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**What experiences and challenges do  
schoolgirl mothers and mothers-to-be face  
when continuing in education?**

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PhD Sociology  
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2015

## **DECLARATION**

I declare that this thesis is of my own compositions, based on my own work, with acknowledgements of other sources, and has not been submitted for any other degree or professional qualification.

Beverley E. Ferguson

Date.....

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## **ABSTRACT**

Previous academic literature and Government agendas and policies share concerns about schoolgirl mothers/mothers-to-be not continuing in education and having lower qualifications. Despite this, research has not considered why schoolgirl mothers/mothers-to-be are more likely to drop out of education or why it is so difficult for them to continue.

This thesis is an in-depth study of the experiences and challenges faced by schoolgirl mothers/mothers-to-be while continuing in education. Within this research consideration is given to: the deficit model that characterises schoolgirl mothers/mothers-to-be as discussed in the existing research literature; the experiences and challenges of schoolgirl mothers/mothers-to-be while attending school; and the support provided by education and health professionals to schoolgirl mothers/mothers-to-be.

The analysis of data (from questionnaires and interviews) was guided by three research questions: What experiences and challenges do schoolgirl mothers/mothers-to-be (aged 18 and under) living in Scotland encounter when continuing in education? What are the different approaches taken by local authorities in supporting schoolgirl mothers/mothers-to-be whilst at school? How do education and health professionals (school staff, health visitors) in schools and the National Health Service (NHS) support schoolgirl mothers/mothers-to-be while continuing in education during pregnancy and the early stages of motherhood?

A review of policy was carried out across all local authorities in Scotland asking for information about how schoolgirl mothers/mothers-to-be are supported in school. The results of the review helped to identify the local authorities to be approached for inclusion in the study. Eleven local authorities and twenty-nine schools or alternative provisions across Scotland are represented in this study. Forty-three schoolgirl mothers/mothers-to-be who attended schools or alternative provisions within the eleven local authorities participated. Schoolgirl mothers/mothers-to-be completed a

questionnaire and participated in an individual or group interview. A follow-up interview was conducted 9-12 months later. Seventeen members of staff from schools or an alternative provision that participants attended were interviewed. An interview was also held with five health visitors from the five NHS Boards across Scotland that the identified local authorities fell within.

Overall, the experiences of participants in this study often do not fit with the deficit model that characterises schoolgirl mothers/mothers-to-be in popular accounts or Government agendas and policies. Many participants had a 'really good' or 'good' experience of school before pregnancy, conflicting with the expectation of disengagement with education. Schoolgirl mothers do have conflicting legal demands to remain in education and care for their baby but the data do not suggest that all are either engaged or disengaged from the education system. Professionals sometimes unintentionally exacerbated difficulties. Only a minority of participants were given the opportunity of a flexible tailored curriculum to attend school and college. Schoolgirl mothers/mothers-to-be could have had a much better experience at school had support such as childcare and transport assistance been provided. The relationship between professionals and schoolgirl mothers/mothers-to-be is key to help them overcome the different experiences and challenges of continuing in education while pregnant or after having a baby.

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# INTERVIEWS

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Adrienne	16
Alexis	17
Britney	17
Elise	15
Erika	15
Gabrielle	16
Jodie	15

Name	Age
Kiera	15
Nia	17
Paige	15
Rhiannon	17
Shelby	15
Tara	15
Vanessa	17

## *Group Interviews*

Interview No	Name	Age	No of people in the Group
1	Bethany	17	4
	Caitlyn	15	
	Jaclyn	15	
	Morgan	14	
2	Cara	16	2
	Eva	17	
3	Amber	15	2
	Madison	16	
4	Demi	16	3
	Rochelle	14	
	Sonia	15	
5	Katie	16	5
	Kerry	16	
	Lena	16	
	Lilly	16	
	Terri	16	
6	Jena	18	2
	Toni	15	
7	Brooklyn	17	2
	Lauren	16	
8	Bonnie	18	2
	Vikki	17	
9	Ella	16	2
	Sam	15	
10	Kyra	17	2
	Nikki	18	
11	Hayley	16	2
	Tessa	15	

# CHAPTER 1

## INTRODUCTION

‘People make it out to be as if it’s the end of the world and I’m never going to have a life and that but I don’t think it’s like that at all’.

(Nikki, 18)

### 1.1 Introduction

The aim of this study is to answer the question ‘What experiences and challenges do schoolgirl mothers/mothers-to-be face when continuing in education?’

As an education practitioner, I am asked on occasions by colleagues for information, advice and childcare assistance to allow pregnant schoolgirls to return to education after having their baby. Remarks are made by colleagues during such conversations about their struggles to keep schoolgirl mothers/mothers-to-be in education, yet no in-depth dialogue is held about why this might be the case.

Concerns about schoolgirl mothers/mothers-to-be not continuing in education and having lower qualifications are highlighted in academic literature and Government agendas/policies. Such concerns are underpinned by economic anxieties as young parenting is thought to perpetuate a cycle of deprivation, poverty, financial dependency, unemployment and isolation. Despite these concerns, previous academic literature and Government agendas/policies have not considered why schoolgirl mothers/mothers-to-be are more likely to drop out of education or why it is so difficult for them to continue. Nor have schoolgirl mothers/mothers-to-be been requested to comment on their experiences and challenges of continuing in education or about support from professionals (health and education) that might help them to do so.

A number of authors have suggested that current official approaches to schoolgirl pregnancies fail to take into account the full range of existing evidence. Given the approach to policy development is now more evidence-based, this is problematic for

schoolgirl mothers/mothers-to-be as ‘policymakers can be selective in the evidence that has informed their strategies’ (Wilson and Huntington, 2006, p63). In practice this has meant that ‘qualitative research on teenage parenting is rarely cited in Government reports and documents’ and has resulted in a ‘one-dimensional view’ of schoolgirl parenting (Duncan, 2007, p322-323). If ‘knowledge and truth are made by science, and scientific discourses determine how we experience the world’ then it is imperative the full range of evidence is taken into account (Wilson and Huntington, 2006, p63).

Practitioners like myself often rely on policies to inform decisions and these help to promote a consistency of approach. Although some Government policies make reference to schoolgirl mothers/mothers-to-be, none of these have had the full impact desired by the Scottish Government to reduce teenage pregnancies and help existing schoolgirl mothers. The policies which refer to young mothers have been written based on assumptions made by adults who have left school or education, and not through the experiences and challenges of schoolgirl mothers/mothers-to-be who are continuing in school or education.

This research will take into account and build on previous work in this field whilst also providing an in-depth study of the experiences and challenges of continuing in education by schoolgirl mothers/mothers-to-be and not adult assumptions surrounding these. The project focuses on schoolgirl mothers/mothers-to-be (aged 18 or under) who attend Scottish schools in the 21<sup>st</sup> Century.

## **1.2 Background**

The study of schoolgirl mothers/mothers-to-be is not a new focus in academic literature. Previous research has discussed schoolgirl parenting through a range of lenses, values and attitudes. Analysis of popular discourse demonstrates that it tends to suppose: schoolgirls become pregnant for the wrong reasons and are bad mothers; schoolgirl pregnancies are unplanned, unwanted, unacceptable and have a negative impact on society; early parenting is linked to a number of social problems and



disruption; and that schoolgirl mothers/mothers-to-be deviate from normative pathways (Phoenix 1991, McDermott and Graham 2005, Daguerre and Nativel 2006, Alldred and David 2007, Henderson et al 2007, Macvarish 2010).

Other representations in policy formation and popular depictions within UK and international research demonise early parenting as ‘a hazard for society as a whole’ (Duncan et al, 2010, p188). Early parenting is also considered in literature through lenses such as statistical outcomes, values, and the construction and role of education as well as reasons and motivations for becoming pregnant. Such dominant and underlying assumptions exist whereby schoolgirl parenting is viewed as contributing to the moral and cultural breakdown of society.

Early parenting was the focus of an international comparison study carried out by the United Nations Children’s Fund (UNICEF, 2001). The purpose of the UNICEF (2001) study was to ‘establish current facts and trends, to identify some of the forces that offer young people both motive and means to delay childbearing, and to look at what might be learned from those societies which have already succeeded in reducing the problem to unprecedentedly low levels’ (p3). Since the release of the international study, academic literature has discussed schoolgirl pregnancies through the variety of lenses mentioned above but also in terms of selective experiences and outcomes of schoolgirl mothers.

The experiences of schoolgirl mothers and the factors that influenced their sexual behaviour was a focus in Arai’s (2004) study. Discussions on the educational experiences of schoolgirl mothers/mothers-to-be was explored in a study by Dawson and Hosie (2005) which sought to identify what factors and forms of provision determined both academic and broader success in returning to or continuing with education. A further study by Cater and Coleman (2006) considered the experiences and perspectives of young women from disadvantaged backgrounds and in particular the motivations and influences which were associated with a ‘planned pregnancy’. Taking a different approach, Alldred and David’s (2007) research sought the views of schoolgirl mothers/mothers-to-be on their experience of sex and relationship education

in secondary school. These studies are all discussed at several points and in particular detail throughout Chapter Two.

Associations between a woman's age at becoming a mother and the subsequent 'outcomes' such as her living standard at age 30-51 was explored in Ermisch's (2003) paper. The findings from the study were that: schoolgirl mothers were less likely to be homeowners later in life; their living standards (measured by equivalent household income) would be about twenty percent lower; their opportunities in the 'marriage market' and their ability to find and retain a partner would be more difficult (Ermisch, 2003).

Other discussions in literature consider the perception that schoolgirl parenting is a social problem which is supported by a 'negative public consensus around teenage conception and pregnancy itself' (Duncan et al, 2010, p8). Such consensus assumes that schoolgirl pregnancies are on the increase, they are unwanted, unplanned and that 'teenage mothers are inevitably also single mothers without stable relationships' (Duncan et al, 2010, p9). Daguerre and Nativel (2006) argue that successive Governments have portrayed early parenting as a social problem and this is the reason why it has become a public issue. In contrast to this, Arai (2009) believes that it is the public who place pressure on political leaders to 'do something' about social problems. All these assumptions are unsupported but they contribute to the negative perceptions and evaluations of schoolgirl parenting which has ultimately influenced the approach taken by policymakers (Duncan et al, 2010). Despite the wide range of research, there remains very little evidence about what the experiences and challenges facing schoolgirl mothers/mothers-to-be actually are when trying to continue in education.

After devolution in 1999, the newly formed Scottish Government had a number of political aspirations and pledges to deliver on a range of areas for the Scottish people. Policy and legislation were produced as the vehicles from which to deliver these aspirations (Equally Well 2008, Achieving our Potential 2008, Early Years Framework 2008, Child Poverty Act 2010). These policies provide an overarching framework for local authorities but they also identified key priorities and targets for

addressing health, education and socio-economic inequalities. Schoolgirl mothers/mothers-to-be are firmly identified as a vulnerable group within these cross-cutting policies (McDermott and Graham, 2005).

There has been a cultural shift whereby generations of women (since the First and Second World Wars) have gained education qualifications and moved into employment. This shift in culture has translated into an expectation that all children/young people should be educated and should progress to higher education or paid employment after leaving school (Alldred and David, 2007). However, young parenting is still viewed by the Scottish Government as contributing to a number of negative health, education and social outcomes for the schoolgirl mother and her baby, increasing the risks of poverty, welfare dependency and continuing the cycle of deprivation. Regardless of the cultural shift towards education, employment, and the changes in policy expectations to reflect this, young parenting continues to militate against political aspirations to improve outcomes for the Scottish people (Alldred and David, 2007).

The importance placed on education as the preferred route for all young people means that education policies focus on raising standards, ensuring effective learning and teaching, gaining qualifications and going on to a positive destination after leaving school (higher or further education, training or employment). Veering away from what is deemed to be the normal and acceptable route for a young person according to their age, can subject them to being disparaged and stigmatised (McNulty, 2008) not least because it is considered that schoolgirl parenting occurs out of inappropriate motivations and a lack of knowledge or sexual embarrassment (Alldred and David, 2007). Such deviation from normative pathways is considered a calamity for schoolgirl mothers/mothers-to-be and a severe problem for society (Duncan, 2007). Approaches taken through policies have thus pathologised early pregnancy and childbearing (Alldred and David, 2007).

Under the wider British Government, schoolgirl pregnancies remain high on the political agenda. This high political positioning followed on from international

comparison studies carried out by the United Nations Children's Fund (UNICEF) in 2001 and 2013. These studies found that British rates of schoolgirl mothers are amongst the highest in the twenty-eight developed countries in the Organisation for Economic Co-operation and Development (OECD). The more recent UNICEF (2013) study showed a decline in schoolgirl pregnancies in all OECD countries between 2003 and 2009 except Britain, Belgium and Spain.

Since the release of the UNICEF studies (2001, 2013), increasing pressure has been placed on the British Government to reduce the number of schoolgirl pregnancies. In response to the UNICEF study (2001), the New Labour Government reacted by rolling out its Teenage Pregnancy Strategy for England under the direction of a Ministerial Task Force. The Strategy had a ten year plan to place duties and responsibilities on local authorities in England to halve the under eighteen conception rate and increase the number of schoolgirl mothers entering education, training or employment.

In England, the Teenage Pregnancy Strategy (1999) has played such a significant role that it has been described as 'the single most influential recent document on the issue of teenage pregnancy in the UK' (van Loon, 2003, p10). The Strategy was a turning point within social policy in Britain regarding schoolgirl mothers/mothers-to-be and this is evident from studies such as Cater and Coleman (2006), Arai (2009), and Duncan et al (2010) where it features prominently in research. These studies used the Strategy as a starting point from which to build research, evaluate the policy's approach to addressing schoolgirl parenting or debate health and socio-economic factors linked with early motherhood. Due to the significance and impact of the Strategy, it is understandable why these dominant themes have become a focal point for researchers.

After devolution, the Scottish Executive's focus (now Scottish Government) included: modernising schools to secure high standards and a world class education system; promoting opportunities for all children (Building Scotland's Future, 1999), and reducing the number of 16-17 year olds who did not go on to education, training or employment. Tackling child poverty, helping parents to balance work and family

responsibilities, investing in childcare provision, expanding nursery education and enhancing the National Health Service (NHS) were other targets set by the Scottish Executive. Additionally, the Scottish Executive felt they needed more research data and information about children's circumstances, their opportunities, difficulties and the challenges they faced as they grew up. This lack of existing data on developmental phases in children's lives, early years and the transition into adolescence led to the commissioning of the longitudinal study 'Growing Up in Scotland'.

The pressure on both Governments (England and Scotland) from the UNICEF findings (2001, 2013) to reduce schoolgirl pregnancies is maintained at an all-time high through the ongoing national and international media reports which have focused on extreme, untypical and isolated incidences of schoolgirl pregnancies as being representative of all cases (Duncan et al, 2010). The belief that schoolgirl pregnancies lead to poor outcomes is a widely promoted message through a variety of forums and avenues. Celebrating the successes and achievements of schoolgirl mothers/mothers-to-be is not attractive to the media who focus their stories 'largely on its negative aspects' and the 'tone of reporting is invariably sensational, sometimes even salacious' (Arai, 2009, p39).

Schoolgirl mothers/mothers-to-be are used as 'scapegoats for wider, sometimes unsettling, social changes' (Arai, 2009, p109). Unspoken and underlying fears exist that there may be an increase in the number of schoolgirl pregnancies. Thus, becoming pregnant during the teenage years is presented through unattractive socially unpalatable messages in the hope that it will discourage schoolgirls from having a baby. Such unattractive messages may mask more deep rooted social fears and present a reason for not addressing the matter through a policy approach. Moral perspectives and the pathologising of early pregnancy and childbirth have been mentioned in this introductory chapter as part of the context in which previous research has taken place but they are not explored further in this study.

The media, Government ministers, professionals and researchers may have unwittingly contributed to previous claims that schoolgirls do not make satisfactory

mothers and become pregnant for the wrong reasons through published reports and research perspectives (Phoenix, 1991). Very little attention has been given to the impact of intense media reporting on extreme cases and whether these have provoked a variety of responses which subject schoolgirl mothers/mothers-to-be to various degrees of judgemental attitudes from family, friends, boyfriends, relatives, peer group, professionals and the Government.

The sensationalisation of isolated stories in the media and the dominant themes in previous research (listed above) may have distracted researchers from fully considering schoolgirl pregnancies through alternative perspectives. A key step that has been missed is for research to be carried out to consider the assumptions surrounding schoolgirl mothers/mothers-to-be and the experiences and challenges they face while continuing in education.

In order to understand the difficulties of continuing in education, more evidence is required about the experiences and challenges facing schoolgirl mothers/mothers-to-be in trying to do so. This thesis aims to obtain further evidence of the experiences and challenges of schoolgirl mothers/mothers-to-be who are continuing in education. This is with a view to ascertaining further knowledge on the question ‘What experiences and challenges do schoolgirl mothers/mothers-to-be face when continuing in education?’ It is acknowledged that the experiences and challenges of each participant will be unique to them and will be influenced by a range of known and unknown factors. Identifying common themes within the experiences and challenges that schoolgirl mothers/mothers-to-be face when continuing in education will help inform the development of local and national Government policies and allow resources and needs to be more specifically targeted.

### **1.3 Scope of the study**

This research provides an in-depth study on the experiences and challenges of schoolgirl mothers/mothers-to-be while continuing in education. In doing so, it has revealed a mismatch between the negative assumptions that are widespread in

Government agendas/policies about teenagers who become mothers and the tenacity and resourcefulness of schoolgirl mothers/mothers-to-be as shown through the accounts of their experiences and challenges of continuing in education.

My study outlines the existing and relevant cross-cutting health, education and social policies produced by the Scottish Government since devolution in 1999 (Chapter Three and Appendix 10). This is important to understand the direction the Scottish Government has taken to meet their stated aspirations and pledges given to the people of Scotland. Reviewing these policies provides the contextual background and helps to clarify understanding on the approaches taken by local authorities to support schoolgirl mothers/mothers-to-be while continuing in education.

Consideration is then given in the thesis to the different approaches taken by a specific selection of Scottish local authorities in their endeavours to support schoolgirl mothers/mothers-to-be while continuing in education. Scottish local authorities have responsibility for managing and delivering a range of services including education, social work and housing. Local authorities are considered by Audit Scotland as having 'a pivotal role in communities' and providing 'vital public service' (2012, p3). Although local authorities have autonomy over the way in which certain elements of their responsibilities are managed and delivered, the Scottish Government's approach to reform across public services is founded on 'four pillars' for change: prevention, partnership working, workforce development and performance management (Audit Scotland, 2012). This is important when trying to understand the complexities of the experiences and challenges that schoolgirl mothers/mothers-to-be face when continuing in education. The first two 'pillars of change' (prevention and partnership working) raise the expectation that they will form the basis of the approach taken by each local authority in their relationships and work with all school aged pupils. The third 'pillar of change' (workforce development) raises a further expectation that local authorities will have embedded the necessary staff infrastructure and relationships with partner agencies to work with all pupils including schoolgirl mothers/mothers-to-be to help prepare and develop them for the next phase in their career which may be the workforce. Lastly, the fourth 'pillar of change' (performance management)

conjures the notion that the first three pillars will subsequently be evaluated through performance management. Comparing the approaches taken by local authorities allows for reflection on which support mechanisms make it easier for schoolgirl mothers/mothers-to-be to continue in education. Lessons can be learned from understanding and comparing the different approaches and types of support provided by local authorities to help schoolgirl mothers/mothers-to-be meet their conflicting legal demands to care for their child and continue in education. In addition to exploring the different approaches taken by local authorities, further insight is gained into how certain Scottish Government policies are translated into practice at a local level.

Very little academic literature which was of direct relevance was available and this research fills a particular gap in the literature on topics relating to schoolgirl mothers/mothers-to-be in a Scottish context. Some academics have highlighted the need for further research on the role of professionals in supporting schoolgirl mothers/mothers-to-be and the influence this has on them (Macvarish and Billings, 2007). This study considers and reflects on the supports that participants identified as being available to them from health and education professionals, family and friends and, on participants' assessments of its usefulness. These data are of relevance to practitioners and contribute to understanding the experiences and challenges that arose for schoolgirl mothers/mothers-to-be while continuing in education (Duncan, 2007).

The findings from this research will be of assistance to both education and health practitioners in their work with schoolgirl mothers/mothers-to-be across Scotland. For local authorities and staff in schools, it is hoped the findings will encourage them to (re)consider the policies and levels of support they currently provide to schoolgirl mothers/mothers-to-be with a view to helping them continue along their education journey. The research will provide practical advice and information for other schoolgirl mothers/mothers-to-be who find themselves in a similar situation and have returned to education or are considering doing so.



*Participants* - Forty-three schoolgirl mothers/mothers-to-be participated in this research project. Participants attended schools within eleven local authorities across Scotland. Twenty-nine schools or alternative provisions are represented in the study although not all of these establishments were visited as in some cases the group interviews brought participants together. Participants were given a questionnaire to complete prior to the interview. Thereafter a group or individual interview was held with the schoolgirl mothers/mothers-to-be and a follow-up interview was conducted 9-12 months later.

*School staff* - An individual interview was carried out with a member of staff from the school or alternative provision which the schoolgirl mother/mother-to-be attended. Seventeen members of staff were interviewed.

*Health visitors* – An individual interview was carried out with health visitors from five NHS Boards within which the identified local authorities were located. Five health visitors were interviewed.

This research provides new insights into the lives of Scottish schoolgirl mothers/mothers-to-be which have previously not been gathered before nor documented.

## **1.4 Structure of the thesis**

This introductory chapter has outlined the wide range and variety of topics contained in previous studies about schoolgirl mothers/mothers-to-be and highlighted the mismatch between Government agendas/policies and early parenting. The chapter also summarised the Scottish and English Government's response to the UNICEF findings (2001, 2013) which stated that British rates of schoolgirl mothers are amongst the highest in the developed countries.

Chapter Two '*Literature Review*' begins by listing the assumptions surrounding schoolgirl mothers/mothers-to-be. The chapter goes on to review relevant literature

regarding the experiences of schoolgirl mothers/mothers-to-be while continuing in education. Finally, the chapter reviews the literature on the service and support provided by professionals to schoolgirl mothers/mothers-to-be.

Chapter Three '*Review of Scottish Policies and Local Authority Approaches to Support Schoolgirl Mothers/Mothers-to-be*' briefly looks at the political aspirations (agendas) and pledges of the Scottish Government before going on to consider the resultant health, education and socio-economic policies produced after devolution in 1999. This chapter discusses the formation and implementation of policy into practice and provides the results of a review of policies in local authorities across Scotland on the different approaches taken to support schoolgirl mothers/mothers-to-be. These findings are important by way of background information and to provide an understanding of the range of support (across local authorities) to schoolgirl mothers/mothers-to-be while continuing in education.

Chapter Four '*Methodology*' provides an overview of the methodological approach of the study including the research design, methods, data collection and sample selection.

Chapters Five, Six, Seven and Eight present the empirical findings of the study. These four chapters discuss the themes which emerged from the data analysis in relation to the assumptions surrounding schoolgirl mothers/mothers-to-be and the experiences and challenges faced by participants while continuing in education.

Chapter Five '*Challenging the Deficit Model that characterises Schoolgirl Mothers/Mothers-to-be and the Existing Research Literature*', has been organised into the four themes of 'lack of knowledge', 'health outcomes', 'maturity and identity' and 'poverty and financial dependency'. Chapter Six '*Experiences of Schoolgirl Mothers/Mothers-to-be when 'Coming out' as Pregnant or Having a Baby While Continuing in Education*', explores the experiences of participants at school before becoming pregnant and then considers the people they chose to tell about their pregnancy. The chapter also considers relevant influences on participants' (dis)engagement with education. Chapter Seven '*Challenges of Continuing in*

*Education*', outlines the health of participants during the early stages of pregnancy and the emerging difficulties they experienced. The chapter also examines in more detail the practical challenges that participants identified in trying to continue with their education whilst pregnant at school and after returning. Chapter Eight '*Sources of Support Available to Schoolgirl Mothers/Mothers-to-be*' discusses the support that schoolgirl mothers identified as being available to them while continuing in education. The chapter considers the professionals and people that participants identified they used as a source of help in and out of school. It also reflects on alternative sources of help and methods of support that participants stated they would use if they could not get help from their existing sources. In Chapter Nine, the findings of the research are drawn together to answer the question 'What experiences and challenges do schoolgirl mothers/mothers-to-be face when continuing in education?'

## CHAPTER 2

### LITERATURE REVIEW

‘I think what people think is.....they just assume because you’re a young mum that you’re going to be a terrible mum but they don’t really give you a chance’.

(Gabrielle, 16)

#### 2.1 Introduction

There has been a considerable amount of literature written about young parenting which covers a range of topics and perspectives from different disciplines. Despite these studies, little consideration has been given to the experiences and challenges of schoolgirl mothers/mothers-to-be while continuing in education. Previous literature tended to concentrate on schoolgirl mothers not continuing in education and having lower qualifications. This has taken attention away from considering the experiences and challenges of schoolgirl mothers/mothers-to-be who do continue in education.

This chapter is divided into four sections. Sections 2.2, 2.3 and 2.4 review the academic literature to highlight: the deficit model that characterises schoolgirl mothers/mothers-to-be and the existing research literature; the experiences of schoolgirl mothers/mothers-to-be while attending school; and what literature says about support provided by professionals (health and education) to schoolgirl mothers/mothers-to-be.

Some of the literature discussed in this chapter has come from North America. America has one of the highest schoolgirl birth rates in the world. This may explain why more literature is available from America rather than Britain. Literature carried out in Britain on schoolgirl mothers/mothers-to-be has mostly been based in England. In Scotland, the number of babies born to schoolgirl mothers (age 18 and under) accounts for 0.3-0.5% of the total number of births registered during the period 2002-2012 (latest available statistics) (<http://gro-scotland.gov.uk/statistics/>

[theme/vital-events/births/time-series.html](#)). Available research on specific topics particularly around the challenges that schoolgirl mothers/mothers-to-be may face (i.e. wearing school uniform) is very limited.

This project will draw upon the themes of ‘lack of knowledge’, ‘health outcomes’, ‘maturity and confidence’ and ‘poverty and financial dependency’ when considering the experiences and challenges faced by schoolgirl mothers/mothers-to-be. These themes emerged from the assumptions about schoolgirl mothers/mothers-to-be as discussed in academic literature and contained in Scottish Government agendas/policies. In doing so, the project will seek to show how these assumptions compare with the actual experiences and challenges expressed by schoolgirl mothers/mothers-to-be.

## **2.2 Deficit model that characterises schoolgirl mothers/mothers-to-be and the existing research literature**

### *Introduction*

Schoolgirl mothers are assumed to be problematic in Government agendas/policies across health, education and socio-economic related areas. Although much of academic literature problematizes the assumptions within Government agendas/policies, at times it uncritically begins from taken for granted assumptions to commence further discussions about schoolgirl parenting. Until recently, most commentators do not appear to see the need to justify their concerns with schoolgirl pregnancies (Macintyre and Cunningham-Burley, 1993). Failing to specify why schoolgirl pregnancies are something to be worried about can result in a lack of clarity and definition of the problem, thus making it harder to ‘analyse its features or propose solutions’ (Macintyre and Cunningham-Burley, 1993, p61).

Previous studies (Daguerre and Nativel 2006, Duncan 2007, Duncan et al 2010) carried out in England about schoolgirl pregnancies focus on the same three broad areas as Government agendas/policies (health, education and socio-economic disadvantage). Within the discourses, debates continue about whether schoolgirl mothers/mothers-to-

be are lacking: knowledge about sexual activity and contraception, the maturity needed to make informed decisions about sex, are too young biologically and socially to raise children, and are financially dependent and live in poverty.

Assumptions contained in the English Government's Teenage Pregnancy Strategy (1999) about schoolgirl mothers/mothers-to-be cover a range of issues. These include low educational and employment expectations and aspirations, a disadvantaged childhood, lack of knowledge about sexual activity and contraception, relationships, parenting, sexually transmitted diseases, increased poverty, unemployment, poor health outcomes and a generational cycle of schoolgirl parenting.

### *Lack of knowledge about sexual activity and contraception*

Lack of knowledge about sexual activity and contraception is presumed to be a leading cause of unplanned pregnancy but on the other hand, planned schoolgirl pregnancies are attributed to naivety about the demands of parenthood (Arai, 2005). 'Ignorance' and the 'lack of knowledge about contraception' were identified in the English Government's Teenage Pregnancy Strategy as being a major cause of schoolgirl pregnancies. Duncan et al (2010) believes 'it is assumed in both the public and media discourses that all teenage pregnancies are unplanned' but there is little evidence to suggest that a lack of knowledge causes pregnancy or that increased knowledge prevents it (p11). Contributors to Duncan et al's (2010) book present a range of recent quantitative and qualitative research on teenage motherhood and fatherhood. Macvarish agrees that unplanned teenage pregnancies are blamed primarily on a lack of knowledge about sex, contraception and 'inadequate skills to negotiate sexual relationships, despite evidence to the contrary' (2010, p316). Macvarish's (2010) paper explored how the problem of teenage pregnancy has been both amplified and redefined. Through an engagement with critiques of teenage pregnancy policy, risk theory and recent developments within the study of 'parenting culture', the paper seeks to explain why the 'teenage mother' has such symbolic power despite an apparent demoralisation of sex.

The English Government Minister with responsibility for the Teenage Pregnancy Strategy called on parents to start talking about sex education with their children. Within academic literature, discussions take place about who is best placed to discuss relationships and sexual activity with teenagers. The arguments which have emerged are divided between two opinions, private and public responsibility. Arguments asserting that sex education is a private responsibility state that a warm, open, comfortable relationship where there is mutual respect and understanding between a parent and child is the most effective means of reducing the likelihood of risky sexual behaviour (Newby et al, 2009). Although there has been positive evidence from previous studies that this approach is effective, family communications about relationships and sex is restricted in UK households. These restrictions can include children and young people having already received information about relationships and sexual activity from somewhere else; parents feeling too uncomfortable and embarrassed to talk about it; or simply parents feeling that their child is not ready for this type of discussion (Newby et al, 2009). Newby et al's (2009) paper describes the development of Intervention Mapping (a tool for the development of theory and evidence-based interventions) that aims to increase the quantity and quality of parent-child communications about sex and relationships. The process involves a detailed assessment of the difficulties parents experience in communicating with their children about sex and relationships. The findings are translated into programme and change objectives that specify what parents need to do to improve their communication. The paper also discusses evidence from 'correlational studies that parent-child communications can have a protective effect on sexual risky behaviour' (Newby et al, 2009, p2).

Discussions around sex education as a public responsibility have not been positive in terms of the quality of information. Sex education information in the UK was described by van Loon (2003) as 'patchy....mealy-mouthed...starts too late and because of the influence of the powerful 'moral right', it fails to give young people the knowledge and skills which they need' (p1). van Loon's (2003) study considered the extent to which sex education in the Netherlands provides an exemplary model for the improvement of the sexual health of teenagers in the UK. The study gathered and

analysed statistical data and literature on sex education and sexual health in the Netherlands, supplemented with UK data and drew on international literature. Eight case studies were conducted with four primary and four secondary schools. Open, in-depth conversation style interviews were conducted with teachers involved in the delivery of sex education. Due to the short timescales for van Loon's study, it was not possible to undertake extensive surveys of school curricula and teachers' views, or obtain the views of pupils.

A different approach was taken by Alldred and David (2007, 2010) in their research which was commissioned as a result of the Teenage Pregnancy Strategy (1999). The aim of their study was to identify those factors that were hindering the delivery of good sex and relationship education in schools and to highlight what factors might help. The research examined the multiple perspectives on the delivery of school sex education by presenting the views of teachers, headteachers, school nurses, boys and girls in school and young mothers and young men not attending school. These perspectives were drawn from accounts gathered during a two year study of sex education in all the secondary schools of one local authority in the north of England. The schoolgirl mothers/mothers-to-be involved in the study did not feel the relationship between staff and pupils were positive enough to support discussions on sex and relationship education. Ten schoolgirl mothers aged fourteen upwards following the birth were interviewed.

Alldred and David's (2007) findings echo those of van Loon in that participants were critical about the lack of quality and quantity of information on sex and relationship education they received. The young women interviewed by Alldred and David were strongly in favour of receiving information on sex and relationship education from their school and could see the benefits of this. However, the information they received from school was described as boring, insufficient, too biological and worksheet based, did not place enough emphasis on the risks, was received too late and was not particularly helpful. Participants in Alldred and David's study reported that they had no-one to talk to about sex and relationship issues. Preference was given to the school nurse rather than subject teachers as a source for sexual health information.



Discussions were taken further by Bonell et al (2005) who considered the hypothesis that schoolgirls who dislike and are disengaged from education do not develop the knowledge and confidence to avoid becoming pregnant. Bonell et al analysed baseline and two sets of follow-up data from girls in two school year cohorts in twenty-seven mixed-sex comprehensive schools in central and southern England within a cluster trial of sex education. Data collection for Bonell et al's longitudinal study began in 1997 when participants were aged 13-14. Baseline questionnaires were completed initially by four thousand two hundred and forty eight schoolgirls. The findings of Bonell et al did not support the theory, neither was there evidence to support a revised hypothesis that disliking school was a predictor of schoolgirl pregnancy.

The focus in policies on a lack of knowledge about sexual activity and contraception is considered by Arai (2005) as restricting understanding about other influential factors on sexual and reproductive behaviours such as 'neighbourhood effects' and geographic variations (accessing services). Arai's (2005) paper reports the findings of a qualitative study of neighbourhood and peer influences on the transition from pregnancy to fertility among fifteen young mothers in three English locations. Data were also collected from nine local health workers. The findings show that from the mothers' perspectives there was no evidence that peers influenced their behaviour. The data did suggest that early motherhood might be normative in some communities and can provide access to a 'social recognition', a 'loving relationship' but also a 'valued identity' (McDermott et al, 2004). McDermott et al's paper draws on a systematic review of qualitative research to explore the resilient mothering practices that young British working class mothers (aged <20) employ to care for their children. The findings suggest that young mothers only use two resources, their families and their own personal capacities.

Explaining and understanding early sexual behaviour and individual decisions on sex is not an easy process. Reasons for schoolgirl pregnancy were categorised by Arai (2004) into three groups. These were: technical/educational, structural and social/cultural. Arai explored factors in the neighbourhood, family and peer contexts that influenced teenage reproductive behaviour. The study used existing survey data

and qualitative material collected from young mothers and teenage pregnancy coordinators in three English locations. Technical/educational factors such as a lack of knowledge about sexual activity and contraception were considered to have more of an impact on early sexual behaviour because they can lead to an unplanned pregnancy (Arai, 2004). Structural factors such as low expectations and disengagement with education were perceived as making an unplanned pregnancy less unattractive to schoolgirls as school is not a priority. Social/cultural influences and messages about sex were considered by Arai as coming from a variety of sources such as family, local community, peer group or the media. Disengagement from education will be discussed in greater detail later on in this chapter.

Similar conclusions to the findings in Arai's (2004) research were found in a study carried out by Turner (2004). Two-hundred-and-forty-eight schoolgirls aged fifteen, from diverse social and economic backgrounds, within four secondary schools in Lothian, Scotland completed a questionnaire which gathered information on their lives and views of teenage motherhood. Two schools were co-educational local authority schools and two were privately funded. Turner found that parents, family values and those in the neighbourhood such as peers or school friends, could exert pressure to initiate sexual intercourse, influence the use of contraception and condemn the use of abortion to resolve unplanned pregnancies. Pregnant schoolgirls from relatively deprived backgrounds were more likely to continue with their pregnancy as compared to their counterparts in more affluent areas. Turner goes on to suggest that a form of acceptance of schoolgirl mothering may be more prevalent in deprived communities as a route to adult status.

### *Physical/mental health outcomes for the schoolgirl mother and her baby*

Early parenting is assumed in Government agendas/policies to have an increased risk of poor physical health outcomes for the schoolgirl mother and her baby. In reality, it is more difficult to measure the impact of early parenting on health outcomes. Poor physical health outcomes can include the death of the baby in the first year of life, premature birth and low birth weight.

Statistics from the 'Information Services Division' (ISD Scotland) show the number of perinatal deaths in Scotland having decreased over the last 30 years because of the impact that science and research has had on childbirth outcomes and the care and support given to mothers at the time of the birth (<http://www.isdscotland.org/isd/3112.html>). This change and decrease in the infant mortality rate is reflected in the most recent UNICEF findings.

'Infant mortality rates (IMRs) have been reduced to fewer than 10 infant deaths per thousand live births. The relatively small differences between countries therefore reflect not variations in the fundamentals of public health such as safe water and sanitation but variations in the commitment and the capacity to deliver whatever services are necessary to protect every mother-to-be, every birth, and every infant in the earliest days and weeks of life' (UNICEF, 2013, p12).

Discussions on schoolgirl mothers-to-be having a low birth weight baby are provided in research studies by Swann et al (2003) and Bradshaw (2006). Both studies refer to the findings of an older project by Botting et al (1998) which states that babies born to schoolgirl mothers tend to have lower birth weights. Swann et al's research is an evidence briefing about the prevention of teenage pregnancy and effectiveness of interventions to improve outcomes for teenage mothers. Bradshaw's study examined the contribution to ending child poverty that might be made by reducing teenage births.

Lawlor and Shaw (2002) suggest young age does not determine the future health of schoolgirl mothers and her baby. The paper by Lawlor and Shaw argues that teenage pregnancy should not be conceptualised as a public health problem and suggests this label is a reflection of what is considered to be, in this time and place, socially, culturally and economically acceptable. The adverse outcomes of a schoolgirl mother and her baby might, according to Daguerre and Nativel (2006), be more related to poverty or a lack of antenatal care as opposed to age. Daguerre and Nativel's comparative study analysed the way in which schoolgirl pregnancy is deemed a social problem in contrasting welfare states. The study also analyses policy responses to schoolgirl pregnancies in three liberal welfare states.

Previous academic studies on the health outcomes of schoolgirl mothers/mothers-to-be are dominated by physical health agendas and mental health outcomes are not so prevalent. The mental health of schoolgirl mothers/mothers-to-be is thought to be affected because they are more prone to post-natal depression (Macvarish and Billings, 2010). Post-natal depression can impact on the maternal bonding between the mother and baby, and affect the baby's neurological and emotional development. Macvarish and Billings (2007, 2010) interviewed thirty seven young white-British parents, mostly from Kent - thirty females (aged 14-19) during their final trimester of pregnancy and seven males (aged 16-18). Postnatal interviews were carried out during December 2005-06 at multiple sites within eight of Kent's Primary Care Trusts with seventeen of the young parents approximately one year after the child's birth. The purpose of the study, carried out during 2004-06, was to gain information about schoolgirl mothers' experiences of postnatal support and care.

Mental health outcomes can be affected if schoolgirl mothers/mothers-to-be receive a negative response to their pregnancy as this is linked to depression (Formby et al, 2010). To reduce negative longer term mental health impacts, a more sympathetic approach was suggested by Formby et al along with a support system which was available and accessible to schoolgirl mothers/mothers-to-be. Formby et al carried out a qualitative study in Sheffield and Doncaster of women and men from three generations who became parents during their teenage years. The study offered some insight into the experiences of schoolgirl mothers/mothers-to-be and to illustrate the importance of life course, upbringing and social context in understanding pregnancy experiences and what it means to be labelled as a young parent.

Depression is also linked by research to a psychological and biological condition which is caused by stressful life events (Gerhardt, 2010). The most common triggers for depression are 'experiences of feeling rejected or abandoned by other people' (Gerhardt, 2010, p114). This 'fragile sense of self', Gerhardt argues is a culmination of certain events and phrases which are wedged in a person's mind to convey the message that individuals are inadequate and ineffective. Creating satisfying relationships with others even as an adult is difficult because negative messages while

growing up such as being bad, not good enough, not having lived up to expectations have been internally accepted. In Gerhardt's study, she observed patients over many years whilst practising as a psychoanalytic psychotherapist and looked at the 'disturbed or malfunctioning relationship between babies and their mothers' (p1).

Despite the very different cultural context, the research questions and approach from a study carried out by Ho and Wong (2006) were very relevant for this research. Ho and Wong (2006) looked at the implications for sex education in Hong Kong. In particular, the study considered changes in sexual attitude and behaviour amongst adolescents. The study reviewed major studies conducted during the period 1981-2001 by different youth organisations in Hong Kong and also interviewed twenty five girls. Most of the participants in Ho and Wong's (2006) study had become pregnant at age fourteen, two were aged thirteen. Findings from the study revealed that when making the decision on whether to have a termination or not: most girls discussed this with other people; most girls had a say in the decision but half were the sole decision-makers and made this decision alone; and parents were often only notified some-time after the confirmation of pregnancy. Ho and Wong (2006) considered the psychosocial impacts of unwanted pregnancy and abortion on adolescents' development. The findings of Ho and Wong's (2006) study highlight the juxtaposition in mental health if participants choose termination or continue with the pregnancy. Ho and Wong's (2006) study indicates that mental health amongst their participants can be affected regardless of whether they continued with the pregnancy or have a termination.

The overall health and well-being of a person is to be considered holistically in the 'positive presence of physical, mental and emotional well-being' ('Health in Scotland 2006', 2007, p7). Despite previous studies on the physical health of schoolgirl mothers (including their babies) and their mental health being informative, they have been addressed separately rather than holistically. These studies are dated and may not reflect the current situation, especially in light of the UNICEF (2013) findings.

### *Maturity and identity of schoolgirl mothers/mothers-to-be*

*Maturity* - James et al (1998) argues that childhood should be 'understood as a social or cultural' construct rather than biological differences between adults and children such as age, capacities and competencies (p146). Nonetheless, assumptions are made in Government agendas/policies ('Respect and Responsibility' 2005, 'Under-age Sexual Activity' 2010') that schoolgirl mothers-to-be are young people who lack the maturity needed to make informed decisions about sex which can then result in an unplanned pregnancy. Additionally, schoolgirl mothers are seen as being too immature to have the appropriate capacities to raise children. These assumptions about a lack of maturity and not being able to raise children continue through social dialogues which assign roles and functions according to age and gender. The teenage years are therefore seen as a period of psychological change and emotional development rather than an appropriate time to have a baby.

In their study of adolescents who had been referred for treatment, Butler and McManus (2000) found that adolescence was perceived to be 'a turbulent period characterised by rebellion and rejection of authority figures' (p81). However, in their observations and study of the general population of adolescents, they found that many young people 'do not rebel against authority but maintain good relationships with parents and teachers' (p81). The notion of adolescence as a turbulent, rebellious period was according to Smith et al (2007) a popular theory during the 1960-70s but these studies and others carried out in the 1980-90s 'may have over-stressed the 'normality' of the adolescent period' (p292). Smith et al use rigorous research based approaches to consider all major aspects of children's development from conception through to adolescence.

The transition to adulthood via motherhood is for some schoolgirls a symbol of having reached adult status and through this they feel they can achieve maturity by becoming responsible and caring adults. The process of mapping the changes that happen with age, understanding how the changes take place and also the course of development in a young person is discussed by Butler and McManus (2000). Consideration is given in their study about whether this process of psychological development takes place in

stages, is a continuous process, biologically determined by nature or if it is influenced by environmental circumstances. The idea of the process of development happening in stages would suggest that everyone goes through this in the same order at the same time and follows a set pattern.

*Identity* - Adolescence is also a time when young people search to find what individual characteristics make them known and recognised as a person. This period of adolescence is believed to be an unavoidable experience everyone goes through and the transition period is a time of experimenting with identities (Henderson et al, 2007). Henderson et al followed 118 young people during 1996-2006 who were growing up in a remote rural landscape in England. Initial interviews at the start of the study were carried out in schools but moved on to home afterwards.

A young person's identity can change during adolescence not least because of the physical changes that affect the body but also because a 'pattern of sexual relationships needs to be decided upon' (Smith et al, 2007, p293). During this period of experimenting with identity, most young people like to associate themselves with something or someone (music, fashion, hairstyles, technology, friends) (Bekaert, 2005). The association with something or someone may not necessarily be fixed but rather it can fluctuate throughout the teenage years and beyond. Bekaert's book was to provide practical information to help practitioners who work with young people in the area of sexual health and contraception.

Obtaining an identity and transitioning to adulthood are not achieved consistently through the same methods, at the same age or for the same purpose (McDermott and Graham 2005, Cater and Coleman 2006). Education and employment can be the method by which policymakers judge whether a person has achieved an acceptable identity and transitioned to adulthood (Cater and Coleman, 2006). The study carried out by Cater and Coleman was undertaken in six different parts of England through in-depth interviews with forty-one young women who reported their pregnancy as 'planned'. Cater and Coleman's paper debates the current policy emphasis on reducing schoolgirl pregnancies and discusses the transition to adulthood.

A certain identity for some young people can hold the key to inclusion not just with their peer group but also into a community. Motherhood can be a socially idealised form of womanhood in the community and one which is accepted as normal (Schofield 1994, McDermott and Graham 2005). This social identity may be found in parenting and deemed to be more important than education and employment (Allred and David, 2007). This is evident from Cater and Coleman's (2006) study where young mothers believed self-worth was gained through pregnancy. Schofield's (1994) study was carried out with thirteen schoolgirl mothers/mothers-to-be between the years 1982-90 who had attended the Ormiston Trust. The purpose of the study was to consider the work of the Trust's tuition unit as a resource for schoolgirl mothers/mothers-to-be. McDermott and Graham's (2005) paper draws on a systematic review of qualitative research to explore the resilient mothering practices that young, British, working-class mothers employ to care for their children. The paper also discusses the 'good' mother identity, maintaining kin relations, and prioritization of the mother and child dyad.

Taking on the role of mother requires an 'emotional maturation that leaves behind the former self' (Thomson et al, 2011, p54). Schoolgirls may already have been undergoing identity changes during the adolescent years. When schoolgirls become pregnant their already unstable identity alters again and they take on the identity of 'mother-to-be'. 'Pregnancy can provoke intense and potentially conflicting forms of identification' (Thomson et al, 2011, p54). Thomson et al's comparative study draws on interviews from sixty-two pregnant women from diverse backgrounds, social class, ethnicity, nationality, fertility history, disability, sexuality and age. The book provides an insight into the changing landscape of motherhood.

Aside from the discussions on maturity, adolescence, the transition to adulthood and identity, policy discourses focus on the need to protect children from sexual abuse during childhood. Sexual activity is viewed as an adult activity which requires maturity beyond the age of sixteen. Anyone under the legal age of consent (sixteen) who engages in sexual activity is viewed as being immature not least because of the efforts put in by policymakers and professionals to protect children and young people



from sexual abuse. Alongside this, education professionals have responsibility within the curriculum to discuss relationships and sexual activity with young people. Any deviation from the legal stance of sex being an adult activity would mean that the advice and guidance provided to young people from professionals (through the curriculum) would be contradictory to the law.

Academic literature has considered schoolgirl mothers/mothers-to-be during the teenage years through a range of topics which include adolescence, physical body changes, identity, social identity and the transition to adulthood. Previous studies have not considered whether schoolgirl mothers/mothers-to-be lacked maturity before becoming pregnant and/or if they gained maturity as a result of being pregnant and if so, at what stage or how this happened.

### *Embodiment of pregnancy*

The transition to motherhood requires acceptance of the embodiment of pregnancy along with the resultant outcome of having a baby. Additionally the realities of pregnancy need to be embraced and integrated ‘into a sense of self as gendered, sexual and maternal’ (Thomson et al, 2011, p53). Readiness for this transition to motherhood is an inward (maturation) and outward battle (appearance) with an already unstable changing identity during adolescence. The automatic identity change from being a schoolgirl to a mother is a pre-defined decision which takes place through pregnancy. Pregnant schoolgirls no longer have the same identity choices which were once available to them. Schoolgirl mothers/mothers-to-be can still identify with certain types of music, fashion or hairstyles but these can in some cases conflict with preconceived ideas of what the identity of a mother is perceived to be and the requirements within motherhood and adult status to be more mature and responsible.

The outward appearance of having a ‘bump’ is the ‘key signifier of pregnancy’ which can arouse strong feelings in all pregnant mothers (Thomson et al, 2011, p65). For Thomson et al, relinquishing control over a body that is changing in shape and size can be an emotional journey. Media images of pregnant celebrities with perfect bodies and positive experiences during pregnancy portray false messages when compared to

the experiences of pregnant schoolgirls. Thomson et al argues that for schoolgirl mothers-to-be, the pregnancy bump can be a 'source of shame' and something they have to learn to defend. Coming to terms with a changing body is a journey which is made more difficult by judgemental attitudes and other people's responses to their pregnancy.

Positive mentality and emotional feelings are constantly challenged by the physical development through a changing body shape, gaining of weight, heaviness of pregnancy, slowing down in pace, discomfort, lack of mobility, less choices, fewer options for activities and just general daily living (Thomson et al, 2011). In particular, weight gain and a changing body image can be difficult to adjust to and can provoke a sense of loss. Overcoming such intense feelings can be achieved through drawing on 'resources which are associated with youthfulness – enhanced health and energy' and the happiness linked to the knowledge of a growing, developing baby inside their body (Thomson et al, 2011, p71).

Thomson et al goes on to argue that 'resources which are associated with youthfulness' are challenged time and time again through having no choice other than to submit to the wearing of maternity clothes (p71). Previous identification with particular fashion styles and the freedom to fluctuate between them is more restricted during pregnancy. The wearing of maternity clothes has no connections with any of the identities that schoolgirls have previously experimented with. Schoolgirl mothers-to-be, therefore, battle with unresolved decisions over the many identity options which were once available to them and being forced into the predefined and fixed identity of a mother. The baby growing inside their body begins the transition to motherhood and defines them as a woman, despite their age (Thomson et al, 2011).

Pregnancy has a pre-set upper time limit of nine months but Thomson et al's (2011) research suggests that the temporality of pregnancy is not always at the forefront of the mind of the schoolgirl mother-to-be. For some pregnant schoolgirls, it may be hard to foresee a time when their body will be back to its normal size and shape, if ever. Bodily choices in terms of food and nutrition, not/smoking, no/alcohol are

determinants in forming other people's opinions of the identity of the schoolgirl mother-to-be as a good or bad mother. Making positive bodily choices in terms of food and nutrition is not always an option for schoolgirl mothers-to-be who may already be living in poverty. This may in turn restrict their ability to foresee a time when their body will return to normal. The barriers to 'positive choices' are not always visible to or considered by external onlookers in their judgements over schoolgirl mothers-to-be. This study will consider the experiences of schoolgirl mothers/mothers-to-be and judgemental attitudes from professionals.

### *Poverty and financial dependency*

Schoolgirl parenting has, according to Macvarish (2010) 'become amplified as a social problem' (p313). Concerns are raised in policies not just about schoolgirl mothers being an 'existing social problem' but also those 'predicted in the future' (Macvarish, 2010, p318). Schoolgirl mothers are viewed in the Teenage Pregnancy Strategy (1999) as being at 'a greater risk of being poor, unemployed and isolated' but also as contributing to poverty and deprivation (Teenage Pregnancy Strategy, 1999, p90). Government agendas/policies have therefore attempted to reduce teenage conception rates with the assumption that this will diminish poverty and deprivation. Previous academic literature on early parenting and poverty (Dawson and Hosie, 2005) have in the past focused on schoolgirl pregnancies causing or perpetuating a cycle of deprivation, increasing the risk of being poor, unemployed, isolated and affecting the educational outcomes of the schoolgirl mother-to-be (Macvarish, 2010). Dawson and Hosie (2005) carried out interviews across ten local authorities in England. The local authorities were chosen to represent: a range of different forms of educational provision available during pregnancy (mainstream school, specialist units for pregnant young women and young mothers, home tuition, Pupil Referral Units and further education college); varying government initiatives to support the educational needs of young people and pregnant young women; varying levels of teenage conceptions and levels of deprivation; different geographical characteristics including rural and city based local authorities and varying levels of ethnic minority groupings.

Dawson and Hosie (2005) endeavoured to understand the previous educational experiences of schoolgirl mothers and identify what factors and forms of provision determine academic and broad success in returning to or continuing with education. Data collection methods included: using baseline data to collate a picture of the experiences of pregnant schoolgirls/young mothers; the direct educational experiences of ninety-three young women (28 pregnant, 35 delivered school aged mothers, 30 post-statutory school aged mothers) in ten local authorities through semi-structured interviews; obtaining the views of key professionals in all schools within the ten local authorities through postal questionnaires and a wide range of professionals involved in supporting young mothers.

Dawson and Hosie (2005) found that for many participants, disengagement from education occurred prior to pregnancy, attendance at school was poor and many experienced bullying from pupils and staff. Other participants in the study reported having experienced a more supportive attitude to their pregnancy from school staff because they had previously been regular attendees with good academic achievements. Staff interviewed by Dawson and Hosie revealed that they had varied personal experience of dealing with schoolgirl mothers. Two thirds of the schools involved in the study had very small numbers of schoolgirl pregnancies on a yearly basis and therefore very limited experience of supporting the young women. When deciding on a suitable educational provision, Dawson and Hosie suggested that the 'health, previous educational experiences, relationships with peers and the school's willingness to accommodate changing needs' of schoolgirls mothers/mothers-to-be is considered and that there is 'a range of provision' available (2005, p191).

The experiences of schoolgirl mothers in relation to their maternal role and their expectations of their futures was researched by Seamark and Ling (2004) in their qualitative study of nine schoolgirl mothers who lived in East Devon (1988-1994). Data were obtained through semi-structured interviews. Some of Seamark and Ling's findings were that motherhood and raising children were valued in their own right and the young women talked about their futures and plans to develop their careers at a later stage. Seamark and Ling highlighted the increasing opportunities for people to

continue their education regardless of age. The study also suggested that it might be more appropriate to consider educational status later in life rather than at the time of being a pregnant schoolgirl. Seamark and Ling considered that deprivation was more related to the background of the schoolgirl rather than the age at which childbearing starts.

A lack of finances is perceived as being significant in relation to the age at which parenting starts as this is regarded as having a negative impact on the schoolgirl mother's ability to care for her child. Evaluations and criticisms are, therefore, made regarding the economic status of schoolgirl mothers/mothers-to-be (Gillies, 2007). Those who are financially independent are more tolerated but those dependent on benefits remain at the centre of public dismay for draining the public purse. Schoolgirl mothers/mothers-to-be become further objects of public consternation for not valuing education as their route out of poverty and into a more secure economic position. Gillies' (2007) research drew on two studies, an in-depth exploration of five white working class mothers (living in areas of high deprivation but not with the baby's father) and therefore parenting outside of conventional nuclear family boundaries and a second study carried out years later which focused on parenting resources.

The above discussions raise the question of 'when is a good time to become a mother?' Answering this question poses three possible options or timings for careers and motherhood. Firstly, schoolgirls who become mothers can delay their careers until a later stage. Secondly, women can choose to combine and balance their careers with motherhood. Thirdly, women can pursue their careers first then opt out of employment to become full-time mothers or try to balance both. Research focuses more on early parenting and schoolgirl mothers who delay their careers but less has been written about women who choose the second or third options of delaying motherhood. A qualitative study by Stone (2007) looked at why women interrupt or quit their careers and walk away from years of training and accomplishment to become full-time mothers. Stone carried out extensive in-depth interviews with six women across America, from a variety of professions such as lawyers, doctors, bankers, scientists and business people who graduated from elite schools in the 1970s, '80s and early '90s

but who had worked in mixed gender fields such as publishing, non-profit management and teaching. The study had a range of findings which included: women struggled to reconcile their old/new identities; quitting their career was a last resort (more related to work considerations and pressure rather than family); maintaining careers on anything other than a full-time basis was penalised not applauded; and there was a lack of choice over continuing in an elite profession. The women in Stone's (2007) study had the finance to provide childcare but the workplace and their elite choice of profession did not allow for combining motherhood and employment.

If continuing in employment was difficult for professional women who had the financial backing, then it is understandable that schoolgirl mothers can struggle to continue in education. Remaining at school means that schoolgirl mothers are dependent on family and friends (as an informal network) to look after their baby because they do not have the finances to purchase formal childcare. Using a variety of informal networks of childcare (family, friends, relatives or neighbours), can be a complex process. Informal networks of childcare take different forms and can mean that schoolgirl mothers rely on a patchwork of caregivers. Such reliance on multiple caregivers helps schoolgirl mothers to ensure their child is cared for when necessary. This patchwork approach of care providers places great demands on the young mother to build up a number of quality relationships with others. Without these relationships informal networks of childcare will not work or be effective. Creating an informal network of childcare amongst friends may not be as easy for schoolgirl mothers (under 16) as their friends and peer group are still at school. This can reduce the choices available for schoolgirl mothers who may be considering remaining in school or returning to education.

Additionally, this informal network of caregivers often operates on interdependent relationships not only for childcare but for the trading of other services and child rearing advice (Hansen, 2005). They bring what Sahlins refers to as reciprocity which is defined as a 'willingness to give for that which is received' (1972, p158). Sahlins states that reciprocal relations cannot operate on a one sided basis of goods or services and it needs to be balanced whereby there is give-and-take across time.

Hansen's (2005) book uses four case studies to investigate the lives of working parents and the informal networks they construct to help care for their children.

Interdependent relationships go deeper than reciprocity and extend to trust, faith and confidence. Trust is vital in interpersonal relationships and has been defined as 'a form of belief that carries within it, something unconditional and irreducible to the fulfilment of systematically mandated role expectations' (Seligman, 1997, p44). Trust and faith, according to Seligman share the same defining attributes of unconditionality. Seligman's (1997) book analyses trust as a fundamental issue of social relationships. Discussions within the book are set in a historical and intellectual context. The act of trusting is not dependent on reciprocity because this would mean it was not an act of trust but something predicated on confidence under a defined mode of exchange in society (Seligman, 1997).

