or behaviour that are outside the woman's usual pattern;

- Encouraging take-up of the maternal 6-8 week check, which should include a review of the young woman's physical, emotional and social well-being;
- Maternity and child health services implementing the NICE clinical guideline on mental health problems during pregnancy and in the first year after giving birth. *Ante-natal and post-natal mental health: clinical management and service guidance* (2007) includes recommendations for healthcare professionals on relevant screening questions to better identify sub-clinical and early signs of depression and appropriate care and treatment;
- Use of the Common Assessment Framework in Targeted Youth Support arrangements to identify emotional health problems which may be outside the scope of the NICE guideline and occur beyond the first year of the child's life;
- Including the emotional and mental health support needs of teenage mothers and young fathers as part of the needs assessment and development of local parenting strategies – as recommended in the *Parenting Support Guidance* (2007). Particular attention should be paid to early mediation and relationship support to help resolve family breakdown or partner conflict, and to ensuring support services are provided in non-stigmatising and accessible settings;
- Providing a range of group-based parent support programmes designed to promote emotional attachment and parental confidence, including programmes that are particularly tailored to suit the needs of young parents;
- Ensuring that school age parents and young parents in FE colleges do not miss out on PSHE and pastoral support and know how to access confidential support from on-site or nearby community services;
- Ensuring teenage parents benefit from the new duty on LAs to provide positive activities, which requires local authorities to identify and overcome barriers to participation; for teenage parents this might include the timing, cost or location of the activity, accessibility of transport and provision and cost of childcare;
- Ensuring that all teenage parents who cannot live at home, are placed in either a dedicated housing project, or have an intensive floating support package which addresses emotional health and well being.

Case Study: Strengthening young mothers' mental and emotional health (Cambridgeshire)

Romsey Mill's Young Parent Programme in Cambridge is run by the voluntary sector to support parents under-20 across the county. It provides intensive personal, educational and parenting support primarily to young women and their babies, but also to young fathers and the extended family if necessary. The programme is highly flexible and is able to respond rapidly to meet current needs.

Trust is built up through one-to-one work between the young parent and the project worker. This begins at the point of referral through the notification system set up with Connexions, health workers, support workers and the Romsey Mill staff team.

The specialist emotional and mental health care provided is integrated into the wider programme through 'embedded' support in regular ante-natal and parenting groups. Issues covered include attachment and bonding, emotional resilience and stress, identity, depression, parent-infant relationships, alcohol use and cannabis use. In addition, the specialist mental health worker offers intensive one-to-one counselling and research-proven infant led therapy which looks at the parent-infant relationship and seeks to improve and strengthen this.

The work relies on building up trust between the worker and the young parent and childcare is available for mothers to leave their babies, allowing them time to think and reflect.

Co-working with other agencies, both statutory and voluntary, is essential as mental health work is often complex and protracted and the mental health issues need to be picked up as early as possible. Partners include Cambridge Parent Infant Mental Health Programme (Campip) and the Office for Children's and Young People's Services for Cambridgeshire, including those responsible for developing Children's Centres across the county.

The majority of the young women who respond to the mental health support offered are referred through the wider Young Parents Programme and so it is important that they can build up trust of all partners in the work.

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6.59 At the national level we will:

- Include good practice on implementation of the NICE guideline and effective support services in the revision of *Teenage Parents Who Cares*, a guide to commissioning maternity services for young parents;
- Identify good practice in strengthening young parents' confidence and skills in parenting and disseminate this through the network of single parent commissioners responsible for local parenting strategies;

- Fund One Plus One to provide training for Children's Centres staff on providing relationship support;
- Publish guidance for FE colleges on providing pastoral support to students, with specific reference to the additional needs of teenage parents;
- Encourage providers of parenting support, funded through the Parent Know-How programme, to ensure their services meet the needs of both teenage mothers and fathers;
- Promote *'Aiming High for Children: supporting families'* published by HM Treasury and DfES in March 2007, which recognised the significant impact of parenting on children's outcomes. It set out a range of measures to support parents, including teenage parents, and asked the then Secretary of State for Education and Skills to lead work across government to look at how best to raise aspirations, to improve support for parents and to engage better with the hard to reach, including fathers;
- Publish cross-Government guidance on parenting and family support for young people in custody dealing with the roles and responsibilities of youth justice agencies and local authorities in relation to the families of young people in custody, and the children of young parents in custody.

Helping Young mothers to achieve economic well-being

6.60 Ultimately, young mothers' ability to lift themselves and their children out of poverty and disadvantage depends on their capacity to compete in the labour market. Given their typically low levels of prior qualifications, it is essential that they are given support to reintegrate into school (if they conceive while still below compulsory school leaving age) or to participate in post-16 learning.

CHILDCARE

6.61 The biggest barrier to engaging in learning for young mothers is the cost of childcare. The Care to Learn programme provides the financial support that young mothers need and has been successful in re-engaging large numbers of young mothers in education or training. This academic year (06/07), it has so far enabled over 6,600 young parents to take up learning which they might otherwise not have been able to.

6.62 An evaluation of Care to Learn showed real evidence of progression among young mothers as a result of the programme. Without it, almost 90% of the 1,000 young mothers interviewed said that they would not have gone into learning. Care to Learn had turned round the situation whereby 38 per cent of young mothers had no qualifications before starting on learning linked to Care to Learn. By the time of the survey in Autumn 2006, very few had no qualifications.

- 6.63** However, for Care to Learn to have maximum impact, there also needs to be sufficient supply of high quality childcare places. And childcare providers need to persuade the most vulnerable young mothers – who traditionally prefer to rely on family members to look after their children – of the benefits of formal childcare. Some young mothers think that they are not being a good mother if they leave their child with strangers while they study or undertake training, and fear censure from their own families, communities or partners.
- 6.64** There has been huge investment and consequent growth in childcare provision in England over the last 10 years – £21bn has been spent on expanding early years and childcare provision since 1997. This has been driven both by the demand from working parents and the evidence of the benefits to children of participation in childcare – which provides opportunities for young children to play and learn with their peers.
- 6.65** Increasingly we are trying to develop childcare provision through universal services such as Children’s Centres and (Extended) schools. This offer is particularly important for young parents. Knowing that their child is in a safe place, which offers good opportunities for early learning and child development, will reassure young parents and enable them to concentrate on completing their own education or training.
- 6.66** Locally we want:
- All schools to offer access to extended services by 2010, providing a core offer of activities, including access to affordable childcare at or through their school from 8am to 6pm all year round, linked to a varied menu of activities;
 - Areas to assess local childcare provision to determine that it is sufficient to meet the needs of parents, in particular, to secure childcare that meets the needs of children at risk of exclusion, including families with a lone or teenage parent;
 - Areas to actively promote Care to Learn through the Families Information Service (CIS), the local Single Parent Commissioner and local Teenage Pregnancy Strategies and to provide co-ordinated packages of support for those young parents using Care to Learn;
 - To identify a lead person to promote Care to Learn who will work closely with the local authority lead on the childcare sufficiency duty.
- 6.67** At a national level:
- We have introduced – through the Childcare Act 2006 – a sufficiency duty on Local Authorities, which is intended to help all parents who are in work and have childcare needs;

- We have taken measures to make childcare more affordable for lone parents and those in lower income households, providing substantial help (over £3m a day) through the tax credit system and through the free early education entitlement for all three and four year olds;
- We are making free early education available to all 3 and 4 year olds, irrespective of the employment status of their parents. From April 2007, 3 and 4 year olds will receive an enhanced entitlement of 15 hours per week, with a long-term ambition to increase the free entitlement to 20 hours. The free offer provides two years of high quality provision before children reach compulsory school age, and is a core building block of a young child's learning and development;
- We have introduced a Childcare Affordability Pilot in London, in recognition that the Capital has higher childcare costs than elsewhere;
- We will continue to fund Care to Learn with the aim of supporting up to 7,000 young parents a year up to the academic year 2010-2011;
- Increase from August 2007 the weekly amounts payable through Care to Learn from £155 to £160 a week nationally, and from £170 to £175 in London;
- Revise the Code of Practice for childcare providers working with young parents issued in 2004, to reflect the impact of recent changes such as a lead adviser for all young mothers and service delivery through Children's Centres.