Wider discussions in social theories on trust consider the range of benefits which it provides. Misztal (1996) claims that trust is understood to shape all aspects of human life and relationships, be essential for problem solving, merge with the idea of confidence, involve more than believing and have an element of risk. Barber (1983) comments that trust 'is an everyday and valued conception in our society and the family is the primordial source and location of trust' (p157). He goes on to explain that the expression 'if you cannot trust your family then whom can you trust' has a lot of 'value and ideological appeal' (Barber, 1983, p157). These comments reflect the assumption that the relationship between the family and trust is automatic but this does not apply to everyone (Misztal, 1996). Misztal's (1996) book provides a comprehensive overview of past and present theories about the role of trust as a means of creating solidarity.

In the absence of a trustworthy family, friends or funded childcare assistance, schoolgirl mothers are faced with the conflicting legal demands of caring for their child while remaining in education until reaching the school leaving age of sixteen. Schoolgirl parenting is viewed as not only ruining the teenager's existing education but also limiting her future educational opportunities and thereby compounding her

already disadvantaged socio-economic position (Seamark and Ling, 2004). This in turn is perceived as contributing to the cycle of poverty and financial dependency.

Reducing teenage conceptions does not guarantee that schoolgirls will continue in education, obtain qualifications, transition into further education or employment and be free from poverty. The extent to which schoolgirl pregnancies is the cause or consequence of poverty remains unclear (Daguerre and Nativel, 2006). Further knowledge and understanding is required about what enables schoolgirl mothers/mothers-to-be to continue in education.

### **2.3 Experiences of schoolgirl mothers/mothers-to-be while continuing in education**

This section reviews relevant academic literature for information on the experiences of schoolgirl mothers/mothers-to-be when attending school. In doing so, this reveals a mismatch between the assumptions in Government agendas/policies and the experiences that schoolgirl mothers/mothers-to-be encounter when continuing in education.

Having positive experiences and relationships can help make school-life more enjoyable and engaging. This can be particularly important as pupils are entitled to one-hundred-and-ninety school days each year (The Schools General (Scotland) Amendment Regulations, 1987). Most pupils are in secondary school for approximately twenty-seven hours per week. This is broken down into eight 40-minute periods per day, or five/six periods per day lasting about an hour (<http://www.educationscotland.gov.uk/parentzone/yourchildatschool/attending-school/schooldayandtermdates/index.asp>).

#### *Disengagement with education*

Schoolgirl mothers/mothers-to-be are considered in academic literature as being ‘disengaged’ from education and dropping out of school. Defining the meaning of ‘disengaged’ from school is problematic as the word itself has different connotations



which include a 'physical disconnection' or a 'mental detachment' from a situation. Poor school attenders could arguably be linked with being physically disconnected from school. Pupils with good attendance could nonetheless still be 'mentally detached' from school. Each participant's circumstances and situations vary extensively so there is no single route or cause leading to a 'mental detachment' from education.

Higher rates of schoolgirl pregnancies have been considered for some time in academic literature as being linked with low educational aspirations and achievement (Hosie and Selman, 2006). Arai (2004) believes that such low expectations might better explain the lack of engagement that schoolgirl mothers/mothers-to-be have with school. Pregnancy is therefore assumed to be the reason why young women drop out of school (Hosie and Selman, 2006). Previous studies have considered potential reasons why schoolgirl mothers/mothers-to-be drop out of school and at what stage this happens. Research has highlighted that 'many young women have either been officially excluded from school or have effectively disengaged themselves from education prior to pregnancy' (Hosie and Selman, 2006, p80). Hosie and Selman's (2006) paper discusses the UK Government's response to teenage pregnancy and parenthood as laid out in the Teenage Pregnancy Strategy (1999). The paper is related to the UK Government's aim of reducing social exclusion and pays particular attention to policy aimed at reintegrating school-aged mothers into education. The relationship between pregnancy and disengagement from school, before and during pregnancy, is considered by Hosie (2007) as being complex but at the root of it is a strong dislike of school. Drawing on the findings of a Teenage Pregnancy Unit funded study (Dawson and Hosie, 2005), Hosie's (2007) article explored the educational experiences of ninety-three pregnant young women and young mothers in England before and during pregnancy to gain a better understanding of the relationship, from the perspective of the young women themselves, between dislike of school, pregnancy and disengagement with education.

These arguments were taken in a different direction by Alldred and David (2007) in their research which found that it was disrespect from teachers which had contributed

to participants in their study becoming disengaged from education rather than disliking school. A more recent study by Vincent (2009) highlighted that some 'schools responded to teenage pregnancy as a difference that could not (or should not) be accommodated within mainstream education' (p235). Reasons given for not accommodating this difference were based on 'dubious health and safety grounds' or that needs would be best met elsewhere (Vincent, 2009, p235). This in turn provoked feelings of rejection in schoolgirl mothers/mothers-to-be and they became disengaged with education. Data collated for Vincent's (2009, 2012) study were gathered over an eighteen month period between 2007-08 and involved three in-depth semi-structured repeat interviews with fourteen schoolgirl mothers/mothers-to-be aged 15-18, in one local authority in England. The aim of the study was to consider how educational institutions deal with pupil difference.

### *Relationships between staff and pupils*

A good relationship between staff and pupils is important as experiences of school can be heavily influenced by teachers. Creating a relationship involves school staff and pupils interrelating across the age division and power disparity. As staff belong to a previous generation, their trajectory through life has afforded them with a different knowledge base, varied experience and a wider understanding of school and childhood as compared to that of their pupils. School experiences across generations differ for a variety of reasons not least because of the change and influence of past and present education policies. Issues and conflicts can arise between a 'young person's experience of their lives' and the 'adult assignment of characteristics to them' (Alanen and Mayall, 2001, p2). A reason for this is that children are viewed in education policies as 'objects rather than subjects of education' (Alanen and Mayall, 2001, p115). Government education policies therefore focus on future economic usefulness rather than children's learning experiences. Alanen and Mayall's (2001) book comprises a variety of contributors that consider child-adult relations using a wide range of data collection methods (i.e. ethnographic methods, observations, autobiography, group discussions, individual interviews, questionnaires).

A bad experience of school prior to becoming pregnant was a key finding in Allred and David's (2007) study. Participants felt teachers were unsupportive, unsympathetic, lacked understanding, trust and were disrespectful towards them before and during pregnancy. This impacted on schoolgirls' willingness to learn and contributed to their negative educational experiences. Allred and David found that participants described feelings of disappointment with their school and having been let down through a lack of encouragement in education which added to their unhappiness and contributed to their disengagement. The schoolgirl mothers also reported feeling physically unsafe in the playground during pregnancy while attending school. Previous research has not fully considered the impact of the relationship between schoolgirls and staff or the consequences of their actions that may have contributed to a positive or negative experience at school.

Evidence was found in Hosie and Selman's (2006) study that some schools removed pregnant schoolgirls from the roll, enforced extended maternity leave and refused to admit them back into school because of the amount of work they had missed. The study also found that although schools were not able to exclude because of pregnancy, some schoolgirl mothers-to-be were told they 'could only stay as long as their pregnancy bump was not visible' (Hosie and Selman, 2006, p81). This was because of the 'adverse effect that the presence of a pregnant schoolgirl might have on younger vulnerable pupils or the school ethos' (Hosie and Selman, 2006, p81). The study further revealed that some pregnant schoolgirls were told they could not remain in school 'due to concerns over health and safety' (Hosie and Selman, 2006, p81). Negative staff attitudes towards pregnant schoolgirls together with a lack of understanding/appreciation about the difficulties they experienced and an inflexibility over school uniform did not provide any enthusiasm to continue in education and especially as their lives and education opportunities were assumed to be over (Hosie and Selman, 2006). Further information on the service and support provided by school staff to support schoolgirl mothers/mothers-to-be is provided in section 2.4.

### *Relationships with peer group*

Social relations with a young person's peer group can be an important facet of school life (Francis, 2005). A schoolgirl's friendship with her peer group and the resultant impact on her school experience is influenced by the unique attachments that girls have to each other (Hey, 1997). Hey's (1997) ethnographic study was carried out in two comprehensive schools in London. School can be attractive to some girls because of its social connections and opportunities to meet with friends or make new ones. Popularity and being seen as fitting in can also impact on a schoolgirl's day-to-day experience at school and is vitally important given the 'consequences of failure' which can result in 'marginalisation or bullying' (Francis, 2005, p10). Francis drew on findings from her own research as well as that of others to contribute a chapter in a book entitled 'Problem Girls'. The chapter explored girls' experiences regarding gendered classroom interaction.

Young people often want to make friends so that they can be in close proximity to another person to allow them to be seen with someone else rather than on their own (Griffiths, 1995). Alleviating loneliness, developing socially, forming self-identity, achieving 'a sense of self-worth and belonging' as well as 'physical and psychological support' are all recognised as important outcomes of friendship (Duck, 1983, p27). Having friends is therefore viewed as an important element of school life especially during the 'vulnerability of adolescence' (Griffiths, 1995). Griffiths' ethnographic study examined the nature of girls' friendships and aimed to show how important these are in providing them with positive self-identity and self-esteem. The research was carried out during 1983-84 in a mixed-sex comprehensive school in West Yorkshire. Griffiths spent most of her time with sixteen girls (mainly working class) and followed them from their second to third year of secondary school.

Leaving aside reasons as to why friendships are made, it is important to understand how they are constructed. Friendships amongst girls are built around agreements and rules, confiding or sharing secrets, problems, fantasies and they are based on trust and loyalty. Choices over friendships can be influenced by academic attainment, common interests, maturity, class and race, or not/obeying school rules (Griffiths, 1995).

Griffiths also reports that during adolescence, girls' friendships are reinforced through 'sameness', looking and dressing the same, having the same opinions and being identified along with their friends. This 'sameness' can exist among those whose physical appearance is more or less mature than others, not/wearing of makeup, having fashionable clothes or not.

Friendships between girls can be close and supportive but when friends fall out these situations can be extremely turbulent. They can trigger jealousy and emotional tension and be viewed as a betrayal of trust (Griffiths, 1995). Longstanding friendships which have developed from infancy or early childhood can be particularly strong 'because they have a basis of shared memories' and a long history from which to draw on during stages of 'temporary differences' or fallouts (Griffiths, 1995). Schoolgirls in Hey's (1997) study did not invest the same degree of emotion about their school as compared to their friendship group. 'Being a mate' was favoured more than educational attainment as this was viewed as more in line with 'the world beyond school' and provided a form of 'feminine social identity' (Hey, 1997, p84). The 'best friend system' offered more fulfilment than the 'adult world of school' and its access to the 'good life' through 'academic compliance' (Hey, 1997, p127). Qualifying for friendships and the resultant desired identity was therefore a priority.

When individuals are noticeably different, or they deviate from what is regarded as normal and acceptable, Vincent (2009) believes this difference can carry a stigma which is socially constructed and based on unquestioned assumptions of the dominant culture. Despite Vincent's views, the link between difference and stigma is not consistent across individuals as many people thrive on difference, regardless of the dominant culture and are still accepted by their peer group. Being different is not necessarily enough reason for teenagers to stigmatise each other and so there has to be another aspect in the relationship between schoolgirl mothers and their peer group which contributes to them dropping out of education.

Stigmatisation of schoolgirl mothers/mothers-to-be is referred to by Arai (2009) as 'social death' from a teenager's peer group and something which might contribute

towards their disengagement and dropping out of school. The need for young people to have friends to fit in at school and not feel alienated is clearly evidenced in previous studies such as Vincent's (2009) and Alldred and David's (2007). Having a baby will mean that the schoolgirl mother will not be as free to participate in social events. This can result in the schoolgirl mother feeling cut off and excluded from her peer group. The exclusion may also be more related to the perception from other teenagers that motherhood is so far removed from their experiences, they have nothing in common any more with the schoolgirl mother and thus the friendship drifts apart. Arai (2009) considers the depiction of schoolgirl pregnancy as a social and public health problem and explores ways in which policymakers, academics and the media have responded to schoolgirl pregnancies. Research for the book was undertaken for Arai's PhD thesis which started in 1999.

Looking beyond stigmatisation and 'social death', another factor linked with disengagement of schoolgirl mothers/mothers-to-be is bullying (Vincent, 2009). Experiences of bullying (prior to pregnancy) were cited in Alldred and David's (2010) study as contributing towards schoolgirls disliking school as well as raising painful memories of loneliness, social exclusion and truanting amongst participants. Schoolgirl pregnancy is blamed as a sole cause of disengagement from school and other contributing factors like bullying can be overlooked.

### *Educational aspirations and attainment*

Previous research has linked low educational aspirations and achievements (qualifications) with higher rates of schoolgirl pregnancies, disengagement from education as well as assuming pregnancy was the reason for dropping out of school (UNICEF 2001, Ermisch 2003, Arai 2004, Alldred and David 2007, Vincent 2009, UNICEF 2013). Although low educational attainment is accredited as being a predictor of early pregnancies, very little is known about a schoolgirl mother's experience of school prior to becoming pregnant. Schoolgirls who become pregnant and keep their baby are said to be 'making one statement about disliking school and another about their own needs in terms of self-value' (Hudson and Ineichen, 1991). Hudson and Ineichen reviewed the current state of knowledge of teenage sexuality,

pregnancy and motherhood in Britain and the USA. Ermisch (2003) used data from the British Household Panel Survey (BHPS) over the years 1991-2001 to study associations between a woman's age at becoming a mother and the subsequent outcomes. The analysis focused on seventy-six women who became mothers by 1991 and who were born in 1950 or later. Outcomes were measured at ages 30-51.

Some believe that parents' social class position can predict a child's success at school, their ultimate life chances and achievements (Lareau, 2003). For others, society is perceived to be open and 'individuals carve out their life paths by drawing on their personal stores of hard work, effort and talent' (Lareau, 2003, p30). Within this open society, children and young people are viewed as having equal life chances. Lareau's study is based on intensive 'naturalistic' observations of twelve families with children who were aged nine and ten years old. The aim of the study was to understand the influence of social class on daily family life and how this makes a difference specifically in children's lives. Lareau argues that working class parents direct their efforts to keeping their children safe and enforcing discipline when required rather than treating them 'as a project to be developed' (2003, p66). Children are able to grow and thrive within these boundaries and are given flexibility to choose activities and friendships. The study highlights that working class families place greater emphasis on kinship and interaction with family members than their middle class counterparts. Siblings in working class families provide mutual support, help each other out and offer companionship to each other.

Both sides of this argument would probably acknowledge that social class differences in achievement do not mean that social class adequately explains differences. Social deprivation may hinder or delay a child or young person's achievements but this should not be confused with the potential that every individual has to learn and eventually become successful. Social class involves multiple factors and influences on an individual's achievement. For example, opportunities and access to support are often more available to those with more economic resources. Other factors may or may not transcend social class differences or be influenced by them such as government policies, procedures and legislation, access to facilities; and additional support needs.

Also the question must be posed about what the definition of achievement and success actually are, especially as this can take a variety of forms and looks different from different perspectives.

Kalil and Ziol-Guest (2008) suggest the limited educational chances which schoolgirl mothers have, would result in them adopting a lower, more realistic notion of educational success, but found that this is not the case. Kalil and Ziol-Guest (2008) found that most schoolgirl mothers/mothers-to-be display mainstream educational goals although few actually attain these and some feel their academic aspirations are unattainable. Kalil and Ziol-Guest's study aims to understand the association between adolescents' school experiences and their academic engagement. Data were drawn from a three wave longitudinal study with sixty-four schoolgirl mothers in a predominantly urban area in a Midwestern state in America. Relationships between schoolgirls and teachers were found to be an important determinant in Kalil and Ziol-Guest's study of achievement and motivation. High quality supportive relationships between schoolgirl mothers/mothers-to-be and teaching staff are thought to establish the school environment 'as an arena of comfort for students whose home lives are often affected by chronic stressful conditions' (Kalil and Ziol-Guest, 2008, p527). The findings of Kalil and Ziol-Guest's study were that schoolgirl mothers' 'perceptions of teacher support correlated with higher levels of positive affect and lower levels of negative effect about school' (2008, p542). Having a 'purpose of learning' also played an important role in the engagement of schoolgirl mothers/mothers-to-be with education.

### *Deviation from normative pathways*

Education is considered to be the preferred route for all young people and deviation from this normative pathway is perceived to be a calamity for the schoolgirl and a severe problem for society (Duncan, 2007). Duncan's paper explores the policy content and context of the Teenage Pregnancy Strategy (which considers schoolgirl parents as victims of ignorance, mis-information and low expectation), connections between teenage mothering and social disadvantage, qualitative evidence about how



young mothers and fathers experience parenting and the stark contradiction between research evidence and policy discourse.

Deviation, therefore, from what is deemed an acceptable categorisation and normalisation of a young person according to age, can subject them to being disparaged and stigmatised (McNulty, 2008). McNulty's exploratory study is composed of the life stories of thirteen women who were pregnant before the age of twenty and who came from six working class families in the North East of England. The biographical narrative interviews are a medium to explore the intergenerational transmission of values, beliefs and practices relating to schoolgirl pregnancies. McNulty refers to 'conceptions of deviance' and examines the shift in moral panics which are linked to deviation from gendered, classed heterosexual norms.

As well as the stigmatisation arising from deviating from normative pathways, young mothers face the dichotomy of judgemental attitudes over good and bad mothering. Mothers who do not fit into the normative expectations of the role can be viewed as being an unfit parent or deviant (Wilson and Huntington, 2005). The study carried out by Wilson and Huntington (2005) explored the way in which normative perceptions of motherhood have shifted over the past few decades to position schoolgirl mothers as being stigmatised and marginalised. In their critical examination of the literature, Wilson and Huntington suggest that schoolgirl mothers are 'vilified'. This vilification was not due to poor outcomes for schoolgirl mothers and their baby but rather they had resisted the 'typical life trajectory of their middle class peers which conform to the Government's objectives for economic growth through education and workforce participation' (Wilson and Huntington, 2005, p59).

For some young women, early mothering can be viewed as an escape route away from a previous negative experience of life and school (Cater and Coleman, 2006). Parental separation and the involvement of step-parents can at times result in moving location frequently. This in turn can mean changing schools and integrating into a new friendship group. Participants in Cater and Coleman's (2006) study not only found

these life events distressing, unsettling and difficult to cope with but their experience of school was negative and contributed to their unhappiness.

Academic literature has considered schoolgirl mothers/mothers-to-be from a range of perspectives and values but not fully in terms of why they may become disengaged from education and drop out, or even why it is difficult for them to continue. Instead, the findings from previous studies are presented in such a manner that not only is disengagement and dropping out of school seen to be stereotypical behaviour for schoolgirl mothers/mothers-to-be but it is also perceived to be their preferred choice.

Full consideration has not been given to the actual ability of a schoolgirl mother/mother-to-be to continue in education, what this would look like for them and whether or not there would be any flexibility built into their timetable. The Scottish Executive's (now Scottish Government) 'More Choices, More Chances' Strategy (2006) together with the new 'Curriculum for Excellence', was to provide 'flexible opportunities tailored to individual need' (p7). Good practice and effective provision was highlighted in a subsequent Scottish Government publication 'Production of Case Studies of Flexible Learning and Support Packages for Young People who require More Choices and More Chances' (2009). Further evidence is required from schoolgirl mothers about whether they have been provided with flexible opportunities in school or college which have been tailored to their individual needs to allow them to continue in education.

The idea that schoolgirl mothers may be torn between their conflicting parental responsibilities and the need to finish their education, in order to become financially independent (through education and employment) has also not been considered (Alldred and David, 2010). In order to understand more about why young mothers become disengaged from education, further research is needed into the experiences and challenges they face while continuing in education.

## **2.4 Service and support provided by professionals**

### *School staff*

While attending secondary school, pupils can have a range of subject teachers and a guidance teacher. The relationship between school staff and schoolgirl mothers/mothers-to-be can be pivotal in determining (dis)engagement with education, not least because they can be working together for up to six years.

The guidance system was introduced formally into the education system in 1968 (Guidance in Scottish Secondary Schools) and is now well-established. Although there is no unified guidance system, it has traditionally been viewed as consisting of three main areas: curricular, vocational and personal. The general role of a guidance teacher involves reactive work when pupil problems arise, proactive work in teaching personal and social skills, managing pupils' progress through their education, maintaining discipline, good ethos, and communications with pupils, parents and professionals (Wilson et al, 2004). Training is carried out for staff in their initial teacher training and continuous professional development in the area of guidance and pupil support is frequently provided by local authorities. Personal qualities, motivation and experience are believed to complement appropriate training for guidance teachers to help them in their role.

A previous study carried out by Howieson and Semple (1996) looked at the role of 'guidance' in secondary schools and in particular, attitudes to this. Howieson and Semple studied six schools across four regions. The schools were based on the type of guidance structure, the socio-economic composition of the school roll, school size, staying-on rates, attainment, type of location, denominational/non-denominational, multi-cultural, and local labour market. The aim of the study was to select schools which illustrated the different types of guidance provision.

Within Howieson and Semple's (1996) study, pupils viewed guidance as necessary but their opinions and experience was heavily dependent on the attitude and approach of the guidance teacher. The qualities of a good guidance teacher included: someone who

was willing to listen; was understanding; liked children; took time; showed an interest; was fair; did not label pupils; was trustworthy; preserved confidentiality; and treated and respected them as individuals. An important finding of the study which is relevant to this research project is that the majority of pupils felt that 'ordinary pupils' only had minimal contact with guidance teachers because they tended to concentrate on those who were 'in trouble' or had 'obvious problems'. Accessing guidance teachers was also a problem because of their lack of time, large caseloads and teaching commitments.

A later study carried out by Wilson et al (2004) gathered the views of young people, parents and teachers about the provision of guidance in primary and secondary schools in Scotland and how this could be improved. The study surveyed all thirty-two local authorities in Scotland, issued questionnaires (2413 pupils, 158 teachers, 100 parents) and carried out individual interviews and case studies. Two Higher Education institutions were also involved in the study. Responses from pupils in Wilson et al's study suggested they would draw on a range of staff, parents and others for help with any concerns. Participants in Wilson et al's study chose to take different issues to different members of staff. For example, participants might approach subject teachers about homework but speak to another member of staff regarding another matter. Guidance teachers were perceived to be one source of help to deal with problems which were not health related or personal. As with Howieson and Semple's (1996) study, the guidance system had become associated with pupils who had problems and this left very little time for others to access the guidance teacher.

Staff interviewed in Wilson et al's (2004) study discussed the need to work with members of other professions to be able to provide an effective guidance service for pupils. One of Wilson et al's findings was that parents and pupils seemed to be unaware of the inter-agency work which was taking place. Inter-agency work to support pupils was effective when the different professionals knew each other and had established good relationships and communication links. Problems did exist, however, in the sharing of information between agencies.

Views and experiences of accessing support from guidance teachers was further explored through the perspectives of thirteen young people in five Scottish schools whose family households had been transformed by the separation of parents, re-partnering of a parent, death of a parent or other forms of significant change in their family life (Highet and Jamieson, 2007). These views ranged across having had a positive experience, only seeking help for school related issues rather than emotional ones, preference for either a counsellor or informal networks, a reluctance to over-burden staff who had to manage pastoral care and teaching duties, and concerns about confidentiality or privacy.

Participants in Highet and Jamieson's (2007) study seemed to be more able to separate what was going on at home in their personal lives to that of school life. Having a baby was not only an emotional issue but also one which required support in terms of other school related matters. It is not possible to separate pregnancy and school related matters in the same way as can potentially be done with the young people in Highet and Jamieson's (2007) study whose households have been affected by changes in their family, namely their parents. The young people who did access guidance in Highet and Jamieson's (2007) study had a positive experience while those who did not approach staff were reluctant because they were afraid their situation regarding being bullied would get worse or that staff would not keep this information confidential amongst themselves. Being pregnant and having a baby is very much a 'public' thing and something which cannot be hidden or denied for long. By comparison, it is possible for young people whose lives have been transformed by changes in their family life, to keep this private.

The role of guidance within schools has been the subject of a number of reviews. The Scottish Executive carried out a review (Happy, Safe and Achieving their Potential, 2005) in light of the new Curriculum for Excellence and endeavoured to re-establish the role of guidance within schools in the 21<sup>st</sup> century. Acknowledgement was given in the review to the importance of teachers taking time to get to know children/young people and responding to them sensitively to help them thrive and develop as individuals who were aware of their talents and abilities. Teaching staff

were recognised as making the difference during difficult circumstances to help children and young people cope and develop resilience. Positive relationships with young people were established when teaching staff spent time with them. Young people needed to know and trust that they could have confidential access to staff when they needed it. Relying on prompt, appropriate information and support to get the help needed by young people was viewed as imperative.

The national review of guidance (Happy, Safe and Achieving their Potential, 2005) provided ten standards of personal support. These standards were not intended to be prescriptive regarding the approach to be taken by local authorities for organising support as this was expected to be developed on a local basis to suit needs and circumstances. The ten standards to support pupils, provide a framework for staff, parents and pupils to enable them to reflect on the level and quality of support in schools. The standards fall into three category headings, 'Learning for Life', 'Review of Individual Progress' and 'Access to Support'.

The role of guidance teachers within the new Curriculum for Excellence is questioned by McLaren (2010) given that guidance is not a curricular area and does not have any 'experiences' or 'outcomes'. According to McLaren, the role of guidance is more linked with a previously agreed entitlement under the 'Guidance in Scottish Secondary Schools' document (1968). McLaren believes that the definitions, roles, remits and functions of guidance now remain uncertain even though it previously fell within a clear structure, was founded on clear principles and had been in operation for over 40 years. Regardless of whether the guidance system stays the same or is reformed to meet the demands of the new curriculum, schoolgirl mothers/mothers-to-be have not been asked about their experiences or the role of guidance teachers in supporting them while they continue in education.

### *Health visitors*

In the same way children and young people are required up to the age of sixteen to follow a statutory number of days of education per year, mothers regardless of their age of giving birth, are entitled to a health visitor. The profession of health visitor is

one which has changed and evolved over many years since being formed in Manchester and Salford during 1862. Health visiting originated from the 'Ladies Sanitary Reform Association' and was originally in response to the high infant mortality rate in some of the poorer districts. Since its inception, the profession has been referred to as 'the mother's friend', 'mini social workers' and now 'public health nurses' (Baldwin, 2012). Baldwin reviewed the development of the role of health visitor and how this has affected their professional identity.

In the Nursing Times magazine, Hunt stated 'there seems to be a common feeling among health visitors that their role is difficult to interpret to others and that it is not well understood or agreed upon by those with whom they work' (1972a, p17). This would appear still to be the case forty years later. Hunt was critical of the title 'health visiting' because he felt it was not clear in describing what the job holder actually did. This view was contested by Cowley (2002) who argued that the title of 'health visitor' did explain the role and this overarching term encompassed a range of different roles and activities. The term 'health visitor' was, therefore, more important than ever. Cowley further argues that the term 'health visitor' can be used as 'a noun to signify the profession as a whole; as a verb which details activities undertaken by health visitors; or as an adjective to describe matters such as service organisation pertaining to health visiting' (2002, p304).

Despite being unique, health visiting has 'struggled to define its role and has suffered from uncertainty over professional identity' (Baldwin, 2012, p15). Baldwin suggests that it is 'the combination of tasks, across health, education, social care, links to wider public health functions, and responsibility in child health and protection, which makes health visiting a unique profession' (2012, p13). Given the historical difficulty in defining the health visitor role, this presents subsequent challenges in being able to evaluate it generally and in terms of the support provided to schoolgirl mothers/mothers-to-be. Despite these difficulties, health visitors continue to support all mothers from day ten after delivery until the child is aged five.

Discussions in academic literature about health visitors have considered and evaluated the way in which the role has evolved. These discussions seem to take an adult or professional's perspective rather than that of service users. There has been a call for more understanding about schoolgirl mothers/mothers-to-be and in particular the role that professionals, such as health visitors, play in supporting them (Macvarish and Billings, 2007).

## **2.5 Conclusion**

This literature review displays a selection of the research carried out regarding schoolgirl mothers/mothers-to-be. It also demonstrates what is known about schoolgirl mothers/mothers-to-be and the support provided to them by professionals (health and education). Previous studies about the assumptions in Government agendas/policies regarding how schoolgirl pregnancies occur, roles and responsibilities of discussing sexual activity, the quality/quantity of information on sex education and relationships, and the role of professionals, have been useful and provided further insight. These studies can influence future policy in areas such as the information provided to young people on sex education and relationships, the role of professionals in supporting schoolgirl mothers/mothers-to-be. However, focusing on these topics has distracted researchers from considering the experiences and challenges faced by schoolgirl mothers/mothers-to-be when continuing in education. The literature is therefore limited in its endeavours to understand the experiences of schoolgirl mothers/mothers-to-be and the challenges of continuing in education.



## **CHAPTER 3**

### **REVIEW OF SCOTTISH POLICIES AND LOCAL AUTHORITY APPROACHES TO SUPPORT SCHOOLGIRL MOTHERS/MOTHERS-TO-BE**

#### **3.1 Introduction**

The Scottish Government professed a number of political aspirations and pledges after devolution in 1999 and this chapter begins by outlining these. Reviewing the political aspirations and pledges given to the people of Scotland is important by way of contextual background to understand the approaches taken by the Scottish Government to meet these as well as providing an understanding of the resultant policies which emerged in relation to schoolgirl mothers/mothers-to-be.

Within section 3.2, key findings from a large scale longitudinal social study called ‘Growing Up in Scotland’ (GUS) are discussed. The ‘Growing Up in Scotland’ study was designed to examine ‘the characteristics, circumstances and attitudes of the families who took part in the research’ (GUS, 2007, p1). It also aimed to track the lives of a cohort of Scottish children from their early years through childhood and to look at their experiences across time. Initial focus in the study was on a cohort of 5,217 children aged 0-1 years old and a cohort of 2,859 aged 2-3 years old. The GUS study was intended to form part of and support the Scottish Government’s strategy for the longer term ‘monitoring and evaluation of early years/children’s services policies in the areas of childcare, education and social work, health and social inclusion’ (2007, p187). The study was to have a specific and unique emphasis on Scotland and be ‘driven by the needs of policy-making, with a particular focus on access to, and use of services’ (GUS, 2007, p2). In addition to providing information to support policy-making, it was intended that the GUS study should be a broader resource which could be drawn on by academics, voluntary sector organisations and other interested parties. Data gathered from the study, together with the wider research community, would provide invaluable information about the lives of Scotland’s families. The study was fundamental in focusing the Scottish Government’s attention (after devolution) on

developing revolutionary health, education and socio-economic policies. The policies which emerged are the vehicles used by the Scottish Government to achieve their political aspirations and pledges given to the people of Scotland.

Section 3.3 provides a review of the key national health, education and socio-economic policies (since devolution) relating to schoolgirl mothers/mothers-to-be. These policies provide the overarching framework and guidance within which local authorities and schools should work. The policies also contain identified key priorities and targets for local authorities and organisations to address health, education and socio-economic inequalities. Local authorities and schools were required to reshape the way they worked in order to meet the key priorities and targets (stemming from political aspirations). A more detailed review of the Scottish Government policies relating to schoolgirl mothers/mothers-to-be is provided in Appendix 10.

Section 3.4 returns to the academic literature to review previous studies on the formation and implementation of policy into practice. Understanding the literature on how policy is formed and translated into practice provides important background information for this research when considering the different approaches taken by local authorities to support schoolgirl mothers/mothers-to-be.

Section 3.5 outlines a review of the different approaches taken by local authorities to support schoolgirl mothers/mothers-to-be while continuing in education. It was originally intended to carry out a review of the policies across local authorities in respect to the approach taken to support schoolgirl mothers/mothers-to-be to continue in education but very few had a policy in place so this was not possible. Initial assumptions were made that where the pregnant schoolgirls and/or teenage pregnancy rates in a local authority were continually high, a policy document would be in place to ensure a consistent, flexible, tailored approach, but this was not the case. This review of approaches taken by local authorities to support schoolgirl mothers/mothers-to-be while continuing in education helps provide an insight into how Scottish Government policies have been translated into practice locally. The findings of the

review were critical in being able to identify which local authorities to approach for inclusion in the study.

### **3.2 Scottish political aspirations pre and post devolution in 1999**

#### *Political aspirations pre and post devolution in 1999*

The run up to the general election in May 1997 saw the Labour Party in Britain making several campaign pledges. These included introducing a national minimum wage, holding devolution referendums for Scotland and Wales and a pledge to produce greater economic competence. In opposition to Scottish Labour, the Conservative party did not support devolution as it feared this would split the United Kingdom. It is unclear how significant the pledge to hold a devolution referendum proved to be to the people of Scotland but the results of the General Election brought a landslide victory for Labour and Scotland was left devoid of Conservative Party representation.

After the election, Scottish Labour kept its manifesto promise and held a devolution referendum in September 1997, during its first term of power. Its purpose was to hold a vote amongst the electorate to establish whether they rejected or accepted the proposal to create a Scottish Parliament with devolved powers and to ascertain whether any such new Parliament should have tax-varying powers. The majority voted in favour of both proposals. The Scottish Executive (changed to Scottish Government during 2007) and the Scottish Parliament were officially convened in July 1999.

After being elected into power, the Scottish Labour Party pledged to deliver changes across a number of areas. Scottish Labour stated they would use the powers of the new Parliament to modernise schools, to secure high standards and a world class education system, and to ‘promote opportunity for all children’ (Building Scotland’s Future, 1999). Education was viewed as the highest priority and providing the qualifications, skills and training needed for the 21<sup>st</sup> century was central to the vision of the Scottish Labour Party. The aim was to build a culture of lifelong learning that would cut across traditional boundaries and reach Scottish people of all ages and backgrounds. It is unclear whether or not an assumption was being made by Scottish

Labour that schools needed modernised and/or if the intention was to reduce the number of young people who were not in education, employment or training. In order to achieve educational excellence from early years throughout life, ten clear targets were set.

One of these ten targets was to reduce by half, the number of 16-17 year olds who did not go on to education, training or employment. This target was to ensure that ‘thousands more young Scots would have a better passport to the world of work’ (Building Scotland’s Future, 1999, p8). Other targets aimed to: tackle child poverty; help parents balance work and family responsibilities; invest in childcare provision to ensure it was high quality, accessible and affordable; expand nursery education to all 3 year olds; and create a National Health Service (NHS) in Scotland that offered patients the treatment they needed, where and when they wanted it.

Scottish Labour believed a good education was the best start in life and all children deserved the best schooling. The Scottish Executive felt that in order to do this, they needed to know more about children’s circumstances, the opportunities, difficulties and challenges they faced and what happened in their lives as they grew up. The Government were also keen to know what worked and did not work for people as well as securing information regarding what influenced them. The Deputy Minister for Education and Young People at the time (Robert Brown, MSP) acknowledged the difficulty in trying to pin down exactly what made a difference to people’s lives.

During the first year of Scottish Labour being in power, a longitudinal scoping study (Scottish Executive, 2007) commissioned by the Scottish Executive in 2000, highlighted that there were a lack of existing data relating to two important developmental phases in children’s lives, early years and the transition into adolescence. The scoping study recommended the Scottish Executive should consider commissioning a longitudinal study in one of these two areas. It was from this scoping study, that the idea to commission a large scale longitudinal social survey called ‘Growing Up in Scotland’ (GUS) emerged.

### *'Growing Up in Scotland' (GUS) study and findings*

The purpose of the GUS study is to track the lives of a cohort of Scottish children from their early years through childhood rather than specifically to consider schoolgirl mothers/mothers-to-be. The GUS sample design was based on two cohorts of children, the first aged approximately ten months and the second aged approximately thirty-four months. It was the age of the child which was important in the sample as opposed to the age of the mother. The small number of schoolgirl mothers involved in the GUS study was not the result of a targeted sampling frame to include them. Only eight percent (weighted percentage) of the mothers involved in the study were under the age of 20.

Topics covered in the GUS study have included: characteristics and circumstances of children and their families; pregnancy and birth; parenting young children; parental support; child health and development; parenting styles and responsibilities; and parental health. The questions used in the GUS Study are determined by a Policy Advisory Group who are based at the Scottish Government. The GUS Study does not explore particular issues in any great depth such as why schoolgirl mothers/mothers-to-be may not attend ante-natal classes. Neither is consideration given to reasons why schoolgirl mothers/mothers-to-be do not continue in education nor what support or help might change or influence this. The first wave of fieldwork began in 2005 and the first report on the key findings from the initial sweep of the survey was published in January 2007.

Of the two hundred and twenty four teenage participants who were involved in the GUS study (not weighted, figures provided in discussion with GUS researcher), eighty eight percent were aged 18 and 19 (at the time of the study) and would have left school prior to data being collected. Given that the interviewees were revisited on a number of occasions over an extended period of time, the timespan and distance after leaving school continues to increase. Therefore the responses from interviewees who were schoolgirl mothers is less relevant.

The data gathered from the GUS Study and the wider research community was intended to provide invaluable information about the lives of Scotland's families. There has not been any wider research community looking specifically at schoolgirl mothers/mothers-to-be and GUS has not provided data from participants who were experiencing pregnancy in Scottish schools at the time of interviewing. Despite this, the Scottish Government have continued to use data from the GUS study as the basis for policy development even though they still do not have enough information on the lives of Scotland's schoolgirl mothers/mothers-to-be. Themes emanating from the GUS study surrounding schoolgirl mothers include: health inequalities; not accessing professional support/groups/ante-natal care; insufficient parenting advice and support; and use of informal childcare. The three significant Scottish policy documents (Equally Well, Early Years Framework, Achieving Our Potential (published in 2008)) which emerged from the initial findings of the GUS study, do not all specifically mention or refer to schoolgirl mothers/mothers-to-be. Assumptions about early parenting in the three policy documents can be divided into four main areas: health outcomes, educational outcomes, social barriers and economic barriers, which increase the risk of poverty. Regardless of the numerous general policies such as 'Getting it right for every child' or other policies which refer to schoolgirl mothers/mothers-to-be, none have emerged as a result of specific targeted research about them.

### *Health inequalities*

The key findings from the first sweep of the 'Growing Up in Scotland' study (January 2007) were that inequalities in health related particularly to poverty and deprivation and this was balanced by a recognition of related lifestyle factors such as drinking, diet, smoking and exercise. The GUS (2007) report stated that parental health and well-being were extremely important key factors in shaping not just the early experiences of young children but their health and development as well. Evidence from previous studies such as Wadsworth and Kuh (1997) also suggested that a child's early year's experiences influenced and partly determined future life circumstances and health. Other findings from the initial sweep of the GUS study (2007) showed that parents who lived in the most deprived areas were more likely to report fair or poor health compared to those in the least deprived areas.

It is important to note that in May 2007, Scotland chose a new Government and, for the first time, the Scottish National Party (SNP) was elected instead of Scottish Labour. The Scottish National Party had clear ambitions for Scotland to become a healthier, wealthier and better place. This was to be achieved by: reducing health inequalities within Scotland through expanding primary and preventative healthcare services in the most deprived areas; reducing poverty and dependency; placing a new emphasis on children's early years with an increase in free nursery education; focusing on delivering high quality integrated services for children and families to create more joined-up services aiming at ensuring that children's needs are at the centre of policy and provision; and considering the impact on children in all areas of policy development and legislation. An additional £10m was also to be provided for cutting edge research in Scotland. These ambitions were to be achieved through 'fresh thinking and a new approach' (SNP Manifesto, 2007).

#### *Professional support and intervention*

Results and key findings from the second sweep of the GUS study (February, 2008) showed that schoolgirl mothers/mothers-to-be in lower income households were more wary of professional support or intervention. Schoolgirl mothers/mothers-to-be were also more likely to suggest that professionals did not offer enough parenting advice and support 'suggesting a degree of misunderstanding around the implications of that support' (GUS, 2008, p160).

It is interesting to note from the GUS study that where contact with professionals was 'service led (the impetus is on the service provider to maintain contact) and targeted (such as health visitors or social work) contact is higher amongst young mothers' (GUS, 2008, pxviii). Where the responsibility and impetus was on the 'user' i.e. the young mother, to make contact with professionals, there was lower use and uptake of professional services (GUS, 2008). In sweep one, young mothers reported feeling shy or awkward about attending any form of group. This dislike of groups was less evident in sweep two. The 2008 stage of the GUS study received funding to recruit a new birth cohort of 6000 babies and to interview their families when the child was ten months old.

### *Informal and formal support*

Young mothers in the GUS study reported having lots of close relationships. These strong social networks were important to parents for 'securing help but also for fostering a sense of positive wellbeing' (2008, p160). The GUS study (2008) observes that the findings in the survey are consistent with other research carried out by Hansen (2005). Hansen sees 'nuclear' families, regardless of social class, as being reliant on the informal support provided by their social networks of family and friends.

A report produced by the Scottish Government from further findings in the GUS study (Parental service use and informal networks in the early years, 2011) has subsequently used the data collated from those involved in the first five years to explore the relative roles of formal and informal support in the lives of families with young children in Scotland. It attempts to untangle the reasons and attitudes behind why some families may not be getting the support they need.

The report (Parental service use and informal networks in the early years, 2011) looked at a number of issues including why schoolgirl mothers-to-be did not attend ante-natal classes and why they did not use childcare. For those who were first time mothers (aged under-25) their reasons included not liking the group format (29%), not knowing where classes were held (9%) and simply for no reason (21%). Reasons such as time, cost and travel were barriers for only a few women. Primary reasons for not using childcare were the respondent preferred to look after the child themselves or because they did not frequently require to be away from the child. Cost was an issue for some families as was a lack of availability or choice for others. For other women who did not engage, an informal-formal support service such as Community Mothers was suggested as the best method of providing support to young mothers to help break down perceived barriers with formal services. Despite the valuable data that has been gathered from young mothers involved in the GUS study, responses to the questions posed may well have been different had participants been attending school at the time of the interviews. The two-three year gap after having left school may explain why participants in the GUS study commented (in response to questions about childcare) that they preferred to look after the child themselves. There is not the same conflicting



legal requirements for young mothers who have left school, to care for their child and continue in education.

### **3.3 Scottish policies since devolution in 1999 relating to schoolgirl mothers/mothers-to-be**

Several research articles and books have been published which evaluate and criticise the English Government's policy approach to schoolgirl parenting (Teenage Pregnancy Strategy, 1999) but this is not the case in Scotland. The results of the GUS Study and other older studies based in England (Perry 2002, EPPE 2004) have been used to produce Scottish policies but these have not, as yet attracted the attention or criticism of researchers. Perry's (2002) paper looks at the effects of the childhood environment, favourable and unfavourable and how they interact with all the processes of neurodevelopment. Evidence is drawn from previous studies carried out by Perry about children in orphanages who lacked emotional contact and a number of animal deprivation and enrichment studies. The Effective Provision of Pre-School Education (EPPE) (2004) project investigated the effects of pre-school education and care on children's intellectual and social/behavioural development for children aged 3-7 years old. A wide range of information was collated on three-thousand children who were recruited at age 3+ and they were studied longitudinally at ages 3, 4/5, 6 and 7.

'Equally Well' (Scottish Government, 2008), one of the social policy framework documents, highlighted caution about some of the research evidence that came from other countries and emphasised the need to test this in a Scottish context. One message, which seems to be consistent throughout previous studies including the more recent ones (Field 2010, Allen 2010) is regarding the benefits of early intervention. Early intervention is the route the Scottish Government has taken in developing recent policies and great emphasis is placed on the benefits of such an approach. This has been at the cost of not specifically targeting research towards vulnerable groups such as schoolgirl mothers/mothers-to-be with a view to gaining insight into their experiences and challenges which could then inform early intervention approaches. If early intervention and the period between 0-3 is as important as the Government documentation suggests (Framework for Maternity Services, Equally Well, Achieving

our Potential, Child Poverty) and as contained in the SNP Manifesto, then this begs the question: why are schoolgirl mothers/mothers-to-be not included in research to improve the outcomes for them and their baby? Inequalities are highlighted as arising during a child's first few years of life and, if this is the period which shapes their future outcomes, then one would expect that early intervention would operate at its best during this time to reduce the longer term health inequalities and reduce the 'cost of failure', one of the Scottish Government's key aspirations. The social return on investment due to early intervention is quoted as 'every £1 spent in the early years generates an eventual saving of £9 for the taxpayer' (Getting it Right for Children and Families, 2012, p10).

It is not easy to pinpoint exactly why the Scottish Government has concentrated on the benefits of early intervention and not targeted research to other areas such as schoolgirl mothers/mothers-to-be. One explanation might be that researchers are focused on and involved in the longitudinal GUS study and are working on this in partnership with the Scottish Government. The Government may be relying completely, or too heavily, on the results from the GUS study given that its intention is to drive the needs of policy and to focus specifically on early years. The political aspirations of the Scottish Government could be restricting research in other areas. Alternatively, the Scottish Government's objective has and continues to be centred on multi-agency partnership working. This might make it harder for practitioners to challenge something they have been part of developing and creating. Even so, this does not explain why other independent researchers have not challenged the Scottish Government's approach in the same way the Teenage Pregnancy Strategy (1999) has been analysed and evaluated through research.

The aims of the social policy framework document 'Achieving our Potential' (2008) has high aspirations whilst also recognising and addressing some of the issues which schoolgirl mothers/mothers-to-be may face. Despite this, the Scottish Government has neglected to provide a national directive to local authorities to address schoolgirl pregnancies within their authority. An indicator has been set to reduce the number of pregnancies to those under sixteen and to move away from crisis intervention to

prevention and early intervention, but other key factors have been missed. The social policy framework stipulates that local authorities and partners are to focus on the most vulnerable young people to ensure positive destinations (in education or employment). This seems futile as some schoolgirl mothers would be unable to take up an education or employment opportunity even if they wanted to, without the necessary childcare provision. The grants which 'Achieving our Potential' claims to have made more widely available and accessible are restricted to part-time learners in higher education. These are not available for schoolgirl mothers who may wish to stay in their existing school. In addition to this, early intervention work is not possible in a school setting, when the schoolgirl mother cannot remain there because of a lack of childcare. These issues seem contradictory to the Scottish Government's ambition to provide opportunities for 'all people to flourish'.

The rationale and thinking behind the lack of a specific policy about schoolgirl mothers/mothers-to-be may have been influenced by the Marmot Review (2010). Professor Sir Michael Marmot was asked to propose the most effective evidence-based strategies for reducing health inequalities in England. In the extensive document called 'Fair Society, Healthy Lives' (2010), Marmot comments that social policies (with a focus on health) implemented over recent years have been targeted at the most disadvantaged groups and those at the lower end of the social gradient. He believes that even if these policies are effective, they do not tackle all the inequalities which exist for other socio-economic groups. Health inequalities he feels are a population wide phenomenon and that a nationally set target defines health inequalities as 'a condition afflicting a sub-section of the national population' (Marmot, 2010, p89). The targeting of sub-groups, Marmot feels excludes many of the deprived groups. Marmot suggests that policies need to be cross-cutting at both a national/local level and spread over organisational boundaries at all levels.

The non-existence of a specific policy relating to schoolgirl mothers/mothers-to-be in Scotland may be influenced by Marmot's belief that targeted intervention to specific groups does not work. This seems slightly contradictory to another section of his review where he looks at and recommends increased investment in the early years.

Marmot refers to evidence-based arguments that ‘returns to investment are high for young disadvantaged children and lower for disadvantaged adolescents, although returns from specifically targeted interventions with young people can be high’ (2010, p96). It is also contradictory to the NICE (2010) report which states that women with complex social factors may need additional support.

Sir Harry Burns, The Chief Medical Officer for Scotland highlighted in his Annual Report on ‘Health in Scotland 2006’ (2007) the need to prepare foundations for positive physical and mental health development which are created during the early years. Burns also emphasises the need to invest in the health of children and young people not least because of the longer term rewards. Targeting support is mentioned throughout the ‘Health in Scotland 2006’ report and reference is given to the effectiveness of this approach in other areas such as crime prevention. Burns comments:

‘If we fail to target our services and continue to provide only our current level of service to these children and their families, we cannot hope for an improvement (‘Health in Scotland 2006’, 2007, p9).

Other Scottish Government policies such as the Sexual Health and Blood Borne Viruses (2011) also call for targeted intervention. Additionally, ‘effective targeted interventions’ have been called for by the Convention of Scottish Local Authorities (COSLA) in their report to the Joint Ministerial Task force (Equally Well, 2008). All these policy documents, reviews and reports have resulted in conflicting messages not just about the positive or negative results of targeted intervention with vulnerable groups such as schoolgirl mothers, but in terms of confusing practitioners regarding whether or not to take this approach.

Within the Achieving our Potential (2008) document, the Scottish Government acknowledged that it was changing its relationship and way of working with local authorities. This change was to ‘move away from micro-management’ by the Scottish Government and a ‘one-size-fits-all’ national solution (Achieving our Potential, 2008, p7). Instead it would provide local authorities with autonomy to make

decisions locally. This message was repeated again in the SNP Manifesto (2011). However, without something which places a 'duty' under legislation on relevant professional bodies to take action, professionals are able to pick and choose what they will respond to. The areas where action will be carried out are those which carry a legal obligation such as the Under-Age Sexual Activity policy and Child Protection legislation (2010).

For schoolgirl mothers/mothers-to-be this can mean very little action if any is taken to fully support them and it has resulted in a variety of approaches and levels of support provided to them while continuing in education. This inconsistency in national approach has not necessarily resulted in a desired flexible approach being taken but rather it has created mixed messages for schoolgirl mothers/mothers-to-be whereby there are rules for one and not for another. The geographical area that a schoolgirl mother/mother-to-be lives in can make a difference as to how she is supported because some local authorities will take action while others may not.

The Scottish Government could argue that there are sufficient policies in place which refer to schoolgirl mothers/mothers-to-be and these give local authorities and Health Boards the mechanisms within which they can operate. It could be said that Scottish policies (Appendix 10) focus on broader and longer term aims of the Scottish Government rather than targeted intervention, consequently, no further action is needed at this time. However, some of the policies reviewed in this thesis operate on 'power' which gives them discretion and not a 'duty' or a legal requirement that must be carried out. Under the Single Outcome Agreement (2012), local authorities can again pick and choose the indicators to which they wish to respond and, in effect decide not to include schoolgirl mothers/mothers-to-be as one of their outcomes. While this allows for local authorities to localise policies to meet the needs of their community, the Scottish Government's aim is to 'promote opportunity for all children' (Building Scotland's Future, 1999). If education is viewed by the Scottish Government as being the highest priority, and providing skills and training is central to the vision for the people of Scotland, then policies require not only to be inclusive but adapted accordingly to meet the needs of all children and young people. Therefore, this raises

the question over whether or not the indicator regarding schoolgirl mothers/mothers-to-be should be optional for local authorities.

### **3.4 Policy into practice**

Understanding the social situation for which a policy is being developed along with being able to interpret research data is vital. Decisions have to be made over whether to start with the problem being studied or to use the data and/or participants that are accessible. The making of policy involves the combination of ‘formation’ and ‘implementation’ and a continuing interaction between the two (Hill and Irving, 2009). Additionally, policymakers need to be able to foresee the impact the policy will have in practice (Spicker, 2008). ‘Social policy is not however, solely an ‘academic’ field, it is also directed to problems of interest to policymakers’ (Spicker, 2008, p218). Daguerre and Nativel (2006) describe policies as being based on ideas about the nature of the problem, core beliefs, value judgements and causal assumptions which are not clearly spelled out but which shape public policies.

Policy is a process which can lead to positive outcomes for those who are impacted by it. This requires an effective and targeted policy development process which involves research with participants who are experiencing the problem being studied. For schoolgirl mothers/mothers-to-be, there has been no wider research community or targeted academic research. The policies developed therefore appear to be as Daguerre and Nativel (2006) point out, based and shaped more heavily on ideas about schoolgirl pregnancies, core beliefs, value judgements and causal assumptions rather than formed from the experiences and challenges of schoolgirl mothers/mothers-to-be.

After the creation of a Scottish Government policy, this is passed to local government (where appropriate), NHS Boards or other organisations for implementation. Conflicts arise when the Government policies and legislation (sometimes as set down in legislation or in the form of guidance), is not implemented in practice. The process of implementation and service delivery changes the ‘character of policy’ (Hill and Irving, 2009). In some instances the policy can become ‘diluted as compromises are

necessary in practice' (Spicker, 2008, p242). Local government, NHS Boards and organisations are influenced by constraints such as finance and the external environment. Decisions are made locally about where resources (staff, money, effort) will be prioritised and allocated.

Where a policy is ineffective, questions must be asked about the 'character of the policy' but also about the implementation process and the organisation which has responsibility for putting this into practice (Hill and Irving, 2009). Those who have created a policy which is ineffective may well ask questions of those tasked with its implementation as to why they have not carried out their responsibilities. Alternatively, those responsible for implementing policy may well ask why they are expected to do so especially when the policy is inappropriate, unrealistic and neither meets needs nor addresses local issues (Hill and Irving, 2009).

Staff on the 'front line' who are involved in the implementation of policy will influence this depending on their interpretation of it and this in turn ultimately affects the outcome (Hudson and Lowe, 2004). Variations in structures, staff, geographical area, policies and procedures exist across all local governments and therefore the implementation of policy can and is interpreted differently to coincide with local needs and demands. The implementation of policy is further complicated because it cannot be delivered by a single person or even one organisation. For example, cross-cutting health, education and social policies require multi-agency input and partnership working. Other questions to be asked in the evaluation of policy concerns the impact of this on the people who are the recipients of its outputs. What is clear from the above is that there can be a gulf which divides assumptions made by policymakers from the perspectives and experiences of practitioners.

A gulf also exists between the assumptions in Government agendas/policies and the experiences and challenges facing schoolgirl mothers/mothers-to-be. Often there is a third gulf between practitioners and their understanding of the experiences and challenges of schoolgirl mothers/mothers-to-be. Nonetheless, local authorities are obliged to ensure that pupils receive education until they reach the statutory school

leaving age of sixteen. Suitable education can also be provided for pupils over the compulsory school age but under the age of eighteen. Legislation such as the Additional Support for Learning Act (2004) and the Equality Act (2010) exist to support local authorities in making arrangements for the provision of suitable education at school or alternative provision for schoolgirl mothers/mothers-to-be. Despite the legislation, the question remains as to why is it so hard for schoolgirl mothers/mothers-to-be to continue in education and what are the nature of the experiences and challenges of those who do.

The Education (Additional Support for Learning) (Scotland) Act 2004 was introduced in November 2005. This Act introduced the concept of additional support needs and placed a duty on local authorities to identify, meet and review the needs of pupils for which they are responsible. This new concept of additional support needs is in reference to any child or young person who may require additional support for learning. Additional support needs are viewed in the Act as coming from any factor which may cause a barrier to learning and can include social, emotional, cognitive, linguistic, disability, or family and care circumstances. Some examples of additional support that might be required for a child or young person are given viz: someone who is being bullied, has behavioural difficulties, learning difficulties, or someone who is a parent.

In June 2009, the Act was amended and these changes form the Education (Additional Support for Learning) (Scotland) Act 2009 (effective from November 2010). While the revised 2009 Act does not change the basic purpose of the 2004 document, it endeavours to strengthen some of the duties contained therein and to clarify sections that were previously confusing. One of the main changes in the 2009 Act is that 'additional support' now includes support that is provided outside of school but which also helps children and young people get the best out of their school education. For example, it might now include a social worker helping a child who refuses to go to school, or a mental health nurse helping a child to cope with situations that are affecting their school life.



In the same year, the Equality Act came into force in Scotland (2010) which brought together over 116 separate pieces of legislation. Amongst other requirements, the Act places a duty on local authorities and the National Health Service to eliminate discrimination, harassment and victimisation. It also requires equality of opportunity and promotion of good relationships between those who share a protected characteristic and those who do not. The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race and religion or belief, sex and sexual orientation.

To help explain the Equality Act and provide practical examples to schools on how the law has changed, the Equality and Human Rights Commission (EHRC) produced a series of guidance documents to support the introduction of the new Act. Under the Equality Act (2010), schools are prohibited from discriminating against, harassing or victimising prospective pupils, existing pupils and in some limited circumstances, former pupils. Schools already had obligations under previous equality legislation not to discriminate against those with a protected characteristic but the new provisions in the Act, relevant to schoolgirl mothers/mothers-to-be are ‘pregnancy and maternity’. Discrimination is said to occur when a woman (including a female pupil of any age) is treated less favourably because she is, or has been, pregnant or has given birth within the last 26 weeks, or who is breastfeeding a baby who is 26 weeks old or younger.

Indirect discrimination as outlined in the Equality Act (2010) can take place where a school applies a provision, criteria or practice in the same way for all pupils. There is also indirect discrimination where this has the effect of putting pupils sharing a protected characteristic at a particular disadvantage or when this provision cannot be justified as a proportionate means of achieving a legitimate aim. Indirect discrimination does not alter even if there was no intent to disadvantage a pupil with a particular protected characteristic. For example, the wearing of school uniform would normally be applied to all pupils. However, for schoolgirl mothers/mothers-to-be, enforcing the wearing of school uniform would be discrimination given that they may have difficulty with this, especially during the latter stages of pregnancy.

Harassment, according to the Equality Act (2010) is said to take place when someone engages in unwanted behaviour related to a relevant protected characteristic and where this has the purpose or effect of violating a pupil's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the pupil. 'Unwanted' means 'unwelcome' or 'uninvited' but it does not mean the pupil has to say they object to this behaviour for it to be deemed 'unwanted'.