Case Study: Promoting uptake of Care to Learn (St Helens)

In St Helens a higher than average number of young mothers under 20 are taking part in the Care to Learn (C2L) scheme which covers their childcare costs with a registered childminder while they take part in learning. St Helens is one of the top 40 LA areas in terms of C2L take up (April 2007).

The key factors to the success are that the teenage pregnancy strategy is closely integrated into the Children's and Young People' service and Children and Young People 's Plan (CYPP), key partners are co-located and work closely together, and a voluntary sector partner – the National Children's Home (NCH) – working in the Borough's hotspot areas, is also involved.

The teenage pregnancy coordinator plays a vital role in identifying the high numbers of teenage mothers who are non-active NEETs – 40% of young mothers have no qualifications and a further 21% only have low level qualifications. This information enables Connexions to target their resources more effectively.

Information about C2L is sent to education and childcare providers, school and college mentors and Connexions. A booklet has been produced through local regeneration funds and events take place regularly to promote the scheme.

Learning and C2L have been promoted to young parents and professionals as 'Support to Progress'. Accredited learning is encouraged because it gives young parents the opportunity to progress and to raise their ambitions.

C2L is being promoted through Children's Centres which are being encouraged to forge links with local colleges or to offer in-house learning. Training about C2L for Children's Centres staff is being put in place, which includes tools for self-assessment to identify weaknesses and track progress.

A mentor from the local college works closely with the young parents offering continuous support during learning.

The teenage pregnancy coordinator works closely with local transport services to survey bus routes and identify issues such as limits on numbers of prams or buggies on buses.

The overall outcome of promoting Care to Learn is to enable teenage parents to participate in learning, achieve their potential and strengthen their future economic well being.

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ENGAGEMENT IN EDUCATION, EMPLOYMENT AND TRAINING (SCHOOL AGE MOTHERS)

6.68 Most school age mothers have their babies in Year 11 which is a crucial time for taking GCSEs, so it is important to ensure that they are able to complete their compulsory education. Research commissioned by TPU shows the positive impact which Reintegration Officers can have on outcomes for young mothers to be, who had previously been missing school.

6.69 Despite DfES guidance that makes clear that pregnancy is not a reason for exclusion, a small number of young women report being excluded from school on grounds of pregnancy, or encouraged not to attend – with only limited home tuition offered as an alternative. There are also cases of pregnant young women reporting being bullied at school once the pregnancy becomes apparent, or not being on school rolls because they have changed their place of residence.

6.70 Locally, we want areas to:

- Have a Reintegration Officer or nominated officer in post to support school age expectant mothers to ensure that they receive the education they need to achieve their potential up to school leaving age and are well placed to continue in learning post-16;
- Put in place arrangements to ensure that the Reintegration Officer or nominated person responsible for the education of school age parents either takes on the lead professional role themselves, or liaises closely with the professional fulfilling this role;

- Ensure that no teenage parent is excluded from school on grounds of pregnancy, or because of spurious health and safety concerns arising from the pregnancy – and that they are allowed to return to school once they have had their baby;
- In the 20 pilot areas of Parent Support Advisers (PSAs), to explore the potential of PSAs in providing additional help in identifying and addressing specific problems faced by school age mothers;
- Provide other options to continue in learning where, in consultation with the young mother to be, it is agreed that a return to mainstream school would not be in the young woman's best interests. This could include studying in FE, home tuition or a specialist unit, where appropriate.

6.71 Nationally we will:

- Update and reissue the Guidance on the Education of School Age parents to include issues which have arisen since 2001, in particular the impact of the more personalised curriculum available to 14 to 19 year olds;
- Consider the implications for expectant teenage mothers of our proposals to raise the education participation age to 17 by 2013 and 18 by 2015, for example on the appropriate period of absence that should be allowed immediately before and after the birth of the baby and on the arrangements for the young mother's return to education.

Case Study: Reintegrating school age mothers back into education (Stockport)

Moat House is a dedicated Pupil Referral Unit which admits pupils from secondary schools within Stockport Local Authority. An Ofsted inspection in 2007 assessed the unit as "outstanding".

Pupils can be referred at any stage of their pregnancy by their school, social worker or a health professional, and on occasions by self-referral. Stockport's teenage pregnancy specialist midwives also notify the unit about pregnancies in girls aged 16 or under as part of Stockport's Teenage Pregnancy Care Pathway. Girls aged between 16 and 19 are referred to the Young Parents' Project Coordinator who is based at Moat House, and who offers support and advice about further education and higher education placements.

Moat House accommodates young women of compulsory school age who are pregnant, and enables them to continue with their learning right up to the birth of their baby in the majority of cases. Young mothers get four weeks authorised absence from education following the birth – with six weeks in the case of a Caesarean Section or difficult birth.

The young mothers can continue with their learning until they reach the end of Year 11. Moat House provides an appropriate learning placement at the limit and offers a broad and balanced curriculum to meet the needs of the pupils at the unit. Pupils are able to study for and take accredited examinations, including GCSEs, across a wide range of subjects.

The unit has enabled all young mums referred in recent years to remain in learning and, in most cases, achieve results that have enabled them to move into further education and then onto higher education – a progression which would not otherwise have been the case.

There is a Young Parents' Project coordinator working with the young parents and Moat House teaching staff, to ensure that all the needs of the young parent and the child are met and that learning outcomes are achieved.

There is a crèche on site that looks after the pupils' babies whilst they attend lessons, staffed by well-qualified and experienced nursery nurses.

Good relationships are developed with the parents and Moat House staff, and there is an open door policy where parents are encouraged to telephone and/or visit as necessary.

Contact: Kathy Burton, Tel: 0161 429 9015, Email: headteacher@moathouse.stockport.sch.uk

ENGAGEMENT IN EDUCATION, EMPLOYMENT AND TRAINING (POST-16 LEARNING)

6.72 Participation rates for teenage mothers remain stubbornly low. This is in part due to their low level of prior qualifications, but is also a result of the lack of availability of foundation level courses and the difficulty of finding courses that are flexible enough to accommodate their needs as new mothers.

6.73 Local areas should ensure that:

- Lead professionals and others working with teenage parents understand the obstacles which teenage mothers face in accessing learning and staying in learning, both on a practical level in relation to childcare and transport (or other issues like their housing situation) and in terms of their own self-esteem and confidence;
- Lead professionals understand the pressures on young fathers and the difficulties they may have in engaging in learning, for example their wish to be a 'provider' and the consequent risk of them dropping out of their own training to take up low-paid insecure employment, without prospects, to provide immediate income;
- Learning providers develop a range of courses for young parents, including provision for those with low attainment, part-time and taster courses at FE colleges which will allow them to identify what they might want to study and to enable them to experience the childcare provision that is made available on-site for their children;

- Learning providers ensure that pastoral support arrangements for teenage parents reflect the pressures of combining learning with the responsibility of looking after a young child – including providing them with easy access to contraceptive and sexual health services, to reduce drop out by young mothers due to further pregnancies ;
- Learning providers apply flexibility when monitoring young parent’s compliance with their EMA contracts, including in relation to eligibility for bonuses – taking account of their child’s ill health which might genuinely prevent them from attending college or other learning provision.