Discrimination against any pupil at a school regarding the provision of education or access to any benefit, facility or service is not permitted under the Equality Act (2010). This means 'schools are not allowed to discriminate against or victimise a pupil: in the way they provide education (or by not providing it) for a pupil; in the way the pupil gets access to a benefit, facility or service (or by not providing it); and by subjecting the pupil to any other detriment' (Equality Act, 2010, p49). Any pupil who feels they have been discriminated against, harassed or victimised by a school can submit a claim to the Sheriff Court (in Scotland) under the Equality Act (2010).

Although the legislation exists for schoolgirl mothers/mothers-to-be to access the curriculum, the practicalities of doing so can be fraught with difficulties not least because they are mothers as well as schoolgirls and, therefore, they have additional support needs. Dawson (2006) comments that if schoolgirl mothers/mothers-to-be are to continue in education then a range of supports need to be put in place. These include: educational provision suitable to individual needs; access to mainstream curriculum but with the chance to learn about child development and how to 'mother'; access to good childcare and accredited courses leading to further education or employment; and finally for the voices of schoolgirl mothers/mothers-to-be to be heard in order to understand their lives and future aspirations.

Reform within local authorities is, as mentioned in Chapter One, founded on 'four pillars' for change: prevention, partnership working, workforce development, performance management. The aims of the Education (Additional Support for Learning) (Scotland) Act 2009 and the Equality Act (2010) reflect these 'four pillars' of change and together they provide key priorities and targets for local authorities in

their ‘vital public service’ (Audit Scotland, 2012, p3). Key priorities and targets for local authorities from both Acts and the ‘four pillars’ of change, in terms of schoolgirl mothers/mothers-to-be centres firstly on providing sex and relationship education (prevention), ensuring there is partnership working and support from outwith school (where appropriate), developing their workforce to be able to support pregnant pupils and ultimately to review performance in these areas. Both these Acts and the ‘four pillars’ for change raise the expectation that they will influence the approaches taken by local authorities when supporting schoolgirl mothers/mothers-to-be.

### **3.5 Review of local authority approaches to support schoolgirl mothers/mothers-to-be**

#### *Introduction*

An objective of this study is to explain the different approaches taken by local authorities across Scotland to support schoolgirl mothers/mothers-to-be whilst continuing in education and to consider the advantages and disadvantages of these. To obtain these data, a review was carried out across all local authorities in Scotland seeking information on how schoolgirl mothers/mothers-to-be are supported in school. Details about the method used to gather this information and analyse it are provided in Chapter Four. The findings of the review have been categorised into four different approaches which have been classified as the: Service provision approach; Ad hoc schools based approach; Policy approach; Getting it right for every child (GIRFEC) approach.

Further explanation on the delineation of these four approaches is outlined below. Staff in all four approaches advised that they worked very closely with other services and partner agencies. These could include: Education, Social Work, National Health Service, Careers Advisors, Colleges, Universities, Family Nurse Partnership, Adoption Team, Health Visitors, Midwives, Outreach Teams, Family Support Workers, Child Protection Teams, Benefits Agency, Housing and Community Support Teams.

### *Service provision approach (4 local authorities)*

Four of the five local authorities with the highest number of schoolgirl pregnancies, support pupils through a service provision. In three of these local authorities, this service provision took the form of a dedicated nursery facility attached to a secondary school. Two of these facilities had been operating for over twenty years while the third had only been in place for a few years. None of these service provisions had ever operated at full capacity despite initial concerns (from internal staff) that a dedicated unit would increase the number of schoolgirl mothers. The fourth local authority operated as an outreach service providing additional support to schoolgirl mothers/mothers-to-be in their own school. Childcare was provided for the baby in the form of a local registered child-minder rather than having a dedicated nursery facility on the site of a school. The decision to adopt this latter approach was due to the geographical spread of the local authority and the inability to have one central location for a school with a dedicated nursery facility.

Attendance at the school with the nursery facility was optional and schoolgirl mothers/mothers-to-be could choose to stay at their own school. Referrals to attend the school with the nursery facility were received from other schools or partner agencies in the local authority. The timing of referrals, stages in pregnancy and stage at school all varied considerably as did the home circumstances of the schoolgirl mother/mother-to-be and their ability and attitude to education. The aim for every schoolgirl mother/mother-to-be remained the same - to support her education and help plan a positive future for her and the baby.

Transport was provided for schoolgirl mothers/mothers-to-be to travel from their home to the school with the nursery facility (or the child-minder and then on to school) and back home at the end of the day. Transport was also provided for attendance at any other appropriate appointments as deemed necessary.

### *Ad hoc school based approach (18 local authorities)*

The Sexual Health and Blood Borne Viruses (2011) policy identifies local authorities, in partnership with the NHS and others, as being responsible for taking a leadership role to reduce schoolgirl pregnancies. On carrying out a review with all local authorities across Scotland, the findings revealed that, while some local authorities had policies in place to reduce schoolgirl pregnancies, eighteen did not have a policy, guidance or service provision to support pregnant schoolgirls to continue in education. At the time of writing, three of these eighteen local authorities were amongst the top ten in terms of the number of schoolgirl pregnancies. Only nine were in the early stages of considering or developing a policy to provide guidance to schools on supporting schoolgirl mothers/mothers to-be.

The 'Framework for Maternity Services in Scotland' (2001) policy clearly states NHS Trusts, in partnership with local authorities are to ensure the specific needs of schoolgirl mothers-to-be are met. It would seem that this policy and the refreshed 'Framework for Maternity Services' (2011), designed to address the care provided from conception throughout pregnancy and during the postnatal phase has not filtered through to local authorities. School staff within these eighteen local authorities responded to schoolgirl pregnancies on an ad hoc basis without a consistent approach.

### *Policy approach (6 local authorities)*

The remaining six local authorities advised they had (or were finalising) a policy document, guidelines or a pathway on how to support schoolgirl mothers/mothers-to-be within their schools. The content and focus of these policies varied greatly and covered a range of approaches and procedures to support schoolgirl mothers/mothers-to-be, including: child protection, relationships, sexual health, parenthood education, health, School Nursing Service, and absence/attendance at school.

### *Getting it right for every child (GIRFEC) approach (4 local authorities)*

'Getting it right for every child' (GIRFEC) is a Scottish Government approach that enables all services and agencies who work with children, young people and their

families to deliver co-ordinated support which is appropriate, proportionate and timely. GIRFEC is about ensuring that leaders, managers and practitioners work together to enable children and young people to reach their full potential. The GIRFEC approach puts a child at the centre of any assessment and allows practitioners to consider their own role when working with families. Multi-agency meetings are held to discuss the child or young person and this enables relevant support to be provided through services like social work, at an early stage rather than waiting until a crisis happens. GIRFEC also ensures that children and young people are at the heart of any decisions made or information shared about them.

The approach operates on a common set of 'well-being indicators' that are designed to help assess what is going on in a child's life and to see if there are any areas that need to be addressed. These indicators are viewed as the basic requirements for all children and young people to grow and develop. Using these indicators helps to prevent issues being overlooked. Assessing a child's circumstances is carried out through the national practice model which combines the well-being indicators with the 'my world triangle' to assess needs, risks and positive features. These along with the 'resilience matrix', help practitioners to understand the child or young person's whole world while analysing more complex information. All this data helps practitioners to weigh the balance between being vulnerable and resilient, adversity and protective factors.

The GIRFEC model is not specific to age, gender or type of need. It does not refer specifically to schoolgirl mothers/mothers-to-be but could be used to assess their needs, risks and to identify any services that could be of assistance. Under the GIRFEC approach, practitioners are to 'work together to support families, and where appropriate, take early action at the first signs of any difficulty, rather than only getting involved when a situation has already reached crisis point' (A Guide to GIRFEC, 2012, p3).

Staff in four local authorities across Scotland explained they did not have a written policy but their approach to supporting schoolgirl mothers/mothers-to-be to continue

in education was that of the GIRFEC principles and SHANARRI well-being indicators (Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included). One of these four local authorities was in the process of developing guidance that would ensure a multi-agency partnership approach.

The GIRFEC approach taken by the four local authorities aimed to ensure each schoolgirl mother/mother-to-be was treated on an individual basis. Following discussions with the schoolgirl mother/mother-to-be and her family, arrangements were put in place by the local authorities to provide relevant support. Numbers of schoolgirl pregnancies across the four authorities that took a GIRFEC approach varied greatly but the principle remained the same; namely the schoolgirl mother/mother-to-be was entitled to an education and, should she wish to stay on at school, consideration would be given to providing childcare. Positive destinations would be sought for schoolgirl mothers/mothers-to-be and this could take the form of home based learning or a college placement.

### **3.6 Conclusion**

Further discussion is provided in Appendix 10 on the wide variety of cross-cutting policies produced by the Scottish Government since devolution in 1999. Given the flexibility that local authorities have to implement policies when targeting intervention and support to specific vulnerable groups (i.e. schoolgirl mothers/mothers-to-be) there is the potential for a variety of methods to be used across the country. This is especially the case given that each individual schoolgirl mother/mother-to-be can differ in terms of their background, culture and ultimately the support they require.

## **CHAPTER 4**

### **METHODOLOGY**

#### **4.1 Introduction**

This chapter provides an overview of the methodological approach which underpins the study. It has been structured around a discussion of the different stages of the research process including the research questions, design, stages of the project, recruitment of participants, data construction and analysis.

The main data collection techniques used in this qualitative study were semi-structured individual or group interviews and questionnaires. The research design used a mixed method and mixed sources approach to corroborate and enhance the quality of data through the process of triangulating data in several themes within the project (Mason, 2007).

The fieldwork was conducted at the sites between November 2011 and February 2013, with follow-up interviews at 9-12 month intervals thereafter with participants (schoolgirl mothers) across the different sites.

#### **4.2 Research questions**

This research provides an in-depth study on the experiences and challenges that schoolgirl mothers/mothers-to-be face when continuing in education. Table 1 outlines the aims of the research and the specific methods selected to address these.

The lack of focus on the experiences and challenges of schoolgirl mothers/mothers-to-be was discussed in Chapter One. The chapter noted that schoolgirl mothers/mothers-to-be are often assumed to be a 'problem' in Government agendas/policies. From the available literature, schoolgirl mothers/mothers-to-be are more likely to drop out of school, have lower qualifications and be disengaged with education.



In an attempt to enable assumptions to be informed by knowledge of the experiences and challenges of schoolgirl mothers/mothers-to-be, it is important to ask the question: ‘What experiences and challenges do schoolgirl mothers/mothers-to-be face when continuing in education?’ The research questions have been formed around this intellectual puzzle, which is a necessary first step for this project.

The research questions are:

1. What experiences and challenges do schoolgirl mothers and mothers-to-be (aged 18 and under) living in Scotland face when continuing in education?
2. What are the different approaches taken by local authorities in supporting schoolgirl mothers/mothers-to-be whilst at school?
3. How do education and health professionals (School Staff, health visitors) in schools and the National Health Service (NHS) support schoolgirl mothers/mothers-to-be while continuing in education during pregnancy and the early stages of motherhood?

### **4.3 Research stages**

The following table outlines the research objectives and the methods selected to address the research questions.

**Table 1 – Overview of research objectives and associated data collection methods**

<b>Research objectives</b>	<b>Data sources</b>	<b>Methods selected</b>
Consider the context of Government discourse and policy assumptions surrounding schoolgirl mothers/mothers-to-be as mothers and as pupils	Literature – critically assessing policy and its evidence base; key Scottish Government policy documents (1999-2014)	Literature Review Review of the policies
Analyse the existing and relevant cross-cutting health and social policies produced by the Scottish Government relating to schoolgirl mothers/mothers-to-be	Scottish Government policies	Preliminary interview with relevant Scottish Government staff Review of the policies
Discover the different approaches taken by local authorities in supporting schoolgirl mothers/mothers-to-be whilst continuing in education	Local Authority Policies/Approaches	Telephone interview/e-mail correspondence with staff in all 32 local authorities
Provide an in-depth study on the experiences and challenges of schoolgirl mothers/mothers-to-be whilst continuing in education	Participants' accounts (schoolgirl mothers/mothers-to-be)	Individual interviews Group Interviews Questionnaires
Reflect on the service and support provided by professionals (school staff/health visitors) to schoolgirl mothers/mothers-to-be whilst continuing in education	Participants' accounts (school staff/health visitors)	Individual interviews Group Interviews

### *Stage 1 – Policy review*

The cross-cutting health, education and socio-economic policies reviewed in Chapter Three were influenced by preliminary discussions with three key members of staff at the Scottish Government. The purpose of the discussions was to obtain guidance on the most relevant policies to consider for review in relation to schoolgirl mothers/mothers-to-be. Great importance was placed by the staff to consider the political aspirations behind policymaking as well as the policies themselves. An individual interview was held with each of the three members of staff. Interviews lasted between thirty minutes and one hour. Handwritten notes were taken during the interviews and typed up shortly afterwards.

Exploring the policies produced by the Scottish Government relating to schoolgirl mothers/mothers-to-be was necessary to meet the research objective and consider any gaps or potential policy areas from a national perspective which may need to be developed in future. This was also an important review to ensure contributions to academic discourses.

High numbers of pregnant schoolgirls and/or teenage pregnancy rates do not mean policies or a service provision will subsequently be put in place within a local authority. Furthermore, local authorities do not routinely produce a consistent approach through advice and guidance to schools about how to support schoolgirl mothers/mothers-to-be.

Cognisance must be given to the differing education systems in England and Scotland and to some of the Government policies reviewed in this study, which may vary. It should be noted that not all experiences and challenges of Scottish schoolgirl mothers/mothers-to-be are as a direct result of policies or the education system in Scotland. This research may, therefore, be of interest to policymakers outwith Scotland.

### *Stage 2 – Review of Scottish local authority approaches to support schoolgirl mothers/mothers-to-be*

In order to explain the different approaches taken by local authorities across Scotland to support schoolgirl mothers/mothers-to-be, a review was carried out to gather this information. This involved a telephone interview and/or e-mail correspondence with relevant members of staff in every local authority across Scotland. Initial contact was made with Education Services within each local authority with a view to establishing which member of staff had responsibility within their job remit for overseeing the support provided to schoolgirl mothers/mothers-to-be. Obtaining this information was challenging because the job titles of staff who have responsibility for schoolgirl mothers/mothers-to-be are different in every local authority. Staff are also located in a range of services across Social Work, Education (mixed in with either Culture, Sport, Leisure or Social Care), Cultural and Lifelong Learning, Health and Wellbeing, Early

Years, Chief Executive's Office, School and Family Support Service, Customer Services and Planning and, lastly, the National Health Service (NHS) itself.

During the telephone interview with the member of staff identified as being the most appropriate person to speak to, each one was asked if they had a policy document to guide schools on how to support schoolgirl mothers/mothers-to-be while continuing in education and if so, a copy of this was requested. For those who did not have a policy document, clarification was sought on the current position, for example, whether a policy was in the process of being developed. Staff were asked to outline briefly how their local authority supported schoolgirl mothers/mothers-to-be and whether a record or database was kept centrally with relevant data and statistics including the overall numbers per year. None of the local authorities held a central database to collate statistics and/or information on schoolgirl mothers/mothers-to-be across their council area. Staff were unable to provide an exact or estimated number of schoolgirl mothers/mothers-to-be in the schools within their local authority. Further information on the different approaches taken by local authorities is explained in more detail in Chapter Three. The data obtained from the review was entered into an Excel spreadsheet for analysis purposes. Local authorities were categorised into the relevant NHS Boards to ascertain whether any specific patterns were emerging.

### *Stage 3 – In-depth study of the experiences and challenges of schoolgirl mothers/mothers-to-be whilst continuing in education*

Chapter One explained that there have been very few studies carried out with schoolgirl mothers/mothers-to-be in a Scottish context. Previous research carried out in England has comprised qualitative studies or evaluations of the Teenage Pregnancy Strategy. A qualitative method is considered to be an effective means of exploring 'a world that is interpreted by the meanings participants produce and reproduce as a necessary part of their everyday activities together' (Blaikie, 2010, p99).

Exploring the world of Scottish schoolgirl mothers/mothers-to-be whilst continuing in education is a critical part of the project given that their voices have been missing from previous academic literature and Government agendas/policies. A qualitative study

allows participants to detail any personal contexts in which their experiences and challenges are located; to describe how they relate to it; and to convey their own meanings and interpretations through their explanations, either spontaneously or from the researcher's questions (Ritchie and Lewis, 2010).

In-depth discussions and allowances for variations in experiences could not be obtained through questionnaires alone. A strength of this qualitative approach is that it not only 'gives a voice to those with marginalised identities but that it allows for a specific focus on the construction and maintenance of those identities' (Elliott, 2008, p178).

#### *Stage 4 – Reflections on the service and support provided by professionals (school staff, health visitors) to schoolgirl mothers/mothers-to-be*

The role of school staff is vital in understanding the service and support provided by them to schoolgirl mothers/mothers-to-be whilst continuing in education. School staff are able to identify any issues which have arisen or are likely to arise for schoolgirl mothers/mothers-to-be who have conflicting legal demands to care for their child and remain in education. School staff are able to provide information about schoolgirl mothers/mothers-to-be dropping out of education and whether they leave school with or without qualifications. School staff can also shed light on whether schoolgirl mothers/mothers-to-be access support from other members of staff such as teachers.

As with school staff, the role played by health visitors is key to providing post-natal care to schoolgirl mothers but it does not feature in previous research studies. Health visitors in particular have access to all schoolgirl mothers within their designated area and they can be pivotal in providing practical help, advice, support, information and in setting up support groups. Obtaining information on the service and support provided by health visitors in the life of the schoolgirl mother is vital to this project to bring further understanding from multiple perspectives and to bridge a gap in the literature.

Using qualitative interviewing methods with school staff and health visitors was important for this research project. The researcher's ontological position suggests that the knowledge, view, understandings, interpretations, experiences, perceptions and interactions are not only meaningful but will help to answer and/or explore in greater depth the research questions being raised (Mason, 2007).

#### **4.4 Sample selection**

##### *Site selection*

An objective of this study was to explore the experiences and challenges of schoolgirl mothers/mothers-to-be across a range of ages and stages in pregnancy and early motherhood. Scotland has over three-hundred-and-sixty state funded non-denominational and Catholic secondary schools as well as over fifty independent secondary schools spread across thirty-two local authorities (<http://www.scotland.gov.uk/Topics/Statistics/Browse/School-Education/Datasets/contactdetails>). Independent schools have not been included in this study but they could be considered for future research projects. In the absence of a list or guide on where schoolgirl mothers/mothers-to-be would be located within these schools, a number of options were available regarding ways of sourcing participants for the study.

Before carrying out the review across Scotland, consideration was given to selecting local authorities on the basis of their policy and the number of schoolgirl mothers in each area so that comparisons could be made on the different methods of support. After conducting the review, this method of selection was not possible as only a few local authorities had a policy document. Consideration was then given to selecting local authorities by the highest number of schoolgirl mothers and any policy documents or service provision. The 'Information Services Division' (ISD Scotland) is a division of National Services Scotland, part of NHS Scotland. ISD Scotland provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care (<http://www.isdscotland.org/>). The 'Information Services Division' also produce

statistics on schoolgirl mothers in a variety of formats but in terms of local authorities, data is only available on a 3-year rolling aggregate basis or collectively for the NHS Board that they fall within. When considering the top six local authorities with the largest number of schoolgirl mothers (under 18) (on a 3-year rolling aggregate basis) alongside the results of the review, one had a policy, four had a service provision and the remainder had neither a policy nor a service provision. A third option was to consider data from the Information Services Division by the highest rate of teenage pregnancies (on a 3-year rolling aggregate basis) and any policy documents or service provision. However, this too produced a completely different picture. A fourth option was to consider data by the teenage pregnancy rate. The rates per 1000, ranged from 18.5 to 2.6. Four local authorities with the highest rate of teenage pregnancies had a policy of some form or were in the process of developing one and only two local authorities had a service provision.

None of the above four methods of selecting sites would have provided a suitable approach for comparison purposes to the way that schoolgirl mothers are supported. It was more appropriate to return to the results of the review with all local authorities and consider the methods used to support schoolgirl mothers/mothers-to-be rather than the policies or specifically the numbers. Analysing the results of the review with all local authorities in terms of the approach taken to support schoolgirl mothers/mothers-to-be helped to identify the authorities to be contacted for inclusion in the project.

The decision was taken to interview participants from three local authorities with service provisions. This would enable comparisons to be made and also to explore any advantages or disadvantages of this method. The location of these local authorities provided a geographical spread and a mix of urban and rural areas.

Eighteen local authorities advised that they did not have a policy, guidance or service provision to support pregnant schoolgirls to continue in education. Schools within these local authorities therefore took an ad hoc approach to supporting schoolgirl mothers/mothers-to-be. Fourteen of these local authorities have fewer than twenty pregnant schoolgirls on a yearly basis. In order to maximise the potential of getting

participants for the study (from these local authorities), the decision was taken to approach the four local authorities with the highest number of pregnancies.

Four local authorities stated that they used the Scottish Government's 'Getting it right for every child' (GIRFEC) approach, to support schoolgirl mothers/mothers-to-be to continue in education. In order to maximise the potential of obtaining participants (from these local authorities), the decision was taken to approach the local authorities with the two highest numbers of pregnant schoolgirls.

Six local authorities advised they had (or were finalising) a policy document or guidelines on how to support schoolgirl mothers/mothers-to-be within their schools. These policies/guidelines varied greatly, and included Child Protection Guidelines; Policy on Relationships/Sexual Health/Parenthood Education, Health, School Nursing Service, Absence and Attendance issues; and lastly, an identified pathway for schools and practitioners to follow. The decision was taken to approach two local authorities within this category.

Five local authorities that fell into the approaches outlined above and that had some of the highest numbers of pregnant schoolgirls were approached initially. Permission was granted by three Directors of Education to conduct research within their local authority but there were either very few, or no, potential participants at that time. Two local authorities did not grant permission due to concerns about ensuring anonymity because of the extremely small numbers of schoolgirl mothers/mothers-to-be or because of existing financial restraints.

### *Sampling frame*

#### *Schoolgirl mothers/mothers-to-be*

The research design required participants who were aged 18 or under. Although other studies such as the 'Growing Up in Scotland' Study involved older teenage mothers who had left school two-three years prior, it was important for this research to focus on participants who were aged 18 or under and still attending school. The age criteria



(aged 18 and under) was chosen for the study in order that the experiences and challenges of participants can be considered while they are of school age and able to attend school. The criteria of being a schoolgirl mother or mother-to-be at the time of interview was chosen to provide further understanding about the different experiences and challenges faced during pregnancy and in the early stages of motherhood, while continuing in education. Narrowing the age criterion to sixteen and under, which is the statutory school leaving age, would narrow the potential pool of participants.

There have been very few studies carried out with schoolgirl mothers in a Scottish context. The aim was to recruit participants who met the key qualifying criteria of being a schoolgirl mother/mother-to-be, who is white and was born in the UK and who lives in one of the identified local authorities, but also to ensure there was some diversity within this in terms of age. The criteria of being 'white' and born in the UK was intended to reduce any cultural or religious differences between participants. Data obtained from participants is extremely valuable and rare especially given that the perspectives of pregnant teenagers on the experiences and challenges they face when continuing in education has not been included in governmental documents or in research in a Scottish context.

Schoolgirl mothers/mothers-to-be are a heterogeneous group who come from a variety of family backgrounds and social class, and differ greatly in all respects including the support they require, educational abilities, aspirations and stages of maturity. This study was not intended to be a statistically representative sample of schoolgirl mothers/mothers-to-be. Instead the selection of participants chosen was a purposive sample, one which enables a 'detailed exploration and understanding of the central themes and puzzles' (Ritchie and Lewis, 2010). The purpose of this approach was to identify central themes that cut across the diverse range of participants and to consider the potential relationship between schoolgirl mothers/mothers-to-be and a wider context (Ritchie and Lewis, 2010). The experiences and challenges faced by schoolgirl mothers/mothers-to-be will be of interest to policymakers not just in Scotland but further afield as an illustration of the difficulties expressed in trying to continue in education (Mason, 2007). However, the data obtained cannot all be generalised across

all schoolgirl mothers/mothers-to-be in Scotland or further afield as it is based on each participant's own experiences and challenges, which are specific and personal to them (Blaikie, 2010).

Much deliberation was given over the term 'schoolgirl mother/mother-to-be'. The intention was to coin a term which made the study sample clearly identifiable in terms of the age range being covered and the location of participants within a school setting. A further aim was to move away from the more commonly used term of 'teenage parents'.

One reason for including schoolgirl mothers/mothers-to-be was to capture the experiences, challenges and outcomes which took place through showing how and when they arose and by identifying possible reasons why there are differences between participants (Ritchie and Lewis, 2010). Capturing the outcomes of participants through the follow-up interview 9-12 months after the initial interview enabled reflections to be made on the advantages and disadvantages of the approaches taken by local authorities. The project gained by including both schoolgirl mothers and mothers-to-be as further consideration was able to be given to the assumptions surrounding them through the data which was gathered about their journey through pregnancy, early motherhood and resultant short-term outcomes. The full data available on these outcomes are limited as it was not possible to regain contact with all participants after the 9-12 month period. Follow-up interviews were successfully carried out with twenty-seven participants.

It was apparent from the outset of the study that it would be impossible to determine a desired number of participants from any one school or local authority. Even when potential participants were available and agreement has been given to participate in the research, early discussions with school staff indicated there was still no guarantee schoolgirl mothers/mothers-to-be would present themselves on the day of the interview. The number of schoolgirl mothers/mothers-to-be also varies extensively across schools at any point in time.

Schoolgirls who became pregnant through difficult circumstances i.e. child abuse or who were deemed to be a 'looked after child', were included in the research although no specific effort was made to include them in the recruitment process. Schoolgirls who were pregnant and opted to have a termination were not included in the project as the research focuses on the experiences before/after pregnancy and the challenges of continuing in education with a baby. Participants who had previously had a termination and then became pregnant again and continued with the pregnancy were included in the study although no specific effort was made to include them in the recruitment process.

### *School staff*

The research design included an interview with at least one member of school staff in each of the eleven local authorities where one of the participants attended school. The purpose of the interview was to look at the existing practical and supporting role that schools play in helping to keep schoolgirl mothers/mothers-to-be in education and not to discuss any particular young person. This aspect of the research design was necessary to contextualise the data received from participants and to ensure multiple perspectives are presented. School staff were asked to offer opinions and make speculations about the experiences and challenges faced by schoolgirl mothers/mothers-to-be when continuing in education. This part of the research design was important to be able to challenge the assumptions and attitudes of professionals (health and education) alongside the experiences of schoolgirl mothers/mothers-to-be.

The factor in determining which school staff should be included in the study was that it should be a key member of staff within a school where one of the participants attends and who had responsibility for, and worked closely with, schoolgirl mothers/mothers-to-be such as a guidance teacher or depute headteacher. As each school's management team, caseloads, job titles and roles vary, the member of school staff to be recruited could not be narrowed down to any one particular role. The research design had to be flexible to accommodate the variations in staffing and roles across Scottish local authorities.

### *Health visitors*

The research design included an interview with one health visitor from five NHS Boards of Residence within which the eleven identified local authorities fall. The purpose of the interview was to gain an insight into the role of the health visitor in the life of the schoolgirl mother. Health visitors did not necessarily require to be working directly with participants in the study as it was not intended to discuss any particular case. The intention was to encourage health visitors to reflect on the totality of their experiences of visiting schoolgirl mothers as well as to discuss the type of practical and supportive role their profession provides in general terms. As with school staff, health visitors were asked to offer opinions and make speculations about some of the experiences and challenges faced by schoolgirl mothers/mothers-to-be. This was to bring further understanding from multiple perspectives, bridge a gap in the literature and, where possible, enable assumptions and attitudes of professionals to be challenged alongside the experiences of schoolgirl mothers/mothers-to-be.

### *Recruitment of participants*

#### *Schoolgirl mothers/mothers-to-be*

Consideration was given to a number of potential methods to recruit participants. These included approaching the NHS, schools or doctors' surgeries. After much deliberation it was decided that obtaining participants would be best achieved through schools. This would help facilitate the recruitment of staff from the schools where schoolgirl mothers/mothers-to-be attended.

To obtain schoolgirl mother/mother-to-be participants, contact was made with the Director of Education in the identified local authorities to discuss the project and ascertain the most appropriate schools to be approached for inclusion in the study. Research requests in local authorities are to be addressed to the Director of Education but these are often processed by staff in a Research Department. A letter was sent to the Director of Education (Appendix 3) along with a supporting letter from the researcher's employer to provide information and reassurance about the project and also the integrity and ability of the researcher to handle very sensitive situations.

Permission was received from the Director of Education to conduct research in their local authority. It was initially assumed that central staff would provide guidance on the most appropriate schools/headteachers to contact within their Authority. However, local authorities do not collate information centrally on the number or location of schoolgirl mothers/mothers-to-be in their schools. Authorities with service provisions have a central point of contact within a school but this does not reflect the total number of schoolgirl mothers/mothers-to-be across the local authority.

Making contact with the appropriate member of staff was easier in the three local authorities with the service provision. In two other local authorities, a member of staff took the decision to contact all the schools within their area and then to advise regarding the location of potential participants. In five local authorities, contact had to be made with every secondary school in the area. The number of secondary schools (Catholic and non-denominational) in these local authorities ranged from six to thirty in the larger authorities. The remaining local authority operates under a joined-up service for children and families which resulted in the search for participants being directed via the midwifery team rather than schools. Staff from the midwifery team were able to identify geographical areas which had a current and historically high number of schoolgirl mothers/mothers-to-be.

Contact was then made with headteachers of secondary schools within the identified local authorities informing them about the study and the permission of the Director of Education (or other member of staff) to carry out research. Headteachers, in consultation with their pastoral staff, acted as further gatekeepers in terms of advising whether they had potential participants within their school and if so, the appropriateness of approaching them. At no point, was the name or address of participants requested.

It was originally intended to meet with potential participants to talk about the project, provide information packs and then allow them time to discuss this with their parent(s)/carer and consider whether they would wish to be involved or not. However, this plan did not materialise as the members of staff who worked closely with the

schoolgirl mothers/mothers-to-be, themselves, requested copies of the information packs and advised that they would discuss the project with the girls and their parent(s)/carer with a view to their involvement. Information packs and consent forms were sent to the member of school staff for forwarding to potential participants. Any participant under the age of sixteen also required her parent(s)/carer to complete a consent form.

### *School staff*

Not all headteachers in the schools contacted (without a service provision) were aware of the overall number of schoolgirl mothers/mothers-to-be within their own school but permission was granted to speak to pastoral staff. Discussions with administrative staff about the project helped them to identify the appropriate person within the pastoral team who worked directly with schoolgirl mothers/mothers-to-be.

It was originally intended to interview one key member of staff within a school where one of the participants attended. In two local authorities it was not possible to bring together participants (from different schools) for a group interview. In order to obtain more understanding of the support provided for the participants, to allow for comparisons across the same local authority and to validate the data (Mason 2007), it seemed important to interview a member of school staff from both schools.

A slight alteration to the original research design had to be made in three local authorities because some participants were either not attending school or attended an alternative provision. It was, therefore, not possible to meet with these participants in their catchment school and arrangements had to be made to meet with them either at a Young Mothers group or alternative education provision where they attended. In order to understand fully the alternative schooling arrangements, the support that had been put in place and how this worked alongside schools, it was necessary to interview members of staff from the Young Mothers group and the alternative education provision.

### *Health visitors*

Approval had to be sought from the NHS Research and Development Offices before contact could be made with potential health visitor participants. After obtaining approval, contact was made with Health Centre Managers in the five NHS Boards to discuss the details of the project and to identify one health visitor to be approached for inclusion in the study. Health Centre Managers approached their staff seeking to identify those with schoolgirl mothers on their caseload and who wished to be involved in the study. Health visitors were then able to respond direct to the researcher.

### *Study sample*

Forty-three schoolgirl mothers/mothers-to-be aged eighteen and under were interviewed between November 2011 and February 2013. As shown in Table 2, the majority of participants (72%) were aged either fifteen or sixteen at the time of the interview. Involving a larger percentage of participants who were still of school age and attending school was important to this study especially as the 'Growing Up in Scotland' Study had a higher number of older teenage mothers who had left school two-three years previously. This is also important given that the policies which have been written refer to or target schoolgirl mothers/mothers-to-be.

Within the study sample, participants came from different social class backgrounds. Eight participants identified themselves as having attended a Catholic school but no reference was made to their personal faith beliefs. It should be noted that attendance at a Catholic school is possible without following that particular faith or any other religion.

***Table 2 – Age of participants***

<b>Age</b>	<b>No. of Participants</b>	<b>Pregnant (at time of interview)</b>	<b>Mothers (at time of interview)</b>
14	2	2	-
15	14	4	10
16	13	4	9
17	11	2	9
18	3	-	3
<b>TOTAL</b>	<b>43</b>	<b>12</b>	<b>31</b>

Twelve participants were pregnant at the time of the interview. Thirty-one participants had already had their baby. Two participants had had two babies. The number of participants (43) was chosen because of the type of data collection methods (individual and group interviews) (Ritchie and Lewis, 2010). Twenty-eight participants were interviewed as part of a group interview which consisted of a minimum of two and a maximum of five participants at any one time. Individual interviews were carried out with the remaining fifteen participants.

Some local authorities have pre-arranged times to bring schoolgirl mothers/mothers-to-be together, sometimes from different schools, for ante-natal care, parenting programmes or time in the nursery. Carrying out the group interviews within one of these allocated times prevented the member of staff from having to make several arrangements for interviews, often at different schools across the local authority. It also prevented participants from missing further school time. This was particularly important for schoolgirl mothers/mothers-to-be whose attendance was inconsistent. Low attendance was generally due to pregnancy-related matters or those who had just changed schools and were in the process of engaging with professionals.

Group interviews were carried out for ethical, methodological and pragmatic reasons. It was recognised that group interviews might enable greater confidence, promote peer support, help some participants discuss questions more freely and perhaps help to obtain better data. Alternatively, group interviews could have brought its own constraints. Even though some participants knew each other beforehand and were used to talking together this could have impacted on discussions as participants may have held back information that they did not wish to share in front of each other.

Other group interviews were carried out because participants were attending a Young Mothers group which has a restricted time allocation on a certain day of the week. Carrying out individual interviews could have extended over several weeks and placed a strain on the Young Mothers group to facilitate this. Additionally, schoolgirl mothers do not always attend these groups on a consistent basis. Group interviews ranged from thirty minutes to one hour fifty minutes.



Individual interviews tended to be in schools where there was only one schoolgirl mother/mother-to-be or when another participant had not turned up for the group interview. Additional arrangements had to be made to return to the school to carry out the remaining interview when a participant did not attend the first time. Individual interviews with participants had the advantage of allowing for detailed information to be given from their perspective, including any personal context regarding the experiences and challenges they faced. Participants were able to respond freely to the questions and to describe in detail any challenges, opportunities, the support provided (or not), and the emotions and experiences they encountered. This approach enabled the researcher to explore broader contexts within which changes and developments in their experiences had taken place and capture the factors that participants felt had contributed to these. Individual interviews ranged from twenty-five minutes to fifty-six minutes.

Prior to carrying out the fieldwork, it was acknowledged that participants may not wish to answer every question during the interview and that this would affect the ability to produce consistent results from the data. Reassurance was provided that participants would not be asked to talk about anything they did not feel comfortable with and could opt out of questions or activities they felt unable to answer or in which to participate. Participants chose which questions they wanted to answer. In a few group interviews some participants either did not respond to questions or everyone spoke at once. Understanding certain accents and deciphering the collective responses made at a fast pace was challenging. Care was taken during group interviews to ensure that every participant had the opportunity to respond to questions if they wished to rather than being overpowered by more dominant members. The group interviews provided high quality discussion around questions and prompted others to reflect on their experiences. Participants gained from hearing about each other's experiences and were able to pass on advice on topics that had previously caused them difficulty.

While the majority of participants were confident and responded to questions in detail, a few were very quietly spoken and only gave the minimum amount of information. The interview procedure required the researcher to ensure that topics were covered in

sufficient detail without influencing the views being expressed or probing areas that participants did not wish to answer. On other occasions, interviewees had to be steered back to the topic. A judgement had to be made on any probing questions and how to phrase these appropriately (Ritchie and Lewis, 2010). Open ended questioning techniques were used to facilitate this process whilst demonstrating a knowledge and interest in the topics being discussed but using sensitivity to discern when participants did not wish to respond. The quality of information obtained from individual and group interviews did not differ because of the data collection method. The data varied depending on whether participants chose to answer specific questions. It would have been interesting to observe some of the more quietly spoken participants in a group setting to see if this would have provoked further discussion or a more in-depth response to particular questions.

Significant consideration has been given to preserving the anonymity of participants. Identifying factors such as names, schools attended and specific information which might identify an individual have been changed throughout the thesis.

All interviews for schoolgirls and staff participants were held either in a school, a Young Mothers group or at an alternative education provision. Interviews with health visitors were held at their local health clinic.

This section has described the characteristics of the sample and reflected on the difficulties experienced at the different stages of the project. The following section will discuss the ethical considerations that arose from the project.

## **4.5 Data collection**

### *Guide for interviews - schoolgirl mothers/mothers-to-be*

A set of questions was used by way of a guide to conduct all interviews and with the aim of trying to ensure consistent results. Some of the questions addressed the assumptions made about schoolgirl mothers/mothers-to-be within Government discourse and policy agendas. These included: knowledge about sexual activity and

contraception; health outcomes for the schoolgirl and the baby; maturity; poverty and financial dependency; school attendance; (dis)engaged with education; and asking for help. Other questions in the interview guide focused on experiences, challenges, friends, sources of support, professionals and reflective feedback from participants on the session.

The questions allowed participants to tell their own story about being a schoolgirl mother/mother-to-be and their experiences and challenges of continuing in education. Additionally, the questions included areas of discussion that the literature suggests might be significant to schoolgirl mothers/mothers-to-be such as friendships, support networks and their experience of professionals.

The questions were then divided into two sets, with one set being asked during the interview and the other set placed in the questionnaire. Questions to be asked during the interview were those which required a more in-depth answer or would lend themselves to group discussion. The questionnaire (Appendix 5) was broken down into a range of sections primarily to gather background information. These included questions such as date of birth, age of baby, description of place where the respondent was growing up, current accommodation arrangements, parental employment, feelings and decisions on pregnancy, future college/employment plans and questions relating to identity. Questions on particular topics (in the questionnaire) such as feelings, decisions on pregnancy and future plans invited participants to write a little more detail in the boxes provided. A few of the topics such as the first person to be told about the pregnancy and identity changes, were also discussed in more detail during the interview. Questions on other topics such as termination, adoption, health issues, childcare and body shape were only asked within the questionnaire but these arose during the interviews in response to other questions in describing the participant's experience.

The questions to be used for this project (interview and questionnaire) were drafted and piloted. The results of the pilot were not included in this research but were used

to make minor amendments to the wording or order of the questions prior to commencing the interviews with the participants.

Questionnaires were distributed to participants prior to the interview date but not everyone chose to complete it beforehand. Some chose to fill this in on the day, at the start of the interview session. In a few local authorities, school staff requested sight of the questionnaire before passing it to participants. Feedback about the questionnaire was very positive in terms of it being very user-friendly and easy to complete. Participants who completed the questionnaire at the start of the interview session were asked for their feedback and this, too, was very positive. The purpose of distributing the questionnaire beforehand was to allow as much time as possible for discussion during the interview. On a few occasions, participants only had a set time available and the interview felt slightly more rushed.

A question on the weight of the baby was not included in either the questionnaire or the guide for interviews for schoolgirl mothers/mothers-to-be. However, this topic did arise during the interview and provided really valuable data. On reflection, a question on the weight of the baby should have been included either in the questionnaire or the guide for interviews for schoolgirl mothers/mothers-to-be in order to provide some data on health outcomes of the baby.

#### *Guide for interviews – school staff*

A set of questions (Appendices 7 and 9) were also used as a guide for carrying out the interviews with school staff and health visitors with the aim of ensuring consistent results regarding topics to be covered but also allowing for different responses. As with the guide for interviews with schoolgirl mothers/mothers-to-be, the questions asked of school staff were based on assumptions in Government agendas/policies.

The guide for interviews with school staff were separated into sections. These were to allow for background information to be provided on topics such as the school, community, socio-economic mix, catchment area of the school. Other questions focused on the support provided to schoolgirl mothers/mothers-to-be, attendance at

school, other professionals linked with the school, attendance at ante-natal classes, (dis)engagement with school, practical challenges of remaining in school, health related issues and other relevant topics. Questions surrounding experiences and challenges faced by schoolgirl mothers/mothers-to-be whilst continuing in education were prepared alongside those asked of school staff. This was to allow for multiple perspectives to be obtained on these particular topics.

Staff interviewed in schools were familiar with their own caseloads and were able to reflect in depth on these but not always on other cases across the school. Two members of staff were fairly new to their posts and were unable to provide as much historical information on trends or the support provided to pregnant schoolgirls. The staff interviewed from the service provisions and units were extremely knowledgeable about their own caseloads (i.e. those who had transferred schools) but not consistently knowledgeable about others who had chosen to remain and be supported in their own school. Members of school staff who had a central co-ordinating role across the local authority were very informed about all cases. These members of staff were located differently in each local authority and some were NHS staff while others were Education staff.

The guide for interviews with school staff were consistent and appropriate in terms of the questions being asked of schoolgirl mothers/mothers-to-be. However, the responses provided great variation because of the inconsistency in being able to speak to staff across all local authorities who had a similar role, responsibility, caseload and experience. The responses were not reflective of a standardised and consistent practice in different schools across the same local authority. In four local authorities, interviews were carried out in more than one school. Different responses to certain questions were received across the schools within the same authority.

#### *Guide for interviews – health visitors*

The guide for interviews with health visitors was divided into sections. Background information was given about health visitors and their caseload, the community, socio-economic mix, ante-natal care provided, the role of the health visitor, the health of

schoolgirl mothers in general, links with schools and other professionals, support provided, relationships and other relevant questions.

Health visitors were very knowledgeable regarding their own caseloads, but as with school staff, they were not consistently aware of cases being handled by other members in their team or across multiple teams within their NHS Board. Although the role of the health visitor is more standardised and consistent in terms of responsibility, geographical locations impacted on responses to questions and ultimately on the way the service was delivered to participants. These variations prompted other questions to be asked during the interviews which were not consistently asked across all health visitors involved in the project but which were relevant to the research questions (Mason, 2007). The intellectual skills ensuring that non-structured questions were asked during the interviews were made easier because of the working knowledge as a practitioner regarding background information on the health and education systems, the general functionality of schools, terminology and education and health policies which underpin and support these.

Some of the questions in the Interview Guide with health visitors, considered ante-natal care provided during pregnancy. These particular questions could not be answered in the same degree of detail by all health visitors. This gave an impression of a more silo style of working in some locations rather than a joined-up approach but there is no further evidence to support this notion. In retrospect, the research design may have benefited from interviews with midwives as well as health visitors. It may also have gained from interviews with more than one health visiting team within an NHS Board.

### *Integration of data sets*

Careful attention has been given to the integration of the data sets. Qualitative and quantitative results are discussed side by side in the following chapters with percentages and sample numbers being presented in the text without any complex modelling (Elliott, 2008).

All interviews were facilitated by the researcher. Although interviews are considered as being a 'neutral means of extracting information' (Holstein and Gubrium, 2004), this process did not render the researcher passive but very much as an active participant (Ritchie and Lewis, 2010). Holstein and Gubrium (2004) argue that 'interactional, interpretative activity is a hallmark of all interviews....all interviews are active interviews' (p140).

The instruments used for gathering the data provided the means to address the research questions and have provided further understanding on the question 'What experiences and challenges do schoolgirl mothers/mothers-to-be face when continuing in education?' Some of the questions strayed beyond the direct experience and knowledge of practitioners but they, nevertheless, produced valuable data which was worthy of further discussion.

#### **4.6 Data analysis**

Audio files were downloaded onto a computer after each interview and notes were made about the discussions that had taken place. All interviews were transcribed as soon as possible following the interview by the researcher and this was a crucial step at the start of the analysis to help become familiar with the data and to provoke thinking and reflections. Familiarisation of the data was carried out bearing in mind the aims and objectives of the project (Ritchie and Lewis, 2010). The interviews were transcribed in full and verbatim. Participants were asked whether they would like a copy of the transcript and if so, how they would like to receive this. For those who did wish to receive a copy of the transcript, some requested this by e-mail or through the post. A few asked for the transcript to be sent via their guidance teacher (some of whom had been present during the interviews). Transcripts were checked for accuracy before being issued to the interviewee/guidance teacher.

Each transcript was read through several times and the computer software package for analysing qualitative data (NVivo, v8) was used to facilitate the coding of the transcripts. The themes, interesting ideas and patterns which began to emerge from

the interviews during the early stages were entered into the computer in the initial stages as notes. Additional thoughts and comments throughout the process were kept in the form of a research diary. Throughout the project, a mind-mapping process was used as a way of making connections with the data and forming ideas or patterns.

The data were managed using an inductive approach and was organised using thematic analysis to explore emerging and recurring themes, meanings and concepts in and across each transcript. This aided the building of theory and enhanced the solidity of the research findings as well as providing generalisations and patterns in the data from multiple perspectives (Blaikie, 2010). Careful consideration was given to the integration of the data sets but this was helped through using the same thematic analysis although adding any new themes as appropriate. Importance was placed on ensuring that the individual meanings of the data were retained and that participants' perspectives were not misrepresented (Mason, 2007). The reasons for any differences were explored to find understanding in their context, rather than attempting to measure any differences. Links between the categories of data were grouped thematically and sorted under main headings and then sub-headings. The main headings in the conceptual framework remained permanent and were informed in the early stages by the research questions.

Some analysts (Ritchie and Lewis, 2010) refer to 'indexing categories of data' whilst others talk about 'coding data' (Blaikie, 2010). Using Ritchie and Lewis' (2010) definition, the data was indexed by 'reading each phrase, sentence and paragraph in fine detail' and deciding 'what is this about' in order to decide which main heading/sub heading it applied to (p224). This process was carried out systematically to the whole data set using NVivo (v8). The data was brought together in themes electronically with careful attention being given to ensure that the material was not removed from its context. Opportunity exists within NVivo to assign data to multiple locations and this facility was used. Although the main headings in the conceptual framework did not change, the sub-headings underneath did alter as new ones emerged from the data during the process of analysing the transcripts.



Interview transcripts were read with the main headings in mind (i.e. experiences and challenges) but while also considering comparisons such as: different approaches taken by the local authority; multiple perspectives from schoolgirl mothers/mothers-to-be; school staff and health visitors; age of participants (schoolgirls); social class; data from individual/group interviews; or patterns that emerged from participants' experiences.

### *Myself as a researcher*

During the fieldwork stage, I was conscious of my advantage as a practitioner in having prior knowledge of schools and their operating procedures (Alderson and Morrow, 2011). This did not prevent school staff from explaining procedures but instead provided a platform to begin discussions. Having background knowledge provided reassurance to professionals that the information being shared was understood and potentially less likely to be misinterpreted. A level of comfort and ease during the interviews allowed discussions to operate as a two-way process. Having a dual role as an 'insider' (practitioner) and an 'outsider' (not working in any of the local authorities visited), brought significant value to the project. It allowed me to be 'able to see issues that insiders overlook' and be 'more free to take an independent critical view' (Alderson and Morrow, 2011, p5).

Being an 'insider' and 'outsider' did bring its own challenges and disadvantages. I had to be very clear with myself about when I was wearing my 'researcher' or 'practitioner' hat (Alderson and Morrow, 2011). Wearing my 'researcher' hat allowed me to be more 'critical and challenging' (Alderson and Morrow, 2011, p6). Wearing my 'practitioner' hat permitted me to build up working relationships with staff and to 'work critically on questions instead of assumptions' (Alderson and Morrow, 2011, p6).

There are a variety of sources from which prior knowledge held by a researcher is obtained. This knowledge and becoming familiar with the literature started to shape the research field and provoked thinking and influenced choices and decisions made regarding the project. Being an 'insider' provides professional contacts, trust, rapport

and good working relationships along with knowledge of the topic. It may appear to have opened more doors and provided quicker, easier access to participants (schoolgirls and staff) than if I had been someone external to the local authority or education system. Being a practitioner in another local authority may have made me seem more of a cross-authority colleague although no words to this effect were mentioned. However, this was not the case and two local authorities refused access due to low numbers and/or a fear of a lack of anonymity due to the small number of schoolgirl mothers/mothers-to-be in their area.

Literature alerts researchers to the power relations between adults and children/young people (Mayall, 2011) and suggests careful consideration has to be given to the 'appropriateness of different (research) methods' in relation to age and the 'lived experiences and consequent competencies of individual children/young people (O'Kane, 2011, p132). A positive engagement with participants 'is not only desirable it is also necessary to improve the credibility of the knowledge we derive from research' (Fraser et al, 2006). There are different elements of my identity that may have contributed to the interaction between participants and myself viz. being female, a student, practitioner, mother, having a caring nature, being softly spoken, with a Northern Irish accent, and having a pleasant demeanour. There is the possibility that my gender and caring/calming approach could have impacted upon responses received to questions but also to the relationship with participants.

Gallagher (2010) argues that 'the ability of researchers to care for others' is related to 'their ability to care for themselves' (p19). 'Practitioners who feel valued, supported and respected' at work are better able to provide the same to those with whom they work (Gallagher, 2010, p19). I enjoy spending time listening and talking to people of all ages. It is difficult to hide the value that I place on the time spent with people I come into contact with or the passion I have for my work and this research. This aspect of my identity and the way I relate to people played a vital role in the research relationship.

I had confidence in my skills to conduct research with participants on sensitive topics through several years' experience as a practitioner. Listening skills and supporting young people and professionals are a key part of my role as a practitioner. A conscious effort was made to ensure that the supporting role with schoolgirl mothers/mothers-to-be was not included as this was already being provided by school staff and other agencies.

At the outset of my fieldwork, I carefully considered what might be appropriate clothing to wear to the interview and what messages would be conveyed as a result. A suit or semi-formal outfit might be considered more professional to other practitioners but too formal for schoolgirl mothers/mothers-to-be. In the end, clothing was often dictated by the weather, how far I was travelling, where I had been previously with my work or where I was heading after the interviews.

## **4.7 Ethical considerations**

### *Scottish Educational Research Association (SERA) ethical guidelines*

The Scottish Educational Research Association (SERA) Ethical Guidelines for Educational Research (2005) were adhered to throughout the duration of the study (Appendix 2). There is no formal internal Ethics Committee within local authorities or schools and the responsibility for decisions on research requests and ethical issues rests initially with the Director of Education. Once approval is given by a Director of Education, research requests and ethical decisions are delegated to headteachers in each school. Headteachers then decide which member of staff (i.e. guidance teacher) can be approached for them to consider whether they wish to be included in the research. Decisions were taken by the guidance teacher about which schoolgirl mothers/mothers-to-be could be approached for possible inclusion in the project.

### *Potential risks to participants*

It was anticipated that the research topic could be sensitive for some participants. The schoolgirl mothers/mothers-to-be who were participating in the study were likely

already to have social work and police involvement especially if the pregnancy occurred as a result of child abuse. Participants may have found the interview quite daunting, or threatening, or they could have been reluctant to share information in any great detail. Some questions had the potential to uncover painful experiences or to lead participants to disclose information they may never or had rarely, shared before. Alternatively, participants with social work or police involvement may have been used to sharing in-depth personal information and this could lead them to reveal more details than was required for the purposes of the research. To address these concerns, a range of measures were put in place.

The research tools and techniques were piloted with five schoolgirl mothers/mothers-to-be from the researcher's own locality area. The purpose of the pilot was to review the research tools and techniques and to make any minor amendments before using these with other schoolgirl mothers/mothers-to-be involved in the study.

Schoolgirl mothers/mothers-to-be involved in this study were invited to participate through an easy-to-understand information leaflet which was given to them by their guidance teacher. Participants were able to discuss this with their guidance teacher, to take the information home, and to discuss this with their parent(s)/carer before making a decision about getting involved. Schoolgirl mothers/mothers-to-be (and the parent(s)/carer of those under age sixteen) returned an informed consent form to let the researcher know they were interested in participating in the study.

The session with participants began by talking about: confidentiality; the importance of feeling safe; respecting and handling data sensitively; not being asked to talk about anything they felt uncomfortable about. The researcher carefully explained what the project was about, why she is interested in it and provided a short outline of her background. Participants were reassured of the role of the researcher in that she was not a teacher and there were no right or wrong answers. The session was carefully planned and thought through to include an introductory activity. Participants were then able to choose which tools and techniques they felt comfortable in participating and working with and opted out of any which they did not feel at ease with. One

advantage of explaining the background about the project to participants was that it was able to be adapted in a way which was appropriate and easy-to-understand. Adaptations in terms of literacy abilities were possible because of the researcher's experience and a working knowledge of young people.

The interview period included time and space for participants to reflect, to talk around the research tools and techniques, or to have a rest should they wish. Should participants have started to reveal more information than necessary, this would have been carefully managed. Participants would have been advised sensitively that this level of detail was not necessary for this project. Any issues of concern raised by participants would have been addressed by advising them who they should speak to regarding these. As the researcher lives outwith each of the local authorities, this responsibility would have been passed to other support providers. This type of scenario did not arise. As mentioned above, staff had a close relationship with schoolgirl participants and were aware of the background details and their current situations. A closing activity took place which allowed open discussion time for participants to review and reflect on their experiences and also to discuss anything else they wished to raise.

There was a possibility that participants might disclose information that revealed they were at risk of experiencing physical, emotional or sexual abuse or neglect. The researcher is trained as a practitioner in identifying child protection issues. Should any issues have arisen during the interviews that would obligate the need to report these to social work, the police or other authorities, the young person would have been advised of this and that the researcher is obliged to follow child protection guidelines. This would have been handled in a respectful manner by listening carefully, providing reassurance and by talking to the participant about what action would be taken. The matter would then have been discussed with a member of school staff. The contact details of the researcher were provided and participants were encouraged to get in touch should they have any questions. This situation did not arise.

The researcher had an Enhanced Disclosure Scotland check at the time of the interviews through her employer and is now a member of the Protecting Vulnerable Group Scheme.

### *Gatekeepers*

Although school staff had communicated with participants about the nature of the project, all schoolgirl mothers/mothers-to-be were asked at the start of the individual and/or group interviews whether they understood the information about the project and whether or not they required to be told anything further. Some participants did ask for further information while others seemed happy with the details they had already received. On the day of the interviews, snacks and juice were provided but not everyone chose to consume these.

In some local authorities, permission was granted to carry out research under the proviso that unsupervised access to participants would not be permitted. However, on arrival for the interview, this procedure as set out by the local authority, was not always adhered to by the school. In other cases, members of school staff asked participants whether they wanted them to stay in for the interview in case they were needed to help provide background information or whether they would prefer them to leave. Participants then made their own decisions.

In another local authority the member of school staff made the decision to stay in during interviews without consulting the participants. It could be viewed that staff staying in during the interviews could potentially restrict participants from speaking freely in response to the questions. However, the participants commented that staff already knew everything there was to know about them. This response from participants was subsequently born out and demonstrated an insight into the depth of the relationship between these members of staff and their pupils. It also highlighted the extent to which some staff had gone to get to know the pupils on their caseload.

### *Informed consent*

Challenges were anticipated in accessing schoolgirl mother/mother-to-be participants given that some would already be classified as being 'vulnerable'. Concerns existed around how much influence gatekeepers (headteachers/school staff) would have and whether potential participants would have the opportunity to consider being involved in the project. In some local authorities potential participants were not informed about the project and were not given the opportunity to make a decision as to whether or not they wanted to be involved.

Obtaining informed consent is a complex and difficult process (Mason, 2007). Consideration had to be given as to whose consent to ask for first. Given that school staff approached potential participants in the first instance, it could be argued that there was an element of 'persuasive influence' by trying to please the teacher (Mason, 2007). It is hard to determine how much choice participants had over participation and whether or not the consent gained was indeed informed.

Additional concerns existed around obtaining parental consent for participants who were under the age of sixteen. Longstanding debates on this topic questions whether it is appropriate for a third party to give consent on someone else's behalf i.e. a parent on behalf of a child (Mason, 2007). In light of this project, it seems a contradictory situation whereby parental consent is required for participants under the age of sixteen who are themselves parents and making decisions about their own children. This is even more the case because the legal position in Scotland 'does not preclude an older and more mature young person making his or her own decision without involving a parent' (Fraser et al, 2006).

Consent was requested at the different stages of the project rather than at one specific time to cover all situations. For example, consent was requested by school staff from schoolgirl mothers/mothers-to-be prior to the interview, then by the researcher at the beginning of the interview session and, finally, at the start of the follow-up interview by the researcher.

A digital recorder was used in all interviews and participants were given the choice regarding whether or not they agreed to this for the duration of the session, part of the session or not at all. This allowed full attention to be given to the interviewee(s) rather than having to pause and take notes and therefore run the risk of missing vital information (Elliott, 2008).

#### *Timing data collection*

It was anticipated at the outset of this project that the experiences and challenges of schoolgirl mothers/mothers-to-be evolve over the course of time. In order to capture these and/or look at the impacts, consequences and outcomes, a second interview (telephone or in person) was held with participants over a 9-12 month period. This timescale provided a degree of flexibility in arranging interviews. It also allowed for changes and developments to be considered diachronically rather than at a single point in time (Blaikie, 2010). Lastly, the 9-12 month period allowed explanations to be considered on how and why there might be differences experienced between participants (Ritchie and Lewis, 2010).

Some young mothers do not return to education straightaway and some do not return at all. However, leaving too long a timescale between interviews may have resulted in losing contact with participants especially if they had left school or moved house. Too long a period might have resulted in participants being unable to recall accurately the experiences and challenges that had taken place since the original interview.

### **4.8 Implications for policy and practice**

Based on the qualitative accounts of forty-three participants in this study, this thesis has highlighted some of the experiences faced by schoolgirl mothers/mothers-to-be when continuing in education. Not only does the thesis go some way towards offering explanations for the challenges encountered by young mothers when continuing in education but it will be informative and assist professionals across Scotland in their work with schoolgirl mothers/mothers-to-be.



The type of support that participants stated was available to them covered a wide range of areas. These included: arranging a key worker, organising multi-agency meetings, reviewing timetables, organising toilet or lift passes, helping source information, attending home visits, providing home tuition, examination preparation, arranging childcare, organising the transfer to another school, assisting with college applications and arranging a Young Mums group. This data is important for policymakers in terms of providing further understanding of the timescales and periods during which schoolgirl mothers feel they require help and support but also the kind of information they need. The data also offers a potential insight into the types of questions that schoolgirl mothers-to-be have during pregnancy and the early stages of motherhood. Questions which participants in this study raised during pregnancy and the early stages of pregnancy covered a variety of topics including health and wellbeing, caring for their baby, timetables, examinations, transport, childcare, finance and budgeting, housing, careers, employment and further education. The majority of questions raised by participants on these topics can be responded to by school staff or health professionals. For school staff who support schoolgirl mothers/mothers-to-be on a regular basis, this information is more readily available. School staff who have small infrequent numbers of schoolgirl mothers/mothers-to-be are less familiar with certain questions such as those on financial issues, benefits and housing matters. A range of information and support was required by all schoolgirl mothers/mothers-to-be regardless of which school they attended or what approach the local authority used to support them when continuing in education.

Practical help was needed from school staff to arrange different supports such as childcare, arranging to get out of class early, providing lift passes and altering timetables which made it easier to continue in education. In addition to this practical support there was the need for emotional support whereby school staff were required to be accessible, approachable, willing to listen and able to provide answers or know who to approach for help, and be able to deal with situations as and when they arose such as addressing bullying issues from the participant's peer group.

Ensuring effective and timely support can impact positively not only on young mothers themselves but on their babies in years to come. Emphasis is placed by Vincent (2012) on policymakers about the need to ‘recognise the different life choices and values placed on motherhood and the timing of motherhood...and to reconsider the implications for educational continuity’ (p158). The testimonies of participants in this study show clearly that although the timing of their pregnancy was not planned, no-one regretted having become pregnant. Indeed, many participants talked about how a baby had turned their life around for the better. Participants were more motivated to continue in education and gain qualifications so that they could get a good job in future and be able to support their baby. Forming policy in consultation with schoolgirl mothers/mothers-to-be who will be affected by the resultant document and subsequent decisions is a key starting point for policymakers (Vincent, 2012). Although there are numerous policies across health, education and socio-economic inequalities, these do not match the experiences and challenges of schoolgirl mothers/mothers-to-be who are trying to continue in education.

#### **4.9 Reflections and future research**

Careful consideration was given to include schoolgirl mothers/mothers-to-be with a range of diverse experiences and challenges but arguably this may not have been accomplished. Diversity of experiences and challenges has been explored across participants but the study does not have representation from all thirty-two local authorities in Scotland. The small number of participants involved in the project is not of a significant scale for ‘measuring the representativeness of sample of people against a wider population’ (Mason, 2007).

Participant recruitment was not a truly random sample given that it was influenced by staff in schools who made decisions about which potential participants they would approach to be involved in the study. There were other schoolgirl mothers/mothers-to-be who were not invited to be part of the research because of concerns that school staff had. These concerns covered a range of issues such as poor attendance, chaotic lives, close to delivery date, unlikely to turn up, too far away geographically and cost

implications of bringing them together in a group interview. School staff that had larger numbers of schoolgirl mothers/mothers-to-be were keen to provide a range of participants across the year stages and those with a variety of experiences.

It was not possible to select an equal number of participants within certain age groups, at particular stages of pregnancy or at specified schools within a local authority. Recruiting participants through categorising them by experiences and challenges was not possible as this information was not available beforehand. Sampling was therefore limited to classifications of being a schoolgirl mother or mother-to-be, aged eighteen or under, white, born in the UK and who live in one of the identified local authorities in Scotland. The chosen sample has provided data which can be generalised but this may not be reflective of the experiences of Scottish schoolgirl mothers/mothers-to-be who have disabilities, learning difficulties, additional support needs, have been in care, or who come from ethnic minority groups.

Future research could take a different approach and consider interviewing participants and those within their sources of support such as their family, friends, health and education professionals. This would provide more information about the type of support provided to schoolgirl mothers from informal sources (family and friends) as well as allowing for insights into the impact of a schoolgirl pregnancy on close family members.

Sex education presented to pupils in Catholic schools takes a different approach compared to non-denominational schools. This research could have considered further questions to consider whether there are more or less schoolgirl pregnancies in Catholic schools as a result of a different approach being taken to deliver sex education to pupils.

## **CHAPTER 5**

### **CHALLENGING THE DEFICIT MODEL THAT CHARACTERISES SCHOOLGIRL MOTHERS/MOTHERS-TO-BE AND THE EXISTING RESEARCH LITERATURE**

‘You do become more confident when you are a mum.....You just see the world from a different perspective because you have a baby, so you are thinking as a mum and not as a teenager’.

(Vanessa, 17)

#### **5.1 Introduction**

Chapter Two considered the deficit model characterising schoolgirl mothers/mothers-to-be and the existing research literature. The chapter acknowledged the assumptions surrounding schoolgirl mothers/mothers-to-be, as contained in Government agendas/policies, uncritically begin with taken-for-granted assumptions to commence further discussions about schoolgirl parenting. Previous studies and Government agendas/policies focus on the same three broad areas (health, education and socio-economic) when discussing schoolgirl parenting. Debates continue within these discourses about whether schoolgirl mothers/mothers-to-be: lack knowledge about sexual activity and contraception; have an increased risk of poor health outcomes; lack the maturity needed to make informed decisions about sex; and are financially dependent and live in poverty. It is important that the deficit model is challenged before full consideration can be given (in the remaining findings chapters) to the experiences and challenges schoolgirl mothers/mothers-to-be face when continuing in education after becoming pregnant through to early motherhood. This chapter challenges the deficit model that characterises schoolgirl mothers/mothers-to-be by comparing this alongside participants’ experiences and including the views of school staff and health visitors where appropriate.

This chapter is divided into four sections. The first section considers the assumption that schoolgirl mothers/mothers-to-be lack knowledge about sexual activity and

contraception. Consideration is given in the section to participants' views about the knowledge and information they received from school about relationships, contraception and sexual activity. It goes on to explore with participants the suggestion presented by Arai (2005) that schoolgirl mothers-to-be are naive about the demands of parenthood. The second section challenges the assumption that schoolgirl mothers/mothers-to-be have poor health outcomes. Drawing on the experiences of participants and the accounts of school staff and health visitors, the section considers the physical and mental health outcomes of schoolgirl mothers/mothers-to-be. In the third section, the assumption that schoolgirl mothers/mothers-to-be lack maturity is challenged. As maturity is not a straightforward measurable aspect of a person, this section focuses on how participants perceive and experience maturity. Finally, the last section begins to challenge the assumption that schoolgirl mothers/mothers-to-be are financially dependent and living in poverty. It is not possible to fully challenge the assumption that schoolgirl mothers/mothers-to-be are financially dependent and living in poverty given that the longer term outcomes for participants are not known. The section begins by looking firstly at the employment status of participants' parents before going on to explore participants' own educational plans and career aspirations for the next five years.

## **5.2 Lack of knowledge about sexual activity and contraception**

Schoolgirl pregnancies are assumed, in literature (Macvarish 2010, Alldred and David 2007), as well as the English Government's Teenage Pregnancy Strategy to occur because of a lack of knowledge about sexual activity and contraception or through an inability to negotiate sexual relationships. A lack of knowledge about sexual activity and contraception is thought to lead to an unplanned pregnancy (Macvarish and Billings, 2010). Such a view is contested in other research (Duncan et al, 2010) as there is insufficient evidence to suggest a lack of knowledge causes pregnancy or increased knowledge helps prevent it. Bonell et al's (2005) study tested the hypothesis that schoolgirls who disliked and were disengaged from education did not develop the knowledge and confidence to avoid becoming pregnant

but the findings did not support this theory. A revised hypothesis was carried out by Bonell et al to test whether early parenting could be predicted from the schoolgirls who disliked school but, again, there was no evidence for this theory.

Respondents to the questionnaire were asked if they felt they lacked information or knowledge from Personal Social Education classes at school about relationships, contraception or sexual activity, which they thought contributed to them becoming pregnant. In response to this question, twenty-six replied no, four did not comment and the remaining thirteen replied yes. Bethany who did not feel she lacked information suggested the existing information could be improved by hearing directly from someone else's experience.

‘The school gave all the right information although it would have been helpful to hear from a young mum's point of view’ (Bethany, 17, Group Interview 1, 4 people).

Participants who answered yes were asked to describe what information could have been better. Six of the thirteen participants who answered yes attended a Catholic school (eight participants in total attended Catholic schools). Four of the six participants stated there was no sex education in their previous school nor were they told about contraception. The remaining two did not make any further comment.

The seven remaining participants (of the thirteen) attended non-denominational schools. Two of these participants did not make any further comment but five (from different interviews) talked about wanting to ‘know everything’ as ‘it didn't get spoken about at school’ (Jodie, 15, Individual Interview). More information was requested on contraception for first and second year pupils in secondary schools (Lauren, 16, Group Interview 7, 2 people). The remaining participant said she was not allowed in the sex education class and was told that she was ‘too immature’ (Paige, 15, Individual Interview).

*Naivety about the demands of parenthood* - Arai (2005) continues the debate about pregnancies occurring because of a lack of knowledge and states that planned

schoolgirl pregnancies are attributed to naivety about the demands of parenthood. Participants were asked in the interview about their thoughts regarding what motherhood was going to be like. Participants had come to a realisation about the demands and responsibility of motherhood at different stages of pregnancy, just before labour, or when they held the baby in their arms for the first time. Only a very small number of participants (one or two) said they had not thought about what motherhood would entail. Six participants who were part of a large family and had to help care for younger siblings or cousins said they were aware of the demands of parenthood. Participants talked about how they knew their life and future was going to change. Preconceived ideas existed that pregnancy would be the easy part of their journey but, for those who had been unwell and really sick, this was not their experience.

Views and opinions on motherhood were influenced by others within participants' own networks and were at opposing extremes. One image of motherhood was portrayed as being an 'easy sugar coated idea' of having a 'nice wee baby' and 'dressing it up like a doll' (Vanessa, 17, Individual Interview). The other image portrayed was about motherhood being extremely difficult, something they would not cope with due to the demands of being up during the night with the baby crying or not sleeping, having no social life or life at all, receiving no support, being stressed, having 'baggy' eyes, looking 'a mess' and that this was 'just the end of the world' (Abbi, 17, Individual Interview). In the middle of these two extreme portraits, Vanessa explained that motherhood was falsely portrayed to her as something which came naturally to females but she found that motherhood required a lot of effort (Age 17, Individual Interview).

Assumptions are made in Government agendas/policies ('Respect and Responsibility' 2005, 'Under-age Sexual Activity' 2010') that schoolgirl mothers/mothers-to-be lacked the maturity needed to make informed choices about sex which resulted in them having an unplanned pregnancy. Yet despite this assumption, Paige (Age 15, Individual Interview) talked about being told that she was 'too immature' to go to the sex education class. Assumptions surrounding schoolgirl mothers/mothers-to-be lacking knowledge about sexual activity, contraception and maturity appears to be placed solely on the young person's part and their apparent lack

of responsibility. The assumption about a lack of knowledge and maturity is considered stereotypical and characteristic of schoolgirl mothers/mothers-to-be. In light of some participants' experiences, as mentioned above, this assumption would appear to be misaligned.

A few participants questioned their readiness for motherhood and their ability to 'step up to the mark to be able to cope' with the demands of parenthood (Britney, 17, Individual Interview). At this stage, ten participants had considered having a termination because they were concerned about not being able to reach the standard of parenthood that would be demanded of them and because they did not know if they would have the support they needed. These preconceived ideas of motherhood manifested themselves differently even for those who had previous experience with siblings and cousins. Some who thought it would be easy went on to find aspects of parenting difficult and they acknowledged they had not fully anticipated how hard it would be. These difficult times revolved around feelings about pregnancy going on forever, a changing body image, having to get up in the middle of the night to feed the baby, being unable to comfort the baby when it cried, being tired from a lack of sleep, facing practical challenges of making up bottles and changing nappies. Even though the changes in participants' body shape were not always welcomed, motherhood brought a new awareness and understanding about 'womanhood' that they had not previously considered. Feelings regarding motherhood for one participant became more naturalised through realising 'we are all women and your body was made to have kids' (Kyra, 17, Group Interview 10, 2 people).

In addition to the notions about motherhood, participants considered the impact a baby would have on their relationship with their family, boyfriend and friends. Thoughts about boyfriends were mainly focused on whether or not they would support them, take on the role of father, or if the pregnancy would be used as an opportunity to part company. The impact of motherhood on future exams and career paths were also considered. Worries and concerns existed about the challenges of juggling the pressures and demands of school work, exams and a baby.



Participants in the study had found their own way to come to terms with the demands of motherhood. Acknowledging how difficult motherhood was going to be and believing in themselves was really important. Knowing that family, friends and school staff were there to help made the thoughts of coping with the demands of parenthood a lot easier for participants rather than having to manage on their own. Establishing a routine and a structure for the baby had become important for three participants in order to get through the daily demands of living and going to school. The early days of motherhood were acknowledged as being hard, but becoming slightly easier as routines became embedded. All participants accepted that despite the frustrating days where 'you feel like you just want to smack your head off a wall', motherhood was, by far, 'the best feeling ever' (Lilly, 16, Group Interview 5, 5 people).

It had taken time for participants to come to terms with the fact that allocating time for themselves to read a magazine, go for a bath, make something to eat or go out, were all important in order to be able to deal with the challenges of change brought about by motherhood. Participants learned to plan their social life ahead of time as they had to ensure childcare was in place. Perspectives on life changed after having a baby and the attraction to activities such as going out every night or at the weekend altered to the extent that the majority of participants no longer wanted to do these things. Life had changed so much for some participants, they could not understand why they had ever wanted to go out drinking and partying. These activities and behaviours were now viewed by some participants as being immature. It is unclear from this study how unique and specific these life changes and identity challenges are to schoolgirl mothers/mothers-to-be.

A few participants commented that those who talked to them about coping with the demands of a baby focused purely on the hard times and that no-one mentioned there would be good times as well or that it would be rewarding. Neither had anyone commented to participants that there would be different levels of 'hard' which would affect them emotionally, physically and psychologically in such a dramatic way both now and in the future. All the hard work, juggling of exams and school work, risk over relationships, changes in social life and less free time were viewed as being

worthwhile because of the end result in having a baby. No participant said they regretted their decision to continue with the pregnancy. Participants did say that they ‘would not change it for the world’ (Sam, 15, Group Interview 9, 2 people).

Arai’s (2005) comments about schoolgirl mothers being naive about the demands of motherhood may well refer to thoughts prior to conception. Given that participants questioned their readiness for motherhood and ability to ‘step up to the mark’, this would suggest they had a preconceived idea of what it would be like and were going through a process of evaluating whether they could achieve this. Being aware of the demands of parenthood is something which can be experienced through caring for someone else’s child but this is different from having your own baby and being entirely responsible for it.

### **5.3 Health outcomes for the schoolgirl and the baby**

#### *Physical health*

*Ante-natal care* – Despite previous research on the socio-economic and health aspects of schoolgirl parenting, debate continues about whether a young age as opposed to poverty or a lack of ante-natal care are more linked with adverse outcomes for the schoolgirl mother and her baby (Arai 2009, Daguerre and Nativel 2006, Duncan 2007, Duncan et al 2010).

Daguerre and Nativel (2006) suggest that the lack of ante-natal care might be more linked to adverse outcomes for schoolgirl mothers/mothers-to-be rather than their young age. The lack of ante-natal care may result in poor health outcomes for some schoolgirl mothers but this does not reflect the findings of this study. Participants were asked in the interview if they had regularly attended ante-natal appointments. Forty-one participants advised they had attended either all or most of their ante-natal appointments. Only two participants did not attend ante-natal appointments and this was due to their pregnancies being concealed. The word ‘concealed’ in this project is used in relation to two different sets of circumstances, firstly a participant not finding out about her pregnancy until the third trimester and secondly a participant knowing

she was pregnant but deliberately concealing this from family and professionals. The participant whose pregnancy was concealed until the latter stages had attended ante-natal appointments when she found out she was pregnant. The remaining participant, Caitlyn, knew she was pregnant but did not attend ante-natal appointments.

On reflection, Caitlyn felt she had missed out, especially as she did not get the ultrasound scans and she regretted not having spoken to someone about being pregnant.

‘I did go to the doctors to actually do a pregnancy test but they tested it for something else. I was too scared to go back, so I didn’t’.....I think it was silly for not telling anybody because something could have went wrong....I shouldn’t have taken the risk that I did and I wish that I didn’t’ (Caitlyn, 15, Group Interview 1, 4 people).

Participants enjoyed ante-natal appointments and were particularly proud of the fact that they had attended them. The reasons given for valuing ante-natal appointments varied but included hearing the baby’s heartbeat, seeing the baby on the screen during the scans, receiving information and booklets with advice, getting their own pregnancy file, checking everything was alright with the baby and seeing other babies in the clinic. Regular attendance by schoolgirl mothers-to-be at ante-natal appointments was confirmed by four of the five health visitors interviewed in this project.

‘There generally was not a lot of failure to attend from these young girls....that was not something that I really ever saw as a massive problem. If you invited them they would come to the midwife because that was what they wanted, to hear the heartbeat.....they would generally come’ (NHS Board 3).

Only one health visitor made comment that attendance at ante-natal appointments in her area varied considerably and depended on the individual family. Reasons suggested by the health visitor for non-attendance included the widespread geographical and rural areas which made it difficult to reach the clinics, not seeing the value in ante-natal care, feeling fine health wise in themselves and not appreciating that something could still be wrong. Concerns about being judged by midwives and doctors may also have been a possible factor.

Daguerre and Nativel's research (2006) which suggests that a lack of ante-natal care might be more linked to adverse outcomes for schoolgirl mothers/mothers-to-be is now dated and does not reflect current practice on ante-natal care across Scotland. In five of the eleven local authorities, the NHS had altered their normal ante-natal procedures for schoolgirl mothers-to-be. These variations in practice included midwives travelling to pregnant schoolgirls as it was difficult for them to get to the clinics. Midwives or the family nurse were able to take the ante-natal care into the schools where schoolgirl mothers-to-be attended, or into their homes. This reduced the amount of time that participants were away from their lessons and prevented transport challenges. Another local authority had a Young Mothers group which took place within the community and ante-natal care was organised as part of the weekly programme. These changes in practice helped ensure that participants received ante-natal care.

*Screening tests* - During pregnancy, women are offered tests to check on their baby's health as part of their ante-natal care. These include an ultrasound scan and blood tests to screen for foetal abnormalities such as Down's Syndrome and Spina Bifida. Although these screening tests do not provide a definitive answer as to whether a baby has Down's Syndrome or Spina Bifida, they can assess the chances of how likely it is that the baby might have one of these conditions. The tests are normally carried out during the first trimester of pregnancy (between 11-14 weeks) but blood tests can be offered during the second trimester. If screening test results reveal a higher than normal risk, women (of all ages) are offered an amniocentesis. This test can be carried out during the second trimester of pregnancy (weeks 15-20) and the procedure involves a fine needle being passed through the wall of the tummy into the amniotic fluid which surrounds the baby. A risk associated with having this test is that it carries a 0.5-1% chance of causing a miscarriage.

While some participants did not comment during the interview, many others were in favour of having the ultrasound scans and enjoyed this experience. Five participants did not mention whether they had taken the ultrasound scans or the blood tests. A further five stated they had not found out about their pregnancy until it was too late to

have the screening tests. Two pregnancies were concealed and so these participants did not have any ultrasound scans or blood tests. Concerns existed amongst participants about an increased risk of having a baby with health problems. Views on having blood tests taken for foetal abnormalities varied across participants for emotional and practical reasons. Emotional reasons for not having the tests centred on concerns about the results coming back positive. Such results would have meant that participants had then to make a decision as to whether to continue with the pregnancy. Having a baby with a disability was acknowledged as something that could happen but it did not deter participants from feeling that they would still love and accept the baby. Practical concerns which participants expressed about taking the screening tests focused on concerns about a potential miscarriage and a fear of needles. Some dubiety existed on the accuracy of tests because of family members or friends whose results had been positive but they had subsequently given birth to a healthy baby. Other participants did want to know the results so that they could psychologically prepare themselves if something were amiss.

*Ante-natal classes* aim to help prepare pregnant woman for labour. They are viewed by the Scottish Government as being ‘one of the cornerstones of the provision of ante-natal education’ (GUS, 2011, p19). Different arrangements and choices for labour can be discussed and assistance provided to draw up a birth plan. All pregnant women can then discuss their plans along with any questions or concerns they might have with professional staff. The classes present an opportunity to meet other pregnant women, obtain useful information on caring for oneself post-nataly and feeding the baby. Classes generally start 8-10 weeks before the baby is due and can run weekly.

Participants were asked in the interview if they had/were planning to attend ante-natal classes. A range of responses were provided to this question (Tables 3, 4). Schools with a service provision organise special ante-natal classes (run by the NHS) for those aged nineteen and under so that they are not in classes with older mums. As with ante-natal care, one local authority had organised classes as part of their Young Mothers group and local midwives delivered these.

As can be seen from Tables 3 and 4, attendance at ante-natal classes which were specifically run for schoolgirl mothers was much higher than the local authorities who did not offer this service. It is not possible to know whether participants in Table 3 would have attended the normal NHS ante-natal classes attended by older mothers. Several participants commented that their preference was to attend a class with people their own age. Other participants had no concerns about joining a class with older mothers.

‘I would have felt a wee bit insecure because they were all older and then there was me sitting there [age] 15’ (Tara, 15, Individual Interview).

‘I don’t think it would bother me either way, just to get out there and talk to other folk that have got young children’ (Bethany, 17, Group Interview 1, 4 people).

Twelve participants were pregnant at the time of the interview. Their thoughts on attending future ante-natal classes are given in Table 5 below.

**Table 3 – Attendance at special NHS ante-natal classes**

<b>Special NHS Classes</b>	<b>No of participants</b>
Service provision <ul style="list-style-type: none"> <li>• Attended</li> </ul>	10
Young Mothers group <ul style="list-style-type: none"> <li>• Attended</li> <li>• Did not attend (participant was not informed, otherwise she would have attended)</li> </ul>	2 1
Project midwives <ul style="list-style-type: none"> <li>• Did not attend (one participant had a concealed pregnancy, the other advised she had too much on at that time)</li> </ul>	2
Classes run in school by midwives <ul style="list-style-type: none"> <li>• Attended</li> </ul>	1
Family nurse partnership <ul style="list-style-type: none"> <li>• Attended</li> </ul>	2
Community group <ul style="list-style-type: none"> <li>• Attended</li> </ul>	2
<b>Total</b>	<b>20</b>

**Table 4 – Attendance at normal NHS ante-natal classes**

NHS Classes	No of participants
<ul style="list-style-type: none"> <li>• Attended</li> <li>• Did not attend</li> </ul>	<p>2</p> <p>9*</p>
*Reasons for not attending:	
<ul style="list-style-type: none"> <li>• Premature birth</li> <li>• Was not informed</li> <li>• Classes were attended by couples/no-one to attend with</li> <li>• Too tired with attending school</li> <li>• ‘Ready Steady Baby’ provided required information</li> <li>• Caesarean section – classes not required</li> <li>• No reason</li> </ul>	<p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>3</p>
<b>Total</b>	<b>11</b>

**Table 5 – Pregnant participants’ thoughts on attending ante-natal classes**

Ante-Natal Classes	No of participants	Thoughts on attending
Service provision	2	Yes
Young Mothers group	3	Yes
Project midwives	1	No*
*No reason given	1	No comment
Classes run in school by midwives	2	Yes
Planning to attend NHS classes	1	Yes
Reasons for possibly not attending NHS classes:		
<ul style="list-style-type: none"> <li>• Insufficient time (homework/exams)</li> <li>• Was not offered</li> </ul>	<p>1</p> <p>1</p>	<p>No</p> <p>Too late now</p>
<b>Total</b>	<b>12</b>	

The reasons provided by participants in this study for not attending ante-natal classes are quite far removed from those provided in the Growing Up in Scotland (GUS) (2011) publication which looks more widely at the use of formal services and informal networks by parents during a child’s early years of life. The GUS (2011) publication states the three main reasons younger mothers do not attend ante-natal classes are: they dislike groups; do not know where classes are held; and no reason given.

The lack of ante-natal care and non-attendance at classes are attributed in literature and policy documents as contributing to poor outcomes for schoolgirl mothers and their baby (Daguerre and Nativel, 2006). Poor health outcomes for the baby can include premature birth, low birth weight and death during the first year of life. Lawlor and

Shaw (2002) disagree with this perspective and argue that poor health outcomes are ‘predominantly caused by the social, economic and behavioural factors that predispose some young women to pregnancy’ and that most schoolgirl pregnancies are a ‘low risk’ (p552). Previous research such as GUS (2011) makes the assumption that non-attendance at ante-natal classes mean that schoolgirl mothers-to-be do not value this service. Too much focus is placed on the non-attendance rather than trying to understand more about why they do not or even if they cannot attend. One of the reasons provided by participants in the GUS (2011) findings stated that they ‘disliked groups’. Consideration has not been given by health professionals as to how they might use this feedback from their younger service users and alter the approach and the way ante-natal classes are provided.

There is evidence from this data to suggest that participants enjoyed their ante-natal classes. Non-attendance at ante-natal classes was not linked by participants in this study to any disvaluing of the service provided or indeed its importance to the health of their baby. Where the approach had been altered, the majority of participants in this study attended ante-natal appointments. In light of Daguerre and Nativel’s (2006) study, further exploration will required into the longer term health outcomes of schoolgirl mothers and their baby, who have received ante-natal care.

*Birth weights* - Bradshaw (2006) comments that schoolgirl mothers-to-be have a forty-percent higher chance of having a baby with a lower birth weight. Participants talked in the interviews about the weight of their baby when it was born. Having a baby with a low birth weight was not a majority experience for participants involved in this study. Of the twenty-six participants who mentioned their baby’s weight these ranged from 6lb 2oz to 9lb 4oz (apart from the premature baby). Low birth weight babies amongst schoolgirl mothers is an issue which is discussed in research but does not always reflect what happens in practice. This variation between research and practice was recognised by health visitors interviewed in this study.



‘I know [from research] that teenage mums are more prone to have low birth weight babies....however in practice I have not found that to be true....I delivered a baby.....it was 12lb 9ozs....anecdotally I think you find a lot of these young ones have 9lb babies but yet the research tells us something slightly different’ (Health Visitor, 3).

One health visitor commented that the weight of the babies born to schoolgirl mothers depended on previous lifestyle. Heavy drinking and smoking were viewed as contributing to low birth weight rather than a schoolgirl mother’s young age. The negative effects of alcohol and smoking on a baby’s birth weight is reiterated through Scottish Government documents such as ‘Health for All Children 4’ (2005) (known as ‘Hall 4’). This is a guidance report to help support the consistent implementation of the recommendations of a review of child health screening and surveillance programmes by the Royal College of Paediatrics and Child Health (RCPCH). Smoking in pregnancy is associated with ‘low birth weight babies, and after birth, for the babies of mothers who smoke, the risks of sudden infant death’ (Hall 4, 2005, p24). Hall 4 ‘reflects a move away from a wholly medical model of screening for disorders, towards greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk’ (p3).

Fascination over a baby’s weight and the health visitor’s scales are not confined to research and policy documents. Nor is the focus on a baby’s weight something which stops after the initial birth. All health visitors interviewed commented that schoolgirl mothers themselves are particularly keen to have their baby weighed regularly. This ‘fascination of the scales’ worked to the advantage of the health visitors by allowing them as professionals to open up relevant discussions with schoolgirl mothers, build a relationship with them and carry out routine check-ups on the health, wellbeing and development of the baby. Keeping a set of scales in the car was standard practice for health visitors.

‘It isn’t a bad thing because that sometimes is your way in the door.....you’ve got a set of scales hanging off your shoulder.....you don’t really need the weight of the baby but you would quite like to see the whole baby undressed and also not just to check from a social point of view but it’s a great opportunity to talk about the baby’s scalp.....wee soft spots.....tummy button.....nappies.....skincare and all sorts of things’ (Health Visitor, 3).

Health visitors felt that schoolgirl mothers gained some reassurance from knowing that their baby had gained weight.

‘I think it’s just the reassurance that they are putting on weight and they are okay. I think we are still very much fascinated by babies’ weights that when people say, ‘Oh they’ve had the baby’. The first question they ask is, ‘What did they weigh?’ As if it matters if its 8½ lbs or 7½ lbs....I don’t know why we are so obsessed with babies weights in this country’ (Health Visitor, 1).

Discussions on the weight of the baby not only provided reassurance for the schoolgirl mother and opened up the dialogue for health visitors, it also helped to develop relationships and links with the wider family. These early discussions were necessary to build relationships and before being able to talk with schoolgirl mothers about deeper issues such as emotions or external factors that might be going on.

‘It’s historic....grandparents and everything.....the conversation just revolves around that [baby’s weight]. They don’t know what else to talk about so they just say ‘what are they weighing now?’ Just an ice-breaker, conversation maker...It’s a link between various members of the family’ (Health Visitor, 4).

Despite the positive aspects regarding discussions on the weight of the babies, health visitors talked about trying to ‘play it down a bit’ because mothers (of all ages) can get too focused on it. Two health visitors commented on having to follow new guidelines and avoid weighing babies because it was viewed as being a ‘waste of time’. This did not prevent mothers (including schoolgirl mothers) from asking for their baby to be weighed.

Being able to discuss the baby's weight allowed health visitors to provide positive feedback and encouragement to schoolgirl mothers about how they were progressing as a parent. This discussion and feedback was felt by health visitors as being a two-way process whereby they as professionals naturally wanted to provide positive reassurance and schoolgirl mothers wanted to hear this. Participants in this study were not questioned about receiving feedback from health visitors on their baby's weight and the issue did not arise.

It is not possible in this study to determine the impact of ante-natal appointments on the health outcomes of the babies given that there are so many other contributing factors. What is clear is that there were positive health outcomes for all the babies involved in the project even though one was born prematurely and one has cystic fibrosis. The good health of the babies in the study and those generally born to schoolgirl mothers was acknowledged by the majority of school staff and health visitors interviewed.

‘The statistics that are out there are that babies are supposed to be smaller to teenage parents and they are worse in terms of their health outcomes. Obviously we don't know their long-term health outcomes but certainly we have had very big babies’ (School, 8).

*Poor health outcomes* - Some school staff and health visitors were able to recall previous pregnancies which had not had positive outcomes. None of these related to participants in this study. Dealing with these situations had had a huge impact on schoolgirl mothers and their families as well as professionals working with them.

‘One girl lost her twins. Another pupil lost her wee one at the same school, we lost three babies, tragic.....still birth for the twins....it's very hard...these are very very difficult situations. Nobody prepares you. Even though I've done it once, I don't know how to do it for this family because every family has got their own strengths and problems’ (School, 5).

*General physical health* – Health conditions can differ after having a baby and are dependent on individual circumstances and whether or not there were complications during labour. Health visitors were very aware of research about poorer health

outcomes for schoolgirl mothers and their baby. Ongoing assessments helped health visitors watch out for signs of poor health both physical and mental.

‘We do need to be mindful as well, that we know that younger mums are much more inclined to have things like pre-eclampsia, high blood pressure, still birth, premature labour. We keep getting told that statistically so we need to be mindful of that’ (Health Visitor, 3).

Despite the previous knowledge from research, school staff and health visitors commented that the general physical health of schoolgirl mothers after delivery, followed the normal patterns to those of older mothers. This was not to say that everything always went well for schoolgirl mothers but rather that their situation was no better or worse because of their age. For a small number of schoolgirl mothers (not all included in this study) who had previous health issues such as epilepsy or diabetes prior to becoming pregnant, more care and attention was required for them before and after pregnancy. Again this was reported by health visitors as being no different from mothers who were not schoolgirls.

Health and diet before and during pregnancy was, for a few participants, a determining factor of wellbeing after delivery. Recognition was given to the possibility that young people’s diet was not as good as it could be but health visitors were able to recall cases of older mothers in the same situation. Two health visitors felt that a poor diet was linked to the socio-economic situation in which the schoolgirl mother/mother-to-be lived rather than age.

*Labour and the recovery process* - One health visitor commented that pregnant schoolgirls were exemplary when coping with labour. Other health visitors talked about them sometimes making a bit of a fuss and not liking labour but despite this, ‘they fire babies out’ (Health Visitor, 3). Complications during delivery was not a consistent theme raised by health visitors or by school staff. One member of school staff made reference to a schoolgirl mother having haemorrhaged slightly during delivery and needing iron supplements afterwards but apart from that there were no issues and her general health had been good.

A recurring theme throughout the interviews with school staff and health visitors was the speed at which schoolgirl mothers recovered after labour. Several members of school staff and health visitors used the words ‘bounced back’ to describe the schoolgirl mothers’ recovery process. Their young age was in fact thought to contribute to their ability to ‘bounce back’ given that they were not old enough to have health issues or complications such as gestational diabetes in the way that older mothers might. Being able to bounce back was thought to be due to ‘mother nature’ and the schoolgirl mothers’ attitude towards it all. Having a ‘young fit body’ was perceived as being an asset to a quick recovery (Health Visitor, 3). Bouncing back after labour and going up the town the next day was seen as being part of the pace that one lives one’s life at that age. Although professionals were pleased that schoolgirl mothers were fit and well enough to get out so soon with their new baby, it could prevent health visitors in particular, from being able to carry out their primary visits and check-ups. This positive picture does not of course represent every schoolgirl mother’s story.

Adapting to a new routine of having a baby and being up during the night did not go unmentioned and it had left a few participants feeling ‘drawn and tired’. Health visitors referred to all mothers being tired due to sleep deprivation and a change of routine rather than something which was age specific. Such tiredness impacted on other areas such as appearance. An assumption may have been made by health visitors that a change in the appearance of schoolgirl mothers was due to a lack of sleep and tiredness. Jaclyn (Age 15) and Bethany (Age 17) talked about previously wearing lots of makeup to school but they were no longer doing this. Participants’ views about their change in appearance and maturity are discussed later in this chapter but their accounts differ from the likely assumption made by health visitors that it was solely linked to a lack of sleep and tiredness.

The health outcomes of schoolgirl mothers after delivery were viewed as being more dependent on the individual and their circumstances rather than age. One health visitor commented:

‘I don’t know if there is much change in health in the young ones because it will just depend on the individual.....I keep saying it depends on the individual but it just does’ (Health Visitor, 3).

### *Mental health*

Previous research about outcomes for schoolgirl mothers/mothers-to-be is dominated by physical health agendas. Research has not considered contributing influences on the mental health of schoolgirl mothers/mothers-to-be. Neither has research explored whether a negative response to pregnancy, a subsequent depression diagnosis and school attendance are linked.

School staff and health visitors were encouraged to reflect on the totality of their experiences of working with schoolgirl mothers/mothers-to-be. Discussions with school staff and health visitors were not specifically linked to participants in the study. Although each member of staff interviewed was dealing with schoolgirl mothers/mothers-to-be at the time of interviewing, it is difficult to ascertain the extent to which responses were generalised or related specifically to current schoolgirl mothers/mothers-to-be. School staff and health visitors were asked to respond in general terms regarding the mental health of schoolgirl mothers/mothers-to-be from the cases they had dealt with overall.

*Termination* – During the interviews, participants discussed some of their thought processes and potential options they had considered after finding out they were pregnant. Termination was considered by ten participants as an option but this impacted temporarily on their mental health in trying to come to a decision. Pressure came from parents, family, boyfriends and professionals to have a termination while others received pressure not to have one. Participants talked about their anxieties regarding telling others about their pregnancy, facing turmoil about termination and the emotional state they had faced regarding these matters.

'I got a scan, got swabbed, jags, blood tests, then the last, it's a two hour appointment [termination]. Me and my boyfriend went into this room, we've got a lot of forms to fill out for abortion. I was like, as soon as my boyfriend said he would be there for me, so it was my choice, and whatever I chose he would be there. I was like, 'I'm not having it' [termination]. My boyfriend and I went out of the room and got my mum. My mum was actually peaking up outside and he went and got the rest of the family. He ran out and got everyone and then I had to sit again' (Sonia, 15, Group Interview 4, 3 people).

The decision-making process of becoming a mother or not, took different forms. Some participants spoke to a range of professionals such as their guidance teacher, health professionals, family members and partners, as part of their decision-making process. Other participants made their decisions during or as a result of discussions with a parent(s), some of whom were not in agreement with each other and this caused family tensions. These findings differ from those in Ho and Wong's (2006) study where one-fifth of their participants never discussed their decision with anyone else and around half were the sole decision-makers.

'My mum tried to talk me into getting rid of it....I knew in a way she....didn't want me to ruin my life really but I didn't quite like it at the time because really it was my choice and she knew that but my dad was kind of behind me saying, 'You can't make her do something she doesn't want to do'' (Amber, 15, Group Interview 3, 2 people).

Sonia's family had strong religious beliefs but despite this, she did not know what decision to take and so a health professional made a referral for her to have a termination.

'I didn't know what to do, I was like, 'I don't know what to do'. I think that's why she referred me up to that clinic because.....she [Doctor] was like, 'What are you going to do?' My Doctor never said anything about termination. She just said just go there, date and time and I didn't have a clue' (Sonia, 15, Group Interview 4, 3 people).

Decisions were not only made after discussions with health professionals and family members but also as a result of their family's subsequent promise of support.

‘I must have put her [mum] through some hell but she was still there for me by my side... When I told her I was pregnant, I had a termination for the week after because I was scared.....She phoned me the night before she was going to take me through [for the termination]. She said, ‘Look here if you want to keep it I’m going to support you in all this’. It was nice that she did that but when the baby arrived it was a lot harder than what it was made out to be when we spoke about it. I would have had a termination if I didn’t have the support I had around me, definitely. I don’t think I could have done it alone [had the baby]. Definitely not’ (Elise, 15, Individual Interview).

‘When my gran came in she was like, ‘I’ll stand by you 100%’.....so I had her but if you have got support and you know that, you’ll be good....I had to make sure, I had to listen to my boyfriend, like if he didn’t want it then I would need to think about it....I’m not going to pressurise him into having something he didn’t really want. He [boyfriend] was so, he was actually excited about it, he was like ‘Sonia look’, cause I was like, ‘Oh I can’t do this’ cause I was thinking about my mum and dad and he was like, ‘Sonia you need to, it’s not about your mum and dad it’s about you’. He was just so supportive. He did want it’ (Sonia, 15, Group Interview 4, 3 people).

Other participants made decisions about becoming a parent as a result of discussions with their partners. These decisions were on occasions unpopular within the wider family network.

‘Me and my boyfriend had this discussion. We wrote up the bad and the good points of having a baby. He was like that, ‘Either way whatever you want I’ll stick by you’’ (Abbi, 17, Individual Interview).

He [boyfriend] said to me, ‘I don’t want you going through that’. I was like, ‘Well you have to go through it if you want to go through with it’. They [partner’s family] were telling me to get an abortion like when I was like about 13 weeks. I was like, ‘No’.....His family was telling me to get an abortion.....My mum was unsure cause she was like, ‘You are only 14’, so I had my mum saying it and then I had all his family and then it’s like, ‘What do you do?’ The whole family doesn’t want you to do it (Rochelle, 14, Group Interview 4, 3 people).



‘He says, ‘Obviously he didn’t want a baby because he was too young’. I says, ‘Well I didn’t want a baby either but we were stupid enough to make the mistake so.....we’ll be big enough to deal with the consequences’ and he didn’t like that. I think he did [want a termination] but he never actually ever came out and said it....maybe that’s because he might have known I would have told him, ‘No’. Obviously it’s my body, it’s my life’ (Gabrielle, 16, Individual Interview).

One participant, Vikki, had made a previous decision not to become a parent because of the pressure put on her by her partner’s mother and this caused great tension in the wider family circle. Having been heavily influenced to terminate her first pregnancy, Vikki had very strong feelings when she became pregnant again.

‘We done the test [first pregnancy] and...she [mum] phoned my boyfriend’s mum, she was like that, ‘Well there is only one decision here isn’t there?’ Then like from that I knew and she told me, my boyfriend’s mum told me that if, ‘I never had an abortion she was going to kill herself’.....My mum came up the night before I was due to go the hospital to get the first tablet and then sort of said ‘I can’t take you tomorrow’.....and started crying and stuff. I was like, ‘Why are you doing this now?’ She’s like, ‘I don’t think it’s your decision’ [not what you want]. I was like, ‘Well mum it’s happening and that’s the way it is’. Then we went to the hospital.....after it I just hated everybody. I was just a horrible, horrible person.....I just hated him [boyfriend] for what, like I just hated him and his mum and I just didn’t like anybody after it. Then I found out I was pregnant again because I was on the pill [different partner] and it obviously hadn’t worked and I was like, ‘I am not going through that again’ so I told everybody out straight....‘Look none of you have a say in what is happening, it’s my baby and I’m keeping it....I’ve been through this before so it’s not happening’. I told my boyfriend, ‘If you want out, you can get out and I won’t involve you in anything but then he decided that he didn’t want to leave’ (Vikki, 17, Group Interview 8, 2 people).

Some decisions on becoming a parent focused on the process for termination, either for the first time or as a result of having had one previously. Some participants explained that they would have had to take tablets to have a termination, others talked about surgical procedures, or going down to England while another participant discussed having to deliver the foetus because she was so far on in her pregnancy.

'I would have had to push if I was wanting to terminate my baby. I couldn't do it. They said, 'Oh you've got so many weeks', but me and my dad had decided that I was going to keep it, then they were like, 'Aye you've got so many weeks you can go down [to England]'. I wasn't going to go down to England I was keeping it' (Demi, 16, Group Interview 4, 3 people).

'I've actually had a termination before through something completely different. It really hit home, it was horrible and that is part of the reason why I needed a counsellor. I wouldn't do it [termination] again' (Rhiannon, 17, Individual Interview).

'Just the thought of going through it all [termination process]. My dad....He was angry with me. Like he stays a distance away and I don't see him that much but when he found out I was pregnant he came to see me and said that I should go to the Doctors and all that. My ma was like that, my ma says, 'I can do what I want', like she will always be there for me....no matter what my decision. My dad was saying, 'I should go to the Doctors'.....but he had nothing to do with me cause like he's never been there for me so he really shouldn't have voiced his opinion (Alexis, 17, Individual Interview).

Some pupils (not all included in the study) were pregnant previously but had had a termination. Information about pupils having a termination was shared with school staff from different sources including a schoolgirl's parents and/or rumours which were spread around the school. When rumours did circulate, school staff often noticed a common pattern of non-attendance by the schoolgirl along with a change in her temperament which resulted in general uncharacteristic behaviours and other issues such as friendship fallouts. Dealing with a termination was compared by school staff as being similar to bereavement and loss. Outward signs and means of coping with termination were played out in reality through sporadic emotional behaviour and periods of unstable mental health.

The psychological impact of having a termination was viewed by school staff as something which never goes away even in later life. Coping emotionally with termination and moving forward took a long time and although it appeared to be the best decision at the time, stress could 'suddenly bring it back into your mind and revisit you' (School, 1). Psychosocial impacts of abortion on adolescents development is described by Ho and Wong (2006) as 'immense'. Adolescents who have abortions

‘may risk infertility (especially in the case of an illegal abortion)’ and they ‘may suffer from post-traumatic stress syndrome which may manifest itself in feelings of guilt about killing their babies’ (Ho and Wong, 2006, p99). Alternatively, schoolgirls who continue with their pregnancy and choose to become a parent ‘may bear the stigma of being unmarried mothers, and their schooling and living activities will be affected’ (Ho and Wong, 2006, p99). Pupils who did not inform school staff, did not consequently gain from services such as the Child and Adult Mental Health Service (CAMHS). For those pupils who ‘bottled and filed it away’ they too were believed to have periods of unstable mental health (School, 1). Further research is needed to fully consider the psychosocial impact on pregnant schoolgirls who decide not to become a mother. Such research would inform both health and education staff to better support schoolgirls who opt for termination.

*Negative impacts on mental health* - One health visitor explained that in her experience of working with schoolgirl mothers-to-be she found some to be living in a ‘false euphoric’ during pregnancy before having a ‘mighty crash after they’ve had the baby’ (Health Visitor, 5). This was similar to older mothers who were not schoolgirls, and was considered to be the case because of an existing preconceived and idealised rosy picture of ‘motherhood’. When reality finally set in, mothers of all ages then realised they were not prepared for the hard work involved in caring for a baby. As discussed earlier in the chapter, full appreciation of the demands of motherhood can only come through personal experience. Naivety about the demands of motherhood is not an issue specifically linked to the age of the mother as suggested by Arai (2005).

Members of school staff believed some schoolgirl mothers/mothers-to-be had poor mental health prior to pregnancy. Home situations had deteriorated to the extent that a small number of participants were now in foster care. One participant had been through counselling to help her cope with the traumas she had experienced. Having a baby did not always improve existing poor mental health.

Strains on mental health impacted on one schoolgirl mother who was trying to involve and unite two families for the sake of the baby. Organising childcare between the two

families was more difficult when the schoolgirl mother and her boyfriend were no longer together as a couple. Every effort was being made to do their best for the baby but it had increased pressure on the schoolgirl mother and she found it hard to be separated from the baby.

‘The hardest part is being away from the baby for a few days of the week. He stays with his dad part of the week....I really miss the baby’ (Abbi, 17, Individual Interview).

*Post-natal depression* - Schoolgirl mothers/mothers-to-be are considered to be more prone to post-natal depression and poor mental health (Macvarish and Billings, 2010). Participants were aware of this and their fears and anxieties were exacerbated in instances where family members had had a history of post-natal depression. These participants expected that, if their mother had had post-natal depression, they would experience it as well. Overcoming these fears was challenging because participants often faced the impact of poor mental health on a daily basis in their family life. Participants did not want a repeat of this lifestyle for themselves or their baby.

During the interviews, members of school staff were asked about the mental health of schoolgirl mothers before and after pregnancy. Staff seemed confident in having sufficient and direct knowledge when responding to this question (rather than making assumptions) and they were able to provide examples.

Mental health was viewed by one member of school staff as something which genuinely went through ups and downs over a six month period after delivery (School, 3). This member of school staff felt there was a circular process across a six month period whereby schoolgirl mothers would alternate between feelings and attitudes of ‘yes I can do this’, ‘no I can’t do this’, ‘I’m running away from everything’, before returning to ‘yes I can do this’ and so on. Coping with these fluctuations of mental health in schoolgirl mothers/mothers-to-be was best achieved by providing reassurance that these feelings were normal and they (schoolgirl mothers) were ‘allowed to feel like that’ (School, 3). The member of staff would put support in place to help schoolgirl mothers/mothers-to-be feel more in control of their situation.

Observations on mental health would primarily be carried out by members of school staff who were working closely with the schoolgirl mothers/mothers-to-be although information was passed on from health staff (midwife/health visitor) if appropriate and where consent had been granted.

Another view on the mental health of schoolgirl mothers/mothers-to-be (from school staff) was that it was impossible to generalise. There was no set pattern but rather there were huge differences and variations amongst schoolgirls. However, there was consistency in the experiences of schoolgirl mothers/mothers-to-be in terms of their feelings and thoughts on the following: the pregnancy had not been planned; they were not sure how they were going to cope; and they were anxious, scared and concerned about their relationship and bonding with the baby. For one member of school staff, bonding made the key difference. If the 'bonding is there, somehow they will make it through' (School, 6).

*Establishing a baseline for mental health* was carried out in one school through the completion of a questionnaire (ante-natal) on the self-esteem and confidence of the schoolgirl mothers. Even with this early intervention work, the schoolgirl mothers still experienced a dip in their mental health after giving birth before coming up again in later months. This was perceived to be normal for all new mothers and not specific to schoolgirls because having a baby was 'a bit of a reality check' (School, 8). This member of school staff believed the mental health of schoolgirl mothers tended to fluctuate for a variety of reasons including concerns about looking after their baby and worrying about whether or not they were 'doing it right'.

The dip in mental health was considered to be a time where schoolgirl mothers were adjusting to motherhood. Recognising and remembering that many of the schoolgirls come from difficult situations and chaotic backgrounds was really important for school staff and so their mental health was not the best to start with (School, 8). Strong emphasis was placed by school staff on the fact that fluctuation in mental health was not as a result of the baby. The point was also raised that it is easy to appreciate how confusion can set in amongst professionals and researchers whereby schoolgirl

mothers are thought to suffer from post-natal depression because of the post-natal mental health test results after delivery. Carrying out assessments on schoolgirl mothers for post-natal depression at a single point in time and making the assumption that low mood was a direct result of the baby was considered a ‘skewed’ message (School, 8).

*Supporting mental health* - Negative responses to pregnancy have been linked in previous studies (Formby et al, 2010) to later diagnoses of depression in schoolgirl mothers/mothers-to-be. Formby et al suggested that in order to reduce longer term negative health impacts, a more sympathetic approach combined with a support system, should be made available and accessible to schoolgirl mothers/mothers-to-be. Staff in schools are the most likely professionals, given their daily involvement with schoolgirl mothers/mothers-to-be, to provide or co-ordinate the type of support system to which Formby et al (2010) refers. This raises the question of how well staff are trained and prepared to support the mental health of schoolgirl mothers/mothers-to-be in order that they can provide such a system. Health visitors, however, may be the professionals who are better trained and more likely to recognise and respond to signs of poor mental health but they are unable to see schoolgirl mothers/mothers-to-be on a daily or even a regular basis.

The Scottish Government’s Mental Health Strategy (2012-15) identifies mental illness as ‘one of the top public health challenges in Europe’ (p3) (see Appendix 10). The period in a child’s life between pregnancy and three years of age is viewed in the strategy as a critical time to shape their life chances. There are two key areas for change within the strategy – child and adolescent mental health – to rethink how common mental health problems are responded to. Within the new strategy, there is a move away from Doctors making a diagnosis and treating the patient, towards people identifying problems themselves and seeking help. The strategy does recognise that this new way of working will not be for everyone.

In light of the above, there would appear to be disagreement and confusion over roles and responsibilities surrounding support for mental health. Research suggests a

sympathetic approach and support system be put in place, health visitors and Doctors are trained in recognising the signs in all new mothers and patients but policy suggests that people, in general, take a more self-help approach regardless of age.

Schoolgirl mothers-to-be were perceived to go through a difficult phase after finding out about the baby and it was hard for them to cope with 'the shock of it all'. After coming through this phase and getting over the initial shock, schoolgirl mothers-to-be started to 'come round to the idea' and began thinking and working it through (School, 15).

Good relationships with parents and family dynamics were considered by school staff and health visitors as key to help schoolgirl mothers/mothers-to-be maintain positive mental health. Having good support in place was also viewed as being a crucial element in helping schoolgirl mothers/mothers-to-be to have good mental health. Positive messages from schools helped participants realise they could carry on with their education and that the school could adapt to allow them to do so. Additionally, the 'attitude' of a schoolgirl mother-to-be during the transition to motherhood along with relevant support, was considered by health visitors to be a contributing factor to positive mental health.

'They seem to react better to the change and the shift with the right support. Like any of us I suppose' (Health Visitor, 3).

Schoolgirl mothers/mothers-to-be were, according to health visitors, very positive about having a baby. They looked forward to the future with the baby in their lives and health visitors confidently stated that the schoolgirl mothers they dealt with would not change anything about having a baby. One health visitor felt that professionals needed to remember that schoolgirl mothers/mothers-to-be are still teenagers who require things to be repeated quite often and that this was to do with the development in their brain (Health Visitor, 1).

Poor mental health was not considered by health visitors to be age related. Health visitors commented that it was mostly older mothers who had 'low mood related'

issues. Influences on the mental health of a schoolgirl mother/mother-to-be was often as a result of previous issues and wider family circumstances. Schoolgirl mothers/mothers-to-be who were being looked after by foster carers or were under legal procedures because of family concerns, were thought to be particularly at risk of poor mental health. One health visitor felt that the issues experienced previously by schoolgirl mothers in foster care, had been suppressed and buried in childhood and it was only during pregnancy and the early days of motherhood that feelings and memories began to resurface. For these schoolgirls, motherhood triggered questions in their minds about why their own parents had allowed situations to happen to them. Motherhood had brought about a realisation and sense of what was right and wrong in terms of how a child should be treated. These schoolgirl mothers' emotions were in chaos when trying to come to terms with how they had been treated themselves by parents and their new found protective feelings (as a parent) towards their own baby.

In other cases, mental health was thought to fluctuate because of the emotional strain of feeling 'torn about being at school and being with the baby' (School, 16). Being allowed to bring the baby into school and 'show it off to the teachers' was a positive message to a schoolgirl mother about her and the baby being welcomed and supported by staff in an education environment. These positive messages and support contributed to and helped improve mental health.

*Positive impacts on mental health* – Several school staff commented that becoming a mother had impacted very positively on some participants' mental health. This positive wellbeing was considered to be due to participants' attitudes towards life and taking everything in their stride. This did not eliminate the need to talk to someone about problems, nor did it change family circumstances or previous insecurities but the whole situation did not seem to be an issue. For some participants, their boyfriends had left them once they found out about the pregnancy and although these situations bothered a few, others had a positive mind-set whereby they had come to terms with the fact that they were probably better off without this partner.



One member of school staff discussed her concerns about a schoolgirl mother who had very positive mental health. Although that was good, the member of school staff felt this particular participant had not taken on the full responsibilities of motherhood and her mother (grandparent) had had to take over. Her fears were that this participant was still viewing herself as a young person attending school rather than a schoolgirl mother with responsibilities, who was attending school. The participant had previously depended heavily on her mother for everything and this had not altered through pregnancy or in the early stages of motherhood.

Information on mental health was expected to be received by school staff from parents or agencies who were working with the schoolgirl to provide a baseline from which monitoring could begin. From this starting point, school staff viewed their role as one of monitoring and looking out for any signs of deterioration in mental health and to keep in regular close contact. Data provided by participants confirms that this monitoring did happen in practice. Close contact involved building in time during the school day for staff to chat to the schoolgirl mother to see how everything was going. Anyone who was not coping could then be referred for appropriate support.

One member of school staff talked about schoolgirl mothers/mothers-to-be having had traumatic and dramatic family circumstances along with mental health issues prior to pregnancy. The birth of the baby had turned their lives around and the schoolgirl mothers now viewed their situation as being the best thing that ever happened. For these schoolgirls, their mental health and well-being had improved tremendously compared to previously, although as before, it had not changed their background circumstances.

*Negative responses to schoolgirl pregnancies* - It is unclear from the data whether health visitors always had detailed knowledge of the personal circumstances of schoolgirl mothers or about how much support they received from other sources but they spoke as if they did. Some questions did stray beyond health visitor's direct experience and knowledge of schoolgirl mothers.

Health visitors were asked if they found, in practice that a negative response to schoolgirl pregnancies impacted on mental health. The replies to this question varied but they provide more insight into assumptions surrounding schoolgirl mothers/mothers-to-be. Health visitors felt that schoolgirl mothers struggled when they felt there was no-one to help or support. Needing support was not considered by health visitors as being age dependent, it was something everyone needed. Support could be in the form of good social networks and friendships. When practical and social support were in place, these 'balanced off the bad things' (Health Visitor, 3).

One health visitor felt that negative responses did not impact as greatly on schoolgirl mothers/mothers-to-be when there were other women in the community who had been a schoolgirl mother. These women in the community were role models for some participants but not in the sense of making them want a baby. Rather, participants were able to see that other women who had been schoolgirl mothers had coped with the demands of motherhood. Having positive role models in the community helped to reduce the negative impact on mental health for schoolgirl mothers/mothers-to-be.

One health visitor was able to refer to examples of schoolgirl mothers whose mental health had suffered because of their pregnancy. This was due to cruel comments which had been made to their face, fed back to them, or because of reactions from the parents of their friends and these were all hard to deal with.

'All of the girls will have it said usually to their face (that they are sluts) but they'll hear about it. That's across the board and that's hard for them to deal with because most of the girls are not. The girls who've had sex and quite often they've got pregnant the first time, they've had unprotected sex so they have that label put on them. The other thing they have is that mothers of other girls don't want their daughters to still remain friends with them, some of the time' (Health Visitor, 5).