Case Study: Supporting young parents back into education, employment and training (Kent)

The Pinnacle Project is a Kent wide initiative to bring young parents back into education and training. It is delivered through local multi-agency partnerships negotiated by Kent Teenage Pregnancy Partnership. Partners include midwifery and health visiting, Home Start and other local voluntary agencies, Connexions, sexual health and children centres.

The project has been developed in response to the reality of working with young parents and in line with evidence that they are often hard to reach, have had negative experiences of formal education and are unwilling to trust and engage with statutory services.

An informal programme of events is provided through YAPS Groups (Young Active Parents), as well as advice and support. Information is available from pregnancy through to parenthood, and contraception is available. Home visiting has brought disengaged young parents into the groups.

There are also YAPS+ (plus) groups which are located in children’s centres, offering multi agency services and ensuring long term sustainability of the work. YAPS+ provide an informal route into education and training. Short courses such as cooking and eating are offered, which are fun and interactive.

The YAPS+ group aims to build confidence and self esteem along with practical skills. The gradual addition of accredited, structured courses leads to the eventual inclusion of formal programmes, including literacy and numeracy work. A number of course providers funded by the LSC provide the educational input.

Establishing links with FE colleges and having support staff enables the young parents to progress into further education equipped with the skills and confidence to complete courses.

Childcare is provided through the children centre, supported by Care to Learn, giving young parents an opportunity to “test” childcare in a safe space and relevant agencies are getting training to ensure equitable referral and support.

Contact: Sam Higgins, Tel: 01304 222284, Email: Samantha.higgins@kent.gov.uk

Case Study: Identifying and removing barriers for young parents returning to education, employment and training (Leicester)

Identifying the barriers young people face in returning to education, employment and training (EET) is critical if participation rates are to be improved.

In Leicester, young mother Rhoda Thomas, a member of the Independent Advisory Group on Teenage Pregnancy, which advises government on teenage pregnancy issues, carried out research with 60 young parents to find out their experiences of young parenthood and to identify some of the barriers they face in accessing services and returning to EET.

Along with a young father, she found that young parents cited very practical problems, including transport difficulties. Not all the city's buses were accessible for pushchairs, which could make the journey to a childminder impossible.

The cost of childcare was also a major barrier to returning to EET, as well as the inflexibility of training and courses, which did not cater for mothers needing days off if their child was ill or if either mother or child had been up all night.

A number of recommendations came out of the research including the need for access to more affordable and trusted childcare, more information for young parents on the Care to Learn scheme and more flexible and accessible learning opportunities.

The work was done under the Returning Young People to Education, Employment and Training (RYPEET) project, run by the Parenting Information and Pregnancy Support (PIPS) team, which was previously Sure Start Plus. PIPS is a multi-agency team of young parent advisers from Connexions, a specialist teenage pregnancy midwife and childcare coordinator. It works with other key agencies in Leicester.

PIPS is now collaborating with the main further education college in the city to improve the recruitment and retention of young parents by providing training for staff, which is delivered by young parents, and by having dedicated young parent support onsite.

An audit of the city's 12 children's centres is also underway to improve uptake of services and to reach EET targets.

Young parents from the RYPEET project have also created a website – youngerparent.co.uk which provides information, a discussion forum, and an opportunity to put questions to the local teenage pregnancy midwife and Connexions advisers.

Contact: Mandy Jarvis, Tel: 0116 262 7254, Email: mjarvis@connexions-leics.org

6.74 At a national level, we will:

- Better publicise the fact that young parents can apply for EMA in their own right (without their parent's income being taken into account);

- Revise the aide-memoire issued by LSC to learning providers about developing attractive and flexible learning for young parents in Further Education;
- Aim to simplify further the EMA application process, including promotion of a DVD outlining the application procedures which is aimed at those with poor literacy skills;
- Review the EMA bonus model to further emphasise progression and achievement over attendance;
- Issue national standards for pastoral support in the FE sector, which recognise the particular needs of students with dependent children;
- Provide funding of £4 million to enable up to 5,000 young parents or parents to be to undertake positive parenting courses as a stepping stone to learning at NVQ Level 2;
- Activity Agreement pilots – which allow young people who are NEET to undertake job search or volunteering opportunities, while receiving a £20 allowance – will continue to recruit eligible teenage parents; DCSF will identify and share good practice that emerges from the pilots.

BENEFITS

6.75 A key problem reported by teenage parents and the practitioners who support them is the complexity of the benefits system, and the conflicting and sometimes inaccurate information given by Jobcentre Plus staff. Although the aim of improving support for teenage mothers is that they will not need to claim means tested benefits in the long term as they will have the means to support themselves, they will need them when the baby is born particularly if they have no partner or parental support to ensure that the baby has adequate care and nutrition.

6.76 We want all local areas to ensure that:

- Jobcentre Plus staff have clear arrangements in place for dealing with claimants under-18 who are expecting a baby or who have responsibility for a child, including speedy referral to Connexions for a learning focused interview and referral to a lead professional who would provide ongoing, holistic support;

6.77 To support local delivery, nationally we will:

- Produce joint guidance with DWP for Jobcentre Plus staff, to enhance their professional practice in relation to benefit claimants aged under-18, who are, or about to become parents. It will highlight their needs and vulnerabilities, the benefits they are entitled to and the support available to them through Connexions (and Targeted Youth Support arrangements from April 2008);

- Explore with DWP and HMRC, the development of a short and simple leaflet targeted at young parents, on the financial help to which they are entitled under the tax credit and benefit systems. Consideration would be given to including this in the 'bounty pack' given out on maternity wards;
- Consider how any changes to the benefit system, including housing benefits, can better support improved outcomes for young parents and their children;
- Monitor how any changes to birth registration arrangements designed to promote more joint registrations by unmarried couples – as proposed in the Green Paper on *Joint Birth Registration: promoting parental responsibility* – can support young couples to stay together and young fathers to maintain contact with their child even if the relationship with the mother is not continuing;
- Continue to offer support through the New Deal for Lone Parents (NDLP), to encourage young mothers to improve their job readiness, through: support from a New Deal Personal Adviser; help with childcare costs for those working up to 16 hours a week and, for those working more than 16 hours a week, the childcare element of working tax credits; funding to ease the transition to work – such as Housing Benefit and Council Tax run on (HBRO) for the first 4 weeks in employment; and, in 22 pilot areas, an in-work credit of £40 a week for the first 12 months.

Case Study: YWCA Kirkby young women's centre, (Knowsley, Merseyside)

YWCA Kirkby takes a holistic approach to young women's needs. *Young mums to be* (YMTB) is funded by the local teenage pregnancy grant, Connexions and ESF. Connexions, midwives and the school inclusion team refer pregnant young women to YWCA.

The course provides a one-stop-shop for young women and looks at their basic needs, like health and practical skills for living, so they can then be ready for employment, education and training. It looks at child health and keeping healthy during and after the pregnancy, covering smoking, alcohol, drugs and contraception after the birth. It discusses what to expect from the birth and how to manage as a new mum, including money management. It also looks at plans for the future, where young women see themselves going through work, training and education. Over the last couple of years young women participating in the course and have achieved National Certificate for Education (NCFE) level 1, others have completed several units which contribute towards an NCFE. Young women have also gained GCSE English.

To offer continuity of support, young mums are invited to return to YWCA Kirkby after the birth of their babies and move on to the *'Parents with prospects'* course, funded by LSC and Neighbourhood Learning in Deprived Communities. Here they can continue to build on credits they gained in YMTB to achieve NCFE level 1. This has worked particularly well for women who have had difficult pregnancies or births and have had a break in attendance.

Young mums can access counselling if requested, for example for post-natal depression. They also attend taster visits to college and training providers. They are supported to use Kirkby's IT suite and their children are looked after in the onsite crèche. As a result of these programmes and the holistic approach taken young women have completed NCFE level 1, moved on to college and training and some have also participated in YWCA's national campaigns.

Contact: YWCA, Tel: 01865 304 270, Email: lucy.russell@ywca.org.uk

Case Study: Supporting young mothers through the voluntary sector (The Girls Friendly Society – GFS Platform)

GFS Platform works with teenage mothers in four community projects in Great Yarmouth, Penge, Skegness and Sandown Bay (Isle of Wight) who may be excluded from many aspects of mainstream society. It also runs shared supported housing schemes accommodating a total of 10 young mothers and their babies in Great Yarmouth.

Floating support funded by the London Borough of Bromley enables staff from GFS Platform Penge to work with teenage mothers in temporary accommodation, helping them find more permanent housing with support workers to help them to maintain their tenancies.

Models of best practice include ante-natal classes and the provision of an on-site midwife at GFS Platform Great Yarmouth, which is funded by the PCT. The classes are specifically for young mothers who may feel intimidated by mainstream classes because they perceive that they are 'full of old people'. Young women are encouraged to attend with their partners and a drop-in for young fathers, led by the PCT's Young Father's Worker, is held on site at the same time as ante-natal drop-in groups for young mothers.

Sexual Health advice and condom distribution are offered at all the projects. Young mothers are trained as peer educators and deliver sex education in local schools.

Education, including Basic Skills, IT and GCSEs is offered at all the projects and is supported by free on-site childcare which removes one of the main barriers to young mothers wanting to return to education and training.

GFS Platform employs a worker funded by Connexions to work with BME teenage mothers. A Connexions PA is employed at GFS Platform Great Yarmouth to work with young mothers both at the project and at the shared supported housing scheme.

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7. Support for Young Fathers

7.1 As earlier chapters make clear, young fathers can have a significant impact on the outcomes experienced by teenage mothers and their children. But their ability to make a *positive* impact is sometimes hindered by service providers who do not appreciate the important role they could or do play – particularly if they are not visible to them – and consequently do not take into account young fathers’ needs when designing services.

7.2 As a result, young fathers often report:

- Feeling excluded from maternity and health visiting services and Children’s Centres and believe that they are unfairly judged by practitioners who have negative stereotypes about them – that they are not interested in their children, do not want to support them financially, are irresponsible, uncaring, and that young mothers are better off without them. Their subsequent disengagement from the pregnancy and birth reduces the support available to the mother at a critical time in her life and reduces the chances that the couple will stay together (potentially removing a source of ongoing support – not only from the partner but from his own parents – that will help the mother better cope with the demands of early parenthood);
- Being denied opportunities to live with the mother and their child if she is placed in Supported Accommodation where services are provided on-site, due to restrictions applied by the housing provider and the financial disincentive of claiming benefits as a couple;
- Not routinely receiving support themselves to cope with the responsibilities of early parenthood – including support on developing positive parenting skills – and do not receive information about the advantages of jointly registering the birth and having ‘parental responsibility’.
- Not receiving support services they themselves need in relation to learning and training to support themselves and their family. They need to be identified as young fathers with additional needs to other young men through the CAF process and to

receive the help of a lead professional through targeted youth support arrangements. They are often tempted to give up learning to take up low paid insecure employment to give them immediate income to support their families.

- 7.3** The consequent lack of support for young fathers, and the dearth of services that provide mediation services for them, mean that too often young fathers do not live with their children, nor have a meaningful input to their children's lives.
- 7.4** The benefits of fathers' involvement on children's cognitive development have been well illustrated in other publications and, as such, are not repeated in detail in this document. Suffice to say that evidence shows that positive involvement of fathers leads to better child outcomes in relation to: educational attainment; attendance and behaviour at school; involvement in crime and substance misuse; peer relationships; and mental health.
- 7.5** Consequently, staff attitudes and service design that result in young fathers' disengagement from their children's lives, serve to further disadvantage children born to teenage mothers. We need, therefore, to develop a culture in which the starting point is that young fathers' involvement in the pregnancy and birth is beneficial for the mother and child and that services should be designed so that they are inclusive of young fathers, rather than one which starts with the presumption that the young father is a 'problem'. While in a minority of cases there may be child protection concerns because of differences in age or situations where a young father's attitudes and behaviour might not support better outcomes for the mother and child, these should not pre-determine professionals' attitudes and their approach to service design.
- 7.6** We know that parenthood can act as a trigger for young fathers to desist from negative behaviours, change their lifestyle and become interested in how they can better support their family. We therefore need to capitalise on the desire of most young fathers to be good fathers (and very often to be better fathers than their own fathers were). But currently work with young fathers is patchy and in many areas there is limited commissioning of discrete work to support them. Its funding is insecure and it is often not sustained.
- 7.7** That is why the Teenage Pregnancy Unit (TPU) commissioned the Trust for the Study of Adolescence (TSA) to publish guidance which identifies and shares examples of promising work with young fathers from around England. The guidance *'Supporting Young Fathers: Examples of Promising Practice'* provides practical details of existing projects. In addition, TPU is establishing a web-based network – managed by the Trust for the Study of Adolescence (TSA) – that will provide a forum for young fathers' workers to share practice and raise issues and problems to which other projects may already have found solutions, including in relation to: commissioning young fathers work and sustaining funding for it; and working with young fathers of compulsory school age.

7.8 The greater challenge however, is to make a reality of the commitments in the guidance issued to mainstream services – through, for example, the NSF and Children’s Centres Practice Guidance – to make services more accessible and welcoming to young fathers who want to engage positively with them.

7.9 Measures that should be considered by local areas include:

- Taking a much more pro-active approach to identifying young fathers through the CAF and targeted youth support processes. Young men who are NEET should be routinely asked if they are also a parent so that a better database on them can be built on the Client Caseload Information Specification (CCIS). Those that are effectively the main carer for the child either temporarily or permanently (for example because of the mother's mental health or substance misuse problems) need to be identified urgently to ensure they get the support they need.
- Looking at the need for and effectiveness of young fathers work as part of the self-assessment process for example in Children’s Centres to complement the Performance Indicator for Children’s Centres of reach to teenage mothers.
- The partners of teenage mothers who are in the age range should be routinely considered for the support provided by a lead professional through targeted youth support arrangements
- They should also be actively considered as participants in the Activity and Learning Agreement pilots as they are often NEET, or, if in employment, are working in low paid, insecure jobs without training, to earn money to support their families.
- Supported housing providers particularly of residential units housing teenage mothers should consider how they can promote better relationships between resident young mothers and their partners by how they manage access by fathers and involving the father in the mother’s transition to independent living.

7.10 The Green Paper *‘Joint Birth Registration: Promoting Parental Responsibility’* (published in June 2007), outlined the Government’s commitment to significantly increase the number of joint birth registrations. It argues that joint birth registration can make a significant contribution to child welfare. The Green Paper recognises that joint registration may not be suitable for all parents and that any system will have to contain safeguards to protect the vulnerable. However, the aim is that joint registration will embed a new culture, which places more equal weight on the role of both parents in supporting their children. It is hoped that this will help young fathers to feel that they have a real stake in their children’s lives and lead to fewer fathers having no clear accountability or commitment to their children, and support better outcomes for the children of young parents.

Case Study: Supporting young fathers (Harlow, Essex)

The Harlow Foyer, a young people's centre in Essex which provides sheltered housing and training courses for disadvantaged young people, identified a need to improve attendance of young fathers at its parenting projects.

A Fathers Forum (supported by Harlow Foyer, Harlow District Council and West Essex PCT) was set up to identify the needs of those young fathers both living at the Harlow Foyer and out in the local community.