There were several reports from research participants about community opinions in this particular NHS Board. Members of the community showed their disapproval through dirty looks, judgemental attitudes and practically when bus drivers would not wait or lower the bus to allow schoolgirl mothers on with their buggy. These issues had led to difficulties with the mental health of the schoolgirl mother/mother-to-be

which had resulted in depression, low self-esteem and feeling that they had done something really bad (Health Visitor, 5).

*Community responses* – One member of school staff talked about a slightly different experience in her area regarding responses from the community to schoolgirl pregnancies. It is unclear from the data whether these views were based on conversations with schoolgirl mothers and/or community members.

‘For a wee while, you see they feel mini celebs within their community.....then of course I think it’s after a few months the novelty of this new baby maybe wears off.....You would hope that they would feel supported within their community but again that is going to be a cross section. In a small village or town as we are here, you are going to get a cross section of views’ (School, 12).

In a different NHS Board the health visitor talked about most of the schoolgirl mothers/mothers-to-be being ‘tough cookies who had not had an easy time during their childhood’ (Health Visitor, 1). Despite this, the community were very passionate about and protective of their families. In comparison to the above where the opinion of the community seemed to triumph over anything other than the norm, this community had the reputation of ‘chasing anyone who would make a judgement because they did not need to put up with that’ (Health Visitor, 1). In this particular health visitor’s experience, schoolgirls who did become pregnant would not necessarily receive negativity from their parents or the community. The pregnancy was not a huge drama in the lives of the schoolgirl mother-to-be which caused massive eruptions nor was it a negative experience (Health Visitor, 1). The health visitor questioned whether this would be the same situation in the more affluent neighbouring areas. Although the parents of schoolgirl mothers/mothers-to-be in the more affluent areas were supportive, this health visitor thought they were possibly dealing with disappointment in different contexts such as social class expectations, future aspirations, career paths and public opinion.

*Returning to school* was an additional emotional stress on schoolgirl mothers which could impact positively or negatively on their mental health. Participants were asked

in the questionnaire what they thought would be an ideal time period to return to school or education. Responses given were very much on a personal basis with the ideal timescale ranging from one week to nine months. Although schools do not have official guidance or legislation to set fixed time limits within which schoolgirl mothers have to return, staff tended to suggest 6-8 weeks after delivery as an ideal period. This timescale runs in line with the standard health visiting 6-8 week check-up.

New national legislation entitles older mothers to maternity leave from their place of employment after having a baby. Schoolgirl mothers do not necessarily, or automatically, get similar opportunities to have this length of 'maternity leave'. Returning to work after a period of absence can be hard emotionally but taking a year out and returning to school after this time would result in schoolgirl mothers having to sit in classes with the year stage below. One member of school staff described the emotional and psychological differences that schoolgirl mothers experienced on their return to school as being very different and difficult.

'We are throwing them back into a world of children and they have now become young adults.....It is a very different world we are putting them back into' (School, 12).

Members of school staff were able to recollect cases where schoolgirl mothers had returned to school one week after giving birth. Staff felt that such a quick return was more about the schoolgirl mother's emotional and psychological needs. In these cases, school was a place of support and schoolgirl mothers preferred to be there and with staff with whom they were familiar rather than to be at home, possibly alone with the baby. This place of support was supplemented by the emotional and psychological help they unconsciously extracted from staff. One member of school staff talked about schoolgirl mothers taking up to a year off because they needed this length of time to come to terms with everything that had happened and to resolve issues at home. The decisions regarding returning to school were dependent on each individual's circumstances and when the schoolgirl mother felt it was right for her to return. However, forthcoming exams could influence the return date.

Only two members of school staff talked about consulting with health professionals on an appropriate time to return. A longer period of time between giving birth and going back to school was considered by all school staff to make the return more difficult. School staff therefore encouraged schoolgirl mothers to return as quickly as possible even if only on a phased or part-time basis. Health visitors did not provide guidance to schoolgirl mothers about when they should return to school. Views amongst health visitors were that they would provide as much information as possible but would allow the individual to make the decision. One health visitor talked about the mothers of schoolgirl mothers having strong but mixed views about whether or not their daughters should return to school. This health visitor thought it was her role to encourage schoolgirl mothers to do what was best for them and their baby rather than be influenced by family, or indeed by professionals, through emotional language and psychological pressure.

Feeling, and actually physically being well enough to return to school was only one part of the deliberations on whether or not to return to school. The physical demands and need for rest was something that health visitors felt should be kept in mind by schoolgirl mothers when thinking about returning to school. Where the birth of the baby had been straightforward and the schoolgirl mother was not anaemic, returning to school after a short period of time was understandable but importance was placed on listening to what the mother's body was telling her. The 6-8 week timescale was mentioned by one health visitor as being better because 'that's when your uterus is back to its pre-pregnancy size so.....anatomically you are not really back to your pre-pregnancy state until then' (Health Visitor, 1). Going back too early could result in having to take time off but it was acknowledged that the decision regarding when to return to school might be determined by the demands placed on each individual at that time. Likewise dictating that schoolgirl mothers had to stay off for a certain period of time was considered to be wrong when this stipulation was not imposed on mothers who were not schoolgirls.

Schoolgirl mothers who had had a caesarean section often did things much earlier than health professionals would have recommended. Their 'youthful energy' and being

'full of life' was considered to play a part in this and it helped them get on better at an earlier stage than older mothers (NHS Board, 3). One health visitor suggested that schoolgirl mothers should look at the reasons why they felt so motivated to go back to school so quickly. Health visitors encouraged schoolgirl mothers to consider all options but in their decision-making process and emotional dilemmas they needed to remember that it comes down to personal choice.

School staff and health visitors talked about methods of feeding the baby (bottle feeding or breastfeeding). Coping with lactation was part of the schoolgirl mother's dilemma and decisions about returning to school. Participants were asked during the interview whether they had bottle or breastfed their baby. Not everyone responded to the question but twenty-two commented they had exclusively bottle fed, nine had breastfed for a period of time (some up to three months) and four (who were pregnant) were still considering both options. Decisions about bottle or breastfeeding were made alongside the consideration of returning to school. Anxieties about breastfeeding centred around the baby not latching on and then both the baby and the schoolgirl mother getting very stressed. Breastfeeding and returning to school caused concern about the possibility of being called out from classes if the baby was in the nursery (in the school) and needed to be fed. One schoolgirl mother did not have the option to breastfeed because of medication she was on for epilepsy. Another schoolgirl mother could not breastfeed because the baby was premature and in Intensive Care. Anxiety was also present about the possibility of being in public and the baby needing to be fed and the schoolgirl mother not being able to deal with this for whatever reason.

Further psychological dilemmas surrounded the stereotypical reputation that schoolgirl mothers knew existed about their choosing not to breastfeed. Participants did not want others to think they were choosing a lesser option which would not be so beneficial for the baby. Schoolgirl mothers were aware that breastfeeding can help attachment and bonding with the baby. Their predicament was that attachment and bonding would just be developing through breastfeeding just as they would have to return to school. This method of feeding the baby might therefore be more of a struggle when leaving the baby with someone else while they were at school.

Different opinions existed amongst health visitors about returning to school so quickly and whether this allowed enough time for attachment and bonding. Defining attachment and bonding was difficult for one health visitor because she was conscious that working fathers return to work quickly and yet many have loving relationships with their children. Emotional and psychological traumas are not just present for schoolgirl mothers who return to school, they exist for older mothers as well. One health visitor made reference to older mothers who have 'lovely water births' and yet had still had terrible post-natal depression and problems with bonding. Going back to school early was therefore not considered to be detrimental to the bonding between the schoolgirl mother and her baby. Attachment and bonding was perceived to be a much wider topic and something about which there was insufficient understanding. Semi-flexible school hours, baby massage and groups for young mothers were viewed as ways to cope with the bonding and separation concerns of attending school (Health Visitor, 4).

Recognition and acknowledgement was given to the challenges for schoolgirl mothers when 'returning to school and trying to make a go of their life as it was before' (Health Visitor, 4). Keeping communications 'open and flowing' between the schoolgirl mother, her doctor, the school and the health visitor were seen as making a positive contribution to better mental health. A few members of school staff commented that early discussions were held with schoolgirl mothers-to-be during the ante-natal stage to help them recognise the signs of poor mental health and well-being so that they could be more informed and better equipped to manage it. One health visitor found it frustrating that doctors would not prescribe medication for poor mental health to schoolgirls under sixteen even for a short period of time to help them get through difficult times.

Poor mental health was not considered by the professionals interviewed to be more prevalent amongst schoolgirl mothers/mothers-to-be because of their age. Rather, poor mental health was thought to be influenced more by background family circumstances. Although a positive experience, motherhood had resulted in some participants having to make themselves homeless because they did not qualify for

financial benefits whilst staying with their parents. Moving out of the family home at such a vulnerable point in their life was not always considered by health visitors as being the best option. One local authority had taken the approach of giving schoolgirl mothers who were aged sixteen, a house within a certain estate. This was not viewed by one health visitor as being positive and contributing to good mental health both because of the pressures of adjusting to motherhood and then the subsequent pressures of running a home. Staying at home with their own parents (where appropriate) for at least a year to get support during the early stages of motherhood was health visitors' preferred option. Health visitors commented that although situations could be difficult for schoolgirl mothers, it did not change their positive attitude towards their baby.

#### **5.4 Maturity and confidence of schoolgirl mothers/mothers-to-be**

Childhood, adult status and maturity are social constructs which should not be reduced to objective facts of biological age, capacities and competencies (James et al, 1998). Children and young people are considered to be 'a set of potentials, a project in the making' and on a journey to 'mature, rational, responsible, autonomous, adult competence' and, therefore, defined as a 'human becoming rather than a human being' (Christensen and James, 2008, p15). There is no single or standardised way of gaining capacities and competencies sufficient to claim having completely made the transition to adult status. Even though society defines adult status as having been reached through age milestones this does not guarantee maturity.

It was intended at the outset of this project to explore what schoolgirl mothers/mothers-to-be thought about whether their maturity had changed as a result of becoming pregnant. Although participants were asked in the interview about their maturity, their responses were related more to factors which they felt increased or decreased their confidence levels. Responses from participants have been separated below into two categories: factors which contributed to participants feeling more confident; and factors which contributed to them feeling less confident.



### *Factors which contributed to participants feeling more confident*

Changes in body shape, size and emotional differences were viewed by a few participants as being worthwhile in order to gain a beautiful baby. A few participants said they were enjoying being pregnant and having a 'bump' and were comfortable and confident with these aspects of pregnancy. This had encouraged some to take better care of themselves and they felt they had something to 'live for'.

Rhiannon described herself as having dressed all in black as an 'Emo' prior to becoming pregnant (Age 17, Individual Interview). During the early stages of pregnancy Rhiannon acknowledged a change in herself which had brought her to a place of feeling that her sense of dress was a very immature look. After opting for more brightly coloured clothes she realised that she preferred her new image. Rhiannon viewed this as an identity change in herself and she was happy and confident with her new image.

Two participants previously spent a lot of time on make-up and hairstyles to help them look more mature. After becoming pregnant these participants felt they no longer needed the tools of make-up and hairstyles to make them more mature. Neither did they have the time to devote to this, simply to impress others.

'I don't really care how much, like how I look when I go out the door now. I grew up a lot because I used to like hair and make-up, now I just shove it up. That's the most it'll get. So can't be bothered doing all that.....no point in trying to impress other people' (Jaclyn, 15, Group Interview 1, 4 people).

Growing in confidence and increased self-esteem was not all about outward appearance nor an inward change of feelings. Having a baby had brought about adulthood through mentally moving on from perceived childish and adolescent ways of thinking and acting as well as a shift away from friends who were immature and liked to gossip. Stereotypical behaviour of teenagers such as arguments became something which was more annoying to participants and less tolerated. Participants started to feel as if there had suddenly been an age gap between them and their friends.

‘To be honest I think losing my pals and all is part of it, I can’t be bothered with them because they gossip and they are quite immature and I just feel like, older than they are’ (Bethany, 17, Group Interview 1, 4 people).

While some participants lost friendships, others found new ones.

‘I felt really shy and I didn’t want to speak to anybody and I didn’t really have many friends and now I’ve got loads of friends and I am really confident and I am really happy with myself’ (Caitlyn, 15, Group Interview 1, 4 people).

Increased self-confidence was something that many participants recognised in themselves even though they had not anticipated this was even possible by having a baby. Some participants talked about being very shy and quiet prior to pregnancy and this prevented them from addressing issues when they arose. The increased self-confidence was displayed across a variety of areas including socially and in approaching professionals. Participants felt more able and confident to approach and communicate with professionals if there was something wrong with their baby or to speak to school staff about any concerns.

For Abbi, she now felt more confident, mature and independent to the extent that if she needed help she would ask for this (Age 17, Individual Interview). Abbi recognised changes within herself, she felt more grown up and did not tolerate anyone trying to annoy her any more but addressed whatever situation arose. Kiera felt she had increased in maturity because she was now able to ‘take being told what to do....rather than just going in a huff about it’ (Age 15, Individual Interview).

Confidence grew through the support of friends, family and the school. It also increased because participants liked the new person they had become since having a baby and the changes and impacts this had had on them. Previous behaviours of acting ‘like a pure dafty’ and ‘hanging about on street corners with friends’ seemed distant and immature to two participants after having their baby (Alexis, 17, Individual Interview).

Being more focused, getting on with life, having more responsibilities and thinking more about actions and possible consequences were consistent themes across interviews. When compared to previous aspirations, participants described a change in their goals for life. The focus had moved from drinking and partying to potential achievements and having a better future for the baby and themselves.

‘You think more about what you can achieve, than what you are going to do at the weekend’ (Lena, 16, Group Interview 5, 5 people).

Realisation of motherhood brought a sense of parental responsibilities and values. Personal experiences of a difficult childhood had enabled a few participants to see that the way they had been brought up was not how it should be. These participants became more determined that their baby would be brought up differently.

‘I know what I went through. I know that it shouldn’t be like that. I know I need to be different from what my family were like when I was growing up’ (Tara, 15, Individual Interview).

Difficult times during childhood had for one participant resulted in a drugs overdose and her running away from home.

‘I had a pretty tough childhood but that’s why having her has really helped because I was running away and going missing for weeks on end, had the police after me’ (Tara, 15, Individual Interview).

The knowledge about being pregnant brought about a change and had a calming influence in behaviours for a few participants. Coming to terms with the pregnancy provided a more holistic perspective that this change was required for more than one person and this in turn, helped a new sense of parental responsibility to develop. Motherhood for many participants brought a fresh appreciation and respect for their own parents and the sacrifices they had made. It also brought a new understanding of the support given to them by their parents growing up and even now during pregnancy or early motherhood.

Similar to Elise (mentioned later), Britney did not like pushing her baby in a pram for fear that someone would judge her and so she got her own mother to push it (Age 17, Individual Interview). Having the confidence to overcome these issues was hard for Britney in the early stages of motherhood and it had taken time to achieve them. The increase in confidence started when Britney realised that other schoolgirls her age had children. Britney accepted that she had to become more mature, take responsibility, have confidence and be less conscious about what other people might think of her.

After becoming pregnant the increased self-confidence impacted on participants' desire for education. In addition to having a reason to sit exams and gain qualifications, participants talked about their mentality changing and their starting to think about what they wanted out of life, then taking responsibility for making it happen. This had resulted in increased motivation to study and actually sit examinations.

‘I would never think of sitting all my exams. Usually my mum would need to moan at me to study and go to school in the morning and do this and do that. Now I just do it because I know I actually have to, that I’ve got a reason for doing it’ (Gabrielle, 16, Individual Interview).

Schoolgirl mothers/mothers-to-be were described by school staff as being more committed, more grown up and starting to enjoy their studies more. The reason for these changes were not exactly clear but school staff assumed they could be due to having to take on responsibility for someone else and about having a newly found focus in life. School staff encouraged schoolgirl mothers/mothers-to-be to be more confident and to take on their responsibilities.

Pregnancy was associated with changing the schoolgirl mother-to-be into a more motivated, determined, independent, confident and caring person. In addition to the general increase in motivation, one participant talked about wanting more out of life but also aiming to be a role model for her baby. Bonnie thought she would have a lot to lose if she ‘mucked things up’ (Age 17, Group Interview 8, 2 people).

The ante-natal scans and seeing the foetus on the screen were sobering but maturing occasions. Seeing the baby with their own eyes seemed not only to have a calming and settling impact on schoolgirl mothers-to-be but it encouraged them take on a parental responsibility.

‘I was still acting like an idiot, I was still toy fighting and all that with everybody and just was not for listening to anybody.....people kept saying ‘watch what you’re doing’.....I just was not listening. Then when I got the scan to see if the baby was okay, that’s when it hit me.....when I started changing....Over this.....I see a change in myself, I don’t know if anybody else can’ (Hayley, 16, Group Interview 11, 2 people).

For Tessa, the ante-natal scan triggered feelings inside which made her feel different. Tessa had opted to have the three dimensional scan which had enabled her to see very detailed pictures of the baby’s face and fingers. This level of detail and ‘seeing the baby for the first time’ although not in the flesh, was a very emotional experience for Tessa (Age 15, Group Interview 11, 2 people).

Schoolgirl mothers were very conscious of what was expected from them as parents. Actually knowing what to do and having the confidence to do it came at different stages. For some, this happened during pregnancy but for others it was when the baby was born. Some participants felt that ‘natural’ motherly instincts took over, although they recognised that it was a continuous learning curve which changed constantly depending on the age/stage of the baby/toddler. Britney knew what level of maturity she expected from a mother and ‘the extent that a mother would grow to’ (Age 17, Individual Interview). Although Britney was conscious that she had matured from what she was, she felt she was still on a journey. Accepting that a baby brings a big change in your life was a ‘reality check’ and participants felt that acknowledging this helped them grow in maturity.

Elise (Age 15) talked about needing professionals to support her as she did not feel she could make it on her own. Increased confidence for Elise was found through professionals answering questions, guiding her in the right direction through different situations which arose and by them just being there when she needed them. The

support Elise had needed to help her grow in confidence was not a short-term requirement but something which had extended over a long period of time.

Increased maturity for one participant was reached when she was in the hospital having the baby. Previous expectations by this schoolgirl mother before having the baby were that midwives and nursing staff would help her in the first few days. When this did not happen, she described feeling a silent message from professionals that they had done their part in delivering the baby. This participant then realised that it was her responsibility to care for the baby and that she would have to take on this role.

School staff noticed a change in schoolgirl mothers when asking for their opinions, things they wanted for the baby and having a two-way communication process for giving and receiving information and feedback. Initiating these daily conversations enabled schoolgirl mothers/mothers-to-be to alter the focus away from themselves for a while and develop confidence in being able to speak to professionals about their baby. This process built on schoolgirl mothers' self-confidence and when other people, staff or friends, spoke to them about their baby, they were able to have this dialogue in a more mature manner, giving and exchanging information.

A few schoolgirl mothers/mothers-to-be felt their confidence levels increased when others listened and took their concerns seriously. Being offered support and guidance were key elements in helping to increase confidence. The positive changes in the confidence of schoolgirl mothers/mothers-to-be was considered by one member of school staff as accelerating because of the content and extent of topics and questions that had to be discussed. These could relate to information about the baby when handing them over to the care of the nursery staff or child-minder. Schoolgirl mothers had no-one else to answer on their behalf and had to respond to questions from professionals. This meant that schoolgirl mothers/mothers-to-be had to mature more quickly and develop confidence in being able to respond.

### *Factors which contributed to participants feeling less confident*

Some participants described their body in terms of a shape (being round) and how others might perceive they looked rather than seeing beyond this external image and thinking about the baby growing inside. This image that participants had of themselves was for some a temporary situation while others struggled to see ahead to a time when their body would go back to what it was previously. For those who had not previously been conscious about their bodies, they talked about now feeling really self-conscious about their appearance and the weight they had gained. Comparisons were made between themselves and friends who were 'really skinny'. Even when others commented about them having returned to their original size, these words were hard to accept because they did not feel that way about themselves. Vikki, saw herself as 'triple the size of her friends' (Age 17, Group Interview 8, 2 people). Comments from extended family about needing to lose weight did not help improve Vikki's confidence. Bonnie felt her hips had moved with childbirth and she was trying to accept that she would never again be the same size or shape, therefore she would never be happy with her body (Age 18, Group Interview 8, 2 people).

Other body changes such as stretch marks did not appear in the same place on everyone. Participants talked briefly about the different places they had stretch marks such as their stomach, legs, chest, sides, bottom and back. Stretch marks impacted greatly on many participants' confidence even though these were not always visible to others. Preventative measures were taken by a few participants to try and stop any stretch marks but this did not always work. Getting rid of stretch marks was viewed as particularly hard even though there was an expectation that they would fade eventually. No participant anticipated that stretch marks could have had such an impact on their confidence, nor that it would happen to them, or even that they would have so many. Although a few participants focused more on a healthy baby rather than how they looked, the impact of stretch marks on the confidence of many others meant they did not want to change clothing in front of other girls in the physical education classes.

A changing body shape affected the clothes which the schoolgirl mothers/mothers-to-be normally wore. Participants no longer felt comfortable or confident enough to wear 'flimsy' outfits but found the need to cover up because of their new body shape and also because of the stretch marks. Putting on weight was not a welcomed part of pregnancy and some participants went so far as to say they hated their body and had lost a lot of confidence. Losing the additional weight gained during pregnancy was hard and the effects of this made some participants very self-conscious and embarrassed about themselves. Getting back into shape was immediate for some participants but not so for others. Buying new clothes was not such an attraction anymore because participants did not feel they fitted these as well because their body shape had changed. For one participant, gaining additional weight was something she knew had to happen and she found this easier to accept because her body 'was not perfect in the first place' and it was worth going through the changes to have the baby (Morgan, 14, Group Interview 1, 4 people). This was not the case for everyone.

Delivering the baby via caesarean section further impacted on participants' confidence. For those who had had a caesarean section the visible scar decreased their confidence when going swimming. Confidence then deteriorated further, especially for the participants who had stretch marks as well as a visible scar. One participant believed her self-confidence deteriorated during pregnancy but then improved after having the baby.

'When I got to the late stage in my pregnancy and I would not leave the house because of how big I was and people would stare at you, they would heavy stare at the bump and I was like, 'they are acting as if they've never seen somebody pregnant before' .....It would really irritate me and make me upset and stuff but after the baby was born I'd walk outside with my pram never even cared what anybody thought, I just seen this beautiful baby. I was like I don't care what anybody thinks any more' (Paige, 15, Individual Interview).

Elise talked about feeling older and more mature for her fifteen years and she was able to recognise that she had changed since having her baby (Age 15, Individual Interview). Despite these changes, Elise lacked confidence to be able to walk into town with her baby in a pram because she felt that people were staring at her. These



feelings were hard to overcome and Elise realised that she was allowing them to affect her to the extent that she was putting herself down and was then upset at herself.

Having a baby did impact on the freedom to go out socialising and this was a major loss for some participants. The restrictions on socialising were partly due to problems with childcare, being asked to go out at short notice, lack of time, change in focus, or not wanting to leave the baby.

### *Participants' perceptions and experiences of increased maturity and confidence*

Participants did not all view themselves as lacking maturity and confidence prior to becoming pregnant but they recognised there was still room for this to increase. It was common for participants to think of increased confidence as something that happened in stages. Transitioning from one level of confidence to another did not happen all at once, neither did participants realise they were making the transition until they reflected back on their journey thus far.

The following discussions outline how participants perceived and experienced increased maturity and confidence. These findings about a continuous process of psychological development and maturity concur with those of Butler and McManus (2000). Step by step changes in confidence levels and maturity happened unconsciously at different stages of pregnancy or after delivering the baby.

'I think it was just step by step just taking every day as it came and then realising every day I just told myself, 'I'm going to be a mum, I'm going to be a mum, I'm going to be a mum, somebody is going to be calling me mum'. Then I got used to that and I was like I need to change for my baby's sake' (Paige, 15, Individual Interview).

Recognition was given by participants to their previous immaturity and the slower pace at which they had been maturing. Participants commented that without having a baby it would have taken them longer to mature. Growth in maturity came with the

understanding that, when making decisions for the future, these had to be carried out keeping the baby in mind and considering what was best for everyone.

‘I think you just kind of get to a point and you realise like I’m not just doing this for myself any more I’ve got a wee baby to think about and whatever my exam results, doing what job I’m doing is going to obviously affect not just my future but theirs as well’ (Gabrielle, 16, Individual Interview).

For one schoolgirl mother, she felt her maturity had to increase when she separated from her partner and realised that the full responsibility of raising the child rested entirely with her. Another participant commented that her confidence levels and maturity increased when she moved into her own accommodation. Participants also talked about feeling that the baby needed them to be confident and mature so they responded to the silent expectation.

‘You sort of know like you have to change. It’s not like a.....an immature little sort of brat like, you know you have to change and you haven’t to keep being, it’s really for the baby’s sake, not for your own. It’s like to be a good mum you want to be, you’ve no option’ (Toni, 15, Group Interview 6, 2 people).

The stage at which someone matures and develops confidence is determined by other external factors and is different for everyone. If external factors differ across individuals and are not age dependent, increased confidence, the transition process to maturity and how one reaches it, is unique to each person. It is not effective to measure or judge the method by which one person reaches maturity against another. Changing the milestones by which society recognises adult status would be a long-term cultural change. What is clear from this study, is that no-one sets out to gain adult status, maturity or increase their confidence by deliberately having a baby, even though motherhood can be viewed as a socially idealised form of womanhood (Schofield, 1994).

## **5.5 Poverty and financial dependency**

Previous discourse on schoolgirl mothers/mothers-to-be has considered their pregnancies as causing or perpetuating a cycle of deprivation and involving a greater risk of being poor, unemployed and isolated (Macvarish, 2010). This view is contested by Daguerre and Nativel (2006) who suggest that the extent to which schoolgirl pregnancies are the cause or consequence of poverty is unclear. Even if schoolgirl pregnancies and conception rates were to decrease, there is no evidence that it would reduce poverty. Seamark and Ling (2004) believe that deprivation is related more to the background of the schoolgirl.

Participants were asked in the interview to describe their birth parent's job title and to describe the area of work in which they were employed. Twenty participants advised that their mother was working either full or part-time or was attending college or university. Seven participants commented that their father was in full/part-time employment. Information was not provided by every participant on their parents' employment and so this data is incomplete. Given that forty-seven percent of participants' mothers were working or in further education, more research would be required to ascertain if this represents the start of a change in the 'cycle of deprivation', unemployment and isolation associated with schoolgirl parenting.

This research has endeavoured to track participants over a 9-12 month period. It would be of interest to carry out a longitudinal study to track the lives of schoolgirl mothers and in particular their educational outcomes, employment opportunities and future careers. This would be of significant interest given that schoolgirl parenting is perceived as affecting longer term educational outcomes by ruining existing education experiences and limiting future opportunities. Poverty together with a lack of education and educational opportunities is considered to create a culture of financial dependency. This is exacerbated by the perception that schoolgirl mothers do not value education as a route out of poverty. Further research has been called for by Bonell et al (2005) on 'the factors underlying dislike of school and lack of future expectations about education and training', p230). Bonell et al also promoted the need

to develop interventions to increase a young person's satisfactory experience at school and their expectations about future education and training.

Participants were asked in the questionnaire to describe their plans for the next year and also the next five years. This information is incomplete as not everyone responded. Some participants did discuss it briefly during the interviews. Collective responses included college and/or part-time work, continuing at school, sitting exams, working, going to university, and an apprenticeship. Some participants detailed a range of courses they would like to study at college or university and what occupation they would like to have. These included: social care, nursing, health care, hairdressing, psychology, catering, medicine, administration, working with children with additional support needs, social work, midwifery, teaching, and studying child development.

Additionally, participants were asked in the questionnaire if they felt the picture of where they wanted to be over the next few years would look different if they did not have a baby. Twenty-one participants did not think their life would look different, two did not comment. Thirteen participants responded that their life was better for the following reasons: they would not be in school nor have qualifications and career opportunities if it were not for the baby (7); they had gained control of their life (3); they now felt more motivated (1); they felt more mature (1); no reasons provided (1). The remaining seven participants felt that their life was slightly worse since becoming pregnant/having a baby because: they had had to leave home (2); they had to delay going to university or getting into employment (2); life would be easier and less stressful without a baby (1); their activities with their peer group was restricted (1); they would have continued in education and achieved better examination results (1). A few participants did not want their plans for the future to change because they had a baby. Pregnancy was a motivating factor for participants and those who had previously disengaged from education were re-engaged and working towards examinations.

School staff were asked if the educational outcomes of schoolgirl mothers/mothers-to-be would have been any different had they not become pregnant. From the responses

received, it would appear that the educational outcomes of schoolgirl mothers/mothers-to-be were affected by their age and what stage they were at in school when their baby was due. The timing of the baby's birth could impact on educational outcomes if this was close to exam dates. Sometimes, where the baby's due date was close to the young mother reaching the statutory school leaving age, it was harder to encourage her to return to school.

Fifth year of secondary school was thought to be particularly tough for participants who had a baby and were sitting higher qualifications. Participants were described by school staff as being overly ambitious and determined to continue with five Highers. Sometimes this resulted in their exam marks not being as good across all subjects being studied. It may have been better for the schoolgirl mother/mother-to-be to reduce the number of subjects she was taking at that time. This was not the case for every participant and some did do much better because of their focus and determination.

The above data indicates a perception amongst participants that school was considered 'a good thing'. One member of school staff commented that many of the schoolgirl mothers were not required to be in school because they were over sixteen. However, they had chosen to stay on and continue with their education because 'they could see a point to it and can see an advantage to it' (School, 5). Chapter Six discusses in more detail, participants' educational experiences before becoming pregnant. Even though participants considered school to be 'a good thing', this did not prevent them from experiencing challenges when trying to continue in education. Chapter Seven goes on to consider the challenges that participants faced when continuing in education.

School staff commented that one of their aims was to ensure that schoolgirl mothers left school having sat exams and achieved qualifications. Advice given to schoolgirl mothers by one member of staff was that 'school would be hard for a very long time but having qualifications would contribute significantly to them going out into the world with their heads held high' (School, 7).

One member of school staff advised that some of their previous schoolgirl mothers had become social workers, nurses, lawyers, an air hostess, a dancing instructor, an architect. Educational outcomes were improved through well managed progression routes to college or university and these had taken years to build up. Fifth and sixth year schoolgirl mothers were paired with a university student or someone who was already in the workplace and had been a schoolgirl mother. This enabled them to have a consistent, successful role model who had been through the same situation and had achieved positive outcomes.

Educational outcomes were not as good for any schoolgirl mother-to-be who did not advise the school about her pregnancy and decided to leave. This resulted in her missing out on the wide range of opportunities and support available either to continue in school or move into further education or employment. These pregnant schoolgirls were already of leaving age and did not need to return to school. Educational outcomes would have been different for other participants had their social group been different (School, 20). Reduced educational outcomes were not as a result of the pregnancy but rather they were affected because of the schoolgirl mother's peer group.

Although schoolgirl mothers are accused in policy of being financially dependent on benefits, many participants talked about not wanting to have this reputation placed on them. Instead, part of the reason for returning to school to try and improve their educational outcomes was the end goal of getting a good job to be able to look after themselves and their baby and not be benefit dependent. Two participants talked about having no other option but to move out of their parent's home because they would not get any benefits if they stayed. Another participant lost out on benefits because she had left the family home.

## **5.6 Conclusion**

This chapter has drawn primarily on the accounts of participants to challenge the deficit model that characterises schoolgirl mothers/mothers-to-be and the existing research literature. It has also, where appropriate, discussed the views of school staff

and health visitors to further challenge the deficit model across the four topic areas of ‘lack of knowledge about sexual activity and contraception’, ‘health outcomes’, ‘maturity and confidence’, and ‘poverty and financial dependency’.

Without exception the schoolgirl mothers/mothers-to-be had not planned their pregnancy or motherhood. At the same time, they did not exemplify the deficits common in popular accounts. Furthermore, most participants did not link the unplanned nature of their pregnancy to ignorance about contraception. Only a minority of participants who attended Catholic schools complained about the absence of relevant sex education. The lack of preparation through sex education from school did not create difficulties contrary to those already reported in literature for other mothers (who are not schoolgirls) in terms of their capacity to be a mother. Moreover, this particular group of schoolgirl mothers were generally healthy, with healthy babies and had positive relationships with health professionals.

Data from this study suggests that schoolgirl mothers, including those who had concealed pregnancies, valued ante-natal care and enjoyed this experience. Unlike previous research, participants in this project also delivered babies with really good birth weights. The mental health of schoolgirl mothers/mothers-to-be does appear to be linked to participants’ background family circumstances as well as the responses they receive to the news about their pregnancy, as opposed to their age.

Participants did not describe any single or standardised method or life experience which they felt had contributed to them gaining sufficient capacities and competencies to declare having successfully transitioned from adolescence to adult status. There is no way of judging the maturity of schoolgirl mothers in this study prior to becoming pregnant. Reaching particular age milestones did not appear to have influenced the maturity or confidence of schoolgirl mothers/mothers-to-be. However, participants did describe their experiences of increased confidence and maturity as an unconscious step by step journey (starting in pregnancy) to ‘mature, rational, responsible, autonomous, adult competence’ (Christensen and James, 2008, p15).

Previous research has focused on issues surrounding schoolgirl pregnancies but less has been given to what might have been gained or lost in young parenting. Having a baby was, for more reasons than one, a life changing event which resulted in some participants' lives heading in a new but more positive direction. For some participants, motherhood meant taking school and education more seriously even though this could result in disruption and difficulties in their endeavours to continue in education. All participants were conscious of the wider accusations that schoolgirl mothers depended on benefits. This insinuation would appear to have been a personal motivating factor for participants to continue in education with the longer term aspiration of obtaining a good job.



## CHAPTER 6

### EXPERIENCES OF SCHOOLGIRL MOTHERS/MOTHERS-TO-BE WHEN ‘COMING OUT’ AS PREGNANT OR HAVING A BABY WHILE CONTINUING IN EDUCATION

‘You know some judge you, just the way they look  
at you, you can tell’.

(Sonia, 15)

#### 6.1 Introduction

The previous chapter focused on challenging the deficit model that characterises schoolgirl mothers/mothers-to-be and the existing research literature. It was important to address the deficit model so that full consideration can now be given to the actual experiences of schoolgirl mothers/mothers-to-be when continuing in education.

This chapter explores participants’ experiences when ‘coming out’ as pregnant or having a baby while continuing in education. In particular the chapter begins by focusing on participants’ reflections about their educational experiences in school prior to becoming pregnant. The chapter goes on to consider the experiences of participants when they realised they were pregnant and how they responded to this. After realising they were pregnant, participants told family members, their peer group and professionals about the pregnancy. The range of people and professionals that participants told about their pregnancy are discussed along with their subsequent reactions to this information. Finally the chapter considers influences on participants’ (dis)engagement with education after disclosing information about their pregnancy as well as the subsequent impacts on them for deviating from what is considered ‘normative pathways’.

This chapter draws primarily on the accounts of schoolgirl mothers/mothers-to-be to explore the different topic areas mentioned above. Data from the interviews with

school staff have been included where relevant to provide further understanding of the experiences of schoolgirl mothers/mothers-to-be.

## **6.2 Educational experiences before pregnancy**

Moving to secondary school is a major event in a child's life. Preparation for this begins with a transition programme which starts in the latter years of primary. Staff in primary and secondary schools dedicate time and effort to ensure the transition is a smooth process and all young people are placed appropriately in their new classes. Background information is obtained about pupils during this transition phase.

‘We are looking to try and get the best understanding we can of where the young person is at, at that point of transition both academically but also within the family structure and how they are getting on with their folks and all the rest of it’ (School, 1).

Secondary schools can assign pupils to registration classes through different means such as a ‘house’ system. The ‘house’ system has a guidance teacher linked to each ‘house’ and that person becomes the point of contact for pupils and their parents within that particular ‘house’. Relationships with the guidance teacher begin in primary school and continue on a more intense basis once the pupil starts secondary school.

Measuring educational experience is not an easy or well-defined process because of the complexity of the interrelated components that add up to make the experience. It could be assumed that, where relationships with staff, enjoyment of course subjects, friendships, practical support are all positive, this might result in a positive educational experience and good attendance at school. Although attendance at school is not reliably indicative of a good experience or engagement, it can be used to provide some form of insight.

Previous studies carried out in England have been consistent in their findings that schoolgirls had had a bad or negative experience of school prior to becoming pregnant and this contributed to their unhappiness and disengagement from education (Cater and Coleman, 2006; Alldred and David, 2007). It was anticipated this research might

have mirrored previous studies but that was not the case. This research challenges previous studies not only through the findings but also by not starting uncritically from taken for granted assumptions to begin further discussions about schoolgirl parenting.

Twenty-three participants talked in the interview about having a ‘really good’ or ‘good’ school experience prior to becoming pregnant, nine did not comment and the remaining eleven stated they did not like school. Reasons provided by those who did not like school were not solely linked with a bad or negative experience. Elise had additional support needs and she disliked school because she felt it was ‘too big and boisterous’ for her (Age 15, Individual Interview, 4 people). A few participants described school as a place where they felt unsettled or bored but these feelings did not arise out of a ‘bad experience’.

*Relationships with teachers* - The importance of relationships with teachers in determining the quality of experience at school was prevalent throughout all the interviews with schoolgirl mothers/mothers-to-be. It was evident that participants were seeking some form of ‘connection’ with teachers. In general, participants liked their teachers although there were a few with whom they did not have a good relationship. Some teachers were perceived as favouring certain pupils and this was viewed as unacceptable because participants felt everyone should be treated equally. It did not stop participants from talking about their favourite teachers.

Negative opinions of teachers were formed by a few participants as a result of actions taken against them for what they considered small and insignificant behaviours. Certain teachers’ actions had caused upset and impacted on participants’ engagement and experience in school as well as leaving a lasting impression in their minds. The lack of knowledge about experiences and challenges of participants did at times unintentionally exacerbate their difficulties especially in terms of their mental health. These actions by a small number of teachers seemed to invite feelings of ‘rejection’ rather than ‘connection’. Schoolgirl mothers/mothers-to-be very quickly picked up on body language and ‘negative vibes’ from teachers. Tessa explained, ‘I don’t think they liked me. I was just a bit slow’ (Age 15, Group Interview 11, 2 people).

From a teacher’s perspective, staff must maintain a professional distance, manage their class effectively, help pupils through the course material and prepare them for examinations. Any acts of misbehaviour from pupils in school must be addressed. Teachers may feel that their actions to address misbehaviour are misinterpreted and resented by pupils because they dislike being told what to do. One member of staff explained:

‘Pupils will say they don’t like their teachers and use it as an excuse not to go to school.....So and so says that to me and that teacher says this to me....it is usually round about the fact that there were issues to begin with. There probably are behavioural issues in class that the teacher is having to deal with.....that can be used as an excuse but it usually is an excuse’ (School, 8).

One member of staff acknowledged lapses in professionalism and talked about judgemental attitudes that could exist amongst professionals which pupils very quickly picked up.

‘What is important is the perception that the kids have of it and how we talk about kids to each other because they are very savvy.....we are all prone to moments of weakness when it comes to our own professionalism’ (School, 1).

*Attendance at school* - Participants were asked in the interview to describe their attendance at school prior to pregnancy. Some responded in terms of percentages ‘it was about 97% I think it was’ (Lauren, 16, Group Interview 7, 2 people). Others like Rhiannon described her attendance in words ‘it was terrible, absolutely awful. I was off all the time just through not being bothered to go to school’ (Age 17, Individual Interview).

**Table 6 - Attendance at school before pregnancy**

<b>Age</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>Total</b>
Really good		3	4	5	2	<b>14</b>
Good	1	3	3	4		<b>11</b>
Bad			2			<b>2</b>
Really bad	1	8	2	2	1	<b>14</b>
Not known			2			<b>2</b>
<b>Total</b>	<b>2</b>	<b>14</b>	<b>13</b>	<b>11</b>	<b>3</b>	<b>43</b>

Twenty-five participants described their attendance at school as being either 'really good' or 'good' prior to pregnancy, sixteen stated theirs was 'bad' or 'really bad' and two did not comment. The description of attendance at school which each participant assigned to themselves was confirmed in the interviews with staff although no specific questions were raised about any individual participant's attendance. Some absences were due to pre-existing health problems such as epilepsy, back problems or because of bullying.

*Exclusion* - The criteria used in judging whether to exclude a pupil from school are set out in the Schools General (Scotland) Regulations 1975 (Exclusion from Schools, 2006). Thirteen participants advised in the interview that they had been excluded once or more from school. Six participants who had been excluded described their attendance at school before pregnancy as being 'really good' or 'good' and seven stated theirs was 'really bad' or 'bad'. The reasons for exclusion varied from being cheeky to teachers, chasing/slapping/pushing/fighting another pupil, a difficult relationship with a teacher, writing graffiti on the wall, and making a racial comment.

*Engaged/disengaged from school* - There is no strong evidence from the data to suggest that participants were either all engaged in, or all disengaged from, the education system prior to becoming pregnant. Tensions in relationships between some participants and teachers seemed to exist but these were not a consistent finding, neither was there any pattern of disengagement. School staff did indicate a variety of (dis)engagement across schoolgirl mothers/mothers-to-be.

'Some girls are kind of running free and wild and not engaged at all and others, very dedicated, in the middle of sitting exams' (School, 2).

The above statement echoes the views of other schools involved in the project. There is no evidence to suggest a 'bad' or 'not as good' educational experience in the early stages of secondary school is a predictor of schoolgirl pregnancies. Information from participants in this study suggests that a minority were disengaged from school prior to becoming pregnant. A majority, however, were not.

Without a pattern or route to becoming ‘disengaged’ from school (mentally and/or physically detached) it is necessary to look deeper into the experiences of schoolgirl mothers/mothers-to-be to find explanations. Some participants talked about circumstances which had diverted their attention from education and these included losing a close family relative and going off the rails, difficult family circumstances (possibly involving drugs/alcohol), being moved between parental homes in different towns (between mother and father), major family incidents, and constantly moving between schools. It seems more appropriate to suggest that rather than there being ‘disengagement factors’ there are instead ‘distractions from education’. School staff commented that it was during these difficult circumstances at home or in the community that schoolgirl mothers/mothers-to-be tended to disengage with education because of the distractions (School, 28). One member of school staff commented ‘for the majority of youngsters who find themselves in this situation, education is not a high priority so their attendance may have been sporadic but they do in general attend school’ (School, 22). It would appear that school staff are aware of the family distractions that affects their pupils and they recognise the signs of deterioration in engagement with school. However, it is unclear from the data, what actions are being taken by staff to re-focus the attention of schoolgirl mothers/mothers-to-be back to education or indeed whether any course of such action was always possible. Such actions may involve partnership working with other agencies linked with the school in order to provide appropriate support during the period of time that schoolgirl mothers/mothers-to-be are distracted from education. This early intervention may help schoolgirl mothers/mothers-to-be to stay focused while also preventing them from being distracted from education in the first place.

### **6.3 Realising, responding and reactions to pregnancy**

#### *Realisation of pregnancy*

As with previous studies, schoolgirl mothers/mothers-to-be in this study advised in the questionnaire that their pregnancy had not been planned (Cater and Coleman 2006, Arai 2009, Macvarish and Billings 2010, Formby et al 2010). Thirty-one participants realised they were pregnant during the first trimester (0-12 weeks), nine found out in

the second trimester (13-24 weeks) and two in the third trimester (25+ weeks). The final participant did know she was pregnant but she had concealed this from everyone apart from her boyfriend and had delivered the baby at home on her own.

The realisation of pregnancy brings the requirement for decision-making. For many, this might seem like a crossroads in their life and the path ahead, no matter which one is taken, will have its own difficulties. Having an unplanned pregnancy does not fit with the idealistic notion of 'proper, planned and prepared motherhood' and 'opting for an abortion risks criticism in a society that channels women into mothering' (McNulty, 2008, p42). Therefore, the risk of stigma and criticism is still prevalent regardless of whether schoolgirls continue with their pregnancy or opt for termination.

*Termination* - Political debate about terminations can draw on moral arguments without considering contextual circumstances around becoming pregnant, the complexity of crossroad decision-making, personal health risks or religious perspectives. While the ability to shoulder the responsibility of motherhood is interpreted differently, in political debates this is mapped onto social class cultures, age dependency and financial positioning (Duncan et al, 2010).

Pregnancy termination rates across Scotland vary significantly. The latest figures released in May 2014 from the Information Services Division Scotland show a decrease in the number of terminations performed in 2013 on girls aged 16-19. Choices and decisions about having a termination are not only life changing but dependent on, and influenced by, a wide range of factors. Young women who live in deprived areas are cited as being more likely to become pregnant as compared to their counterparts who live in more affluent areas and are less likely to use termination as a way of resolving unplanned pregnancies (McDermott et al, 2004). This theory was considered by Turner (2004) who concluded that there was 'no solid body of research that demonstrates a link between socio-economic background and subsequent responses to childbearing' (p222). The high numbers of pregnancies amongst disadvantaged women could possibly reflect a greater degree of disapproval regarding terminations than those from more affluent backgrounds (Turner, 2004). As

terminations in some areas can carry more stigma than early motherhood, the decision to keep the baby may reflect the values of the local community rather than being specifically linked to schoolgirl mothers (Alldred and David, 2010). Participants in this study were from mixed social class backgrounds.

Participants were asked in the questionnaire if they had considered other options such as termination or adoption. Thirteen participants responded yes to this but the topic also came up during some of the interviews. Eight schoolgirl mothers/mothers-to-be commented during the interview that they had considered having a termination but for different reasons, outlined below, they had decided to continue with the pregnancy. Two of the eight participants had previously had a termination. Another schoolgirl mother considered having a termination during the early stages of pregnancy with her second baby.

A study carried out by Vincent (2012) of fourteen schoolgirl mothers/mothers-to-be aged 15-18 revealed that many participants in her study had strong anti-abortion views which were underpinned by ideas about responsibility and the sanctity of life. The views of participants in this study on abortion were similar to those in Vincent's (2012) study but concerns and fears also existed that having a termination would affect their ability to have children in future. These fears were enough to prevent participants from terminating their pregnancy. Anti-abortion views appeared to be, if not engrained, then certainly heavily influenced by parents and this has been a common finding in previous studies (Alldred and David, 2007). Amber (Age 15, Group Interview 3, 2 people) commented that her father did not like abortions but for Abbi, it was her mother's opinion about abortion which influenced her decision.

‘My mum went onto the website and showed you what your baby looked like at that point and stage when you got rid of it. Then she turned round and started shouting at me and said, ‘This is what your baby looks like and this is what you are going to do, you are going to kill it. Your baby has legs, toes, fingers’’ (Abbi, 17, Individual Interview).



Such strong views and pressure from one parent caused family ructions and disagreements at home. Abbi described the tense and difficult situation between her parents.

‘My dad was annoyed with my mum. My dad was angry, he was like that, ‘Why would you do that? She has got one decision that is going to change her life’’ (Age 17, Individual Interview).

Although parental pressures and personal views were strong, these were mixed with participants’ concerns and uncertainty about their future education and career should the pregnancy continue. Without a clear path ahead or having figured out a way forward, a few participants considered termination. These participants thought they would not get anywhere in life and that their situation would be more difficult. The concerns over their education and career were tangled up with fears about future relationships after having a baby.

In addition to family pressures, mixed feelings and uncertainties about the future, two participants (Sonia, Rochelle) faced unexpected challenges in respect of terminations. These pressures came from professionals in health and practitioners in a youth organisation to resolve the pregnancies through a termination.

‘They [youth organisation] gave me the option of termination and they were trying to drill it into my head to get a termination and that. They kept giving me like leaflets. I was like, ‘I don’t want these leaflets. I don’t want a termination’’ (Rochelle, 14, Group Interview 4, 3 people).

For the two participants who had had a previous termination, this had not been a pleasant experience. Not only was it an experience they did not wish to go through again, it was something for which they said they had taken full responsibility. Previous experience of having a termination influenced both participants’ decisions to continue with this pregnancy.

### *Responding to pregnancy*

Motherhood is associated with responsibilities and the decision to continue with a pregnancy is framed as taking these on while adapting to new ones (Alldred and David, 2010). It is recognised that for some schoolgirl mothers-to-be, their crossroad decision-making will be influenced by cultural notions of family, marriage, sexual relationships, termination, community opinions, personal opinions and views expressed by family and friends (Franz et al, 2009). This research found additional factors that influenced some schoolgirls to continue with their pregnancy.

Additional factors which influenced some participants' decisions to continue with the pregnancy linked back to experiences during the first ante-natal scan. Seeing the baby moving on the screen and hearing its heartbeat were life changing moments for many schoolgirl mothers-to-be. These experiences brought a sense of ownership whereby the baby belonged to them.

‘It was a totally strong heartbeat, it was not just a flutter it was proper beating. Just seeing him, seeing the scan picture of him, knowing that he was a baby and he was mine’ (Adrienne, 16, Individual Interview, 2 people).

In their study, Macvarish and Billings (2010) found that through ‘disavowing abortion’ and accepting responsibility for their ‘mistake’, schoolgirl mothers-to-be were able to transform their pregnancy into something positive. For the majority of participants in this study, abortion was never a viable option and so they did not ‘disavow abortion’. The concept that acceptance of responsibility is achieved through ‘disavowing abortion’ is a misinterpretation of how schoolgirl mothers process their situation to arrive eventually at a decision. Acceptance of responsibility was present with participants in this project and their part in it all was clear in their mind. The problem some participants faced was in trying to figure out the way ahead. Discussing potential options with someone and being offered help and support to raise the baby were key factors which influenced participants' decision-making process on whether to continue with the pregnancy.

‘If I was being supported by all that family like they said, then that’s why I kept going’ (Sonia 15, Group Interview 4, 3 people).

Schoolgirl mothers/mothers-to-be are identified in previous studies as being less likely to access professional services and more likely to find it difficult to know who to ask for help (Hosie, 2007). This was not prevalent in this study and participants were clear about whom to speak to for help. Schoolgirl mothers-to-be chose whom to confide in regarding their pregnancy. From the interview data, there were five main categories of people that participants told about their pregnancy. These were parents, boyfriends, school staff, health professionals and friends. Parents and boyfriends were primarily the first people that participants confided in about their pregnancy.

*Parents* - Participants described their own or their parents’ feelings regarding the news about the pregnancy as a mixture of emotions including being scared, tearful and surprised rather than pleased (Table 7). Mothers (of schoolgirls) tended to be more tearful and surprised about the pregnancy as compared to fathers who, although surprised about the pregnancy, were reported as being angry about the situation. The relationship between participants and their mothers is discussed in more detail later on in this chapter. Without having interviewed the mother of any participant, it is difficult to make evidence-based links between the main reactions of mothers (surprised and tearful), as described by participants, and their relationship with schoolgirl mothers/mothers-to-be.

**Table 7 - Responses to pregnancy**

	<b>Own feelings</b>	<b>Mothers</b>	<b>Fathers</b>
Scared	27	8	4
Pleased	4	1	2
Tearful	13	17	8
Angry	0	4	11
Frustrated	2	6	8
Surprised	21	19	10
Don’t know		2	4
Other (Shocked, disappointed, quiet)			3

It is unclear from the data whether there is any link between participants feeling scared about their pregnancy and their experiences of knowing how their parents (fathers in particular) might react to the news. Adrienne explained:

‘He [dad] was shocked, he was a bit angry, he was shouting. I’m his youngest so of course he is going to be mad’ (Age 16, Individual Interview).

Being afraid of parental reaction is something which was found in Alldred and David’s (2007) study. An angry reaction from fathers on hearing that their daughter is pregnant might be understandable and possibly even expected for those schoolgirls who are a little younger in age, for example thirteen, fourteen or fifteen. Nine of the sixteen participants who were aged fourteen and fifteen at the time of being pregnant described their father’s reaction as ‘angry’. There is some evidence from the data in this project to suggest that this could be the case but as interviews were not carried out with the participants’ parents, it can only be assumed that there may be a link between the age of the schoolgirls and the angry reactions from fathers. There was no consistency in terms of an angry response from fathers and any particular social class background.

*Partners* – Previous studies have suggested that unplanned conceptions for schoolgirls are unwanted, single mothers are without stable relationships and their partners are more likely to be poorly qualified or unemployed (Duncan 2007, Duncan et al 2010). At the time of interviewing, seventeen participants were still with their partners, eighteen had separated and the remaining eight did not comment. Sixteen participants identified that their partners were among the first people they had told about being pregnant. In a few cases it was actually the partners who noticed a change in their girlfriend’s behaviour during the early stages of pregnancy or they were concerned about them being very sick and not eating. These alterations to normality prompted partners to encourage participants to seek help and advice from the doctor.

‘Well at first my boyfriend asked me if I had had the time of the month, I hadn’t so we went to Boots. We sat looking at the test hoping it would not come up, I don’t know, hoping for something, an answer. It came up positive. His face was like wow, he didn’t know what to say. I started crying. I didn’t know whether to cry or be angry at myself’ (Abbi, 17, Individual Interview).

The reasons given by participants for not being with the baby’s father any more extended across a range of factors: the change in personality of the schoolgirl mother-to-be during pregnancy (hormonal/moods/emotional); complex issues going on at home for the partner; the partner living a distance away; relationships having not been good to start with; the partner not wishing to know or become involved with the baby; both choosing different paths in life; the partner going off the rails, not knowing what to do about the pregnancy; being uncertain as to the identity of the father; and the partner having found someone new who was now pregnant. This research did not set out to raise questions about participants’ partners but the subject arose during interviews. No significant amount of data were obtained on the relationships with partners or about their employment status. A few participants mentioned that their partner had left school and got a job.

Duncan et al’s (2010) findings about schoolgirl mothers not being in stable relationships with partners echoes to an extent, data obtained from this study. What is missing from previous studies is details regarding partners’ reactions to the news about becoming a father and information on why schoolgirl mothers were not in a stable relationship with the father of their baby. Participants in this study detailed a variety of responses from partners to the news about the pregnancy during the interview. A few mentioned that their partners were really happy about the news while others anticipated that this information would make them ‘do a runner’, which it did in a few cases. In one extreme case, a schoolgirl mother-to-be was threatened by her partner and remaining with him would have been detrimental to her safety and the baby’s.

‘He’s threatened me loads of times so I don’t want him near. He said he was going to batter me’ (Madison, 16, Group Interview 3, 2 people).

In addition to being shocked about the news, two partners did not believe the news that their girlfriend was pregnant. One of these partners also demanded a DNA test while another wanted to see some evidence.

‘He was shocked, he didn’t believe me.....I’d send him scan pictures when I’d go for a scan’ (Adrienne, 16, Individual Interview).

Relationships with partners were strained for a few participants during pregnancy for different reasons. Two participants believed their hormonal changes during pregnancy contributed to the relationship difficulties they had with their partner.

‘We split up, we weren’t getting on for ages but I think it had a lot to do with my hormones being everywhere’ (Adrienne, 16, Individual Interview).

Partners also reacted in different ways throughout the pregnancy. One partner seemed to be embarrassed by the physical size of his pregnant girlfriend.

‘I’m getting bigger and he gets embarrassed when you’re getting bigger. Its cause like he’s so skinny as a person. I feel like I’m fat, you feel like you’re bigger than him’ (Rochelle, 14, Group Interview 4, 3 people).

Other partners were over protective and did not want their girlfriends to go out. Rochelle explained:

‘He doesn’t let me go out myself. He doesn’t let me walk home myself, he’s over protective’ (Age 14, Group Interview 4, 3 people).

Concerns from some partners existed over their pregnant girlfriend being able to stay safe in school because of the busy corridors and the sizeable number of pupils moving around.

‘My boyfriend was really annoyed [about the busy corridors and the stairs at school] and he was like that, ‘What happens if you get hurt and you end up losing the baby?’’ (Abbi, 17, Individual Interview).

For a few participants the relationship with their partner had broken down either before telling them about the baby or during pregnancy. Things had gone well for one participant and her relationship with her partner was good during her pregnancy and initially after the baby was born but had changed thereafter. Nia commented:

‘At the start when the baby was just born he was fine with everything, it could not have been better and then by the time it hit last year, it was like, he was just going out, getting drunk and being the usual teenager so I just thought right fine, if you want to be like that. I just ended it all’ (Age 17, Individual Interview).

A couple of participants had high hopes that the birth of their baby would bring reconciliation in the relationship with their partner as well as some involvement with the baby. In contrast to this, several participants described longstanding and ongoing relationships with their partners whereby they had set up home and were planning their future together. One schoolgirl mother-to-be explained that she and her partner had known each other since childhood and she was confident that he would ‘stick by her no matter what’ (Rhiannon, Age 17, Individual Interview).

*School staff/other professionals* - After discussing the pregnancy with parents and in the minority of cases partners (where there was an ongoing relationship), schoolgirl mothers-to-be informed their guidance teacher at school. The role of the guidance teacher can provide the opportunity for staff to really get to know about pupils including their personality, skills, relationship with peer group, problems, family backgrounds and wider areas of strengths or areas of need. It could be justified that one might expect schoolgirl mothers-to-be would confide in their guidance teacher after talking to their family and if there is an ongoing couple relationship, a partner. Although this was the situation for many, two participants spoke to a member of school staff before talking to parents and partners. In one of these cases, the participant requested that the depute headteacher inform her mother about the pregnancy because she was afraid of her mother’s reaction.

‘I didn’t want to tell my mum cause I knew she would go angry so I thought it would be better if they [school staff] told her’ (Rochelle, 14, Group Interview 4, 3 people).

In another case, the deputy headteacher allowed the participant three days to tell her parents herself. If the participant was unable to speak to her parents, then a member of school staff would inform them.