They found that young fathers generally felt excluded (especially by health professionals) and did not feel able to access mainstream provision. The fathers said they wanted information on the role of a dad and what was expected of them and felt they needed to understand their rights as a dad, and wanted to engage as a father from the earliest opportunity.

The young men thought there should be an information pack for fathers (mothers get one), and an informal but informative 'drop in' for males only where they could access support and advice and get hands-on practice at tasks such as bathing a baby. They also wanted information on how to deal with mothers who were ex-partners.

Having identified the needs, Harlow Foyer has now come up with an action plan and has started group drop-in sessions, with support from the Harlow sexual health promotion group whose members are from all key agencies. Input into the dads' group comes from West Essex PCT, Essex Youth Service, Harlow District Council and Essex Connexions.

Local teenage pregnancy funding set up the group and is also being used to produce an information pack, put together with young fathers for fathers, covering the areas that the young dads had requested.

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8. A new Approach to Housing Support for Teenage Mothers

- 8.1** It has long been a concern, identified in the original teenage pregnancy strategy in 1999, that vulnerable young mothers under the age of 18 are allocated independent tenancies, without support. Living alone, often in poor quality housing and potentially in an area that is some distance from their family and friends can add to the isolation that many young mothers feel – which increases the risk that they will experience poor emotional health and well-being. In addition, research in the South West^{xxii} and East Midlands^{xxiii} regions into the housing need of teenage mothers found that a small number of expectant and young mothers were either not registered with housing authorities or, through a complex combination of circumstances, are not getting the supported accommodation they need.
- 8.2** While we have made some progress over recent years in reducing the number of 16-17 year old mothers in independent tenancies, Housing data suggests that there remain about 1,000 young mothers in this position.
- 8.3** We intend to issue later this year, best practice guidance to local housing authorities and voluntary sector housing providers, which provides examples of effective work on issues such as mediation and the allocation of housing to teenage parents. It outlines some of the gaps and difficulties in the provision of support for teenage mothers and why it is essential that they are placed in good quality accommodation, with support. This will help them to achieve better outcomes in terms of their parenting, re-engagement with learning, their own and their babies' health and will prepare them for their eventual move into an independent tenancy.
- 8.4** The guidance addresses key issues including:
- Accommodating teenage parents with very high levels of need;
 - The role of mediation that helps young mothers to remain within the family home – but only where this is possible, safe and desirable – to avoid the need for recourse to social housing;
 - The need to provide 'move-on' accommodation and avoid bottlenecks in supported housing;

- The important role of floating support, both as an alternative to on-site supported housing and as part of a phased transition to independent living;
- The Supporting People (SP) Outcomes Set, whose 5 high-level outcomes are similar to the Every Child Matters outcomes. These will be a valuable tool for authorities to effectively monitor the impact that SP funded services have in meeting the support needs of the young people who use those services, including teenage parents;
- The importance of not using bed and breakfast accommodation for teenage mothers under-18 and their children, except as a last resort and then for not more than six weeks; and
- The importance of considering the housing and other support needs of young fathers.

8.5 In 2005-06, £21.4m of the SP programme budget was allocated to help teenage parents, the majority of which was delivered through voluntary sector organisations. These organisations can offer great expertise in supporting teenage parents to stabilise their often chaotic life situations by providing intensive housing support and helping them move on into sustainable independent living. This involves careful assessment of the level of support required; links with specialist services to provide advice on returning to learning and on health issues – such as contraceptive advice from health professionals to prevent second conceptions – and providing tapered support in the move-on period to ensure young parents continue to develop and maintain the necessary confidence and skills.

8.6 In the long term we want to ensure an appropriate housing offer with high quality support. We will be exploring with CLG how this might be achieved in the context of the programme of work being taken forward later this year to address the issues raised by John Hills' review of the future role of social housing, published in February 2007. John Hills recommended that a more 'varied menu' of housing offers should be available, to ensure that the housing offer is more responsive to people's circumstances at different stages of their lives. Our aim will be to enable young mothers to develop key life skills and stay engaged with learning and employment to prevent social exclusion and improve outcomes for them and their children.

Annex 1: A Model ‘Care Pathway’ for Teenage Mothers

	Journey	Standard
Pregnant girl aged 15	Jane suspects that she may be pregnant. She is 15 years old. Jane visits the drop-in health centre on her school site, which is provided as part of extended school services. She has her pregnancy confirmed through access to free pregnancy testing. She thinks that she is about 12 weeks pregnant.	
Access to confidential advice and information	Jane is offered confidential and impartial advice from a nurse, Femi, who is attached to the centre. Jane has been reluctant to tell her parents as she is worried about their reaction. As Jane is only 15, Femi is concerned for Jane’s welfare and the circumstances surrounding her pregnancy. She asks Jane about the father, reminding her that any information she gives will be regarded as confidential and will not be shared, unless not to do so would place her at risk of significant harm. Jane refuses to name the father but tells Femi that he is in year 11, is 16 years old and was her boyfriend until they split up about a month ago.	Children and young people have access to an appropriate range of support if they feel troubled (Ofsted, Inspecting children’s services, section 1.4; NSF 9)

Journey	Standard
<p>Femi talks with Jane about the support available from the Teenage Pregnancy Support Service (TPSS) should she choose to keep the baby and the options for an abortion or adoption. Femi stresses the importance of Jane making the decision she feels is right for her and asks whether she would like to speak to a pregnancy counsellor, to help her consider the options in more detail. She also encourages Jane to speak to her parents so they can support her in what she chooses to do. Jane accepts Femi's suggestion to see a pregnancy counsellor. An appointment is made for Jane in two days time at the school drop in centre.</p>	
<p>Femi tells Jane that despite the information Jane has provided about the circumstances of her pregnancy, given Jane's age, she has a responsibility to take precautionary action to safeguard Jane's welfare. To this end Femi tells Jane that she will need to discuss Jane's situation with the local Child Protection (CP) lead. Femi explains the role of the CP lead to Jane and reassures Jane that the information she has given will be treated confidentially and that Jane's identity will not be disclosed in any discussions she has with the CP lead at this stage, unless not to do so would place her at risk of significant harm. She also tells Jane that in line with the schools confidentiality policy she will not at this stage disclose the information Jane has provided, to her form tutor or any of her teachers, unless not to do so would put her at risk of significant harm. Jane, although not entirely comfortable with this, understands from Femi's explanation why a discussion with the CP lead is needed and is confident that her identity will not be revealed.</p>	<p>Safeguarding and promoting the welfare of children is prioritised by all agencies, working in partnership to plan and provide co-ordinated and comprehensive services in line with national guidance and legislation (DH, 2004, NSF 5)</p>

Journey	Standard
	<p>Femi checks ContactPoint to see if Jane has any current or prior involvement with other services. No service involvement is recorded other than universal services such as the GP and the school. Femi contacts Jane's form tutor without disclosing the reason why she has come into contact with Jane. He confirms that she is a reasonably well behaved pupil who seems to enjoy school and that despite a recent dip in her attendance she presents no cause for concern. She contacts the nominated CP lead to discuss the situation. Based upon the information that Jane and the form tutor have given, and Femi's own assessment, the CP lead feels that at this point a referral to children's social care is not necessary and that the relationship was consensual. She advises Femi to monitor Jane's welfare closely and to contact her should she have further cause for concern.</p>
<p>Support for decision-making</p>	<p>Jane sees the counsellor on three occasions over a period of a week. She enables Jane to discuss every option and how she feels about the pregnancy. After some deliberation Jane decides to keep the baby. The counsellor helps Jane overcome her concerns about telling her parents that she is pregnant and about the decision she has made. She advises Jane to meet with Sarah the Teenage Pregnancy (TP) Advisor as soon as possible. Jane can opt to see the adviser either at the children's centre or at the young people's drop-in centre attached to the school. Jane agrees to meet Sarah at the drop-in centre on the school site.</p> <p>The counsellor contacts the TP adviser Sarah, to arrange an appointment for Jane and outlines Jane's situation. A meeting for Jane with Sarah is arranged for three days later.</p>