The range of staff or professionals whom participants initially chose to tell about their pregnancy included: guidance teachers (25), deputy headteachers (4), school nurse (2), pupil support (2), social worker (1), subject teacher (1), doctor (1). The remaining seven did not disclose which member of staff they had spoken to initially at school about being pregnant. Table 8 below shows the stage at which participants first advised a member of school staff or other professional about their pregnancy.

**Table 8 - Stage of advising school staff/other professionals**

Role of staff	Gender*	Age	Stage in months					Total
			0-3	3-6	6-9	After birth	Don't know	
Guidance – 2	2 x N/c	<b>14</b>	1				1	2
Guidance - 11 Pupil Support – 2 Depute HT - 1	3 x M 7 x F 4 x N/c	<b>15</b>	9	1	1	1	2	14
Guidance - 7 Don't know - 4 Depute HT - 1 Subject teacher - 1	1 x M 6 x F 6 x N/c	<b>16</b>	1	7	3		2	13
Guidance - 5 Depute HT - 2 Doctor - 1 Social Work – 1 School Nurse - 1 Don't know - 1	5 x M 3 x F 3 x N/c	<b>17</b>	7	2			2	11
Don't know - 2 School nurse - 1	3 x N/c	<b>18</b>	1				2	3
<b>Total</b>			19	10	4	1	9	43

\*M – Male; F – Female; N/c – No comment

Such a range of staff, raises questions about why schoolgirl mothers-to-be decided to approach these particular professionals and whether the gender of the staff member influenced this. It also raises the question of ‘what makes a good professional?’ from the perspective of participants. Sixteen participants advised that the member of staff they approached (at school or other professional) was a female. Nine stated that their guidance teacher was a male and the remaining eighteen did not comment. The



reasons given for choosing the female member of staff/professional included: confidentiality, the member of staff had babies, trust, and gender.

There is no consistent theme emerging from the responses as to why each participant chose the person that they did to confide in regarding their pregnancy. What is clear is that each of them had thought about it carefully and made a deliberate choice about whom they would approach. The data would suggest that Scottish schoolgirl mothers-to-be have made choices on whom to approach based on an 'expectation of reaction' from professionals. These specific 'expectations of reaction' are predicted by each individual and are based on what they personally view as important to them and their situation. There is, for example, the expectation that the school nurse will not tell anyone else because she is bound by patient confidentiality.

'I just guess I thought if you tell the school nurse she is not allowed to tell anybody.....just....the comfort of knowing she was not allowed to tell anyone' (Vikki, 17, Group Interview 8, 2 people).

For Elise, her reason for speaking to the member of staff was because of the support she had previously received and expected again.

'They [school staff] were always dead supportive with us, they always knew that I had my troubles and they always phoned up and even when I was not at school they always phoned and asked if I was alright' (Elise, 15, Individual Interview).

Bonnie described a very positive relationship with a teacher and the respect and commitment she had shown her in their relationship, prior to becoming pregnant, was now (in her head) demanding the same in return. Bonnie felt she had needed to do what she perceived to be the right thing and tell her favourite teacher, whom she trusted, about the pregnancy.

Guidance teachers as a daily point of contact are expected to be able to deal with whatever problem or situation a pupil might raise with them and so some participants simply used their normal source of help. Terri (Age 16) had deliberately approached a member of staff because 'she had babies' and so there was an expectation that her

situation would be met by the common denominator of understanding. In addition to this, a theme that was dominant throughout all interviews was the ‘expectation of being able to talk to someone’. Two participants discussed their preference to speak to a female member of staff rather than a male.

‘My guidance teacher is a male and I felt because he is a guy I couldn’t really speak to him about it as much as I could speak to a woman about it so I came to the Depute Headteacher’ (Rhiannon, 17, Individual Interview).

Allred and David’s (2007) study highlights a strong sense of disrespect from teachers towards schoolgirl mothers. The lack of sympathy, understanding and trust from teachers had contributed to participants in Allred and David’s study feeling unhappy and disengaged from school. Such views are consistent with Allred and David’s (2010) study where the lack of respect from teachers had contributed to participants not disclosing anything as they felt they could not trust teachers to be non-judgemental or gossip to other teachers about them. This was not a finding in this study given that thirty participants in total chose a member of school staff to tell about their pregnancy.

As mentioned above, many participants were keen and expected to be able to talk to staff or professionals quite early on in their pregnancy. Approaching a member of staff or professional may be difficult but only one participant (aged 14) made this comment.

### *Reactions to pregnancy*

#### *Education professionals’ reactions to the pregnancy*

A previous study by Macvarish and Billings (2010) refers to schoolgirl mothers as being more prone to post-natal depression. Additionally, Formby et al’s (2010) study links a negative reaction to a schoolgirl’s pregnancy with diagnoses of depression and poor mental health. Formby et al suggested that a more sympathetic approach and support system should be made available and accessible to help address poor mental health issues for schoolgirl mothers/mothers-to-be.

Commitment was given in the Mental Health Strategy (2012) for Scotland to publish a booklet called 'Steps to deal with stress'. This provides an easy guide to understanding common mental health problems and contains practical ways for people to start dealing with stress. Within the booklet there are different sections which could be relevant for schoolgirl mothers/mothers-to-be. In particular, one very appropriate section refers to anxiety and depression. Ongoing stress is viewed in the booklet as 'leading to depression which affects our energy and concentration, making life even harder and more stressful' (Mental Health Strategy, 2012 for Scotland, p30). Stress is identified as having a number of symptoms including not sleeping properly, eating more comfort foods, having less energy, lack of motivation and concentration (p5). Two of the solutions suggested to deal with anxiety and depression are to talk about problems with someone or a doctor one trusts about one's feelings.

Participants described a variety of reactions in the interview from school staff to whom they spoke regarding their pregnancy. There was no consistency or pattern of reaction in terms of the age of schoolgirl mothers-to-be, or even across the local authorities where there were participants in different schools within the same authority. The initial reactions from school staff when informing them about the pregnancy were described by participants as: shock; surprise; congratulatory; positive; reassuring; nice; and supportive. In some instances there was no reaction at all.

'She seemed kind of shocked but like she said, I'm not going to be the first and I'm not going to be the last' (Lauren, 16, Group Interview 7, 2 people).

'She was surprised. She was like that, 'You?' and I was like, 'Yea me'. She was like, 'You are one of the people who you would not see getting pregnant'' (Abbi, 17, Individual Interview).

Twenty-seven participants were pleased overall with the way school staff reacted to their pregnancy. Eight commented that they were disappointed because staff had not been supportive, were judgemental, were not flexible regarding school uniform, did not allow them out of class or provide a lift key or had only organised two hours of home tuition prior to final examinations. Four participants were pleased with some

elements of support provided to them and disappointed about others. The remaining four did not comment.

After the initial reactions from school staff, participants described a range of responses which would appear to have happened over a period of time throughout pregnancy. Staff within schools that had a service provision tended to take a more practical approach in their reactions. The responses from all school staff have been separated into two categories: encouraging and discouraging.

*Encouraging* – In addition to a range of reactions, participants also talked in the interviews about practical responses from staff. These included starting to make plans for examinations, adjusting the timetable to suit their needs, looking at benefit entitlements (only a few mentioned this), speaking to other staff about the pregnancy (on the participant's behalf), providing opportunities to talk to professionals or staff and generally being available and helpful.

‘She automatically got planning...and spoke to everyone to see.....what benefits I could get and stuff like that’ (Rhiannon, 17, Individual Interview).

‘They were like, ‘If you need to talk to anybody’ ....Some of the teachers already had kids and if I needed to talk to them about anything they would let you talk to them’’ (Abbi, 17, Individual Interview).

The topic of receiving gifts and cards from staff after having given birth, came up in four separate schools in different local authorities. Other participants detailed very practical help from teachers. One subject teacher had offered to give the participant a pram because his wife had had a baby a few months beforehand and they had no longer needed it. Referring to her guidance teacher, Rhiannon commented:

‘She always makes sure that I’ve got food in my belly and a bottle of water to carry around’ (Age 17, Individual Interview).

Even though one participant had moved to another school, the guidance teacher had still kept in touch and was encouraging her to visit the school.

'I still get e-mails saying 'Are you wanting to come into this or that'. I got loads of presents from the school, it was really nice. I didn't expect it' (Elise, 15, Individual Interview).

*Discouraging* – During the interviews, fourteen participants described reactions from their subject teachers as more negative and discouraging - judgemental, 'acting weird', being quiet, excited, opinionated, inconsiderate, disappointed, unhelpful and saying nothing.

'You get the odd comment that they say to you and that, like, 'You've mucked your life up' (Rochelle, 14, Group Interview 4, 3 people).

'They were like that, 'What are you going to do, you are only 14 turning 15, what's out there for you, what are you going to do because you aren't allowed to start college until 16?'' (Abbi, 17, Individual Interview).

'They tried to act like it was not happening to be honest. I only had the one teacher for the periods I was doing because it was the same teacher that taught every class and she just kind of acted like it was not going on' (Kiera, 15, Individual Interview).

Talking through problems with another person appears to be straightforward. However, difficulties arise for schoolgirl mothers-to-be when they are met with reactions whereby school staff go quiet and/or pretend the pregnancy is not happening and the opportunity to talk through problems is not provided. As highlighted previously, not all schoolgirl mothers approached their guidance teachers and one chose a particular subject teacher to speak to. This difficulty of a non-response from teaching staff is intensified especially as all participants in this study demonstrated an expectation of being able to talk to someone about their problems.

Some participants advised during the interviews that they had to inform other subject teachers themselves about their pregnancy while for others, their guidance teacher had done this for them. Finding the courage to inform the guidance teacher about being pregnant can be difficult especially if several members of staff share office accommodation. This is, however, arguably easier than having to approach another eight subject teachers at the beginning or end of a lesson thus making the sharing of personal information in any great length or detail much harder. Further research would

be required to see if there is a link between the negative responses to pregnancy (as identified by Formby et al, 2010) from professionals such as teaching staff who have not provided a sympathetic approach and support system, and subsequent diagnoses of depression in schoolgirl mothers.

Bonnie and Vikki explained that their teachers did not know anything about their pregnancies until they (staff) were required to sign their leaver's form. This approach prevents help and support being provided to schoolgirl mothers/mothers-to-be at an early stage. For the small minority of participants in this study who encountered teaching staff who did not want to talk about the situation presented to them, this added further stress and exacerbated their difficulties. It may have been that staff did not know whether they should or could talk about such issues with their pupils. One reason for their uncertainty could be connected to the Data Protection Act 1998 by which organisations, including schools, are bound. The Data Protection Act is a United Kingdom Act of Parliament that defines UK law on processing data on identifiable living people. The Act is the main legislation that governs the protection of personal data in the UK and was enacted to protect people's fundamental rights and freedoms, in particular their right to privacy in respect to processing personal data. In practice, this provides a way for individuals to control information about themselves. Any organisation that holds personal data which complies with the definitions in the Act is legally obliged to comply with it (subject to certain exemptions). Failure to comply with the Act is a criminal offence and can result in an enforcement notice and could force a data controller to cease processing personal data. Officers of a company such as a Director or Manager can be personally liable if an offence has been committed with their consent or by neglect. Employees can also incur criminal liability if they disclose personal data without the authority of the data subject controller. The introduction of custodial sentences under the Act is being considered by Parliament.

Given the severity of the consequences of breaching the Data Protection Act 1998, school staff must take extreme care with personal data. This fear of consequences is acceptable but staff are not always aware of whom they can and cannot discuss information with. When a schoolgirl mother-to-be approached a member of staff and

wished to discuss concerns, it is unclear why some teaching staff did not enter into a more in-depth discussion but chose instead to say nothing or say very little.

‘The guidance teacher e-mailed them all so they knew but they didn’t say anything to me until I started to kind of show. We didn’t talk about it or anything because they said it was not right to tell or say anything out loud in case I didn’t want the rest of the class to know but they did know because it gets about’ (Kyra, 17, Group Interview 10, 4 people).

It is not being argued in this study that personal sensitive data about schoolgirl mothers/mothers-to-be should be shared randomly. Rather, the severe consequences of breaching such an Act may be preventing some staff from entering into discussions with schoolgirl mothers/mothers-to-be which might otherwise have helped prevent stress and anxiety building up, which in turn, could then lead to poorer mental health. For this reason, the Mental Health Strategy approach (outlined in the Steps to deal with stress booklet) and the Data Protection Act 1998 do not consistently work together for the advantage of schoolgirl mothers/mothers-to-be. Not only is this a difficulty in terms of mental health, it is also a practical issue for staff who are not fully informed of pregnancies but also about what they are or are not permitted to say. Schoolgirl mothers/mothers-to-be approached professionals for different reasons which included specific personality qualities and characteristics but also because of their understanding that staff (education and health) would be unable to share this information with anyone else. The Government documents discussed above make different demands on modifying confidentiality but these create a tension amongst health and education staff and confuse the boundaries and expectations of ‘what makes a good professional?’ In an attempt to answer the question ‘what makes a good professional?’ from the perspective of participants, it would appear that a warm approach built on a good relationship, combined with the appropriate formalities and understanding of Government legislation, together with a reputation of following through on agreed action points and support would be a good starting point.

*Practical matters* - There were very real practical matters which had to be addressed for participants who were taking physical education, chemistry, home economics and technical subjects (woodwork). Two participants in the same authority commented

that their teachers had tried to stop them doing physical education. Participants were able to understand and accept the obvious changes for handling chemicals in chemistry and also the potential dangers surrounding the use of machines in their technical classes but they could not accept the rationale behind them being withdrawn from home economics or stopping physical education. Participants felt that some physical exercise would be good for them. It was accepted by both participants that there would be certain parts of physical education (such as the trampoline) in which they would be best not to participate but they saw no reason why they could not be involved in other activities especially during the early stages of pregnancy. Two participants fought really hard to retain this part of their timetable only withdrawing from activities when they felt ready to do so (nearer the end of their pregnancy). This was different from two other participants, Adrienne (16) and Erika (15), who wanted to take the decision to withdraw from physical education themselves rather than be told they could not participate.

Homework was an issue which was raised by participants in separate schools in different local authorities. In one school three participants commented that their guidance teacher was very supportive but class teachers had no consideration for their situation.

‘Some teachers do but like when the baby is born and you are running about and that, you can’t do homework, they don’t take that into consideration’ (Demi, 16, Group Interview 4, 3 people).

In another school one participant stated:

‘Two subject teachers were giving me essays and then I had not finished the essay already but they were giving me more on top of them’ (Tessa, 15, Group Interview 11, 2 people).

*Continuing in education* - Participants were asked in the interview whether they had been asked to leave school because of their pregnancy or whether they had been encouraged to stay on in education. No participant stated that they were asked to leave and the majority were encouraged to stay on at school. One participant did comment:



‘They didn’t ask me to leave but it was kind of like they wanted me to. It was just by the way they were talking kind of thing...Some of them were really supportive but others were just kind of like, ‘Oh so that will be you leaving school now’’ (Lauren, 16, Group Interview 7, 2 people).

Adrienne felt that her guidance teacher was advising her to leave school. During the interview with the guidance teacher, he commented generally, that given Adrienne’s career choice along with her age and being pregnant, she should take a year out from education and go to college the following year. This, he thought, would be a more positive and practical suggestion for Adrienne as school could not offer the course she wanted.

Participants did discuss recommendations that had been made to them. Twenty-two participants talked about being recommended to transfer from their own school to another school or a flexible learning unit to continue with their education, which they did. Elise talked about how staff encouraged her to stay on even though they knew that school may not be the best option for her. Elise was eventually placed in a flexible learning unit which better suited her needs. Moving to a new school without having friends or knowing any teachers was difficult for some participants. This is discussed in more detail in Chapter Seven.

Two participants both aged seventeen at the time of the interview (aged 15 and 16 at the time of having their baby) talked about college being suggested to them as a better option. It is unclear from the data whether this suggestion was provided by school staff because of the more flexible curriculum, which would allow young mothers to combine a baby and education more easily. Although the suggestion of going to college may have been well-intended, it was not well-received as a solution to continuing in education. Vikki (Age 17) was thinking about how attending college would affect a future bursary or grant she might need to further her education at a later stage. Bethany (Age 17) had been weighing up her options in terms of the childcare assistance that was being offered to her if she stayed within a school environment. Had Bethany moved to college she would not have benefited from the childcare assistance being provided.

The encouragement or pressure (as in one case) to stay on at school came from different sources such as family members and school staff. Madison stated:

‘My mum says to me if I didn’t go to school, I would have to go and find my own house.....so I made a deal with my mum to go back to school and I wanted to come back anyway so I can get my Highers done (Age 16, Group Interview 3, 2 people).

Bonnie and Vikki (aged 16 and 17 at the time of having their baby) had not felt able to return to school immediately and had taken a year out. On returning to school they had been placed in the year group below their own.

‘My guidance teacher tried to get me to come back like in the year and not miss a year. I’m like, ‘No. I would be like 2 months after giving birth, no way I’m not coming back then’. I was nervous because it was not my year. I’m now in the year below me so I felt as if I would not know anybody. I did know one girl and her friends before then but they was the only people I knew and I didn’t really know anybody in my [new] class so it was a big thing’ (Bonnie, 18, Group Interview 8, 2 people).

Both Bonnie and Vikki felt there was a difference in their maturity and outlook on life but the year out had made the decision to return to school really difficult. Having to leave the baby with someone else was difficult because both Bonnie and Vikki felt they had lost their social skills as they were not up-to-date with normal teenage issues. These participants commented that their conversations now revolved around teething and nappies rather than false eyelashes and going out at the weekend.

The decision to stay at school or continue in education was easier when support was put in place to enable them to do so. This support took different forms but included childcare, having the option to return on a part-time timetable, being able to stay with their peer group, and teachers being supportive and talking to them about options as well as any concerns that arose. It was not just the reaction of the teachers which influenced decisions to continue in education but also the relationship that participants had with teachers. Participants were particularly pleased about staff talking to them about their situation but also in return, being able to approach them with any concerns.

Table 7 shows the participants' reactions to their pregnancy as being mostly scared and tearful. It is understandable therefore why younger schoolgirl mothers-to-be in particular would desperately want to have someone to talk to in school about their education and discuss future options away from home influences (at times). Nia found it hard when her guidance teacher (male), whom she had for a few years, left school to take up another post and had been replaced by a female guidance teacher. The close relationship with the male guidance teacher was identified by Nia as being important.

'I actually preferred the man so I did. Cause she is a woman she probably understands more and stuff like that.....I don't know I think it's because I went through first year to fifth year with him.....I got on with him better' (Nia, 17, Individual Interview).

For others, it was the newly formed relationship with staff in the new or alternative schooling that had influenced their decision to remain in education. This newly-formed relationship had made it easier to go to these members of staff and talk to them. Without this contact and the support which was offered, participants felt that their decision to return to school would have been harder.

Decisions to leave school were easier for four participants because they had already planned to leave (at the end of fifth year) and go into full-time work or college. Two of these participants had not enjoyed their last year at school.

Dilemmas over continuing in education were hard when contemplating the need to leave the baby in the nursery or with a child-minder. This is discussed further in Chapter Eight. For one participant, Abbi (Age 17), the decision to continue in education was difficult because her baby was born prematurely. Abbi had wanted to be at the hospital with him every day and had been torn between this and continuing at school. Another participant, Bethany (Age 17) returned to school to complete two subjects that she wanted to study. Bethany felt that she had no option at the end of fifth year other than to leave because school could not offer her courses to help her progress to the next stage in her career. Arrangements were made for Bethany to transition to college after fifth year.

For Jena (Age 18), continuing in education was not possible because she had had two babies and could not afford to pay for childcare to allow her to do so. Jena did not feel able to manage a house, prepare meals, study and look after two babies.

The decision to continue in education was something which participants appear to have continually reviewed. During difficult times, when participants were physically tired with being up during the night with the baby or when the baby was unwell for whatever reason, the decision to continue in education was regularly challenged. As discussed previously in Chapter Five, one member of staff (School, 3) felt that schoolgirl mothers go through a circular process for a period of six months where they fluctuate between feelings and attitudes of being able to continue in education, not being able to continue and wanting to run away from everything.

#### *Health professionals' reactions to the pregnancy*

Previous literature suggests that schoolgirl mothers-to-be are less likely to access professional services, they do not report their pregnancies until late on and are therefore in more danger of adverse health outcomes (Hosie 2007, Daguerre and Nativel 2006). Although the stage at which schoolgirl mothers-to-be report their pregnancy may continue to vary, the data from Table 9 below shows that a large percentage (69.4%) of schoolgirl mothers-to-be in this study reported their pregnancies to health professionals within the first trimester (0-3 months) but this is contrary to national research (Daguerre and Nativel, 2006). Clarification on this point was sought through interviews with health visitors and school staff and the comparisons are provided in Table 10. The results show agreement across four local authorities on reporting times of schoolgirl pregnancies. In another local authority, the data from the participant and the health visitor are in agreement. A variation exists in a further local authority but this could be because pregnant schoolgirls transfer into this school (from all over the authority) and there could be a delay resulting from the internal referral processes.

**Table 9 – Pregnancy stage of participants/reporting to health professionals**

Stage	0-3 mths (0-12 wks)					3-6 mths (13-24 wks)			6-9 mths (25-36+ wks)	*0-3 (0-12)	*0-3 & 3-6 (0-12 & 13- 24)
	14	15	16	17	18	15	16	17	15	16 & 17	17 & 18
Totals	3	7	6	6	1	4	3	1	3	1	1
Grand Total	23 + 2 = 25 (last columns)					8			3	1	1
Percentage	69.4%					22.2%			8.3%		

\*Two participants from one local authority had had two babies at the time of being interviewed. One advised that she had reported both her pregnancies in the 0-3 month stage. The other schoolgirl mother had reported one pregnancy in the 0-3 stage and one in the 3-6 month stage. Only the reporting stage of the first baby has been used in the figures.

**Table 10 - Comparisons of pregnancy stages/reporting to professionals**

Stage of pregnancy	Participants			Local Authority				Health Visitors			
	0-3	3-6	6-9	0-3	3-6	6-9	Varied	0-3	3-6	6-9	Don't know
Totals	10	8	3	8	4		1	2	3	1	1

*Health Professionals* - Participants were asked in the course of the interview about the reactions of health professionals (i.e. midwives, health visitors, doctors) towards them during/after pregnancy. The answers revealed a variety of reactions from health professionals and these are outlined below according to the age of the participant. Some local authorities had a slightly different ante-natal process whereby midwives would go into schools or participants would access ante-natal care and services at a Young Mothers group. These are also discussed below.

Neither of the two participants aged fourteen commented on how health professionals had reacted to their pregnancy. Two of the fourteen participants aged fifteen at the time of the interview made no comment. The remaining twelve described mixed experiences (ranging across negative, judgemental and very positive) in relation to reactions from professionals. Judgemental, unfriendly or unwelcoming attitudes came from different sources and not always from health professionals but from office staff within the surgery/health clinic.

‘They [staff in doctor’s surgery] are not as friendly. I don’t really like going there, they are quite unfriendly and kind of to the point and a bit blunt but my actual doctor, my GP they don’t treat me any differently, they just treat me exact same as any other mum that would go in.....the midwife, she is really nice they [midwives] are all really nice’ (Kiera, 15, Individual Interview).

Two midwives had caused a certain amount of alarm with two participants (aged fourteen and sixteen at time of pregnancy) because of their comments on the possibility of them having a small baby.

‘They said I was meant to have a 5lb or 6lb baby. He came out 8lb 8oz. When he got taken away to the incubator my mum was like, ‘That is not a small baby’’ (Tessa, 15, Group Interview 11, 2 people).

There was some annoyance expressed by Jodie over a lack of continuity in staff and constantly having to discuss her pregnancy with different midwives at each appointment, even though each one was nice and treated her well.

‘My midwife she was never there. I always had different midwives, she was always off.....so I had all different midwives every appointment I went to’ (Jodie, 15, Individual Interview).

Elise who was aged fifteen at the time of the interview (fourteen when pregnant), described a very negative experience in her dealings with her doctor.

‘My partner.....and I.....had been together since I had started high school.....the doctor.....he was horrible about it....absolutely awful.....he was making my partner feel quite crap about himself and that he could go to jail for this and get on the sex offenders list. Everybody else was alright. All my midwives and things like that were all dead supportive about it and things like that’ (Elise, 15, Individual Interview).

Five participants, aged 15-17 at the time of interview, talked about a very positive relationship with their midwives and health professionals. These participants attended a weekly Young Mothers group, where the local midwives came to them at allocated times and very close relationships had been formed.

Six participants commented that health professionals had treated them well and were helpful and supportive. Reassurance in doctors was found because it was the same person who had been the family doctor for many years.

‘Well because my doctor has been my mum’s doctor as well, he was just like shocked’ (Madison, 16, Group Interview 3, 2 people).

Hayley expressed her frustration because she had not understood certain questions being asked of her by the midwife due to the complex language being used.

‘I’ve only met my midwife twice.....she is not bad, she is kind of funny. She needs to kind of start using other words for me but, she sat in my room.....for an hour and she was getting me to fill in things and she was asking me questions. I was like looking at my boyfriend and thinking, ‘Do I know these answers?’ I think she is going to need to change a lot of words for me so that I don’t feel stupid’ (Hayley, 16, Group Interview 11, 2 people).

For Lauren, the age of the midwives was the determining factor that influenced the reaction from health professionals to her pregnancy. Lauren explained:

‘Some of them are really nice, really supportive and stuff and then you get the older ones that are kind of snippy and kind of looking at you as if you are rubbish.....but you get that everywhere, I just kind of ignored it’ (Lauren, 16, Group Interview 7, 2 people).

A few participants raised concerns about how health professionals would handle their personal information and keep it confidential. For Adrienne in particular, she expressed a lack of confidence or trust in staff. Her main concerns seemed to focus around the fact that she lived in a small rural community and did not want anyone knowing her business.

‘I don’t want folk knowing what I’m doing or stuff like that.....I’m quite bothered about that’ (Adrienne, 16, Individual Interview).

Only Eva commented about negative reactions from midwives while in the hospital during labour.

‘The midwives were horrible but the doctor like when I first found out I was pregnant she was like okay congratulations but when I was in labour the midwives.....they were looking down on you cause you were young’ (Eva, 17, Group Interview 2, 2 people).

This negative reaction from midwives had also been picked up by Eva’s mother at the time of being in hospital. Eva continued:

‘My mum is someone who is like not judgemental but then like once I had the baby, she was like, ‘Did you not feel like the whole time you were having the baby that they were just like looking down on you and stuff?’ I was like, ‘Yea’ (Eva, 17, Group Interview 2, 2 people).

Six participants aged seventeen at the time of the interview (aged 14-17 at the time of pregnancy) expressed very positive comments about the way health professionals had responded to their pregnancy without expressing judgemental attitudes. Some participants expressed personal preference at times towards one doctor over another within the surgery but they had felt able to speak about their health and their pregnancy.

‘I can talk to my doctor. I don’t feel stressed or anything I am relaxed, I can tell her what is wrong with me’ (Abbi, 17, Individual Interview).

Abbi who was aged fourteen at the time of being pregnant (fifteen when her baby was born) described a very sensitive approach from her doctor. It was a situation where she did not feel able to tell her mother herself about being pregnant but she was confident that her doctor would be able to do so in a protected environment with a sensitive approach.

‘We went to the doctors about the sick. I kept on throwing up. I already knew what it was but my mum thought I had a really bad bug. My doctor asked me if I was in a relationship and I was like, ‘Yes’. She was like, ‘Have you took that relationship too far?’ I was like, ‘Yes’. She asked, ‘by any chance could you be pregnant?’ and I was like, ‘Maybe’. She said, ‘I need you to go and take a test’ (Abbi, 17, Individual Interview).

The three participants who were aged eighteen at the time of the interview did not have many comments about the reaction of health professionals. As mentioned previously



with regards to Kiera, Bonnie, too, did not like her local health centre but this was related to the doctors rather than office staff.

‘Doctors I think in our surgery they can be like, ‘Contraception, contraception’, really, really strong about it, which is fair enough but.....I felt as if it was like you are a slut or something.....no way was I going there myself to tell them I was pregnant.....so I went with my mum’ (Bonnie, 18, Group Interview 8, 2 people).

Further frustration was expressed by Bonnie towards the doctor for him not having given her folic acid during her pregnancy.

‘One thing that annoyed me was he didn’t give me folic acid which you are meant to have from the start. My midwife was quite confused about why he didn’t.....that was an error I suppose’ (Bonnie, 18, Group Interview 8, 2 people).

*School nurse* - Two participants (included in the above) in the same school had a very close relationship with their school nurse. She had previously been a midwife and the girls’ relationship with her (and other pupils) started during the primary school years and had built up over time. Both Bonnie and Vikki approached the school nurse who subsequently carried out the initial pregnancy tests (prior to attending the doctors for confirmation). Bonnie and Vikki described very positive familiar interactions and reactions from the school nurse even in difficult circumstances when Bonnie had to attend for the cervical cancer immunisations which were being administered at the time. Vikki had not been sure if she was pregnant or not and so had approached the school nurse to obtain confirmation in a confidential way prior to going to her doctor. The response from the school nurse had been supportive but practical in her being able to carry out a pregnancy test.

Caitlyn advised that it was the school nurse in her school who had approached her and offered support.

‘I was a bit surprised because I was not expecting her to be there but it was just good for her to be there to let me know that I could speak to her’ (Caitlyn, 5, Group Interview 1, 4 people).

It should be noted that all schools who participated in this research study had a link school nurse who was not based on site every day but would be in the building on an allocated day of the week. All pupils had access to the school nurse but not every participant had spoken to her. A few participants did not know their school had a school nurse. Different schools had members of staff who were trained in first aid and participants were aware of this.

*Link midwife* - A different approach was taken by one NHS Board whereby a specific link midwife attended the school on a set day of the week. Even though the sessions operated as a dedicated drop-in for schoolgirl mothers/mothers-to-be within the school, one participant, Kerry insisted that she would not attend without having first made an appointment.

‘They might not have an appointment for a couple of weeks and there is something you want to ask her and she’ll be there.....I would not just....not if I didn’t have an appointment.....maybe if I was really worried I would phone her or something’ (Kerry, 16, Group Interview 5, 5 people).

The link midwife was well thought of by all the participants and the reactions from her along with the service provided was very positive. Value was placed on the availability and close proximity of the link midwife for pregnant schoolgirls.

*School nursing service* - Another Health Board had a similar kind of approach where a health professional from the school nursing service travelled round a number of schools and met with pregnant schoolgirls. This member of staff had previously been a midwife and the schoolgirl mothers-to-be were really fond of her for several reasons: she knew what they were going through during pregnancy and what they would face during labour; she had a supportive reaction to the news about their pregnancy; and she had a positive disposition.

‘Really happy woman. I’ve got her phone number in my bag.....I’ve met her twice, really jolly....I was speaking to her for an hour last week, she was good to speak to....she knows what it’s like and she understands better’ (Sonia, 15, Group Interview 4, 3 people).

This member of staff was preferred by all three participants in this local authority, to the school's own nurse, with whom the participants did not have a particularly good relationship.

'If you are feeling sick or that she [school nurse] doesn't let you go home or that because I've tried it like loads of times when you feel like really sick and you don't feel like staying or nothing, she just says, 'Oh go and get something to drink' or, 'Go and get something to eat'. You feel like saying, 'I've been doing that all day'.....The other nurse, I think she is quite a good nurse, she is better than the actual school one.....she knows what you are going through and that.....she understands better' (Rochelle, 14, Group Interview 4, 3 people).

### *Other professionals' reactions to the pregnancy*

The age of legal consent to participate in sexual activity is sixteen and this is set out in the Sexual Offences (Scotland) Act 2009. Within the 'Under-Age Sexual Activity' National Guidance (2010), practitioners have a duty to consider the impact that under-age sexual activity has had on the young person and whether their behaviour is indicating a wider child protection concern. Guidance is given in the document on decision-making but it does not specify the processes or protocols to be put in place at a local level.

Table 11 below shows the participants (9) who already had social work involvement prior to becoming pregnant. The reasons given by participants for social work already being involved were: participants were in foster care (2); family situations (4); attendance at school (1); running away from home (1); participant did not know (1).

It was anticipated at the start of this project that the age of the participant might influence whether a social worker or child protection officer was involved. It is acknowledged however that involvement of either of these two professionals is dependent on individual circumstances. Of a possible twenty-nine participants only six stated that they now had social work involvement. Twenty-three participants from across all age ranges stated that they had had no social work involvement or that of a child protection officer. Given the lack of a specific directive, it is not surprising that

participants across the different local authorities described a range of professionals who were involved with them, including social workers, child protection officers, police and the family nurse. Other participants had not experienced involvement of any of these professionals. For those participants who had been involved with one of these professionals, they discussed a range of reactions to their pregnancy and ongoing interactions with them.

**Table 11 – Social work involvement**

	Age					Total
	14	15	16	17	18	
<b>Already had social work</b>	2	5	1	1		9
<b>Did not previously have social work but do now</b>	2	3	1			6
<b>Did not have social work and still don't</b>	2	5	8	7	1	23
<b>No comment</b>		3	2			5
<b>Totals</b>	<b>6</b>	<b>16</b>	<b>11</b>	<b>9</b>	<b>1</b>	<b>43</b>

**Table 12 – Other professionals involved**

Age when pregnant	Social Worker	Child Protection Officer	Family Nurse	No other professionals	No comment	Total
14	3	1		2		6
15	8*	1*	2*	5	3	19
16	1		2	7	2	11
17	2**		1**	7		10
18				1		1
<b>Total</b>	<b>14</b>	<b>2</b>	<b>5</b>	<b>22</b>	<b>4</b>	<b>47</b>

\*One participant had involvement with social work, child protection and the family nurse.

\*\*Two participants had involvement with social work and the family nurse.

*Social worker/child protection officers* - Eleven participants, aged either fourteen or fifteen at the time of their pregnancies, mentioned that they had been involved with a social worker or child protection officer (Table 12). Two participants commented that they did not like their social worker, eight did like their social worker and one did not comment.

Rochelle (Age 14) who was pregnant at the time of the interview did not make any comment about the reactions she experienced from health professionals but she did

take the opportunity to express her feelings about the social worker. Feelings of dislike towards the social worker were partly due to previous and possibly embarrassing prior encounters Rochelle had had because of her family's background and not entirely in response to her as an individual. Rochelle's fears were about being judged by social work on her mother's lifestyle, not being given the chance to be judged as a future parent on her own merits and that a preconceived judgement, by social work, would lead to her baby being taken away from her.

'I didn't like the social worker. I just got my visit on Friday....she really like treated you like you were a baby.....she was saying all that stuff to you, 'You won't be able to cope, you'll find it hard and that' ....'I found it hard because my mum was an alcoholic like most of her life and then like I thought they would have judged me because she is still, she is quite a bad alcoholic and I thought, awe they are going to judge me, or they will do something.....like, I'll not get the baby' (Rochelle, 14, Group Interview 4, 3 people).

This negative view of social work was not consistent across the same local authority but based on Rochelle's experience. Sonia, from within the same local authority expressed a very positive encounter and the role of the social worker seemed to be a career towards which she was aspiring.

'Social work came out. She was really understanding...Some rich woman. I want to be a social worker. That's what I'm doing. I want to do social work. She was rich, she had a massive jeep, came in with a nice dress' (Sonia, 15, Group Interview 4, 3 people).

Demi (in the same local authority), had experienced a difficult family background and parental breakup, but she had found the experience with social work to be positive.

'My social worker.....already knew because.....my mum's got bad depression so I watch my sister and that's on my file anyway.....I think they are nice and they are supportive. I don't think I've ever had a nasty person dealing with me when I was pregnant' (Demi, 16, Group Interview 4, 3 people).

Within two separate local authorities, two participants stated that they had had a change of social workers. Elise explained that she had had five social workers.

‘You just need to find the right people to help you.....I’ve had like about five social workers and all that process. It took all them five social workers to get the right one to help me through all that process.....its finding the right person really. As soon as I met my new social worker it was all okay.....it kind of made us [Elise and her partner] feel better in ourselves, that we had that support group about us to help us through. It was nice, it was really nice so we just decided to keep the baby’ (Elise, 15, Individual Interview).

The relationship between the social worker and Elise was really important and she was looking for specific qualities in professionals.

‘She knows everything, she is not just there for me, she is there for my baby, she is there for my baby’s dad and she supports my mum. She is not just my social worker she is everybody’s. She speaks to everybody and then she comes back to me and tells me what everybody said, so it’s dead nice to know that she isn’t just saying it because she thinks that’s what they are saying. She goes to them and speaks to them about it as well’ (Elise, 15, Individual Interview).

For the participants who had social work involvement, the majority appeared to be clear about why these professionals were involved with them. Lauren explained:

‘Social work has been involved just because of my age and because of the age of the baby’s dad. They were kind of concerned about that.....she was really nice. She was just kind of giving me advice because I was 14 when I fell pregnant, the baby’s dad was 17 or 18. They were just kind of near me....just making sure it was not like forced upon me and stuff like that’ (Age, 16, Group Interview 7, 2 people).

Eva had social work involvement when she had had the baby although she still was unclear why this was the case. Eva had built up a good relationship with her social worker and she was the first person to be advised about the pregnancy.

‘I told the social worker at school cause I was already going to her anyway. I don’t even know why but I just got referred to her one day.....I actually genuinely don’t even know why. They were like, ‘Yea you are going to start seeing the social worker like once every 2 weeks’.....I was like, ‘Okay then’. So yea it was her that I told first’ (Eva, 17, Group Interview 2, 2 people).

*Child protection officer* - Elise was one of two participants who stated that she had been allocated a child protection officer initially and she commented about the positive reactions she had experienced with this professional. Elise had also been allocated a social worker and a family nurse.

‘He was absolutely fantastic I must admit.....he was brilliant. I only met him a few times but because there was no risk at the start we didn’t have to have him’ (Elise, 15, Individual Interview).

*Family nurse partnership* - Other participants, some of whom are already mentioned above under the discussion surrounding social workers, had had more than one professional involved with them. These participants were located in a Health Board where the family nurse partnership was in operation. Variations existed across the two local authorities within the same NHS Board in terms of the number of professionals involved in each participant’s case. While it could be assumed that participants might have confused child protection and social work, this was not the case. One participant clearly identified two separate people and talked freely and positively about them both, one of which was a male and one a female.

One participant, aged fifteen, did not have a family nurse. This was due to the criteria set by the programme whereby eligible participants must be first time mothers, aged nineteen years and under, and be enrolled with the programme prior to their 28<sup>th</sup> week of gestation. As this participant had moved outwith the local authority for a period of time and had returned after having delivered the baby, she was not eligible for the family nurse partnership. For the remaining five participants who did have family nurse involvement, their experience of this was positive.

‘We get family nurse for young mums.....they stay on until the baby is two. I think that’s really helpful as well because they come through and see you every second week and things, it’s really good. It’s nice to have and to know that somebody is still looking after you, you’ve not been dumped with a baby’ (Elise, 15, Individual Interview).

### *Peer group reactions to pregnancy*

Friendships amongst peer group and fitting into the school environment are recognised as important parts of every young person's school experience (Vincent, 2009). Previous studies by Alldred and David (2007) and Vincent (2009) also clearly evidence the need for young people not to feel alienated or as described by Arai (2009) not to experience 'social death'. All participants were asked in the interview to think of up to five people who had been their best friends before they became pregnant. They were then asked to think whether they had gone to primary school together, whether they lived close to these friends, and whether they saw them outside of school. Participants were also asked to think of up to five people who were now their best friends, to consider whether any of the names had changed, and then to reflect on the reactions they had received from their friends in respect of their pregnancy.

*Friendships* - Participants were able to identify three or more close friends whom they had had prior to becoming pregnant. Over half of the participants had gone to primary school with these friends. Sixteen participants advised that their friends still lived within close proximity. Twenty-one participants commented that they would sometimes see these same friends outside of school.

Nineteen participants stated that their original friendships had stayed the same and in some instances they had made new friends because of the pregnancy. Twenty-four participants talked about their previous friendships having all, or the majority having changed because of their pregnancy. Losing friends had impacted slightly on the views of one schoolgirl mother-to-be about attending school. Reasons given by other participants about their friends having now changed were: their friends wanted to go out drinking/partying (7); they had nothing in common any more (6); they had made new friends at new school (5); judgemental attitudes (2); their friend had gone to university/moved away (2); parents had influenced their daughter's decision not to be friends with someone who is pregnant at school (2).



‘When one of their mums found out and they said to her, ‘Stay away from her, you are not allowed to go about with her’....probably thought I would have led her on and made her do the same thing, I don’t know....Everyone just thought I was like wanting attention. It just got to the point that I didn’t want to go back....they were going about the whole school saying, ‘Oh she is not even pregnant she just wants attention’ (Cara, 16, Group Interview 2, 2 people).

‘They didn’t like the fact I was pregnant, they didn’t want to be seen with someone who is 14 and....pregnant, they might come across as a slut or something’ (Abbi, 17, Individual Interview).

For one participant, being pregnant had changed both herself and her friendship group.

‘I think the one [friend] that I was closer to.....definitely influenced a lot of who I was before I became pregnant and then I’ve changed a lot since [for the better]. I think that’s down to him not being there anymore’ (Rhiannon, 17, Individual Interview).

A few participants felt that there was no going back to their old ways some of which had involved drink and drugs. Views about some previous best friends included them being ‘stuck in the past and needing to grow up’. A few schoolgirl mothers were exhausted after having been at school all day and then coming home, looking after a baby and doing homework. As a result, they had not felt up to meeting with friends or going out.

‘With me it’s just because you can’t go out and do the things that you used to be able to do because like you can’t find a babysitter or like you’re too tired. Then you just basically fall apart’ (Lena, 16, Group Interview 5, 5 people).

*Friends’ reactions to pregnancy* - All participants were then asked about their friends’ reactions to their pregnancy; whether any of their friends had told others about their pregnancy against their wishes; what had happened to the friends they had lost; and what makes a good friend. There were no specific patterns emerging from the data and so the responses from participants have been themed according to the reactions they experienced from their peer group.

*Social media* - A few participants, across different schools, described a variety of reactions from their peer group to their pregnancy. These included unpleasant things being said on social media by pupils whom they did not know as well as lifelong friends who had fallen out with them.

‘I’ve had it on Facebook, folk telling me to die and that.....folk I don’t even know’ (Sonia, 15, Group Interview 4, 3 people).

These particular participants accepted that other pupils had the right to talk but they felt it would have been easier on them personally if things had been said to their face and not behind their back. Other experiences included pupils with whom they were not friendly and who were now befriending them, providing support in some shape or form either practically or through friendship.

*Eye-contact* - Some participants were very conscious that their fellow pupils and peer group had lost eye contact with them. There were feelings of annoyance and frustration expressed by schoolgirl mothers-to-be that some other pupils no longer seemed interested in them personally because their attention had turned to the baby in their tummy.

‘I went up to school to hand in some of my old text books then everybody is sitting looking at my stomach when they are sitting talking to me and I’m standing looking at their face.....when people ask to see your stomach it’s like, ‘No’’ (Jaclyn, 15, Group Interview 1, 4 people).

Participants described the staring at their tummy and not speaking as being embarrassing and worse than someone actually saying something either positive or negative. It made them feel that they no longer existed as a person. This staring continued for some participants when they were taken out of class by guidance teachers for a few minutes to speak to them about something (which is normal practice in schools). The other pupils would then stare as they left the class and watch closely as they returned. This was an especially difficult situation for a younger participant in one school but it was not shared amongst the older participants within the same school. The older participants were of the opinion that the two-year age difference might

explain this and they felt that their peer group were a little more mature in their reactions to their pregnancy.

*Physical education* – Six participants mentioned that they were keen on continuing with physical education during pregnancy. One of the six participants commented that while most of her friends were protective of her during these sessions, others used it as an opportunity to deliberately hit her with a ball. This incident is discussed further in Chapter Seven.

*Other frustrations* around friends were expressed when fellow pupils would go to the guidance teacher and ask why the schoolgirl mother-to-be was not at school or why she was at one class and then not at the next (due to an ante-natal appointment). Being able to keep their personal life personal was difficult and one participant found this really hard especially in the early days when she had not felt ready to tell everyone about her pregnancy. Another schoolgirl mother-to-be commented that her friends who were boys had reacted totally differently to her pregnancy from her friends who were girls. The boys she described had stopped joking around, they did not stare at her tummy and as far as she knew, they did not gossip.

*Temporary supportive reactions* - Other reactions experienced by participants ranged from their friends being excited for them and supportive throughout the pregnancy as well as initially after the baby was born, to non-existent shortly thereafter.

‘They were just a bit shocked at first but they would still come up and touch my belly and stuff like that and think they were all excited and then once it was here I didn’t see much of them’ (Tessa, 15, Group Interview 11, 2 people).

Another participant Bethany described an unusual offer from one of her friends.

‘I had one girl in my class who wants to be a midwife when she is older and she was like, ‘Oh imagine how great it would be if I could give birth to your baby’’ (Bethany, 17, Group Interview 1, 4 people).

*Angry reactions* - Abbi described a very difficult time she had with her peer group during pregnancy whereby they had threatened to 'batter her' when she told them she was pregnant. Her peer group were angry with her and told her she 'could not lie about being pregnant, that was stupid' (Abbi, 17, Individual Interview). The baby had arrived two months prematurely and Abbie found coping with this, her exams and a previously stressful time with her peer group very difficult.

*Spreading the news* – In a few cases, participants explained that they had told their friends in confidence but they had not kept this information to themselves.

'My friend shouted it out in the changing rooms at school. I didn't want anyone to know because I was not that far along and I did fall out with her for a wee while because I didn't want anyone to know' (Amber, 15, Group Interview 3, 2 people).

*Suspicious reactions* - For a few other participants, their friends had suspected they were pregnant but they had not said anything to anyone else.

'Because I had a belly.....she had said to me, 'Oh you're putting on the weight'. I think they knew by that point' (Britney, 17, Individual Interview).

*Attributes of a good friendship* – Participants identified a number of key attributes as being important for friendships. Some of these did not involve words, or actions, it was more about being supportive, inclusive and understanding without asking loads of questions.

'I don't feel I have to lie to them about where I'm staying.....and things. They know why I'm here so I don't feel as uncomfortable as I should do, they know all my troubles with my family.....they are dead supportive through all that' (Elise, 15, Individual Interview).

Other attributes which made good friends covered a range of areas and the majority of participants mentioned several of them. These have been divided into three categories: interpersonal attributes; practical support; other attributes. Within the interpersonal attributes, participants appreciated when their friends were: understanding; listened;

provided advice; were patient even when their hormones were erratic; showed that they cared, appeared interested; had time for the baby; talked; still liked some fun and were a 'good laugh'. By way of practical support, participants welcomed their friends: helping them with the baby; babysitting sometimes; and including the baby in plans to go places together. In the third category, participants felt that good friends: respected their decision about keeping the baby; were loyal; protective and would 'stick up' for them when others were not being nice. Good friends would also be there when participants needed them and would provide support, checking that everything was alright. Having lifelong friends (from primary school) who lived close by was also considered to be a great advantage and support. Lastly, having friends of a similar age who were in the same situation (pregnant/had a baby) was a comfort in knowing that they understood the challenges.

Some schoolgirl mothers/mothers-to-be commented in the interview that they had been advised that they might lose some friends and so they were aware of this. In some situations this did happen but for others it did not and they did not foresee this happening in the future. One schoolgirl mother-to-be felt that as her friends were slightly older and had left school, their maturity in age would help ensure that they continued to support her. Another participant described how she had temporarily lost friends because of their initial shock at the news but this had not lasted long.

Having friends and fitting in was very important to all the participants in the study. The negative experiences which they discussed, however, were not widespread across all friendships and no-one described a situation whereby they had absolutely no friends or anyone else in their peer group that they could turn to for support. For those who did lose friendships because of their pregnancy, some were temporary while others gained new friends in their place as a result. Each schoolgirl mother/mother-to-be had had her own experience of reactions from friends to the news about their pregnancy but for some the support after having a baby was more important.

## 6.4 Deviation from normative pathways

*Deviation* - Education is viewed as being the preferred route for all young people and any deviation from this is seen as a calamity for the schoolgirl mother (Duncan, 2007). This arguably refers to discourses amongst policymakers and wider perceptions about schoolgirl pregnancies rather than how young mothers view their situation. Vincent (2009) argues that for individuals who are noticeably different or who deviate from what is normal and acceptable, the difference may carry a stigma. McNulty (2008) too suggests that any alternative other than that which is deemed age- and-stage appropriate can subject a young person to being disparaged and stigmatised.

Young people in many Scottish schools are part of a diverse peer group in terms of culture, religion, interests, hobbies, aspirations for the future and family background circumstances. Pupils can also be in classes at school with different academic levels of ability and year stages all at the same time. This is partly due to the Scottish curriculum which is flexible enough to allow pupils to progress at different levels whether this be further ahead or behind that of the normal pace anticipated for that year group. It could be argued that researchers are so far removed from current school practices that they assume deviation causes more stigma than it actually does. Deviation may have caused stigma in previous years but pupils in Scottish schools are unfamiliar with anything else. It may be therefore that deviation in some aspects of school life is more acceptable amongst young people than it is potentially with adults.

*Social death* - The discussion on stigmatisation from a teenager's peer group or 'social death' is continued by Arai (2009), whereby she sees this as contributing towards disengagement and/or dropping out of school. This suggests that 'social death' or isolation is in direct relationship with the peer group of a schoolgirl mother/mother-to-be. There needs to be a clear distinction and separation made in discourses about schoolgirl mothers, between the impacts of stigmatisation from a young mother's peer group and wider public perceptions about schoolgirl mothers. Schoolgirl mothers/mothers-to-be are very aware of the wider perceptions about them and although this is upsetting, it is not sufficient to make them become disengaged from school or drop out.

The discussion on ‘social death’ requires further consideration in light of the data from this research project. ‘Social death’ as a phrase, implies negativity but some of the participants in this study had a positive experience in growing away from their previous friends. Arai (2009) suggests that schoolgirl mothers/mothers-to-be may possibly disengage or drop out of school because of social isolation from their peer group. As mentioned above, this would not appear to be the case in this study as there is no evidence to suggest a lack of friendships or losing friends either temporarily or long-term, made participants so unhappy that they considered dropping out of school. Cara discussed a difficult time with her peer group and stated that she did not want to go back to that particular school but this is different from being disengaged from school and dropping out. Discussions earlier on in this chapter referred to ‘distractions from education’ rather than ‘disengagement factors’. These ‘distractions from education’ related to issues at home or in the community rather than ‘social isolation’ from a schoolgirl mothers’ peer group. Participants in this study very openly discussed a variety of reactions from their friends to their pregnancy but not in terms of the meanings of ‘social death’ that Arai (2009) is suggesting. In light of this, it would be necessary to separate the idea of social death or isolation outwith school and consider whether this impacts on the attendance of schoolgirl mothers/mothers-to-be at school.

*Bullying* – Alldred and David’s study (2010) found that bullying contributed to young mothers not liking school. This is similar to Vincent’s (2009) study which found that bullying was linked to disengagement from school. Ten participants in this research referred to times either in primary or secondary school, before/during pregnancy, when they felt they had been bullied. There is evidence to suggest that some schoolgirl mothers/mothers-to-be experienced bullying but this was not to the extent whereby they became disengaged from school or wanted to drop out. The incidents ranged from being quite severe, to playground gossiping, whispering, talking behind their backs and staring. Morgan explained:

‘I was bullied a lot before and then when I didn’t know but I had problems with my back so I was getting bullied for that.....they tried to push me down the stairs and trip me over chairs and things’ (Age 14, Group Interview 1, 4 people).

Eight participants discussed how they felt about other pupils talking about them behind their back (during/after pregnancy) but they did not class this as bullying.

‘You know that everybody is talking about you because when you are walking around they just, everybody stops talking and looks away from you. They would never come up to you and say it to your face’ (Bethany, 17, Group Interview 1, 4 people).

*Good and bad mothering* - Mothers who do not fit neatly into the normative expectations of their role can be viewed as unfit or deviant parents (Wilson and Huntington, 2005). Motherhood is considered by McDermott and Graham (2005) as being ‘socially constructed and is a historically specific category that is produced through regulatory discourses relating to what constitutes the good mother’ (p61). Constructions of good mothering, is according to this study, defined in relation to ‘providing for the child and ensuring they become responsible citizens’ (McDermott and Graham, 2005, p61). Schoolgirl mothers are also considered to be outwith and deviating from the normative boundaries and pathways of good mothering because they are thought to be ‘rejecting fathers’, have a ‘dependency on the state’ and are reluctant to ‘form a conventional family’ (McDermott and Graham, 2005, p61).

Two participants Adrienne and Hayley did make reference to the topic of good and bad mothering. Both participants had felt that other people were making pre-judgements regarding whether or not they would be a good or bad mother.

‘I went on Facebook one day and I had hundreds and hundreds of people that were saying, ‘Congratulations’ and all that, ‘You’ll be a great mum’’ (Hayley, 16, Group Interview 11, 2 people).

‘There’s a lot of people saying I’m not going to be a good mum but no-one knows how I’m going to be till it’s here.....it just makes me want to prove them all wrong’ (Adrienne, 16, Individual Interview).

Public perceptions about early parenting and comments did have an impact on one schoolgirl mother to the extent that she did not like being seen in public with her baby. This was not linked with her attendance at school.



‘My confidence has gone down a lot. I can’t walk into the town with my baby and I feel people are staring at me and it puts me down, it really makes you quite upset at yourself.....When I used to get on the bus in the morning to come here [flexible learning unit] there was always people on the bus that didn’t agree but obviously I got shouted at and things, like saying horrible things to me and that. It’s not nice.....They were calling me a ‘tramp’ and a ‘dirty wee whore’ and things like that.....It’s quite upsetting because they don’t know what happened, they don’t know the situation’ (Elise, 15, Individual Interview).

*Socialising* - Comments were made by participants about difficulties in being able to socialise after having their baby. Schoolgirl mothers were not able to be so impulsive in their decision-making over going for a night out at short notice and they were less in control about the length of time they could stay out. They also, now, required a few days’ notice so that they could organise a babysitter.

‘I try to tell them that I don’t have the same time as what I used to. If you ask me, you’ve got to ask me a couple of days before it or something so that I can make arrangements. Then when I do go out like they moan at us cause I don’t stay out late enough or something, I’ve got to go home and settle the baby’ (Cara, 16, Group Interview 2, 2 people).

For some participants their life had taken a different direction, they had new priorities and sometimes new friends who were mothers and with whom they had a lot more in common. Conversations with these new friends centred on the baby, the different stages of growth and any difficulties being experienced at that time. What still seems to be important, however, is the communications between schoolgirl mothers and other young people of the same age. Time spent with friends seemed to happen primarily during school times and not consistently outwith school. Where friends were supportive outside school and arrangements included both the schoolgirl mother and the baby, this was a really positive experience.

‘They’ve always got time for me and like if I bring the baby along I’m sure they wouldn’t mind. They always want me to bring the baby to places and stuff. Like I can still stay at their houses and stuff and just bring the baby with me’ (Eva, 17, Group Interview 2, 2 people).

The whole experience of motherhood was harder when friends, unintentionally, did not support schoolgirl mothers. Frustration was also present when friends did not seem to appreciate what the lack of peer group companionship and communication meant to schoolgirl mothers/mothers-to-be.

‘It’s not even that you want them to help, it’s just you want that adult conversation....they wouldn’t understand how much it would upset me to let me down....you are just so excited to go see somebody cause it’s such a routine every single day.....they let you down....they obviously don’t realise they just think.....they won’t be that bothered about it but they don’t understand how much it did upset me’ (Bonnie, 18, Group Interview 8, 2 people).

Many schoolgirl mothers/mothers-to-be experienced a difficult time from their peer group before and after pregnancy but motherhood was by no means an escape route from a previous negative experience of school and life, as suggested in Cater and Coleman’s (2006) study. There is no evidence to suggest that participants were disengaged or intended to drop out of education either because of a lack of friendships, or ‘social death’, either inside or outside school.

For the schoolgirl mothers who do continue in education of some form (school or college), they have not deviated from normal age or stage appropriate activities. It would be easy to assume, therefore, that cognisance would be given to this fact and that stigmatisation in any form would be less, and with credit possibly being given to schoolgirl mothers for continuing in education. This was not always the case, especially from people outside the school environment.

## **6.5 Conclusion**

This chapter has drawn on the accounts of participants to explore the experiences of schoolgirl mothers/mothers-to-be when ‘coming out’ as pregnant or having a baby while continuing in education. Where appropriate, the chapter offers some contextual information obtained from school staff to provide clarity on the experiences of schoolgirl mothers/mothers-to-be while attending school. The three topic areas

discussed were ‘educational experiences before pregnancy’, ‘realising, responding and reactions to pregnancy’, and ‘deviation from normative pathways’.

A large number of schoolgirl mothers/mothers-to-be, including those who had been excluded from school, had not had a bad experience at school prior to becoming pregnant. Participants did not report having had a bad relationship with their teachers but rather they seemed to be looking for a ‘connection’ with school staff. Attendance at school was described by many participants as being ‘really good’ or ‘good’ with only a minority having been excluded from secondary school. Overall, there is no strong evidence to suggest that participants were either all engaged or disengaged from the education system before becoming pregnant.

The data from this study highlights the difficult decision-making process that schoolgirl mothers-to-be go through after finding out they are pregnant. Very few participants had considered adoption and only a small number had thought about termination. Participants had not ‘disavowed abortion’ as this had never been a viable option for them. Decisions to continue with the pregnancy were based on a number of influences from family members and also on experiences of seeing the baby on the screen during the ante-natal scan.

Contrary to previous studies, participants were clear about whom to speak to for help regarding their pregnancy and they had made a purposeful choice over approaching this person. There was no consistent theme from the data to suggest why participants had chosen certain people and professionals to approach regarding their pregnancy. Nonetheless, choices made over people and professionals were based on an individual and personal ‘expectation of reaction’ from education and health staff which centred on confidentiality, values, relationships, respect, trust, non-judgemental attitudes and the anticipation of being able to talk with that person about their situation.

Participants expressed a range of reactions to the news about their pregnancy from parents, partners, professionals and their peer group. In general mothers (of schoolgirls) had tended to be more tearful and surprised while their fathers had been

angry about the situation. News about the pregnancy had placed a strain on the relationship between schoolgirl mothers-to-be and their partners. Ultimately, the pregnancy became a reason for partners to finish the relationship with participants.

Participants discussed a variety of reactions from school staff to their pregnancy. Although the majority of participants were pleased with the way school staff responded to them, a minority were disappointed because of the unsupportive, judgemental, inflexible approaches and lack of practical help provided to them during pregnancy and after having a baby. Responses from staff fell into two categories which either encouraged or discouraged participants to continue in education. Practical support such as exam preparation or re-arranging their timetable had helped encourage participants to remain in education. Judgemental attitudes, inconsiderate, nil or opinionated responses had contributed to participants feeling discouraged from continuing in education. Being unable to talk to school staff about their situation had been particularly discouraging to participants and had unintentionally aggravated their difficulties in terms of their mental health. Additionally, some participants had had to manage their own information and share the news about their pregnancy with other teaching staff rather than have this passed on to the relevant people by their guidance teacher. Further frustration existed for participants who were taking subjects such as chemistry and physical education especially when the required adaptations were either not put in place during pregnancy or were enforced. No participant had been asked to leave school but over half had been recommended to transfer to another school or flexible learning unit to continue their education.

Reactions from health professionals to pregnant schoolgirls varied considerably. For those whose local authority had specific ante-natal procedures or link midwives, participants had tended to have a more positive experience. Responses from staff in local health clinics and a few hospitals had not always been positive or professional but tended to be judgemental and unwelcoming. For the participants who experienced the family nurse partnership and the school nurse, this too had been generally a very welcoming and encouraging interaction with health professionals.

A small number of participants had had involvement with other professionals such as social workers and child protection officers. The relationship between other professionals and some participants was viewed as having been really important. Some participants had had a good relationship with other professionals, but this had not been everyone's experience.

Many participants talked about their friendship group having changed since becoming pregnant and having a baby. There were no specific patterns which emerged from the data regarding the reaction from participants' peer group to the news about their pregnancy. Factors which had significant impacts on participants in many ways, including their attendance at school, had included social media responses, losing eye-contact with their friends, pupils staring at their tummy, violent reactions to their pregnancy and being unable to keep their personal life to themselves.

A minority of participants in this study had experienced bullying in primary or secondary school but not sufficient to lead to them becoming disengaged from school. Talking behind participants' backs regarding their pregnancy had not been particularly welcomed but schoolgirl mothers/mothers-to-be did not feel that this was bullying. Only a few participants commented that they felt other people were making pre-judgements on whether or not they would be a good or bad mother. Despite some participants experiencing a difficult time from their peer group, becoming a mother had not by any means been an escape route from a negative school experience. The stigmatisation that participants had faced on a regular basis from sources both internally and externally to the school environment, had not decreased in any way for those who were continuing in education and had not deviated from the normative pathway of education.

## CHAPTER 7

### CHALLENGES OF CONTINUING IN EDUCATION

‘I miss the baby. Sometimes I want to leave school and be at home with the baby. It’s hard’.

(Vikki, 17)

#### 7.1 Introduction

Chapter Six discussed the experiences of participants when ‘coming out’ as pregnant or having a baby while continuing in education. The chapter identified a mixture of thoughts, feelings and experiences identified by participants after finding out about their pregnancy. Within the chapter, the range of responses and reactions from family members, peer group and professionals, to the news about the pregnancy were discussed.

This chapter considers the challenges that participants experienced when trying to continue in education during pregnancy and the early stages of motherhood. The chapter begins by exploring the health of participants during the first trimester of pregnancy before going on to discuss the emerging practical difficulties they experienced of continuing at school while pregnant. Participants revealed their thoughts and feelings about returning to education after having a baby and the challenges they experienced in terms of childcare. These thoughts, feelings and challenges over childcare are discussed within the chapter along with the sources of support that schoolgirl mothers/mothers-to-be said were available to them to help them look after their baby.

The chapter draws on the accounts of participants to explore the health and practical challenges of continuing in education during pregnancy and the early stages of motherhood. Data from school staff has also been included where relevant to provide further understanding on the challenges faced by schoolgirl mothers/mothers-to-be when continuing in education.

## 7.2 Health during pregnancy

‘Morning sickness’ is one of the most challenging problems in pregnancy. Despite the term ‘morning sickness’ by which it is known, the effects of it can continue throughout the day and during the night. Nauseous feelings and vomiting can have a significant effect on a person’s day-to-day activities, their quality of life and it can create a reluctance to leave home. For those who experience very severe nausea and vomiting throughout pregnancy (hyperemesis gravidarum), this requires specialist and sometimes hospitalised treatment. Some of the symptoms of hyperemesis gravidarum are prolonged and severe nausea and vomiting, dehydration, weight loss and low blood pressure. These symptoms can have a significant effect on a person’s life and can lead to further complications such as depression (NHS Choices, 2012).

Morning sickness comes at a time when a person can also feel tired and emotional. Those in close proximity may not know the person is pregnant and will expect them to be their usual self. Managing morning sickness can be helped by getting plenty of rest, getting up slowly in the morning, drinking fluids (little and often), eating small frequent meals, distracting yourself as much as possible, and wearing comfortable clothes without tight waistbands (NHS Choices, 2012).

Coping with morning sickness as a pregnant schoolgirl presents its own challenges and it is not easy to follow the recommended advice. For example, accessing food that may help relieve morning sickness (dry toast) is not possible after leaving home nor is the ability to drink regularly during the day whilst in class. In the event of actually being sick, it is not easy to freely access toilet facilities nor is there the freedom to choose comfortable clothing.

Participants were asked in the questionnaire to describe their experiences of morning sickness during pregnancy. Over half of the participants described themselves as being either very sick/unwell at times or having normal morning sickness during the early stages of pregnancy. Eight participants experienced health concerns during pregnancy which included kidney infections, blood clots, epilepsy, high blood pressure, anaemia, extreme vomiting and other minor complications. It is not known whether any

participant had had previous health issues before becoming pregnant. Two participants had been hospitalised because of extreme morning sickness and dehydration and this in turn had affected their attendance at school. Eva explained:

‘I was off loads. I was in hospital about seven times....I was on the drip for like my whole pregnancy....I just had really really bad stomach pains and they would always keep me in like overnight and stuff to watch me so I missed quite a lot of school’ (Age 16, Group Interview 2, 2 people).

Table 6 in Chapter Six described participants’ attendance at school *before* pregnancy. Table 13 below compares the information shown in Table 6 alongside participants’ own description of their attendance at school *during* pregnancy.

**Table 13 – Attendance at school**

Attendance before pregnancy	Attendance during pregnancy					Total
	Really good	Good	Bad	Really bad	Not known	
Really good	5	4	1		4	14
Good		3	8			11
Bad		1			1	2
Really bad	1	4		4	5	14
Not known					2	2
Total	6	12	9	4	12	43

Fourteen participants described their attendance at school during pregnancy as having improved or stayed the same. Thirteen participants said their attendance at school had deteriorated during pregnancy. Reasons provided for the deterioration in attendance during pregnancy included morning sickness and other health conditions.

‘I was always not well. I used to fall all the time when I was having the baby like I used to bleed....I used to fall on my belly, like take wee dizzy turns. I used to pass out’ (Alexis, 17, Individual Interview).

Although morning sickness and other health conditions were cited as making it difficult to continue in education, bullying and difficulty in physically getting to school while pregnant were stated as well for not attending school. Chapter Two outlined the transition to adult status, maturity and identity as discussed in previous research. The chapter considered how adult status is defined by age milestones before going on to



look at the variety of lenses used to discuss maturity. These lenses included: responsibility; caring; roles and functions assigned according to age and gender. Identity was then discussed within the chapter as being defined through: characteristics; physical appearance; inclusion; and self-worth. Previous research does not combine both to consider the idea of a more ‘responsible identity’ through behaviour such as improved attendance at school. This chapter considers the challenges that schoolgirl mothers/mothers-to-be faced when trying to continue in education. Although participants’ attendance at school improved and was sustained, this may have been easier had they not faced some of the challenges they did when trying to continue in education. The more ‘responsible identity’ demonstrated by participants, through improved attendance at school, challenges the assumptions made in Government agendas/policies and previous research about schoolgirl mothers/mothers-to-be being stereotypically poor school attenders.

Reactions to pregnancy from participants’ peer group was discussed in Chapter Six. The geographical location of schools will be discussed in more detail later on in this chapter.

### **7.3 Practical challenges of continuing in education during pregnancy**

#### *School uniform*

Enrolling a child or young person in school is normally the responsibility of parents/carers. Completing this process generally involves following standard procedures such as completing an enrolment form. Acceptance into any school and the signing of an enrolment form brings with it a presupposition that the standards and rules of that establishment will be adhered to. One such standard within a school environment is that of a dress code (school uniform) and all pupils are expected to conform to the guidelines on this.

Schools require to be inclusive and are expected to adapt and accommodate a wide variety of pupil differences but they have not in the past had to deal with what

Vincent (2012) refers to as the ‘uncomfortable image of a uniform-clad pregnant schoolgirl’ (p1). Any pupil not conforming to the school uniform guidelines can very quickly be identified as standing out from the others. Purchasing additional items of school uniform throughout the school year can be difficult for families on low incomes. For pregnant schoolgirls, it is hard to know how far and at what rate their waistline will expand during pregnancy. Relaxing the dress code can bring about a perceived situation of favouritism or a relaxing of school rules for some and not for others.

Participants were asked in the interview to describe what their school allowed them to wear during pregnancy. Some participants were clearer about what the school uniform was for everyone else but less clear on what they were allowed to wear during pregnancy. Experiences across participants included being able to wear anything, flexible but school colours, wearing leggings or maternity jeans, adhering to a strict school uniform (blazer, blouse, tie, skirt, no trousers). Fourteen participants described difficulties they had had in having to continue wearing school uniform. Another participant, Sam, was requested to buy a new school uniform in a larger size.

‘They were wanting me to go and buy a full new uniform and never just let me wear comfy clothes.....Some people don’t have the money to do that. I did but I never done it’ (Sam, 15, Group Interview 9, 2 people).

Discussions took place with participants about being allowed to wear leggings, jeans or trousers. Wearing trousers or leggings seemed to be of less concern to participants than having to wear a blouse. Two participants felt that their school was too strict and that they required to be more understanding and not expect them to wear a blouse all of the time. This was due to the blouse being uncomfortable and participants having problems getting it fastened during the later stages of pregnancy. Vanessa talked about the practicalities and frustrations she had had over school uniform.

‘They said, ‘You just need to wear it’. I couldn’t fit into it. I can’t squeeze into it.....trying to get a blazer, they were really expensive like £90.....shirts and stuff they only go up to a certain size....your body is like out of proportion like your belly is bigger, it doesn’t work like that’ (Vanessa, 17, Individual Interview).

Britney was ‘told off’ by a teacher for the clothes she wore.

‘I had to buy maternity wear. I had leggings because that’s all I could get on. One of the teachers had said to me that I was inappropriately dressed for school. My teacher had to say to him, ‘She is pregnant, that is the only thing she can fit into for school wear’’ (Britney, 17, Individual Interview).

Keira described her experience:

‘The teacher that I had at school.....she kept on questioning me and challenging me about my uniform and I had to keep explaining to her that things weren’t fitting me anymore and every day she would get on at me about what I was wearing and stuff’ (Age 15, Individual Interview).

Erika explained that she required an excuse slip by way of explaining and justifying to teachers why she was not wearing school uniform.

‘I need a uniform excuse note because some teachers can’t tell that I am pregnant so they always ask me why I’m wearing leggings and you don’t really want to say to them in case they just stand awkwardly’ (Erika, 15, Individual Interview).

Jaclyn talked about her headteacher telling her off for wearing a top rather than a blouse.

‘The headteacher got on to me for wearing a plain white top because I was not able to get my tie on with it. She didn’t even know I was pregnant until I was six months’ (Jaclyn, 16, Group Interview 1, 4 people).

Rhiannon felt that her fellow peer group were quite accepting of the school uniform being relaxed for her because she was pregnant.

‘When I started to get too big for my school uniform everybody understood and it was fine. Even the pupils didn’t complain because they knew it was not because I was getting away with it, it was because I was just too big to fit into anything’ (Rhiannon, 17, Individual Interview).

Staff were asked if flexible arrangements would be made for pregnant schoolgirls regarding wearing school uniform. Four of the seventeen members of staff interviewed talked about the school being very strict and that pregnant schoolgirls had to adhere to the full school uniform (blouse, tie, skirt/trousers, blazers). Reasons given for adhering strictly to the uniform were because participants were ‘attending a mainstream school’, to ‘ensure equality’, ‘youngsters in that situation do not want to stand out from the crowd’, it was important to ‘minimise the discrepancy between regular pupils and pupils within the unit’.

In one local authority with a service provision, a member of staff commented that she has ‘constant niggles’ and challenges from staff in schools who were insisting that pregnant schoolgirls had to wear full uniform. In another local authority, a member of staff referred to a participant approaching her to advise that she could not fit into her school trousers. Wearing leggings was permitted for this participant but not welcomed and the member of staff tried to discourage her from doing so.

The experiences described by participants did not accurately match those of staff within their school. Thirteen members of staff interviewed discussed a more relaxed approach of wearing clothes which were school colours, being allowed to wear a polo shirt instead of a blouse, wearing leggings but not jeans, not having to wear blazers. The mismatch could reflect that the staff interviewed (guidance teachers/depute headteachers) were aware of the procedures but subject teachers possibly were not.

Participants who attended a flexible learning unit or inclusion base were not required to wear school uniform of any kind and they were able to wear normal clothes. Staff in these bases felt that there were benefits to this approach and they placed more emphasis on having pupils in school who were actually learning rather than focusing on what they were wearing.

‘We have no uniform here whatsoever. We want....the young people to come as relaxed as possible.....Many of them have rejected school for the authoritarian reasons and a whole load of issues along with that and we want them to come and be quite relaxed. It’s a very different relationship we have here with the young people compared to school’ (School, 29).

From the data, it would seem that unrealistic demands were placed on some families to maintain compliance with school rules on the wearing of uniform and that there was an inconsistency across schools in terms of taking a more flexible approach. However, there is also some evidence to suggest that not every participant was fully aware of what they were required to wear during pregnancy in terms of school uniform. It may be that for some participants, their school did take a flexible approach but this message either was not conveyed to them or they were unclear about it. In any case several participants continued to be challenged by staff about not wearing school uniform.

The lack of flexibility in wearing comfortable clothes during pregnancy may have had an impact on participants’ ability to continue in education. Participants from families on a lower income may feel that they have no option but to drop out of school or not attend if they are unable to meet the school uniform requirements. In light of the Equality Act (2010), enforcing the wearing of school uniform to ‘ensure equality’ especially during the latter stages of pregnancy would be discrimination as some pregnant schoolgirls would have difficulty with this.

#### *Distance to school/geographical location and getting to school*

Under the Education (Scotland) Act 1980 (Section 51), local authorities are required to make arrangements for the provision of school transport and to take into consideration the distance between a pupil’s normal place of residence and school. Each local authority is required to determine the details of their own arrangements but they must make free travel available to pupils who live outwith the statutory walking distance (Section 42(4) of the Act). This statutory distance is two miles for any pupil under the age of eight and three miles for all other pupils this age and over. The set distances in the Education (Scotland) Act are stated as being related to school attendance issues and are used to determine what would ‘constitute a legitimate reason

for not sending a child or young person to school' (Scottish Executive Education Department, 2003).

Information on the distance between home and school for participants has not been collated for this study nor have the methods of transport used to get there. Nonetheless, issues about getting to school and methods of transport did arise during the interviews and these are worth further discussion. Staff were asked during the interviews to describe the catchment areas of their school. Although responses to this question varied between urban, rural or a mixture of both, all schools visited were either surrounded by or located on the edge of housing estates. Specific geographical data has not been gathered on the schools visited but three were very obviously located quite high up on a hill and one was set in a more rural location. A member of staff referred to the geographic location of her school and the difficulties this had for pregnant schoolgirls.

‘There is one of our girls who was at school and it is at the top of a huge big hill and she found that difficult. That was a practical difficulty for her. She was fine getting the bus and all the rest of it, the underground and the bus but actually walking up that hill to the school was difficult for her later on in pregnancy’ (School, 8).

The physical location and the ability to get to school was an issue for five participants. No pattern evolved from the data in terms of social class or age regarding the geographical location of the school or methods of getting there. There was, however, an emerging picture from the different approaches taken by local authorities with regards to the sources of support to help with this practical challenge. What is also apparent from the data is that there is a lack of consistency in terms of sources of support provided by schools even within the same local authority. While variation and flexibility in support is required (across schools within the same local authority) to enable the variety of needs and family circumstances to be accommodated, not every participant in the same local authority was given the offer to have transport assistance provided for them.

*Service provision approach* - All twenty participants who were in a service provision had transport provided for them and the baby, from their home to school (if the nursery was based within the school) or from home to a child-minder (for the baby) and then to school. This seemed to make a difference to participants' attendance at school. One of the main reasons for transport being provided by service provisions is because schoolgirl mothers/mothers-to-be can be transferred from their own school to another one (with a nursery provision) in a different part of the local authority. Others chose to stay in their own school and attend the service provision on certain days for specific programmes or events. Travelling across a city or local authority would not be achievable for schoolgirl mothers/mothers-to-be without transport. Recognition of the geographical location, practical challenges of getting to school and the background socio-economic influences that affect attendance at school were apparent to staff. One staff member stated:

'If there are already socio-economic issues or issues with school or whatever then we might think that that might be raised as a possible support that the pupil transfer here. We would pay the transport regardless of where the pupil comes from' (School, 8).

*GIRFEC approach* - Only one of the six participants whose local authority responded through a GIRFEC approach had transport provided for her and the baby to and from school/nursery. The other participant (who attended a different school within the same local authority) was not receiving any transport assistance whatsoever. This particular participant without transport assistance lived in a very rural location which made it difficult for her to get to school even before becoming pregnant.

'I live out in the middle of no-where. Either I need to take a 30 minute walk to the nearest bus stop or just drive' (Rhiannon, 17, Individual Interview).

The remaining four participants (in a different local authority to those above), were in different schools from each other within the same local authority. Although staff had mentioned that nursery provision and transport would be considered on an individual case-by-case basis, participants had commented that they had not been offered nursery assistance or special transport. None of these participants were in school at the time

of interviewing. One of these schools was in a more rural setting and transport assistance would have been required for anyone who had lived in outlying areas simply because of its location.

*Ad hoc schools based approach* - Thirteen participants were in local authorities where individual schools had taken an ad hoc approach to supporting them. Their arrangements for getting to and from school had varied significantly. Seven of these participants across two local authorities had attended a flexible learning unit but only five (in the same authority) were receiving transport to attend this or to go to work experience or college. The remaining two (in another authority) made their own way to the flexible learning unit. One participant talked about the difficulties she had experienced in walking to school before being moved to the base. Travelling to the flexible learning unit had been easier for her.

‘I found it very difficult when I got quite far on in my pregnancy, actually walking to school. It was quite a walk’ (Tessa, 15, Group Interview 11, 2 people).

*Policy approach* - No specific reference was made to transport by school staff within this approach. It could be that participants were entitled to, and were already receiving, transport assistance under the Education (Scotland) Act as mentioned previously. If this were the case, then issues may well have arisen if participants had wanted to travel on the bus with their baby. However, it is more likely that alternative childcare arrangements (possibly taken on by the family) would be in place given that these schools did not have a nursery located on site.

Four participants across two local authorities where a policy was in place to support schoolgirl mothers/mothers-to-be did not receive special transport assistance. These participants may already have qualified for transport because they were distance entitled under the Education (Scotland) Act 1980, but this was not mentioned. A member of staff from one of the two local authorities had commented that transport assistance would be considered if requested. Given the rural location of the school and wide catchment area, the member of staff advised that more than half of the pupils



were already transported by school bus. The member of staff in the other local authority explained that they had provided child-minding assistance but it was the responsibility of the schoolgirl mother to get her baby to the child-minder and then to make her way to school.

‘Transport would just bump the costs up quite a lot and it’s that bit about responsibility and getting them to take on their responsibility of their baby. You’ve got to get yourself to school so you have got to get up that bit earlier and that’s your part in it. Sometimes it works and sometimes it doesn’t’ (School, 3).

The practical challenges and physical implications of getting to/from school during pregnancy and after having a baby combined with the methods of transport can impact on attendance at school. From the data, there is evidence to suggest that providing specialist transport to and from school for schoolgirl mothers/mothers-to-be and their baby had had a positive impact on attendance. Whilst it is not possible to alter the geographical location of schools (unless they are being rebuilt) individual consideration needs to be given to the place of residence of a schoolgirl mother/mother-to-be.

Discussion on how participants felt about leaving their baby with someone else (nursery or family) is mentioned later on in this chapter.

### *Corridors & stairs, desks & chairs, toilets*

Participants were asked during the interview to describe any other practical challenges they had faced such as the corridors, stairs, desks, chairs or toilets when pregnant and attending school. No specific pattern emerged from the data in terms of the age of the participants regarding the practical challenges of accessing corridors or stairs within the schools.

*Corridors & stairs* - Nineteen participants talked about the challenges they had faced when negotiating the corridors and stairs within their school. Most of these concerns had focused on the volume and pace of pupils using the corridors and stairs. The total

number of pupils on the school rolls in each school (excluding flexible learning units) ranged between 400 and 2050. It is easy to assume that participants who attended schools with the larger number of pupils would have had the greatest concerns about negotiating the corridors and stairs whilst pregnant because of the sheer volume, but this was not the case.

‘Sometimes I’m a bit like, ‘Watch, please don’t nudge into me don’t’....It’s like big tall 6<sup>th</sup> year boys are always like running down the stairs because they are always rushing but you don’t know what to do. I just stand still most of the time’ (Erika, 15, Individual Interview).

Corridors and stairs were very busy places between classes. Data were not gathered on the number of periods that pupils had per day in their school but this would normally be between five and eight. Pupils would still be required to move around the school several times throughout the day. Only ten participants mentioned that they had been offered the use of the lift.

Six participants in total commented that they had been offered the opportunity to leave classes five minutes early to assist them in making their way round the school before the rush, but this had not always helped.

‘I didn’t like the busy corridors....that’s how like I always used to try and leave early to go to my class but then you were halfway down the corridor when they all used to come out’ (Shelby, 15, Individual Interview).

Others commented that their friends had taken on the role of bodily protecting them as they had moved about the school. Vikki explained:

‘My friends are all like around me so that nobody would barge into me in the corridors and all this’ (Age 17, Group Interview 8, 2 people).

Participants who had attended the flexible learning units did not have the same issues over the volume of pupils nor did they have busy corridors or stairs in the building with which to contend. Some participants who attended these units made reference to their experiences prior to transferring from their old school.

Not every member of staff had commented on procedures for allowing pupils out of class early to be able to avoid the busy corridors. Seven members of staff mentioned that they had already made such arrangements or would do so if requested. Similarly on allowing access to the lifts in the school, only seven members of staff had made reference to this already happening or demonstrated a willingness to put these arrangements in place. This is not to say that it was not happening in other schools but rather, it was not mentioned. There was no correlation between participants' accounts and those of members of staff regarding the use of lifts and being allowed out of classes early. It should be noted that any member of staff who is pregnant would also encounter the same issues of busy corridors and moving around during the school day. Arguments that attending school while pregnant is a health and safety risk which should be avoided, could not be considered as this would have to apply to members of staff as well.

*Desks & chairs* - Participants were asked in the interview about their experience of sitting at the desks and on chairs at school during pregnancy. Not everyone responded to this question but those who did talked about their personal experiences. Five participants stated that sitting at the desks in the majority of their classes had not been a problem. There were a few comments about the difficulties of doing this during the last trimester of pregnancy where it was difficult to sit close to the desk. Alexis explained:

‘Because my belly couldn’t, I couldn’t like see when I was sitting, like my chair had to be away out because my belly was that big’ (Age 17, Individual Interview).

Sitting on plastic chairs was suitable for some participants but not for others. Stools in the science classes were acknowledged as being very uncomfortable not least because of their height and lack of a back support. Three participants spoke about how some of their teachers had offered them their seat (swivel chair/computer seat) or a cushion for more comfort.

‘I’ve been told to bring a cushion in but in science its stools but the teacher has got me a special, like one those stools that has a shoulder, because I kept complaining I couldn’t do my work, I was lying on the desk’ (Sonia, 15, Group Interview 4, 3 people).

Eight of the seventeen members of staff interviewed had not commented on whether pregnant schoolgirls had raised concerns about the desks and chairs being uncomfortable. The remaining four could recall having had someone raise it as an issue (including the science stools) and that this had been addressed.

‘Chairs are uncomfortable. If you are big and pregnant you are uncomfortable regardless of where you are sitting. That is one of the things that I speak to schools about as well is about being okay and having a cushion or something in class with them. The girls.....made a whole load of cushions that they can take to class with them if they want to but they still say it’s uncomfortable because quite often they are like these chairs here (wooden) that don’t have a back to put a cushion against but they sit on a cushion. At least it’s a wee bit easier’ (School, 8).

*Toilets* - Participants also talked during the interview about the challenges they faced in accessing toilet facilities whilst pregnant and attending school. Accessing toilet facilities in schools can be a complex process in any case depending on the layout of the building, where these are located and the school’s procedures for allowing pupils out of class to access a toilet. Pregnancy brings the requirement to use toilet facilities more frequently. Doing so whilst in a classroom setting is not straightforward as this can be viewed by teaching staff as a disruption to their lesson. Intervals and lunch breaks are staff’s preferred times for pupils to access toilets.

Participants were asked in the interview about their school’s procedures, such as a toilet pass to allow them out of class. Having a toilet pass is not necessary providing pupils have been given permission to access these facilities when they ask. While this seems a simpler process, difficulties had arisen when some of the subject teachers had not been informed about the pregnancy. This had been due to reluctance, by some members of staff, to share information with all subject teachers about a pupil being pregnant.

Eleven members of school staff commented that pregnant schoolgirls had been allowed to go to the toilet whenever they requested. Sixteen of the twenty participants who responded to this question confirmed that this was the case and they had been allowed to use the toilet facilities whenever they wanted. Four participants did not feel that staff's perceptions of what was happening reflected actual practice in the classroom because they had had a less positive experience. Kiera talked about her experiences but also about what she would have liked regarding accessing the toilet facilities.

‘When I used to ask to go to the toilet she [subject teacher] was usually quite rude about it.....I don't know I just, things like when I had asked to go to the toilet I would be told, ‘You should have went beforehand’ and I'm like, ‘Well I did go beforehand but I need again’ (Kiera, 15, Individual Interview).

Responses from participants regarding the difficulties they experienced in accessing toilet facilities highlights a growing tension between school staff and schoolgirls as their pregnancy progresses. This tension was unnecessarily exacerbated by the lack of vital background information being given to school staff. Despite this, the question has to be asked about how any member of staff comes to a decision over who has the right to go to the toilet or not. Indeed, to maintain dignity, every pupil, whether pregnant or not, should have the right to access toilet facilities whenever they need to, without having to provide a justification to satisfy staff's suspicions.

### *School buildings*

This thesis did not set out to look at the age or condition of school buildings and their appropriateness as places attended by schoolgirl mothers/mothers-to-be. Nor had it set out to consider the experiences and challenges these groups face whilst attending school. The topic arose during interviews and participants commented on the challenges they are presented with by the nature of their school building.

At the time of interviewing, the age of the school buildings ranged from 4 months old to 104 years old (Table 14). The school complex as a whole had also varied between

brand new state-of-the-art purpose built facilities to a mixture of old and new buildings. In some areas, schools had first been established as long ago as 1586.

**Table 14 – Age of school buildings/campuses**

Age in Years					
< 1	1-15	25-45	50-60	100+	Unknown
1	17	15	7	1	4

Consideration was given to potential advantages and disadvantages of a new school compared to older ones but there was no pattern or consistency. The age and design of school buildings had had different effects on participants. Patterns were also looked for by age of the participant and the approach taken by the local authority but again there was no consistency in either of these. The data have been presented by the age of the school building.

New school buildings seemed to provide a more positive and inviting learning environment for pupils not least because of their improved and more compact design compared to older schools. In one local authority, two schools had been completely rebuilt but the participants’ experiences of these new buildings during pregnancy were different. The school roll at one establishment had been almost double that of the other. In the school with the smaller number of pupils (over 600), Rhiannon described the stairs and corridors as ‘very crowded, very very crowded.....it’s just insane’ (Age 17, Individual Interview). Rhiannon found being pregnant and attending school under these conditions very difficult. At the larger school, with over 1000 pupils, Nia commented that she had not been afraid in the corridors because ‘they are quite wide in here so you’ve got a lot of space to walk’ (Age 17, Individual Interview). The member of staff at this school explained that it was a very busy school and that some teachers had even raised concerns about the volume of pupils moving throughout the school. Despite this there had not been any accident involving a pregnant pupil or member of staff while manoeuvring through the building.

Sam (Age 15) attended a school with over 1000 pupils which had been built less than ten years earlier. Her attendance at school both prior and during pregnancy had been poor but part of her frustrations were due to staff not letting her out of classes five

minutes early before the rush started at period changes and at the end of the pupil day. These feelings of frustration were echoed by participants across schools in other local authorities. Britney, whose school also had over 1000 pupils, and had been built less than ten years prior, commented, 'They should have made more time for me to walk rather than let me go through all the crowds' (Age 17, Individual Interview). The member of staff interviewed at this school had not commented on whether pupils were allowed out of classes early. The member of staff in the other school did mention that part of the support put in place to avoid being jostled in the stairwells was to allow pregnant schoolgirls out early.

Adrienne attended a school which was over 50 years old and the campus was very spread out. The school had over 1000 pupils on the roll. Adrienne commented:

'Its poor [attendance at school]. I don't go to classes because I just can't go up the stairs or anything like that. Just too much hard work or I've got a lot of classes but I just don't go to them' (Age, 16, Individual Interview).

The member of staff interviewed from the same school confirmed the issues that Adrienne had expressed regarding the school building.

'We have got a big campus so we are big and we knacker you.....physically it's really tiring.....cognitively it's a lot to deal with too so you've got the size of the building, the physicality of it....dealing with all the questions, dealing with thinking about what people might ask you, dealing with its whole idea of, 'What am I going to do [about the baby]'.....it's exhausting.....and a lot of emotion gets attached to it all' (School, 1).

Schools with larger numbers of pupils did create some issues for participants. For one school in particular, the original building was over 70 years old although new extensions had been added to it. The sheer volume of pupils (over 1800) in the one place at any time was of concern to Erika who described it as being really busy and a place where 'everyone crushes going to class' (Age 15, Individual Interview). Even though a lift pass had been offered, Erika had been slow and it had taken her a while to move up and down the levels of the building.

Bethany (Age 16) attended a school which was over 100 years old and had just over 400 pupils on the roll. The school campus had a mixture of new and old buildings. Bethany explained that there were only two main exits out of the building and, although there were just over 400 pupils, everyone tried to push out through the same doors at the end of the day. This had caused her to feel really anxious when attending school whilst pregnant.

Altogether six participants (aged 15-17) had stated they had felt particularly tired during the early stages of pregnancy. Negotiating large school campuses and the volume of pupils during the early stages of pregnancy and feeling unwell were not welcome challenges. Neither was the requirement to manoeuvre through large school buildings when feeling particularly tired and exhausted after returning to school following the birth and having been up through the night with the baby.

Where there are large numbers of pupils, schools can, and do, put into place certain procedures such as a one-way system through the corridors and up/down stairs. They can also identify multiple pupil entrance and egress exits to help with crowd control. Discussions were not held with schools on these issues and it may be that such systems were in place. However, the concerns mentioned above were raised by participants during interviews and were highlighted by them as being of great concern in some cases.

### *Timetables and examinations*

*Timetables* - Under the previous Scottish curriculum (i.e. up to 2013), pupils would normally choose a maximum of eight subjects at the end of second year which they wanted to study. This would then entail a two-year programme of study with the aim of achieving qualifications such as Standard Grades, Intermediate 1 or Intermediate 2. Depending on the results of these qualifications, pupils would then have moved on to a one-year programme and work towards higher qualifications, where a maximum of five subjects would be studied. Under the Scottish Government's 'More Choices and More Chances' Strategy (2006), the curriculum should be flexible enough to accommodate other options such as part-time attendance at college. Following a full



timetable of either eight or five subjects is demanding for all pupils. Participants talked in the interview about their school timetable being full/part-time. Table 15, below, shows the year stage of pupils at the time of interviewing.

**Table 15 - Stage of pupils at school**

Age	Stage at School						Totals
	S3	S4	S5	S6	College	Left/Not attending	
14	2						2
15		12	2				14
16		1	10			2	13
17			3	6	1	1	11
18				1		2	3
<b>Total</b>	2	13	15	7	1	5	43

Twelve participants aged 14-17 were pregnant at the time of interview. Six pregnant participants (S3, S4, S5) stated that they were currently following a full timetable with the maximum number of subjects appropriate to their stage (eight or five). This was likely to change after the baby was born but would not be finalised until nearer the time. Four pregnant participants were on a part-time timetable, one was attending college full-time and one was not attending any educational establishment. Of the remaining thirty-one participants who had delivered their baby, twenty-seven had varied timetable arrangements which involved either being in school full or part-time but with a reduced timetable. One participant was attending college full-time and one was attending school part-time and college part-time. Four participants were not attending school or college.

Following a full or part-time timetable was not dependent on age or stage in school, by a policy or even the approach taken by the local authority but tended to be more for schoolgirl mothers who had returned to school after having their baby. A part-time timetable did not mean that participants were only in school for a reduced number of hours as compared to everyone else. Instead, it meant that participants would undertake fewer subjects but would have their remaining periods allocated for study time/homework for spending time in the nursery with the baby (attachment/bonding time), or learning how to feed or bath their baby.

**Table 16 - Timetables**

	<b>Part-time</b>	<b>Full-time</b>	<b>College (Full time)</b>	<b>Left school/not attending</b>	<b>Total</b>
Service Provision	18	2			20
Schools	10*		1	2	13
Policy		4			4
GIRFEC	1	1		4	6
<b>Total</b>	29	7	1	6	43

\*One participant was attending both school and college part-time.

All members of staff who were interviewed advised that consideration would be given as to what the schoolgirl mother/mother-to-be wanted to achieve on her return to school. The timetables would, where possible, be tailored and made flexible to meet their needs and to help them get to the next stage of their education, whether that be college, university, or employment. Staff also advised that, in general, schoolgirl mothers did not initially follow a full timetable on their return to school.

*Examinations* - The year stage that participants were in when they became pregnant and when the baby was due, were two factors which impacted significantly on whether they were able to sit their examinations as normal. Examinations were not affected as much in instances where participants became pregnant and delivered in S3 or during the early months of S4 as prelim and final examinations are not normally held until S4. The length of time taken to return to school (maternity leave), did impact on the amount of work on which they had to catch up, with their subjects.

Some participants across S4-S6 stages had missed either their prelim examinations or final examinations because of the date that their baby was born. Prelim examinations were more likely to be affected for those participants whose baby was born between November and February, but this could depend on the date that local authorities normally set for these. For any participant whose baby was born between April and May, this could affect their final examinations. Other participants whose baby had been born between June and October had been less likely to have their examinations affected but they might miss some school work at the beginning of term. Leaving school in June at the end of S4, aged sixteen would seem to be a natural break for any

pregnant schoolgirl whose baby was due over the summer months. This could well influence her decision to return to school or not, and might possibly make it harder for her to do so.

Special examination arrangements can be made for pupils where appropriate and in such cases a separate room is identified and an invigilator provided. Participants were asked if any special arrangements had been made for them during examinations possibly to allow them to use toilet facilities if required without disturbing the other pupils. The responses received from participants varied but there was no consistent pattern that emerged. Any arrangements that had been put in place appeared to be in response to the individual needs or preference of the schoolgirl mother/mother-to-be rather than her age or the approach taken by local authorities, or even the stage of pregnancy.

Ten participants commented that they would not have wanted to sit in a separate room and preferred to be in the main hall along with their friends. Lilly stated:

‘It’s good because you don’t feel like...because you are not being singled out....you feel like a normal person’ (Age 16, Group Interview 5, 5 people).

Participants seemed more comfortable sitting in the main hall but still knowing that they were allowed to go to the toilet when they needed. Eva described her situation:

‘I was allowed to go to the toilet when I wanted and like for my exams and stuff they were like oh...if you need to go out to the toilet just go’ (Age 17, Group Interview 2, 2 people).

For others, the smaller setting with easy access to the toilet suited them better and was, therefore, preferable. Three participants explained that they were not bothered about either being in the main hall or a separate room.

‘I got put into my own room for my exams.....it was fine, it was only so if I needed the toilet I could get up and go so it was fine.....it was not just me in the room there were another two people so it was fine.....I was not that bothered’ (Madison, 16, Group Interview 3, 2 people).

School staff commented that the girls had generally wanted to be seen as normal and fitting in with everyone else. Sitting in the main hall was also viewed by one member of staff as ‘contributing to engagement’ (School, 8). Talking to schoolgirl mothers/mothers-to-be about their preferences was a key step in the process of making arrangements and decisions had not been made without consulting them first.

Where separate arrangements had been made, this was not viewed by participants as singling anyone out because such arrangements were normal procedures in schools and were organised for other pupils. Another member of staff commented:

‘There are a lot of youngsters who have additional support needs who get alternative exam arrangements. I mean there are a lot for a whole variety of different needs. Some youngsters just get anxious and under-perform because they are in a room with other people, so they need separate accommodation. It’s not seen as different’ (School, 3).

### *Subject classes*

The maximum number of subject classes that pupils can take in the different year stages from S3-S6 was discussed earlier. During the interviews, schoolgirl mothers/mothers-to-be highlighted challenges that they had in different subject classes. There were no patterns in terms of age or approach taken by the local authority and so the following data have been organised by the different experiences that participants mentioned.

*Physical Education* - During the first four years of secondary school education, physical education is a core part of the curriculum. All secondary schools aspire to have two hours of physical education per week for pupils as this is a requirement under the curriculum. Once pupils move into fifth and sixth year, physical education is no longer a mandatory part of the curriculum unless it is one of their chosen subjects to study. Six participants talked about their experiences with physical education. Erika

and Adrienne had made comments about being ‘very sporty’ and part of a school team. Neither participant had been asked to stop attending but instead had made the decision to advise their teacher that they wished to stop participating.

‘I was scared about them finding out because I’m quite sporty and I was in a school team and that so I was quite scared in case my coach found out and she questioned me but she has been fine and everyone has still been friendly’ (Erika 15, Individual Interview).

Demi who was a fifth year pupil reflected on her experience during fourth year. Demi talked about getting hit in the stomach by other pupils during physical education.

‘I took physical education and then I was getting hit with the ball so my dad told the school that if I didn’t get to come out I was just not to go [to school]’ (Demi, 16, Group Interview 4, 3 people).

Jaclyn (Age 15) and Bethany (Age 17) attended different schools within the same local authority. Both participants talked about how their physical education teachers had wanted them to stop participating in the class and explained that they had to address this matter with their respective schools. Paige had also been told that she was not allowed to participate in physical education.

‘I was not allowed to do physical education and stuff so they changed that a bit. The time I was supposed to do physical education, I would sit in a room and do whatever I wanted on my phone or whatever’ (Paige, 15, Individual Interview).

*Science subjects* - Two participants mentioned during the course of the interview that they were taking a science subject. The difficulties that participants expressed when sitting on science stools was discussed earlier in this chapter. Another concern raised by Vanessa (Age 17) and Sonia (Age 15) was about having to use certain chemicals with which no pregnant mother-to-be should have had to come into contact due to their harmful nature to the unborn baby. Part of Vanessa’s concerns referred to the subject teacher who, she felt, had ignored the fact that she was pregnant and had treated her the same as everyone else rather than recognising there were things she should not be doing.

‘Working with chemicals.....when you are doing chemistry so it’s like well you need to kind of acknowledge it in some way’ (Vanessa, 17, Individual Interview).

*Practical subjects* - Home economics, hospitality and technical classes posed specific problems for four participants. For Abbi, these problems had been about the subject teacher not being happy about having a pregnant schoolgirl in her class.

‘My home economics teacher was not happy about it. That was the one who didn’t like the whole idea but everyone else was fine with it’ (Age 17, Individual Interview).

Terri and Gabrielle, both aged 16, were more concerned about the extreme heat/temperature in the home economics class from the ovens, their lack of energy because of the heat; being on their feet constantly; and being unable to bend down to gain access to cupboards. Bethany advised that she had not been allowed to use certain machines in her technical class (woodwork) because she had been pregnant (Age 17, Group Interview 1, 4 people).

*Work placement* - Practical challenges in attending a work placement were mentioned during the interview by three participants. These challenges had differed in their nature and context. Kyra (Age 17) who was pregnant at the time of interview, explained that she had been doing a work placement as part of her college course but after a risk assessment had been carried out she had not been allowed to continue. Wearing the appropriate uniform had been difficult for Kyra during pregnancy. Hayley (Age 16) also highlighted problems with her work placement (as part of the school curriculum). This had resulted in Hayley being told about certain things she would/would not be able to do but she had still been expected to carry big cartons of milk and heavy trays. Brooklyn (Age 17) had left school to take up a full-time work placement but had had to leave because she was told she could not get maternity allowance.

### *Other practical issues*

Chapter Two discussed the importance of a young person having a good relationship with their peer group at school. Friends and fitting in were also mentioned as being a vital part of school experience. Twenty-two participants (51%) in this research project transferred from their own school to another school or to an alternative flexible learning unit to finish their education. During the interviews, some participants commented on their feelings about having had to leave their peer group behind at their own school and start making friends afresh. Transferring schools was most common in local authorities with a service provision. Seven of these twenty-two participants had transferred from their own school to a flexible learning unit or inclusion base. One participant had moved to a school in a different part of the country due to family circumstances. Although participants came from three different local authorities, their comments on the impact of changing school were very clearly themed by age.

*Changing Schools* - Nine participants were aged fifteen at the time of the interview. Six of these participants made either no comment about having to transfer schools or stated they had not been bothered about moving schools. From the remaining three participants, two had been quite upset by having to leave their friends and peer group and one was grateful for the fresh start. This transfer away from their own school and friends had had wider implications, which were affecting certain course subjects and methods of working and learning.

‘I don’t really like the Maths and English it makes it a lot more boring than what it was at school....we used to always like do stuff in groups and groups of friends and we always used to have a laugh with the teacher....in there I sit with a girl I don’t know and don’t talk to and then this boy that I don’t even look at....I still wish I could be at school with my friends’ (Tessa, 15, Group Interview 11, 2 people).

‘It was a fresh start basically when I came here. I didn’t know anybody and I didn’t know any teacher. I was like they don’t know what I was like so maybe I could give it a try here and I could actually do it’ (Paige, 15, Individual Interview).

Seven of the eight participants aged sixteen at the time of the interview had all seemed pleased with their new friendship group at their new school and to have left their previous peer group. However, most of these participants had been at their new school for some time and so their feelings at the time of transfer may well have been different. The remaining schoolgirl mother seemed to have had mixed feelings and, although she appeared to have had problems with her previous peer group, the transfer to the new school had still impacted significantly on how she was settling in.

‘All my mates [at previous school] turned against us....I don’t really speak to anyone [here].....I feel dead awkward.....it would be better if like all the schools had one [a nursery] instead of having to move from your own school’ (Cara, 16, Group Interview 2, 2 people).

Four participants who were aged seventeen or eighteen had transferred schools. Two of these schoolgirls seemed to have been quite pleased to transfer schools, either to be away from their friends who were being unkind or just to enjoy the new school more than their previous one. The remaining two schoolgirl mothers (different local authorities) had been quite upset at having to change schools and at losing the familiarity and comfort of being with friends that they had known and with whom they had grown up over a long period of time.

‘I do miss it, like my friends and stuff and like obviously just being in that environment with people that you have something in common with and you just know it’ (Vanessa, 17, Individual Interview).

‘I had loads of friends but now I don’t really speak to that many people cause I’ve had to move schools so I don’t really know anyone.....In classes everyone is speaking and you are just sitting there....cause it’s so awkward’ (Eva, 16, Group Interview 2, 2 people).

The above experiences of participants regarding desks, chairs, accessing toilets, information being shared with staff, age of the school buildings, timetables, examinations, subject classes and changing schools are not limited to schoolgirl mothers/mothers-to-be. If these elements of school life require at times to be considered and subsequently altered for schoolgirl mothers/mothers-to-be then there is the possibility that other pupils, who are not pregnant, may also struggle with similar



issues and may need alternative arrangements and adaptations to meet their needs and produce a more positive outcome. Pupils are entitled to one-hundred-and-ninety school days each year and if their experiences and relationships are positive, this can help make them feel more connected to other pupils, staff, the school building but also contribute towards them having a more pleasant overall school experience.

#### **7.4 Challenges of continuing in education during the early stages of motherhood**

Schoolgirl mothers in general, do not normally have the finance to purchase formal childcare because they have no income and so they are dependent on family and friends. This presents them with the conflicting legal demands of caring for their baby and remaining in education until they are of an age to leave school.

Participants were asked in the questionnaire to describe their feelings (from five different categories – Table 17) about returning to education and their childcare arrangements. One participant (Age 16) who was pregnant at the time of the interview commented that she did not want to return to school or college immediately after having the baby even if she had childcare but did plan to return in a few years. Thirty-three participants (26 delivered, 7 pregnant) had returned to education or were planning to go back to school after having had the baby and had childcare arrangements. One participant (Age 17) who had already had two babies commented that she wanted to return to education but did not have childcare. This particular participant was not attending school. Five participants (aged 15, 17, 3 delivered, 2 pregnant) were concerned about managing a baby and education but were all attending school at the time of interviewing. Of the three remaining participants (aged 15-17, 1 delivered, 2 pregnant, all attending school) one said she would find it too hard to leave her baby with someone else and the remaining two participants did not respond to the question.

**Table 17 – Participants’ feelings about returning to education**

Categories		Age					Totals
		14	15	16	17	18	
1.	I do not want to return to school/college, even if I have childcare			1			1
2.	I plan to return to school/college and have childcare	2	10	11	7	3	33
3.	I would like to return to school/college but do not have childcare				1		1
4.	I have plans to return to school/college, I have childcare, but worry that it will be too hard to manage school/baby		3		2		5
5.	I would find it too hard to leave my baby with someone else		1				1
	No comment			1	1		2
<b>Totals</b>		<b>2</b>	<b>14</b>	<b>13</b>	<b>11</b>	<b>3</b>	<b>43</b>

*Formal childcare* can be obtained from a range of sources including local authority nurseries, private nurseries, and child-minding services or by employing the services of a nanny. At the time of interviewing, thirty-one participants had delivered their baby and twelve were pregnant. Table 18, below, shows the formal/informal childcare arrangements that participants were using at the time of the interview or planning to use after their baby was born.

Participants who lived in a local authority which had a service provision (20 in total) with a nursery on site had the option to change schools, remain at their own school and have a fully funded nursery placement, or have a child-minder. Secondary schools with a nursery on site were located within a deprived area. Although participants came from different social class backgrounds, it is unclear from this data whether schoolgirl mothers/mothers-to-be from more affluent areas would change to a school in a more deprived area, even though they would be offered a funded nursery place and transport assistance. As discussed previously, four participants were quite upset and one had mixed feelings about having to change school but this was linked to friendship groups rather than the area within which the school was located. Nor is it possible to know whether participants who were receiving formal childcare (nursery/child-minder) would still be in education had they not been provided with this funded placement.

Three of the four participants whose local authority took a policy approach to supporting schoolgirl mothers had the option to have a fully funded child-minder to care for the baby while they returned to education. The remaining schoolgirl mother-to-be, Adrienne, who was in a different local authority, was not offered any childcare assistance. Adrienne was pregnant at the time of interviewing and found it difficult to contemplate being able to trust anyone else with her baby other than family. Even if another form of childcare assistance (nursery or child-minding) had been available, Adrienne did not think she would use this.

‘I’d still leave him with my family.....I trust them and I don’t think I’d like other people.....you don’t know what they do’ (Adrienne, 16, Individual Interview).

Purchasing a nursery placement or the services of a child-minder is an option for families regardless of which local authority they live in providing this is available locally and they have the necessary finance. Only one participant advised that she was purchasing childcare from a private nursery provider.

**Table 18 - Childcare arrangements**

Childcare	Delivered/ Pregnant	Age					Total
		14	15	16	17	18	
<b>Formal</b>							
Nursery	- Delivered		4	7	4		15
	- Pregnant			1			1
Child-minder	- Delivered		1		1		2
	- Pregnant	2	2				4
Purchased nursery place	- Delivered						
	- Pregnant					1	1
<b>Informal</b>							
Grandparent/Siblings/family	- Delivered		3	1	3		7
	- Pregnant		1	1	2		4
Self (Not attending school)	- Delivered		1	1	1	2	5
	- Pregnant		1	1			2
Foster carer	- Delivered		1				2
	- Pregnant			1			
	<b>Total</b>	<b>2</b>	<b>14</b>	<b>13</b>	<b>11</b>	<b>3</b>	<b>43</b>

*Informal childcare* can include family, friends, relatives or neighbours. The choice of which members within this network would be used to provide childcare assistance can be based on qualities such as the type of care provided, meeting the needs of childcare or personal relationships that already exist. Informal childcare, for participants depended on the options available to them at the time and their existing trustworthy relationships.

In the local authorities which responded to schoolgirl pregnancies on an ad hoc basis, none of the thirteen participants were offered/received childcare assistance. Two of the thirteen participants were not attending school at the time of interviewing and were caring for the baby themselves. Six participants commented that their baby was being cared for by close family (grandmother) and this had allowed them to continue at school. A further two participants commented that their foster carers would be providing childcare assistance to allow them to continue with their education. Two participants did not comment and the remaining schoolgirl mother was paying for childcare privately (discussed above). These thirteen participants were asked if they would have liked the option to have formal childcare (nursery/child-minder). Not everyone responded to this question but three said they would have liked a nursery; five did not want a nursery or a child-minder and were happy with close family or foster carers; four did not comment; and the last participant had plans to put her child in a college nursery when she returned to higher education. One of these participants (Tessa) felt that a nursery on site would have allowed her and the baby to learn together. This would also have meant she could have stayed with her friends.

‘It would be easier for me and my mum because she works and I have to like come here so I need a babysitter.....I’d like that [nursery on site] because then I’d still be with everyone like other people and then I could take the baby with me and well we’d be learning and stuff like that as well’ (Tessa, 15, Group Interview 11, 2 people).

Britney (Age 17) would have liked a nursery on site so that she could attend school and not have to depend on her mother every day to look after the baby. Being reliant on family members for childcare was comforting in allowing a schoolgirl mother to

know that the baby was well cared for but Britney felt like this was an imposition on her mother.

Four of the six participants whose local authority took a GIRFEC approach to supporting schoolgirl mothers had never returned to school since having their baby and were caring for the baby themselves. One of the four participants, Lauren (Age 16) would have liked some form of childcare to allow her to do some part-time work. Lauren did not say whether having a nursery on site would have encouraged her to stay on at school but she did comment that she only had a small number of family members who could help her with childcare. This restricted Lauren from being able to do other things. Lauren was able to work one day a week and she also took her baby to a Young Mothers group once a week. Of the two remaining participants (in the same local authority but different from the four above), one was receiving childcare assistance. The other participant (Rhiannon) was pregnant at the time of interviewing. Rhiannon would have liked a nursery on site but she did not think she could have put the baby in straightaway. Comfort in returning to school was, for Rhiannon, best found through the knowledge that the baby was being cared for by grandparents rather than someone she did not know.

‘It would be a lot easier but I don’t think I’d do that for quite a few months so it doesn’t really make a difference...I think that child-minding would be good but I think I’d feel a lot better sitting in class knowing that the baby is with their grandparents rather than someone I didn’t really know’ (Rhiannon, 17, Individual Interview).

Participants who had no alternative but to use informal childcare had had to rely on close family to provide this. In a few cases, the new grandparents had had to reduce their working hours in order to be able to care for the baby and allow their daughter to remain in education. This option is obviously not available to every schoolgirl mother and for some (not included in this project) they might not have had any other choice but to drop out of education. The data from this study would suggest that the majority of schoolgirl mothers/mothers-to-be did want to be in school and did not have plans to ‘drop out’ of education.

### *Leaving the baby*

Coping with pregnancy whilst attending school presents its own difficulties as outlined in Chapter Seven. For those who return to education, further challenges exist in having to leave the baby with someone else (formal/informal). Seventeen participants were offered a formal nursery placement in a school. At the time of interviewing, only one pregnant schoolgirl (Erika, 15) was not planning to change schools or take up the formal nursery place. Erika was planning to use informal childcare when she returned to education. A further seven participants (different local authorities) had been offered a child-minder to allow them to return to education. One of the seven participants (Sonia, 15) was pregnant and was not planning to use the child-minder when she returned to education. Another of the seven participants (Demi, 16) had delivered her baby and was using informal childcare rather than the child-minder. The remaining nineteen participants had not been offered any formal childcare.

Participants were asked to describe in a few words their thoughts and feelings about leaving their baby with someone else (formal/informal) while they returned to education. Two participants aged fourteen were both pregnant at the time of interview and they had very real concerns about having to leave their baby with someone else. Both participants were in different local authorities and had been offered child-minding facilities until they left school. This could be in S4, S5 or S6 depending on their school leaving age or plans for the future. The two participants knew that it was something they would have to do because of their age, their need to return to education and because of not having any other option, but this did not console them in any way. Part of the concerns over leaving their baby with someone else (child-minder) was due to separation anxieties. Rochelle would have liked a nursery on site, 'I suppose I would feel better because I would know my baby was like somewhere beside me' (Rochelle, 14, Group Interview 4, 3 people).

Thirty-eight participants (28 delivered, 10 pregnant) were aged 15-17 at the time of interviewing. Twenty-eight participants (delivered) described their feelings about leaving their baby with someone else initially as very difficult (10), worried (7), fine (6), sad (2), scared (1), agitated (1), no comment (1). Although participants who

had their baby still tended to worry on a daily basis, they had built up trust with those who were caring for the baby. The ten participants who were pregnant at the time of interviewing described their thoughts about having to leave the baby in the future with someone else as: anxious/worried (5), fine (3), very difficult (1), no comment (1).

Vikki commented:

‘Sad, I miss the baby. Sometimes I want to leave school and be at home with the baby. It’s hard because trying to have people do things your way doesn’t work so there’s too many different rules from different people’ (Vikki, 17, Group Interview 8, 2 people).

Three participants aged eighteen at the time of interviewing seemed to have fewer concerns and anxieties about leaving their baby with someone else other than family. Strong feelings had existed around what they regarded as an appropriate age to leave a child with someone else and about staff being properly qualified. One participant in this age group was already using private childcare arrangements to allow her to attend school on a part-time basis. The remaining two participants were not attending school at the time of interview. One participant was caring for the baby herself and the other had two children under the age of two. The latter participant seemed comfortable with the idea of leaving them with someone else if she had to but she did not have the option.

It could be argued that the age of the younger participants contributed to their overly anxious thoughts about having to leave their baby with someone else. At the opposite end of the age range, it could be assumed that the older participants had more understanding and knowledge of how nursery systems and child-minders operated, hence their less-resistant attitude towards formal childcare. It would be easy to focus attention on these two apparent extreme and contrasting views from participants and to overlook the group in the middle. This middle group provides a potential missing link to show the overall journey of how schoolgirl mothers/mothers-to-be move from one set of feelings to the other.

Overlooking the depth of feelings and emotions that schoolgirl mothers/mothers-to-be have when contemplating leaving their baby with someone else is too easy. Stereotypical assumptions may presume that schoolgirl mothers would too readily

hand their baby over to ‘anyone’ in order that they can go and do their own thing. For the participants in this study this has not been the case. A key point to be remembered is that regardless of age, for schoolgirl mothers, natural feelings of attachment, bonding and motherly instinct can still come into play. Anxiety around being separated for too long and concern for wellbeing can arguably, be regarded as perfectly normal for mothers, regardless of their age. If the challenge of attending school has to be tackled then taking comfort from the knowledge that family or friends (who are trusted) will be caring for the baby is understandable even though it may or may not, to an outsider, be the best course of action or preferred option for the schoolgirl mother and her baby.

Initial anxious feelings and worries about leaving their baby with someone else is perhaps a reasonable reaction. Trusting adults and professionals at the outset might have been hard for younger schoolgirl mothers. The passage of time, and an increase in maturity, knowledge and understanding shows that although many schoolgirl mothers are not overjoyed with the prospects of having to leave their baby with someone else, seventy percent of the 15-17 year olds had learned to trust a professional or family member with caring for their baby.