	Journey	Standard
Support from teenage pregnancy advisor and access to multi-agency team	<p>Having told her mother about her pregnancy and the decision to keep the baby, Jane's mother agrees to go with her to meet Sarah at the drop-in centre. Jane tells Sarah that she has decided to keep the baby. Sarah explains how the service works and what support is available. Jane can access ante-natal care, parent support and advice, a dedicated health visitor and support for her education all through the TPSS.</p> <p>Sarah recommends a common assessment of Jane's needs and tells Jane and her mother about the Common Assessment Framework (CAF). She explains how the information may be used and how this will help in securing the right support for Jane</p> <p>Sarah also tells Jane and her mother about ContactPoint and how information from the common assessment and the services she receives, are recorded. Jane tells Sarah that she is feeling worried about how her friends and teachers are going to react and doesn't want everyone to know just yet. Sarah reassures Jane and her mother that as the TPSS is classed as a 'sensitive service', details of the service would not be shown. She also tells them that the information recorded on the CAF will only be shared with others with her consent, unless it was felt that not to do so would place her at risk of significant harm.</p> <p>Based on the information Sarah has given them, Jane and her mother agree to the assessment. Jane is reassured that she will be supported in coming to terms and dealing with her pregnancy and that the information on the CAF will help to ensure that she receives the kind of support she feels is right for her and her baby.</p>	Children and young people and families receive high quality services which are co-ordinated around their individual and family needs and take account of their views (DH, 2004, NSF 3)

	Journey	Standard
Common Assessment	<p>Sarah undertakes a common assessment of Jane’s needs using the CAF and by drawing upon the information already collected by the school nurse and by the school. Jane is a fit and healthy girl who has been doing reasonably well at school. She has a fairly good attendance record with only a few recorded absences during Year 9 and has been making good progress in studying for her GCSEs. However her attendance and performance at school has deteriorated recently. Jane’s mother reports that this has coincided with her seeing a boy, Matt, from year 11. Jane is not prepared to talk about Matt or to confirm whether he is the father. Jane reports that she has been so worried about being pregnant that she has not been able to concentrate on her studies. Jane’s mother says that her father has not taken the news very well at all and Jane has been very upset at his reaction. They are very worried about their daughter’s welfare, her education and how she is going to cope with a new baby.</p> <p>Sarah emphasises how important it is for Jane and her baby to receive regular ante-natal checks and suggests that an appointment is made for Jane with a midwife as soon as possible. Jane agrees for the information in the CAF to be shared with the team of midwives. Jane is worried about having time off school for ante-natal care. Sarah tells Jane and her mother that Jane is entitled to up to 18 calendar week’s authorised absence and that she will be supported to remain in school and continue with her education. Sarah suggests that Jane and her parents and herself, meet with the school’s pastoral lead and the Reintegration Officer from the local authority’s School Inclusion Team to discuss how Jane can be supported through her pregnancy. Sarah explains to Jane and her mother about the role of the Reintegration Officer.</p>	<p>A single assessment and recording system is in place (Ofsted, 2005, section 6.3c; NSF 3).</p> <p>The needs of individual children, young people and their families are effectively identified, recorded and communicated (Ofsted, 2005, section 6.3c; NSF 3)</p> <p>The health and wellbeing of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention where possible (DH, 2004, NSF 1)</p>

	Journey	Standard
	<p>Sarah explains to Jane that she would like to take on the role of lead professional. She tells Jane what the role of the lead professional involves and how she would be the main point of contact for any questions or concerns that Jane and her mother may have. She would also act as the point of liaison between Jane, the TPSS and her school. She explains that as lead professional her name and contact details will appear on ContactPoint but not details of the TPSS. Given this provision, Jane is happy for Sarah to be her main point of contact and for her details to be recorded on ContactPoint. They agree for Sarah to share the information from the common assessment with Michelle, the Reintegration Officer and liaise with them regarding a meeting.</p> <p>Sarah ensures that she is recorded on ContactPoint as lead professional and records the common assessment information on the eCAF system. This automatically updates Sarah's record on ContactPoint, which now shows that a common assessment has been undertaken. It also shows the involvement of an undisclosed sensitive service. Sarah uses the information from the CAF to complete a TPSS referral and passes this information, along with the common assessment to the team of designated midwives.</p>	
<p>Access to dedicated midwife and ante-natal care</p>	<p>Jane is assigned to Anita, one of a team of dedicated midwives who will see her through her pregnancy. Using the information from the common assessment Anita agrees a care plan with Jane. Jane's scan at 15 weeks reveals all is normal and Jane and the baby are doing well. However, given her age, Jane will need to be monitored regularly to ensure that any complications that may arise are detected early.</p>	<p>The common assessment framework is used to reduce the time spent on repeated assessments (NSF 3; Ofsted 2005, section 6.3c)</p>

	Journey	Standard
	<p>Jane is given information about the options available to her for ante-natal care, and for the birth of her baby. Jane opts to attend the teenage ante-natal drop-in service at the children’s centre where she can meet other young mothers and access information about health and nutrition, breastfeeding, ante-natal and parenting classes. The service operates all day once a week. Jane is apprehensive about attending but the midwife reassures Jane that it is a friendly and relaxed space only used by young mothers under 20 years of age and that she and the TP adviser can meet Jane there as well. Anita tells Jane she will also visit her at home up to and after the birth. She asks Jane about the father and tells Jane that the he is welcome at the drop-in if she would like to invite him. Jane says that she is not sure. As ContactPoint already shows that Jane is receiving an undisclosed sensitive service (TPSS) and that Sarah is recorded as Jane’s lead professional, Anita is confident that she does not need to add details of her involvement with Jane as a TPSS midwife.</p>	<p>Maternity provision is accessible and targeted to individual needs (Ofsted, 2005, section 1.1; NSF 11)</p>
<p>Multi-agency support for Jane’s education and care</p>	<p>Sarah discusses the information from Jane’s common assessment with Michelle the Reintegration Officer and arranges a meeting for Jane and her parents at the school with Michelle, the schools pastoral lead and Jane’s form tutor. As lead professional Sarah will act as chair.</p>	<p>The common assessment framework is used to reduce the time spent on repeated assessments (NSF 3; Ofsted 2005, section 6.3c)</p>

Journey	Standard
<p>At the meeting each member explains their role to Jane and her parents. Michelle reassures Jane and her mother that provision for Jane's education up to and after the birth will be planned in consultation with Jane and her family, with the support of the TP adviser and the school. Jane feels that she would like to remain in school as long as possible as she doesn't want to lose touch with her friends or miss out on her schooling. Michelle confirms that as part of the school's policy on teenage pregnancy, Jane is entitled to a maximum of 18 calendar week's authorised absence from school for the period up to and after the birth. The school remains responsible for Jane's education and care and will work together with the TPSS to ensure that adequate provision based on Jane's needs is provided throughout her pregnancy and after the birth, and that Jane does not miss out or fall behind in any of her learning.</p> <p>It is agreed that Jane will remain in school until she is 34 weeks pregnant when she will start her authorised absence period of which she will be taking 16 weeks. Until then she will be allowed additional authorised absence to attend the teenage ante-natal drop-in once a week. During her period of absence Jane opts to complete work at home for which she will be supported by her parents, her form tutor and a learning mentor. She can also attend a parenting and childcare class run by the TPSS. The school nurse will provide pastoral support to Jane whilst at school via the school's drop-in health centre. As lead professional, Sarah will coordinate regular reviews of Jane's progress and care.</p>	<p>Teenage mothers receive multi-agency assessment and targeted support services (DH, 2004, NSF 2)</p> <p>Children and young people are enabled and encouraged to attend and enjoy school and to achieve highly (Ofsted, 2005, section 3.4)</p> <p>Action is taken to ensure that children who are not able to attend school receive education suitable to their needs (Ofsted, 2005, section 3.5; NSF 6 & 7)</p> <p>Parents and carers receive support to help keep their children healthy (Ofsted, 2005, section 1.1, NSF 2)</p>

	Journey	Standard
<p>Accessing ante-natal support from the children's centre and involving the father</p>	<p>Jane visits the teenage ante-natal drop-in service at the children's centre and enjoys meeting other girls in a similar situation and talk about how she feels about being pregnant and becoming a mother. Jane meets Sarah at the drop-in and tells her that Matt is the father of the baby and that although she is no longer in a relationship with him she feels that she would like to involve him but is unsure how.</p> <p>Sarah tells Jane that the ante-natal drop-in holds a young mum's and dad's group to support young fathers becoming involved in the care of their child before and after the birth. Sarah offers to support Jane in speaking to him about his responsibilities as the father and in encouraging him to attend the ante-natal group. She gives Jane some information about the young mum's and dad's group to give to the father. Although he was initially a bit reluctant, Matt attends the young mum's and dad's group and finds it provides really useful information about caring for baby and on issues like birth registration and putting him in touch with Connexions on training he wants to undertake to improve his employment prospects. Sarah also discusses the issue of contraception with Jane and supports her in choosing a method that is right for her.</p> <p>Jane receives her third scan at 24 weeks and talks with her midwife about options for the birth of her baby. She decides to have her baby in the midwifery led unit at the local hospital. Jane is very apprehensive about caring for the baby but tells Anita that talking with other young mothers and Sarah has helped her a lot. Anita reassures Jane that either she or one of the midwives from the TPSS will deliver her baby. Jane decides to have her mother as her birth partner.</p>	<p>Maternity provision is accessible and targeted to individual needs (Ofsted, 2005, section 1.1; NSF 11)</p> <p>Services are provided in venues that are accessible to children, young people and their families (Ofsted, 2005, section 6.2c, NSF 6, NSF 7, NSF 8)</p> <p>Women are able to choose the most appropriate place to give birth from a range of local options including delivery in midwife-led units (DH NSF for Children, Young People and Maternity services, 2004, NSF 11)</p>

	Journey	Standard
Reviewing Jane's support in school	Jane is supported in keeping up with her studies by her learning mentor and continues to attend the ante-natal drop-in. As her pregnancy progresses Jane begins to feel uncomfortable at school and different from her school friends. She tells Sarah, that she is feeling increasingly conscious of her pregnancy and tends to feel happier with the new friends she has made at the ante-natal drop-in. However despite her feelings Jane would prefer to remain in school. Sarah encourages Jane to use the drop-in centre on the school site as a place to take time out during school breaks and talk with the nurse about how she is feeling as this is sometimes used by other young mothers. It is agreed with Jane's form tutor and Michelle that Jane should be able to leave school slightly earlier than the other pupils so that she can avoid the school rush.	Children and young people, particularly those from vulnerable groups, are supported in managing changes and responding to challenges in their lives (Ofsted, 2005, section 4.2) Children and young people have access to an appropriate range of support if they feel troubled (Ofsted, Inspecting children's services, section 1.4; NSF 9)
Provision of alternative education and care out of school	At 34 weeks Jane begins her period of authorised absence from school. Her form tutor co-ordinates work set for Jane to complete at home and the learning mentor visits once a week to provide additional support with her studies. Jane enjoys attending a parenting and childcare course at the ante-natal drop-in where she learns about all aspects of caring for a new born baby including the benefits of breastfeeding. She is pleased that with Sarah's help Matt has attended the young mum's and dad's group with her. Anita, Jane's midwife, also visits Jane at home to check on how her pregnancy is progressing and discuss any concerns Jane has about the birth.	Action is taken to ensure that children who are not able to attend school receive education suitable to their needs (Ofsted, 2005, section 3.5; NSF 6 & 7)

	Journey	Standard
Supported birth	<p>At 40 weeks Jane has a problem free birth with the support of Anita and her mother at the midwifery led unit in the local hospital. She gives birth to a boy, Ethan. Whilst in hospital Jane is helped and encouraged to start breastfeeding Ethan by a maternity support worker Helen. Helen tells Jane about a peer breast feeding scheme that is run by one of the maternity support workers from the TPSS with support from older mothers. The scheme has four trained peer mentors, all of whom are young parents. Jane is very resistant to the idea but with the encouragement of Anita and her mother she resolves to try.</p> <p>With Jane's agreement Anita arranges for the maternity support worker to visit Jane at home so she can tell her about the scheme and introduce one of the mentors to Jane. She and Ethan are discharged home three days after the delivery with information about post-natal care, including a leaflet about the breastfeeding scheme, which has been developed by young mothers themselves. Jane is given the contraception she has chosen to use and asked whether she has any queries or concerns about its use.</p>	<p>Up to date information on breastfeeding and breastfeeding support for mothers is provided in line with the governments commitment to improving the health of the population (DH, 2004, NSF 11)</p>
Post-natal support and advice for Jane and her parents	<p>Anita the midwife and Sarah, visit Jane and her baby at home soon after the birth to see how they are doing. Jane is having difficulty adjusting to looking after her new baby, especially coping with breastfeeding but a visit from the maternity support worker and a peer mentor has helped. Jane has arranged to meet her mentor twice a week for the first month. Anita re-emphasises the benefits and advantages and stresses to Jane's mother how important it is that she support Jane as much as she can in her decision to breast feed.</p>	<p>Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies (DH, 2004, NSF 11)</p> <p>Parents and carers receive support in helping their children to enjoy and achieve (Ofsted, 2005, section 3.1; NSF 2)</p>

	Journey	Standard
	<p>Jane and her mother report that Jane’s father is finding it difficult to accept the new baby, which is causing a lot of tension at home. Sarah agrees to visit Jane and her family on a regular basis to support them in adjusting to the change a new baby has brought and to provide emotional support for Jane.</p> <p>She also gives Jane and her parents’ information about Jane’s entitlement to claim child benefit for Ethan and that if her parents are in receipt of child tax credit that she and Ethan could be included in their claim. They may also be eligible for a maternity grant.</p>	<p>Action is taken by partners to support families in maximising their economic well-being (Ofsted, 2005, section 5.1)</p>
<p>Eight week post-natal check and continued support for Jane and her baby</p>	<p>Ethan’s eight week post natal check reveals he is doing well. Jane has been assigned a peer breastfeeding mentor and enjoys the opportunity to share her concerns and experiences with someone of her own age. As a result she feels more supported and encouraged to persist in breastfeeding Ethan. Anita asks Jane whether everything is okay with the contraception she has chosen and that she has sufficient supplies. Anita explains to Jane that support for herself and Ethan will be transferred to Eleanor, a health visitor from the TPSS, who will support Jane over the next three months. Jane agrees for her TPSS case records and information from her common assessment to be shared with the health visitor. She reassures Jane that the TP advisor will continue to support her over the next 12-18 months.</p>	<p>The health and wellbeing of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention (DH, 2004, NSF 1)</p>

	Journey	Standard
Return to school	<p>At the end of her authorised absence Jane returns to school. She is apprehensive about being at school again and leaving Ethan but is reassured that she will continue to be supported by Sarah and her learning mentor. The work she completed whilst she was on authorised absence means that she is not too behind in her learning. Her learning mentor helps her to settle back into school and catch up with her studies. Whilst at school Jane's baby is looked after by a crèche operating from the school site as part of extended school services. She is encouraged to spend her lunchtimes and breaks with Ethan allowing her to breastfeed him and meet other young mothers. Jane's health visitor arranges to meet Jane at the schools drop-in health centre.</p>	<p>Children and young people are provided with a safe environment (Ofsted, 2005, section 2.2)</p>
PSHE and Sex and Relationship Education	<p>Jane benefits from a supportive whole school environment which places an emphasis on the link between emotional health and well-being and achievement. The school has achieved Healthy Schools status and provides a comprehensive programme of personal, social and health education (PSHE), including sex and relationship education and citizenship, and has an ethos of promoting pupil participation in school life. Through Assessment for Learning Jane is involved in setting targets for and evaluating progression in her learning. The development of a bullying policy in partnership with all staff, parents and pupils ensures that Jane understands how incidences of bullying are dealt with in the school.</p>	<p>Children and young people are supported in developing emotionally and socially (Ofsted, 2005, section 1.4; NSF 1)</p> <p>Healthy lifestyles are promoted for children and young people (Ofsted, 2005, section 1.2; NSF 1)</p>

	Journey	Standard
Support for Jane to remain in education	<p>Not long after returning to school Jane's attendance begins to deteriorate. Jane's learning mentor contacts Sarah via her details on ContactPoint, and visits Jane at home. Jane says that she is feeling tired and unable to cope with looking after Ethan and concentrate on her studies at the same time. She feels that she is falling behind at school and worried that she is going to fail her GCSEs. Jane's mother supports her as much as she can by looking after Ethan when Jane comes home from school so that Jane can do her homework, but her mother has recently had to increase her hours at work. She also feels that her friends at school don't really understand her anymore.</p> <p>Sarah suggests that Jane take advantage of an after school homework club provided on the school site as part of extended services, so she can concentrate on her studies, whilst Ethan is looked after in the crèche. Seeing as Jane has enjoyed the time spent with her peer breastfeeding mentor, Sarah tells Jane about a local teenage mothers group that is coordinated by one of the health visitors attached to the TPSS and a youth leader. As Jane's lead professional and with Jane's consent, Sarah speaks to Jane's learning mentor who arranges a place for Jane at the homework club. She also speaks with Jane's health visitor about the teenage mothers group.</p>	<p>Children and young people have access to an appropriate range of support if they feel troubled (Ofsted, Inspecting children's services, section 1.4; NSF 9)</p> <p>Children and young people are enabled and encouraged to attend and enjoy school and to achieve highly (Ofsted, Inspecting children's services, section 3.4)</p>
Teenage Parent Group	<p>With the support of the health visitor, Jane attends the teenage mothers group. Although apprehensive at first Jane enjoys feeling part of a group. The group is led mainly by the young mothers themselves, with support from a health visitor and a youth leader. Jane is able to talk about how she feels about being a new mum and gain useful information about support from her peers.</p>	<p>Children and young people are supported in developing socially and emotionally (Ofsted, Inspecting children's services, section 4.1)</p>

	Journey	Standard
Review of Jane's progress	<p>At 4 months Sarah coordinates a review of Jane's care with the health visitor, Eleanor and Jane's learning mentor. Ethan is doing well and is at a normal stage of development and weight for his age. Support from Sarah is helping Jane and her family adjust to the new baby and as a result things are gradually improving at home. Jane reports that although she is still finding it difficult to cope with studying and looking after Ethan, the support of the learning mentor, young mothers group and the homework club is helping her to stay motivated and keep up with her studies.</p> <p>It is agreed that the learning mentor will continue to provide support to Jane at school and Sarah will provide on-going support as Jane's lead professional. As the health visitor is satisfied that Ethan and Jane are doing well she will no longer remain in direct contact with Jane. If Jane has any concerns she can contact the health visitor via Sarah as lead professional.</p>	
Support for post-16 education	<p>Jane completes her GCSEs gaining 4 at grade C and above. She would like to stay on in education, but feels that this may be difficult now that she has Ethan. Sarah tells Jane that a range of financial and practical assistance is available to help in looking after Ethan and to continue with her studies. Sarah suggests that Jane access advice about the options available to her for post-16 education from the Connexions service, which will be able to support her in identifying courses and applying for any financial support that she may be entitled to. Jane agrees for the information from her common assessment and the TPSS case notes to be shared with the Connexions personal adviser based on the school site.</p>	<p>All young people have access to age appropriate services which are responsive to their specific needs as they grow into adulthood (DH, 2004, NSF4)</p> <p>Young people 11-19 are helped to prepare for working life (Ofsted, 2005, section 5.2)</p>

	Journey	Standard
Information, advice and guidance from Connexions	Jane meets with Adele, the Connexions personal adviser. She tells Adele that she would like to stay on in education but wonders whether this is the best decision for her and how she is going to attend college whilst having to look after her son Ethan. Adele tells Jane about the colleges nearby. She also tells Jane that she can apply for an Education Maintenance Allowance (EMA) for financial support with her studies and that her parents income will not be taken into account for this, only her own income. She can also access financial help for childcare whilst she is at college through Care to Learn funding. Adele updates her case management system with details of support given to Jane which automatically updates ContactPoint with her details. She supports Jane in identifying a suitable course and in applying for financial support.	Action is taken by partners to support families in maximising their economic well-being (Ofsted, 2005, section 5.1) Local planning includes the early identification and co-ordinated provision of support services for teenage parents to ensure that young parents have maximum opportunity for educational attainment and a productive adult life. (DH, 2004, NSF 2)
8 month review	Jane has been successful in enrolling to study part-time for a diploma in travel and tourism at a further education college not far from home and is feeling more optimistic about her and Ethan's future. Through Care to Learn she is able to access the college crèche facilities whilst she is attending classes and has also been awarded an EMA which helps with books and other things she needs to buy for her course. Jane has been asked to go back to her school to talk to the students about being a teenage parent as part of a PSHE lesson. She continues to attend the young mothers group and is also considering joining the peer breast feeding scheme to offer her support to others teenage mothers.	Action is taken to ensure that young people have decent housing (Ofsted, 2005, section 5.5)

	Journey	Standard
	<p>Sarah will remain in touch with Jane for another year to continue to provide support. Jane reports that things are better at home now that her family have adjusted to the new baby; however she feels that would like her own accommodation at some point in the near future. Sarah advises Jane about her eligibility for benefits, including Income Support. She tells Jane that as she is now 16 years old she would be eligible for supported housing and offers her support should she decide to pursue this option.</p>	<p>Action is taken to ensure that young people have decent housing (Ofsted, 2005, section 5.5)</p>
12-18 months	<p>Sarah continues to enjoy college and has decided for the time being to remain living at home. Although Sarah and Matt are no longer together, Matt has a strong relationship with Ethan and spends time with him every week.</p> <p>Sarah advises Jane that she will be closing her case but that if she needs any further advice or guidance she can contact the TPSS or her Connexions PA. Sarah closes Jane's case which automatically updates ContactPoint. The involvement of TPSS as an undisclosed sensitive service will remain on the system for one year. Sarah sets a reminder to review retention of the involvement in 10 months time.</p>	

Endnotes

- i TPU estimates derived from ONS births data for 2001-2005, adjusted for parity using DH Hospital Episode Statistics. These estimates correspond closely with those derived from HMRC child benefit data
- ii Figures derived from National Statistics' *2004 Birth Statistics: Tables 3.6 & 3.8*
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