The above data provides a little more insight into the potential journey that schoolgirl mothers/mothers-to-be may go through when considering returning to education. It also offers some clarification around the development of thinking and understanding of childcare provision of schoolgirl mothers/mothers-to-be as they get older. It could be argued that the reluctance to leave their baby with someone else (formal/informal) shows a strong sense of attachment, bonding and relationship. Assumptions on why schoolgirl mothers ‘drop out of school’ may have been incorrectly assigned and misinterpreted. No consideration has been given to the strength of the relationship between the schoolgirl mother and her baby or why she might choose to care for her child herself initially, before returning to education and pursuing her career at a later stage.



The above outlines participants' general feelings and thoughts about leaving their baby with someone else. However, in addition to this, three different themes emerged from the data regarding participants' views on their baby being in formal childcare. These were 'taking your baby to nursery', 'sending your baby to nursery' and 'leaving your baby with the child-minder'. Despite the underlying concerns about someone else caring for their baby, schoolgirl mothers felt more comfortable with the idea that they were taking their baby with them to the nursery in the school and that they were physically located in the same building within close proximity. This knowledge, along with the relationships developed with the nursery staff, made it easier to return to school and to place their baby in a formal childcare provision.

'I think it's just the fact that you go to this school and the nursery is based in this school which means you can just go and see your wain whenever. You would have to go a full day without seeing them which obviously would be a lot harder' (Katie, 16, Group Interview 5, 5 people).

Gabrielle did not think she would have returned to school had she not been able to get a place in the nursery on site.

'I know I'll be here but she'll be in there most of the time and I'll get dead nervous about leaving her.....I'll have the whole summer off with the baby....and then I'll just come back at the starting time as everybody else and the baby will be in the nursery.....I don't think I would have put the baby into a normal nursery so that's....another reason I think I would have left school because I would not have put the baby in a nursery' (Gabrielle, 16, Individual Interview).

'Sending your baby to nursery' did not feel like an option for Bonnie but it was something she felt she had had to do to be able to continue in school. Bonnie's family were able to pay for some time at a private nursery. The cost of sending her baby to nursery was begrudged by Bonnie as it was so expensive and also because she felt she was trying her best to stay in education.

‘I’m at school, it’s not as if I’m sitting wanting her to go into nursery. I’m trying to better my grades and it seems like I’m battling money wise. Sometimes I do feel just like, what’s the point? Why didn’t I just leave school and forget it?...I’m lucky she is only in 1½ days....That’s like £300 odd per month for a day and a half per week’ (Bonnie, 18, Group Interview 8, 2 people).

Two local authorities provided child-minding facilities. One of these authorities fully funded the transport and the child-minder costs, while the other only funded the child-minder. For those within this latter local authority, participants had to make their own way to the child-minder and then to school. Having to leave their baby with the child-minder, possibly a distance away, and then travel to school did not help participants feel comforted when contemplating their return to school. Not everyone who had been offered a child-minder commented on how they felt about this.

Sonia, who was pregnant at the time of interviewing, explained that she did initially want a child-minder to allow her to return to school but her parents had persuaded her against this.

‘I wanted a child-minder but because I thought, me and my boyfriend thought that if the baby goes to one of theirs [in-laws] then it would call them mum. That was my biggest fear....then my mum and dad put in my head that they [child-minders] don’t feed the bairns’ (Sonia, 15, Group Interview 4, 3 people).

Being offered formal childcare (nursery/child-minder) does not alleviate participants’ concerns over leaving their baby with someone else. From the data, younger participants appear to have had more concerns initially about formal childcare but these tend to decrease with age and maturity as well as through building up a trusting relationship with professionals. Trust is considered by Seligman (1997) as being vital in interpersonal relationships. For schoolgirl mothers, handing over care of their baby to professionals whom they do not know and have not learned to trust is a challenge. Entrusting a family member or foster carer with the care of their baby was easier and ‘automatic’ for the majority of participants (Misztal, 1996).

However, despite prior learned trust in family or trust and confidence that had been built up between schoolgirl mothers and professionals (nursery/child-minder), this is not sufficient to overcome emotional feelings about having to leave the baby. As can be seen from the data above, many participants struggled between trusting professionals and their emotions over leaving their baby to return to education. For a small number of participants, their emotional feelings about leaving the baby were stronger than concerns about trusting a professional and these could not be sufficiently overcome to allow them to return to education.

## **7.5 Conclusion**

This chapter has drawn on the accounts of participants to explore the health and practical challenges of continuing in education during pregnancy and the early stages of motherhood. Where appropriate, data from school staff have been included to provide further understanding of the challenges that schoolgirl mothers/mothers-to-be faced when continuing in education. The three topic areas discussed were: ‘health during pregnancy’, ‘practical challenges of continuing in education during pregnancy’ and ‘challenges of continuing in education during the early stages of motherhood’.

Coping with morning sickness while attending school was difficult for many participants. This impacted on some participants’ attendance at school especially for those who were subsequently hospitalised. Participants discussed a range of other practical matters which made it difficult for them to continue in education. These included the enforcement by some staff for schoolgirl mothers-to-be to wear school uniform. Many of the participants who transferred from their own school to a service provision or flexible learning unit were able to wear more comfortable clothing in school colours but others were not. The practicalities of having to wear school uniform and the lack of choice in being able to choose alternative clothing was not only an unachievable demand on participants but also a breach of the Equality Act (2010). School buildings in terms of their size and layout, old and new, all presented schoolgirl mothers-to-be with a challenge when continuing in education. The design and layout of the school building was particularly difficult for participants as they moved from

one subject class to another, especially when other pupils were running up and down the stairs or along the corridors. A small number of participants were unable to cope physically with the size of the school campus when pregnant, and this impacted on their attendance at school.

The provision of transport or childcare assistance during pregnancy is dependent on how local authorities implement Scottish government policies locally, where in Scotland schoolgirl mothers/mothers-to-be live, and the school they attend. The data from this study shows variations in childcare assistance and transport in the same local authority as well as across Scotland.

Participants had not all been given the option of a flexible, tailored curriculum that allowed them to attend school and college on a part-time basis. Schoolgirl mothers who had transferred to service provisions may be restricted in their option to go to college given that their baby is in the nursery on the school site. Participants in local authorities that had provided child-minders or where no childcare assistance was given or required, may have had more opportunities to follow a flexible and specifically tailored curriculum.

The majority of participants found it difficult to leave their baby with someone else and return to school. Many participants valued having a funded nursery place and transport assistance but they still found it difficult to place their baby in the care of someone else. Schoolgirl mothers/mothers-to-be had benefited from the co-ordinated support provided by nursery and school staff across a range of areas including practical help with the baby, financial advice, careers information and college or university applications. A small number of participants were disadvantaged when changing schools and having to leave their peer group behind.

Without exception, participants have continued to persevere in education despite the challenges they faced and in doing so, demonstrated strength of character. None of the challenges presented to schoolgirl mothers/mothers-to-be were insurmountable but the different approaches taken by local authorities and staff had made it easier for some participants and more difficult for others to continue in education. The different approaches taken by local authorities had also produced different educational outcomes.

## CHAPTER 8

### SOURCES OF SUPPORT AVAILABLE TO SCHOOLGIRL MOTHERS/MOTHERS-TO-BE

‘At first I was kind of worried about it but at the same time they [child-minder] are qualified to do what they do. When I first met her, like immediately I kind of knew she was just good with the bairn’.  
(Bethany, 17)

#### 8.1 Introduction

Chapter Seven considered the health and practical challenges that participants experienced when trying to continue in education during pregnancy and the early stages of motherhood. The chapter identified morning sickness as a key challenge for participants when continuing in education, especially through the first trimester of pregnancy. It also highlighted a range of frustrations and difficulties over the practical challenges of continuing in education, such as wearing school inform, being able to get to school, negotiating corridors and stairs, accessing toilets and managing the school building.

This chapter explores the sources of support that schoolgirl mothers/mothers-to-be identified as being available to help them while continuing in education. Responses from participants have been divided into two categories, viz. formal and informal sources of support. The chapter begins by providing an overview of the professionals (formal sources of support) that participants had approached for help regarding their pregnancy or the baby. It also considers the role of these professionals in the life of a schoolgirl mother/mother-to-be. Informal sources of support such as family and friends are then considered. The chapter goes on to explore the type of help that participants had requested from their formal and informal sources of support and their reasons for approaching professionals, family members and friends. Additionally, other identified sources of support that participants said they would use if they could not get help from existing formal and informal sources are then explored. Finally,

consideration is given in the chapter to identifying those whom schoolgirl mothers/mothers-to-be contact first regarding support (formal or informal sources) and whose advice they listen to the most. The discussion reflects on the relationship between participants and their parents.

This chapter uses data from participants, school staff and, where relevant, health visitors to explore the formal and informal sources of support that schoolgirl mothers/mothers-to-be stated were available to them.

## **8.2 Support for schoolgirl mothers/mothers-to-be**

Previous research (Macvarish and Billings 2007, Hosie 2007) suggests that schoolgirl mothers/mothers-to-be: do not access professional services (including ante-natal classes); they merely look to professionals to ‘fill in the gaps of expertise’; they find it difficult to know whom to ask for help and actually ask for help; and they make a deliberate choice regarding whom to approach for support.

Hansen (2005) highlights the creativity of older parents in obtaining help from their sources of support. Research about schoolgirl mothers/mothers-to-be has not referred to a similar creativity in sourcing help. If schoolgirl mothers/mothers-to-be are as creative as older parents in sourcing help and support then further understanding is needed about whom they approach and the criteria on which they base their choice. Further information is also required about whether schoolgirl mothers/mothers-to-be know whom to approach for help and support, whether they are able to ask for this themselves and whether they make an informed choice over whom they contact.

During an activity exercise in the course of the interview, participants were asked to draw a mind-map showing the people they would normally ask for help (i.e. professionals, family, friends). Participants were then asked to list the kind of help or information they had requested from these people about concerns regarding the pregnancy or the baby. The data were then used as an aide memoire and explored during the interviews with participants. More emphasis and importance was placed in

this exercise on understanding the range of professionals and people whom schoolgirl mothers/mothers-to-be approached and the types of support they requested rather than the frequency of contact or comparisons between them.

The sources of support that schoolgirl mothers/mothers-to-be identified have been separated into two categories viz. formal and informal. Formal sources of support have come from a variety of professionals including education and health professionals and the voluntary sector. Table 19 provides an overview of the range and combination of professionals whom schoolgirl mothers/mothers-to-be stated they used among their sources of support. Informal sources of support have come from a range of people including mothers, fathers, partners, family members, extended family and the community. An overview of the range and combination of informal sources of support that participants used will be discussed later in this section.

***Table 19 – Overview of professional staff approached for help***

<b>Professionals</b>	<b>No.</b>
Key Worker	21
Health Visitor*	15
School Staff (i.e. Guidance Teachers, Depute Headteachers)	12
Midwife*	8
Young Mums Group	3
Doctors	1
Cystic Fibrosis Team	1
Dietician	1
Nursery Staff	1
School Nurse	1
Looked After Co-ordinator	1

*\*Some pregnant participants identified their midwife rather than the health visitor as a professional they used within their sources of support. Health visitors take over from midwives 10-14 days after delivery.*

#### ***Formal sources of support (professionals)***

In addition to mapping out an overview of the formal sources of support whom schoolgirl mothers/mothers-to-be used, participants were also asked in the interview to identify their main contact person within school. Responses to this question varied across local authorities but also according to participants' personal preferences (Table 20).



Local authorities with a service provision had identified key workers to whom schoolgirl mothers/mothers-to-be were assigned rather than a guidance teacher. These members of staff worked closely with those on their caseload and participants were able to approach them freely regarding any concerns. Key workers in local authorities without a service provision were located in flexible learning units or inclusion base.

In the local authorities where schools responded to schoolgirl pregnancies on an ad hoc basis, participants identified a range of staff as their main contact person. The identified member of staff for participants could vary in the same school as well as across local authorities. This could be due to personal preference on the part of participants, involvement with other professionals (i.e. social work) or the member of staff who had pastoral care responsibilities.

Four of the six participants whose local authority took a GIRFEC approach had left or were not attending school. The remaining two participants (different local authority) attended separate schools and had different identified members of staff as their support. In those local authorities that took a policy approach to supporting pregnant schoolgirls, three participants identified their guidance teacher as their main point of contact. One participant identified the deputy headteacher as her point of contact.

**Table 20 - Main contact person in school**

	<b>Service Provision</b>	<b>Ad hoc</b>	<b>GIRFEC</b>	<b>Policy</b>	<b>Total</b>
Key Worker	15	6			21
Guidance Teacher	4	2	1	3	10
Depute Headteacher		1	1	1	3
No-one	1	1			2
Subject Teacher		1			1
Left/not attending school		2	4		6
Totals	20	13	6	4	43

Participants were not asked the question ‘what makes a good professional?’ However, as with the findings in Chapter Six, regarding ‘what makes a good friend?’ participants identified a number of key attributes as being important for a positive relationship between themselves and professionals. These attributes were: reliability; confidentiality; non-judgemental; approachable; interested; having time; ability to

listen, understand and problem-solve; supportive; respectful; empowering; and inclusive. Such findings are similar to Howieson and Semple's (2006) study as discussed later in this chapter.

All participants were asked in the interview if they thought having a main contact person had helped, made things worse or had singled them out in any way. Twenty-two participants stated that having a main contact person within school had helped. One participant felt that she had been let down by the person allocated to her. This appeared to be more about the relationship between the participant and the member of staff rather than the procedure of having a main contact person. Twenty participants did not respond to this question.

Only thirteen participants commented on whether a main contact person had singled them out. Eleven participants were very clear that this procedure had not singled them out but two of the thirteen felt that it had.

‘Just a wee bit when they pull you out of class [normal procedure to discuss school issues] like all the time, cause.....folk think, ‘awe what is she getting pulled out of class for?’’ (Rochelle, 14, Group Interview 4, 3 people).

Members of school staff did not express any concerns that schoolgirl mothers/mothers-to-be might feel singled out because they had a main contact person. This could be due to the fact that having a main contact person (guidance teacher or key worker) was a well-established school procedure for all pupils and, therefore, no different from normal.

*The role of guidance teachers/key workers/other professionals in supporting schoolgirl mothers/mothers-to-be*

One aim of this study was to explore how education and health professionals support schoolgirl mothers/mothers-to-be while continuing in education during pregnancy and the early stages of motherhood. The intention was not to evaluate the support provided by education or health professionals.

Howieson and Semple's (1996) study looked at the role of 'guidance' in secondary schools. The study highlighted that pupils viewed the role of guidance as necessary, but opinions and experience depended on the attitude and approach of the guidance teacher. Good guidance teachers were considered to have specific qualities such as: being willing to listen, showing an interest and understanding, and having time for and liking children. Howieson and Semple pointed out that 'ordinary pupils' felt that guidance teachers concentrated on those who were in trouble or who had problems. These findings are relevant to this research project given that schoolgirl mothers/mothers-to-be could be identified as 'being in trouble and having problems'.

The role of guidance teachers in schools is to 'meet the care and welfare needs of all children and young people so that they achieve their fullest potential' (Scottish Executive, 2005, p7). Despite the various models of guidance in operation across local authorities, the Scottish Executive 2005 review, did not find any particular one as being more effective. In the review, local authorities and staff supported the idea of an 'extended pupil support and guidance team' which included a school's partner professionals and agencies (i.e. health, community partnerships). The review also found that an integrated approach across different agencies resulted in a wider range of staff being approached by young people.

School staff in this study were asked to outline the support that schoolgirl mothers/mothers-to-be would be offered and by whom. Eleven local authorities in Scotland are represented in this research project and the processes outlined below may not be reflective of other local authorities. The data gathered came from interviews with seventeen members of staff. Support offered by school staff can be dependent on participants' circumstances, their stages of pregnancy and the approach taken by the local authority and can be in response to any situations that might arise. Many of the responses to this question were similar across schools but a few variations from staff who worked in a service provision or flexible learning unit were noted. The responses highlight the range of support that school staff provide to schoolgirl mothers/mothers-to-be. Having a single point of contact in the form of a guidance teacher is easier for

schoolgirl mothers/mothers-to-be and pupils in general but this does not simplify the procedures and complexity that school staff have to undertake.

The responses provided also indicate the challenges that schoolgirl mothers/mothers-to-be have to negotiate. Individual family circumstances and backgrounds are different and their complexity can mean that the support provided to schoolgirl mothers/mothers-to-be requires a range of multi-agency staff to work collaboratively together to ensure the best outcomes for the schoolgirl mother/mother-to-be and her baby.

In some instances, staff firstly had to clarify that a schoolgirl was actually pregnant, because previous experience had revealed that some thought they had become pregnant as a result of having 'slept with somebody once and had not used contraception' (School, 1). Pregnancy tests can be carried out by the school nurse in school if required. Where schoolgirls had not informed their parents about the pregnancy, staff had found themselves in the position of having to share this information through a home visit or at a meeting at the school. The reaction from parents to this news had not always been one of welcoming or believing the disclosure. This was particularly difficult for staff, especially where the parents had previously been in conflict with the school or had had a 'bad' experience of school themselves. Reactions from parents fluctuated between empathy and disappointment because they had not wanted this to happen to their daughter. After having time to absorb the news, parents were then supportive. One member of staff commented that parental support could sometimes depend on the school's reaction to the pregnancy and how they proposed to help.

Some school staff believed that the support required for schoolgirl mothers/mothers-to-be needed to be tailored to suit each individual as their needs were so varied and each had their own views on what they wanted to happen. Staff had to observe certain procedures and some felt that it would not be possible to follow a flowchart of procedures given the variety of ages, stages and circumstances of participants. Other school staff thought that the lack of a protocol made them more vulnerable to making

mistakes or forgetting to do something (School, 1). One member of staff in a local authority (policy approach) had a stipulated pathway (or flowchart) to follow and she had felt more confident about what to do and how best to support schoolgirl mothers/mothers-to-be.

‘Over the last three years within the authority, I would say it has become much more coherent and consistent across the board so we are very clear about how best to support young people’ (School, 3).

The support provided by school staff has been organised below into three categories, viz: short, medium and longer term actions. This information on support has come from the accounts of the seventeen members of staff who were interviewed as part of this project. In practice, these actions may not all follow on neatly from each other as the background circumstances and needs of each schoolgirl mother/mother-to-be is different.

*Short-term support* – Having a single point of contact was considered important for schoolgirl mothers/mothers-to-be and her parents. A decision was taken by staff, pregnant schoolgirls, parent(s) on whether the guidance teacher would continue to be the first point of contact or whether a separate key worker would be required. School staff acknowledged they might not be the best person for the schoolgirl mother/mother-to-be to talk to because of their gender or in the case of another member of staff having a better relationship with the schoolgirl mother-to-be. Staff were aware of the limitations of having only one identified key person as there may be times when this person was not available. On the contrary, there were also dangers of having too many people involved as this could potentially result in conflicting advice being given to schoolgirl mothers/mothers-to-be from a variety of sources. As a compromise, a few other members of staff had been identified as potential contacts for schoolgirl mothers/mothers-to-be if the guidance teacher or key worker was not available.

‘You’ve got to have a team approach because if you think you are the lone ranger, you’re not going to help that child at all’ (School, 20).

Another unpredictable and unavoidable problem arose with staff turnover. A change of guidance teacher or key worker could be a difficult and unhelpful situation in instances where participants found it hard to engage with the new member of staff. Additional work had to be carried out to support the transition from one guidance teacher or key worker to the next.

All guidance teachers/key workers looked at the support already in place for the schoolgirl mother/mother-to-be in terms of her learning and teaching needs and then considered anything further that might be required due to the pregnancy. Such support could be to relax punitive measures for a pregnant schoolgirl being late in the morning due to ‘morning sickness’ and/or to relinquish school uniform requirements. This is contrary to the experiences of some participants as already mentioned in Chapter Seven. The flexibility claimed in school-level policies was not always available to pupils in practice. Pregnant schoolgirls who were in S3 could potentially be working with school staff for up to three years and this allowed time for more support mechanisms to be put in place. Where schoolgirl mothers-to-be had announced their pregnancy just prior to leaving school, this had not allowed any time for school staff to work or engage with them in a meaningful way.

Other short-term actions by some staff included: arranging multi-agency review meetings; determining who needed information; reviewing the timetable; arranging toilet and/or lift passes; helping with information on benefits or Educational Maintenance Allowance (EMA); organising a ‘leaving class early pass’; carrying out risk assessments; arranging home visits (service provision) and offering support or advice on home safety; involving other agencies (i.e. child protection, social work, homeless, health); providing a place to rest; changing chairs or desks; providing cushions; making daily phone calls or calling meetings; and supplying food and water.

*Medium term support* – This level of support for pregnant schoolgirls came in a variety of formats. One member of staff commented that she had tried to prevent rumours and

gossip from spreading. Another member of staff (service provision) had helped schoolgirl mothers/mothers-to-be to deal with and manage nasty comments on social media or in public. This had helped to 'normalise' the situation for the schoolgirl mother/mother-to-be and she had learned skills to help her cope with the 'stigma'. For pregnant schoolgirls who remained in their own school, staff (service provision) provided peer support including, in particular, on how to manage the change of relationships. Providing support to manage the change of relationships had been required by the pregnant schoolgirl's peer group and in working with professionals. Managing the change of relationships could take time to develop and establish. Some support provided had been related to participants' self-esteem, wellbeing, positive decision-making, ambitions, goals, achievements so far in life, their personal development plan, sexual health, money advice, budgeting, and relationship education groups.

Support by guidance teachers/key workers is not limited to personal support. As schoolgirl mothers-to-be progressed through their pregnancy it was necessary to look at their timetables and to make further adjustments for subjects such as physical education. Preparing for forthcoming examinations was a key element of support in all schools which needed to be addressed. At times this could include arranging for examinations to be taken in a separate hall with a dedicated invigilator and nearby toilet facilities.

Medium term support from some staff could include encouraging regular weekly visits to the school nurse or arranging for the pregnant schoolgirl to go to the learning support base for a period of time if she was not feeling well. Arrangements also had to be made to allow pregnant schoolgirls to have time away from school to attend health appointments.

In contrast to this, not every schoolgirl mother/mother-to-be required support. One member of staff referred to a pregnant schoolgirl whose family were not only very supportive but were financially very able to cope with this change in circumstances. The pregnant schoolgirl herself was a very able pupil who had a university destination

already confirmed and which was waiting for her when she left school. The member of staff commented that there was very little support that the school needed to provide for this particular family.

*Longer term support* – For some staff this could involve: identifying childcare; arranging time in the nursery; involving careers officers; arranging a Young Mothers group; facilitating home education; helping with the transition to college or further education; organising swimming for the schoolgirl and her baby; ensuring educational and extra needs are met to obviate interruptions to learning; arranging enhanced curricular activities; one-to-one support; providing a separate learning base for extra study; ensuring peer support from other schoolgirl mothers; helping with a phased return to school after delivery; transferring schools; and arranging visits to a service provision or flexible learning unit.

Local authority held multi-agency meetings were attended by the schoolgirl mother-to-be, her parents and sometimes other relevant staff such as the midwife, health visitor, school nurse, guidance teacher, social worker and the person responsible for arranging childcare. The purpose of these meetings was to develop an action plan and outline the support required. This support was designed around the schoolgirl mother-to-be and what she needed at certain times during or after pregnancy. Several staff believed younger schoolgirl mothers-to-be (S3 and S4) were more likely to do what they were told by their parents rather than voice their own opinion on the support being offered.

Two members of staff from different local authorities talked about having gone out to the home of the schoolgirl mother/mother-to-be to tutor them personally or deliver work to allow her to continue with her studies. Identifying problems early on had allowed staff to arrange for help to resolve any situations rather than allowing them to escalate. Support provided by staff especially in service provisions could extend beyond school for a period of time. One member of staff talked about having to support schoolgirl mothers when the child was going into the nursery or school. This was due to judgemental attitudes being expressed by older mothers at the school gates.



Helping pupils gain qualifications is a priority for schools but some staff acknowledged that it was not the 'be all and end all' of education (School, 3). The main goals were to have a happy, healthy, resilient schoolgirl mother with the necessary life skills and a clear pathway towards a sustainable future which had support available if and when required as well as having a happy and healthy baby (School, 3). Success could mean the schoolgirl mother leaving school without qualifications but going on to a part-time college course and attending a Young Mothers group, for example, to continue being supported.

A few members of staff talked about having to help other staff support schoolgirl mothers/mothers-to-be. Frustration existed when teaching staff had been informed of the pregnancy by the schoolgirl mother-to-be but they in turn had not shared this information with those who needed to know i.e. senior management. The reasons for not sharing were due to teachers feeling they had been told in confidence and were unable to share this information. Recognition was given to the pregnant schoolgirl's right to confidentiality but there were still certain procedures such as child protection that sometimes required to be followed.

Local authorities with a service provision were able to offer a full curriculum and a holistic package of support which could include a variety of external agencies and professionals from health, social work and local community projects. These services might be offered either as part of a rolling programme within the school or schoolgirl mothers/mothers-to-be might be taken out to projects in the local area. Such services also required staff from different partner agencies to work effectively together. Programmes offered might include specific parenting programmes delivered by school staff, in the community or from other trained practitioners in the local authority. It could be argued that providing support within a school setting is less stigmatising for schoolgirl mothers/mothers-to-be rather than accessing services in the community. School plays a central and important role in the life of a young person. Providing support through the medium of school and within familiar surroundings would appear to make services more easily accessible to young mothers and to facilitate better engagement. However, by providing support in a school setting, schoolgirl

mothers/mothers-to-be may not feel that there is an element of choice for them to opt in to these services.

The role of guidance in secondary schools is a standardised procedure which as outlined in Howieson and Semple's (1996) study is a necessary and valued role. Chapter Six highlighted the importance of the relationship between school staff and schoolgirl mothers/mothers-to-be. The findings from this study are in line with those of Wilson et al (2004) whereby participants had chosen to raise issues with different members of staff. Although effective measures can be put in place by school staff to support schoolgirl mothers-to-be, there still remains the practicalities of physically being able to continue in education after the baby is born. Support provided to participants in terms of childcare is discussed later on in the chapter.

*Other Professionals* - The discussions above have looked briefly at the main contact person within schools whom schoolgirl mothers/mothers-to-be approached and their experience of this. All schools also have a range of other professionals that may not be based in the actual school building but who come into school regularly to work with pupils on a variety of matters. Schoolgirl mothers/mothers-to-be are often accused of not knowing whom to approach for help and support. If this is the case, the question has to be asked as to whether schoolgirl mothers/mothers-to-be are indeed approaching other professionals as a source of support such as the school nurse instead of a guidance teacher. Although school nurses are not based in schools full time, they are in school one day per week and run a drop-in service for all pupils.

Participants were asked in the interview whether they knew that their school had a school nurse and, if so, whether they had spoken to her about any concerns. Seven participants said they were unaware that their school had a school nurse. There is no further information from the data to explain why participants were unaware that their school had a school nurse. Twenty-four participants knew their school had a school nurse but they had not approached her even though they had been encouraged to do so. Reasons provided by participants for not approaching the school nurse varied across the local authorities. One local authority which had a service provision also

had a link midwife to whom participants could speak regarding information and advice and so they did not require to talk to the school nurse. Participants from this local authority said that they were more likely to speak to their key worker from the nursery within their school about any concerns. Another local authority had family health project midwives who have responsibility for certain groups including schoolgirl mothers. These midwives went into schools and were available for schoolgirl mothers in person and via a direct mobile telephone number as well. Other participants whose local authority took a GIRFEC approach tended not to speak to their school nurse even though the majority of them (4 of the 6 participants) knew their school had one.

Five participants whose local authority took an ad hoc approach to supporting pregnant schoolgirls advised that they had not used the services of the school nurse. For those who had spoken to the school nurse, they had found her to be an invaluable source of support. Relationships were key for these participants and they extended across both the school nurse and other professionals. Two schoolgirl mothers reported that they did not have a good relationship with their own health professionals (the doctor's surgery) and felt extremely judged by them. These two schoolgirl mothers had tended to use the school nurse where possible rather than the doctor's surgery.

A source of support open to participants whose local authority responded to schoolgirl pregnancies through a policy approach was through a specific tailored school nursing service. One member of this service had previously been a midwife and was viewed by participants as a really valuable source of support and a person for whom they had the highest respect. This school nursing service was not just valued by schoolgirl mothers/mothers-to-be but also by members of school staff as a resource and point of contact if they were unsure about anything. A member of staff from the school nursing service had attended review meetings (where appropriate) and she had been available whenever schoolgirl mothers/mothers-to-be or their parents needed information or advice.

One participant, Adrienne, discussed the open access and physical location of the school nurse's office as off-putting for her. Although Adrienne had been encouraged

to make use of the services of the school nurse she did not feel the system in place allowed her privacy.

‘I don’t like going because you have to wait up in front of people and that, I just don’t like it’ (Adrienne, 16, Individual Interview).

Chapter Three (see also Appendix 10) discussed the different Scottish Government policies relative to schoolgirl mothers/mothers-to-be. One of the policy approaches is the family nurse partnership which is an intensive home-visiting programme delivered by specially trained nurses to schoolgirl mothers/mothers-to-be. Acceptance onto the family nurse partnership programme has specific conditions whereby schoolgirl mothers-to-be must: be aged nineteen or under at their last menstrual period; have no long-term plans to relinquish care of the baby; be a first time parent; live in the agreed catchment area; and be registered no later than the 28<sup>th</sup> week of gestation (NHS Scotland, 2013). Schoolgirl mothers-to-be would still be eligible for the programme if their previous pregnancies had ended in miscarriage, termination or stillbirth. In Scotland, the family nurse partnership has been piloted in Lothian and Tayside NHS Boards. This was extended to Fife, Greater Glasgow and Clyde, Ayrshire and Arran, Highland and Lanarkshire NHS Boards over the course of 2013 and others were added during 2014. As this is a fairly recent policy approach in Scotland, it was not anticipated at the outset that there would be a large number of participants in this research who had been enrolled on the programme. The topic arose, however, during discussions and five participants mentioned that they had been allocated a family nurse and that this was the person to whom they spoke rather than the school nurse. Participants were very positive about the help and support which the family nurse provided to them. Having a family nurse was described by participants as being a good experience because she: went through everything during the ante-natal classes; helped with bathing the baby; was there every fortnight until the baby was two years of age; and because she goes to the home to see the schoolgirl mother and the baby, which reduces the need for public transport.

## *The role of health visitors in supporting schoolgirl mothers/mothers-to-be*

The following information on the role of health visitors in supporting schoolgirl mothers/mothers-to-be has come from the testimonies of the five health visitors interviewed as part of this project. Five of the fourteen NHS Boards in Scotland are represented in this research project. The processes outlined below may not reflect other NHS Boards or health visiting teams across the country. Health visitors were asked to describe their role and/or the process they followed in the life of the schoolgirl mother from the point at which they took over the caseload. Timescales for taking over caseloads and carrying out assessments are standardised across NHS Boards but the allocation of cases and quality of support is subject to variation. The following data have not been gathered before and so the information is new. The data have been collated from an individual interview with five members of staff.

A health visitor is a registered nurse or midwife who has undertaken further training and education in child health, health promotion, public health and education. The aim of the health visiting role is to improve the health and wellbeing of families and children in the crucial first few years of life, covering a specific geographical area (NHS Careers, <http://www.nhscareers.nhs.uk/explore-by-career/nursing/careers-in-nursing/health-visiting/>). Health visitors aim to prevent illness by offering practical help and advice. The role involves working in the community, often visiting people in their homes, and supporting new parents and pre-school children. There are four principles that guide and direct the role of health visiting. These are to search for health needs, create awareness of health needs, influence policies affecting health and facilitate health enhancing activities (NHS Careers, <http://www.nhscareers.nhs.uk/explore-by-career/nursing/careers-in-nursing/health-visiting/>).

Health visitors were asked in the interview about the allocation and number of caseloads they had per year in total and what percentage of these would have been schoolgirl mothers. Responses to this question about caseloads ranged from 300-400 (children and families) including between 1-20 schoolgirl mothers per year. The allocation of cases varied across the different Health Boards. Some were allocated

geographically, others pro-rata depending on how many full/part-time hours that staff worked, or depending on the overall size of the practice to which they were attached.

The process for handing over caseloads varied across Health Boards. Difficulties existed when midwives were physically located in another building from health visitors. The handover of caseloads could be carried out by telephone between the midwife and the health visitor but it could also take the form of a message left on an answering machine or a voicemail message. This was partly due in some Health Boards to the rural location of health centres. Concerns had been raised about these arrangements not being conducive to best practice but to date no plans were in place to change this despite the benefits it would bring.

Face to face meetings with midwives did not take place as a matter of course. In one Health Board, the midwives and health visitors were located in the same building and face to face discussions were carried out and followed up with written paperwork. Being physically located in the same building was not only useful in terms of the formal case handover but it was also advantageous in terms of the informal but ongoing 'conversations about caseloads' which took place on an ad hoc basis and in passing. Some health visitors (in a different Health Board) mentioned that they would be involved in conversations on a weekly basis with midwives prior to taking over the caseload. This was made easier because of the physical location in the same building.

Information shared between the midwife and the health visitor regarding a case did not vary by the age of the mother and they expected the same standard information to be provided. The type of information shared during the handover of cases was recorded on a discharge summary sheet and could include: name; background; social background; age; information about the boyfriend/partner; details about the delivery; how the schoolgirl mother presented (any concerns i.e. drugs or alcohol related issues); whether she engaged or not; ongoing care plans; details on whether other agencies/services were involved; the health of the mother and the baby; problems during the 10-14 days post-natal period; details about the schoolgirl mother's mood; how she had been feeling; information on support available for the schoolgirl mother

and what seems to be in place; the housing situation; how things were at home and whether or not they were suitable for the baby; notes about how the baby was being fed; the baby's weight; and the baby's general health and wellbeing. Additional information such as details of the schoolgirl's parents might be shared because she would be likely to be living in a house that did not belong to her personally. Other discussions could focus on whether or not the grandparent was likely to take over the role of 'mother' or whether she would allow the schoolgirl mother to do this. Relevant paperwork would then follow the conversation between the midwife and the health visitor. Copies of social work reports or child concern forms would be passed on to health visitors but this system was reliant on professionals remembering to do so.

Health visitors did not contact schools regarding schoolgirl mothers but neither did schools contact them. Social workers might contact health visitors but this would only be if there were other related problems which may or may not be to do with the schoolgirl mother's age. Social work was perceived to be the service that would link with education or schools regarding any concerns.

After the initial appointment with a midwife, a copy of the 'booking in' sheet is normally photocopied and sent to the health visitor so that they can see in advance how many new babies and families were coming onto their caseload. In practice this did not always happen due to human error. Neither did this standardised procedure take place in every Health Board. One health visitor whose local authority had a specific teenage pregnancy link midwife advised that she would be contacted direct by this person or by the doctor. All mothers, regardless of age, were transferred from the midwife's caseload to the health visitor 10-14 days after delivery. Some health visitors did see pregnant schoolgirls during the ante-natal stage and would also carry out a home visit but this was not consistent practice across NHS Boards.

Gathering as much background information as possible prior to a home visit was viewed by all health visitors as imperative. Beginning this process during the ante-natal period was intended to build relationships and provide a contact number in case they could not get access to their midwife. Grandparents-to-be were also provided

with a contact number for the health visitor in case they too had any questions. When paperwork had not been received from the midwife, this meant that on taking over a case, health visitors would be going into the initial visit without details such as complications at birth or any background information.

During the primary 10-14 day visit, health visitors carried out checks/assessments and discussed information across a range of topics. These included: the health visiting role; immunisations; registering with a doctor; health issues; sudden infant death syndrome; health/social problems; background information; the mother's health, whether she smoked or not; her level of maturity; and her ability to cope with the child. Forms such as 'family health needs' and 'family health records' had to be completed and these allowed the schoolgirl mother to identify everyday areas where she might have felt that help or support was necessary or could benefit from. Topics covered on the forms might include: financial matters; housing; any history of domestic violence; and access to health or other services. The visit was an opportunity for health visitors to see what the dynamics were within the wider family.

Generally the new grandparent was present at the first visit and health visitors would initially speak to both her and the schoolgirl mother. It was common practice for the health visitor to ask 'grannie' to leave for a few minutes so that she could have time with the schoolgirl mother herself but this was not always well-received. Schoolgirl mothers tended to be more confident about seeing the health visitor on their own after the first few visits. Where there was apprehension about the visits from the health visitor this was thought to be due to a lack of clarity of their role. Midwives in comparison had a very clear, understandable and definable role but a health visitor's was not so widely known.

None of the above procedures were specific to schoolgirl mothers but health visitors commented that they would try, typically, to see all schoolgirl mothers on a weekly basis for the first 6-8 weeks but that this was not set down in protocol anywhere. Rather, it was left to professional judgement and was dependent on the schoolgirl mother's level of need. Age and occupation were not perceived as determinants of the



level of need required or how good a parent that person would be. These weekly visits were felt to be vital to build up a relationship with the schoolgirl mother and to observe how they were managing and what support they were getting from family.

A secondary visit by the health visitor was scheduled in protocol for a 6-8 week development assessment and included using the Edinburgh Post-Natal Depression Score. Using this measure was part of a pathway that health visitors had to follow and could also be carried out ante-nataly.

These two scheduled visits were followed by a series of immunisations at 2, 3 and 4 months, 1 year, with pre-school boosters also being administered. Immunisation rates were considered to be higher when the relationship bridges had been built between the schoolgirl mother and the health visitor. Between immunisation appointments, some health visitors would endeavour to get schoolgirl mothers to attend the clinic on a fortnightly basis to familiarise them with visits to see professionals and to build up the relationship. A visit to discuss weaning the baby onto solid foods took place around week 14 and a further home visit would be scheduled around week 16. The Edinburgh Post-Natal Depression Scale would be repeated again at the weaning visit or during the week 16 visit. Health visitors were conscious that the accuracy of this score depended on the mothers' honesty. Professional judgements were, therefore, required in interpreting the results of the Edinburgh Post-Natal Depression Score.

Health visitors were keen to try to keep their pattern of working with schoolgirl mothers on the same lines as older mothers but they were also conscious that their younger age did not always imply a need or desire for more support or help from the health visitor than that required by older mothers. The schoolgirl mother's needs depended on the support that she had round about her. Communication with schoolgirl mothers was often best achieved by sending them a text rather than telephoning. Health visitors were mindful of having 'good robust tools which were evidenced based' to use for recording information (Health Visitor, 1). As professionals, health

visitors were aware that they could be held accountable and questioned about what they had observed and written regarding any mother.

Further scheduled health visiting assessments take place at 4-6 months, 12 months (including another Edinburgh Post-Natal Depression Score) and 27-30 months. Health visitors assessed the baby's walking and their speech and language to see if there were any issues. They would also observe the way the schoolgirl mother was looking, her demeanour, the way she was talking, how she dressed, her ability to sleep when she was able to, and her anxiety levels.

Health visitors across all the Health Boards talked about whether or not they should be in uniform. Non-uniform made health visitors feel more like social workers. This presented a problem as social workers were not as well-received by families as health professionals. Midwives had no problems accessing their patients or having a good relationship with them and consideration was given as to how much this was due to them being in uniform. The uniform clearly identified midwives as 'nurses' and generally people liked and trusted a nurse. Health visitors were able to recall occasions when people on their caseloads had expressed surprise because they had not appreciated that they too were nurses. This lack of knowledge generally about health visiting left health visitors feeling that there was work to be done to clarify their role and their background qualifications. This would allow people to understand that they, too, were nurses and therefore professionals who could be trusted.

Concerns existed about the intensive work and support that could take place with a family until the child turned five, when this support suddenly ceased once they had started school. Health visitors felt there was a need to continue with home visits on a monthly or three monthly basis to answer any questions. The need for school nurses to take over from health visitors at the transition stage to primary school was also raised. This did not happen nor was it likely to because the role of the school nurse and the health visitor were completely different.

Health visitors viewed their role as one of continuous assessment from the time they took over the caseload until the child turned five. This was not just for schoolgirl mothers but for all mothers. Assessments were not confined to home and clinic visits and they could take place in the community if the health visitor happened to meet the schoolgirl mother. These assessments might include: the interaction/communication between the schoolgirl mother and the baby; attendance at events such as 'Bounce and Rhyme'; generally getting out with the baby; confidence in handling the baby; safety if strapped into a car; playing with the baby; observing eye-contact between mother and baby; and whether the schoolgirl was enjoying her baby and if she was managing day-to-day matters. The data observed by the health visitor would then be recorded accordingly.

A key strength of the health visiting role was identified as being able to know family histories through the generations and subsequent connections/links in the community. This knowledge made health visitors appear to be part of the community as opposed to someone who sat in an office and did assessments. Recognition was given in the community that health visitors genuinely knew what they were going through and what they had to deal with, and this provided reassurance that someone was trying to help them rather than be a person who just asked lots of questions. For any new health visitors that did not have the background community and relationship knowledge, who then went to a home and started asking lots of questions, it appeared to some communities to be quite cheeky and 'nosey'. Resultant concerns were then aroused about professionals potentially coming in and taking the baby away from the schoolgirl mother. Talking to a perceived stranger i.e. health visitor, about issues such as feeling low in mood or feeling depressed was also not so easy and health visitors recognised that one of their key functions was initially to build relationships. These relationships, acceptance and a trust of new health visiting staff did not happen in a single visit and it required caution over every word spoken and the methods used to obtain the necessary information. Failure to do this would result in families not allowing professionals back into the home.

The relationship between health visitors and schoolgirl mothers could, in some NHS Boards, initially be distant. This was thought to be partly due to the age of the health visitor being similar to that of the schoolgirl mother's own mother and partly because it was 'a teenage thing'. In other NHS Boards, health visitors had a different experience whereby schoolgirl mothers responded better to older members of staff and this was thought to be due to their 'motherly' appearance and approach. Schoolgirl mothers were described as being 'pretty confident' in their communications with health visitors and as the relationship developed they engaged really well. Health visitors did not perceive the task of engaging schoolgirl mothers as being any more complex or difficult than that of older mothers. There were of course exceptional cases where schoolgirl mothers would not engage for different reasons but this was not believed to be linked to their age. Schoolgirl mothers normally posed appropriate questions to health visitors and not 'silly questions' (NHS Board, 3).

On occasions health visitors would not be available when schoolgirl mothers were looking for them (i.e. holidays, absence from work). During these times, other health visitors who were part of the same team would be available to help and support. Given that schoolgirl mothers were making contact with professionals and asking for their own health visitor by name, this was taken as an indication that the relationship between them was positive. Health visitors were under no illusion that mothers could tell them 'whatever they thought we wanted to know' but this was not felt to be an age-specific issue or directly linked to schoolgirl mothers. It could take between three weekly visits and three months before schoolgirl mothers started to relax in the company of health visitors and become more 'chatty'. Health visitors believed that investing in the relationship during the early stages was vital as was the need to 'give them time, not rush them and let them see that you are actually a friendly person who is kind of on their side' (NHS Board, 5).

The health visiting role was considered by the health visitors interviewed to be one in which people tended to stay for a long time and this allowed for generational relationship building. Where this was the case, the health visitor for the schoolgirl mother was often the same one that the schoolgirl's mother had. Families tended to

relax more when this was the case because the relationship had already been well-established and their role was known and understood. However, generational perceptions as passed down from parents still existed whereby the role of the health visitor was perceived to be one of checking to see if the house was clean and if the girl was managing the baby. The perception was that if this was not the case, health visitors would take the baby away. These generational perceptions could be dispelled very quickly by explaining the role of a health visitor and by sharing some personal information to demonstrate that the flow of information was not a one-way process but a two-way communication channel. Sharing personal information did not make the relationship equal as one person was acting in a professional capacity whereby judgements and decisions were being made. It did, however, allow schoolgirl mothers to understand that the professionals were there to help. Should difficult conversations then have to take place at some point in the future, these were slightly easier and better accepted. One health visitor considered what her job would look like if the building of relationships aspect were to be taken out of the role.

Once a child reaches the age of three, he/she was entitled to attend a nursery class. Nursery schools/classes had a link health visitor while primary and secondary schools had a link school nurse. Service provision units in a local authority might also have a link health visitor.

Prior to commencing primary school, health visitors handed over to the school nurse. This could take the form of a multi-agency meeting with the school nurse, midwife, schoolgirl mother and the grandparents. The handover might be a telephone conversation but this was more likely to happen when there were no specific issues or concerns. Being located in the same office or building was also an advantage in the handover process from the health visitor to the school nurse.

Part of the role of a health visitor is to signpost mothers to parenting programmes or support groups if required. The uptake on both of these varied greatly. One health visitor discussed an excellent parenting programme that was being run in the ante-natal and post-natal stages but neither got the uptake expected by the professionals. In the

same area, a different parenting programme had significant uptake and was very successful. There was no indication as to why one parenting programme had failed and the other had worked.

In addition to the parenting programmes being run in the community, some schools also ran these as part of the curriculum. Health visitors presented the offer of a parenting programme as a toolbox to schoolgirl mothers that they could use. Promotion of these programmes and encouragement to attend did, in some areas, have to compete with television programmes such as 'super-nanny'. Parenting programmes were thought to have a longstanding stigma attached to them and for this reason attendance at them was low. Geographical location and transport were two issues that further contributed to low attendance at parenting programmes and prevented schoolgirl mothers from attending. This was exacerbated when the bus on the required route only accommodated one pram and ran on an hourly timetable. Transport was an issue that schoolgirl mothers had to plan around. Getting from one place to another was not easy without their own transport. Schoolgirl mothers often had to walk a lot to reach places or had to travel by train. This was not always possible due to the distances involved and the cost.

Participants had a good experience of health visitors when they were supported and treated well by them, or where that particular member of staff had been involved with the family for many years, and when they did not receive any judgemental attitudes. Local support groups or Young Mothers groups were also successful in being able to engage schoolgirl mothers. These were made more attractive by not having a lecture style approach but instead operated by providing talks on issues which were of relevance and interest to them. Topics covered might be first aid, playing with the baby, child development and baby massage.

Health visitors believed that they could see the difference that their role had made in the lives of schoolgirl mothers but as with previous research (Baldwin, 2012), each one found it hard to evidence this. Concerns existed in some Health Boards around the introduction of the family nurse partnership and the impact that this might have on

the health visiting role. These concerns were regarding a possible erosion of the health visiting role, and a loss of expertise, skill and contact with schoolgirl mothers. Concerns over the family nurse partnership focused on the programme being very prescriptive, with small caseloads compared to that of health visitors potentially restrictive qualifying criteria, and a shorter period of time to work with the family compared to that of the health visitor. The family nurse partnership had an enhanced transition period to the health visitor and this began before the child was two years of age. Despite this, health visitors were still concerned about not having developed a relationship with the schoolgirl mother from the beginning and about the dramatic change from intensive support to the limited support that they could provide. Health visitors viewed their role as invaluable and effective because of its ability for early detection and intervention, for avoiding crisis and providing liaison with other agencies. These qualities were something that health visitors did not feel schoolgirl mothers, or any mother, could afford to be without.

One aim of this project is to provide an in-depth study of the experiences and challenges of schoolgirl mothers/mothers-to-be whilst attending school and also to reflect on the services provided by professionals such as health visitors. Participants were asked in general about their experience of health professionals but not specifically about health visitors. Twelve participants were pregnant at the time of interviews and may not all have met their allocated health visitor at that time. The remaining thirty-one participants were in different stages of working with, or having only recently met their allocated health visitor. Responses to questions about health professionals have been reflected further throughout the different chapters.

### *The value of personalisation of support*

Chapter Three outlined the different approaches taken by local authorities to support schoolgirl mothers/mothers-to-be. The wide range of Government agendas/policies provides flexibility to local authorities when interpreting and implementing these locally. While there is an argument and value in localising approaches to support schoolgirl mothers/mothers-to-be, there remains not only a tension but also a contradiction in doing so. Discussions throughout this thesis have highlighted the

advantages and disadvantages described by participants' personal experiences, of the different approaches taken by local authorities to support them.

What is clear from the findings of this research is that there is a lack of consistency of provision across local authorities. This should not be confused with the need to be flexible in order to accommodate the individual needs of schoolgirl mothers/mothers-to-be and their complex, diverse family backgrounds and circumstances. It is clear from the research findings that there is value in the personalisation of support provided to schoolgirl mothers/mothers-to-be and indeed, this is required in order to produce the most effective outcomes.

Chapter Three discussed the current legislation (Additional Support for Learning Act 2004), Equality Act 2010) which exists to support local authorities when making arrangements for the provision of suitable education at school or alternative provision for pupils including schoolgirl mothers/mothers-to-be. Not only is there value in the personalisation of support but this is under the Equality Act (2010), a legal requirement whereby schools are not permitted to discriminate against those with a protected characteristic by treating them less favourably because they are pregnant or have had a baby. Applying the same provision, criteria or practice in the same way for all pupils is, according to the Equality Act (2010), indirect discrimination. Legislation and previous research (Dawson, 2006) provides guidance to local authorities about the need and value of personalisation of support. In addition to this, previous research (Dawson, 2006) also calls for the voices of schoolgirl mothers/mothers-to-be heard in order to gain further understanding about their lives, their future aspirations and their individual needs. Valuing the personalisation of support should not be confused with a schoolgirl mother/mother-to-be's right to be autonomous. Neither would it be possible to produce a complete list of actions which staff must follow for every schoolgirl mother/mother-to-be. Rather, consistency of provision across local authorities should take the form of a basic minimum which should not preclude the offer of a full range of subjects across the curriculum and a holistic package of support which considers a nursery place, childminder and transport, being offered. This



personalisation would then allow the support to be built upon and tailored according to individual need.

### *Informal sources of support (family and friends)*

The data from the mind-map activity with schoolgirl mothers/mothers-to-be present a diverse picture of informal sources of support. Participants described their mother and father as being part of their informal sources of support but this did not necessarily imply that both parents were married and/or living together. Some participants' mothers and fathers had new partners who were also involved within their informal sources of support. One participant's father had died shortly after her baby was born and another participant's mother had also died.

Two participants were living with foster carers who played a role in providing support to the schoolgirl mother/mother-to-be. Four participants were living with their boyfriend or their boyfriend's parents but this did not alter the overall informal sources of support. Other participants lived with family members such as a grandparent or with a sibling and their family. Further information on living arrangements is provided in Appendix 1. Although living arrangements did not alter the informal sources of support to a great extent, they did influence the person whom participants first contacted for help.

Table 21 below shows the relationship of the people to the participants within their informal sources of support. Participants of all ages used a combination of these people. Each participant had her own reasons for choosing people to contact for help and support and these were dependent on individual and personal circumstances at the time.

**Table 21 - Informal sources of support**

<b>People contacted for help</b>	<b>Nos.</b>
Mum	29
Relative/family	24
Friends	21
Boyfriend/partner	17
Grandparents	17
Dad	16
Boyfriend/partner's family	8
Foster Carer	2

Despite the variety of people and professionals that schoolgirl mothers/mothers-to-be used within their formal and informal sources of support, many commented that their parents (mostly their mother) would be the first person to whom they would speak. Macvarish and Billings (2010) refer to the relationship between parents and children as being temperamental during the teenage years. With this in mind, participants were asked in the interview whether they felt comfortable talking about the relationship between themselves and their parents. Only one participant did not wish to talk about her relationship with her mother when being interviewed.

Thirteen participants described their relationship with their birth mother as having always been good. Even though there had been some disagreements while the schoolgirl was growing up, the relationship remained good and improved further after the baby was born.

‘It was good growing up. It was always just like me, my mum and my brother and we had that kind of close bond between ourselves’  
(Britney, 17, Individual Interview).

Twenty-three participants talked about their relationship with their mother (or foster carer) as being good while they were growing up, turbulent during the teenage years (albeit there were not major fallouts) and back to being good during pregnancy. This good relationship had continued after the baby was born and participants felt they were now really close to their mother.

‘It was fine growing up.....we used to always argue. I would always be nasty to her but when I found out I was pregnant....then after that we started talking a lot more and doing stuff together.....then we just got a lot closer and she helps me with everything now’ (Tessa, 15, Group Interview 11, 2 people).

There was no particular pattern from the remaining responses. Five participants did not make any comment about their relationship with their mother. Only one participant stated that her relationship with her mother was not good. This had deteriorated to the extent that the increased number of arguments during the teenage years had resulted in the relationship having broken down and both had drifted apart. The remaining participant’s mother had passed away.

A large proportion of participants did not comment about their relationship with their paternal father. For those who did make such reference, the responses varied from one extreme to the other where the father was either not in their life at all or they expressed having a good or really good relationship with him. Two participants felt the relationship with their father was slightly better than their mother. One schoolgirl mother-to-be explained that her father had not been in her life until recently but that they had been reunited and were working on their relationship.

‘My dad left when I was three months old because he was addicted to drugs and alcohol. He was a young guy so he could not handle a kid and keeping up with his addictions so he left and I didn’t hear a word from him for fifteen years’ (Rhiannon, 17, Individual Interview).

#### *Type of help requested, reasons for choice of professionals and people*

After listing the people they would normally approach for help from professionals, family or friends, participants were asked in the interview to write down the kind of help they might request from these individuals. The responses to this question were then discussed in more detail. The two participants aged fourteen who were pregnant at the time of interview advised that they had only requested advice from professionals about their pregnancy and financial help from family. It could be argued that these two participants were still in the early stages of pregnancy and so their need for help in a wider range of areas was less.

Participants in the age bracket 15-17 listed a much wider range of issues for which they had requested help. From professionals, participants requested: advice on pregnancy or health (their own and that of the baby during/after delivery); general advice about the baby; and school issues. From family and friends, participants requested help regarding: housing; social issues; diet; transport; money; advice; the need for someone to talk to, who would also listen; seeking someone to provide company; seeking opinions; obtaining practical advice; support including emotional support; childcare; baby equipment; baby clothes; love; help with the baby; school; shopping and family issues.

The three participants who were aged eighteen commented that they had asked for help from professionals on their own health, that of the baby and school issues. From family and friends these participants had requested: help with babysitting; transport; money; and help in finding someone to listen and to provide opinions or comments on issues as and when they arose. It could be argued that these participants required help in fewer areas because they were older, had some knowledge, were more mature and established emotionally, whilst already being more independent, self-sufficient and less dependent on others.

After identifying a list of people whom participants had approached for help and the type of help requested, the final part of this exercise was for participants to consider the reasons why they had chosen these particular people. Participants gave multiple reasons across their choices and although common themes did emerge from the data these did not pertain to any one professional or person. The reasons were not specific to the age of the participant nor the approach taken by the local authority to support them. Each reason was directly connected and attached to the professional or individual which the participant identified. Participants were not given a pre-prepared list of reasons or characteristics but a free flowing conversation did take place.

The most common theme which participants highlighted as their reason for choosing specific people to help them was trust. Trust is viewed as being an essential component of all social relationships and something which is 'rooted in fundamental

indeterminacy' (Seligman, 1997). Seligman believes that trust is predicted on the development of stable relations of mutual trust between people. Yet difficulties exist when one person is more vulnerable than the other and they must allow themselves to be 'exposed' to the other in the hope that they will not be taken advantage of by being open about personal situations (Seligman, 1997).

Seligman further defines trust as being based on commonly shared norms and something which arises when a community shares a set of moral values. For Seligman, while trust remains vital in interpersonal relations, participation in functional systems such as the economy or politics requires confidence, rather than trust. Participants had placed a lot of trust in the people that they approached for help but they also had a great deal of confidence in the 'system', arguably the 'school system' and the 'role of professionals'. This confidence was formed through different means such as the reliability of information provided, obtaining straight answers to questions posed and the personal knowledge that person had of the participant. It also stemmed from knowing that all information would be kept confidential where possible.

'There is a lot of trust in them and I know what they are going to tell me isn't crap really. They will tell me straight. Like my social worker, if I had a question and it was a silly question she would tell me the answer straightaway. She would not give us all this crap first and another story, she'd get straight to the point with it. My health visitor she just tells me everything that I need to know' (Elise, 15, Individual Interview).

Collins Dictionary (2003) offers multiple definitions of the word 'trust' and these include: honesty, safety and reliability, entrusted with important information, to believe in someone, to believe someone's account or story, to expect, hope, have confidence in the truth and obligation. While participants did not specifically allude to all the definitions of trust, their responses made reference to many of them.

'Well I trust both of them but it just feels like because they are so close no matter, I could turn round and say something totally stupid and they would not laugh' (Lauren, 16, Individual Interview).

Previous research by Highet and Jamieson (2007) discusses those whom young people feel comfortable talking to. The study highlighted the importance that young people placed on the issue of trust and confidentiality when confiding in a person. Having someone outwith the family who could be trusted but who would listen was an attractive idea.

Individual characteristics and traits of people within a source of support were important to participants. The ability of others to make themselves available to listen to participants without making judgements was vital. Talking to people was, for a small number of participants, easier if the person (maybe a friend) was similar in age. Reassurance was found in the knowledge that participants could go to people within their network, ask for help and have confidence that they would help.

‘Sometimes I would probably go to my friend. Obviously because she is the same age as me and I’d find it easier to talk to her’ (Gabrielle, 16, Individual Interview).

Participants did not always find people (professionals or otherwise) easy to talk to and, consequently when someone was found with whom they were comfortable, it was easier to talk to them regardless of the difficulty of the subject matter.

‘I think she is the easiest to talk to, easiest to tell somebody something rather than a teacher that you’ve not really spoken to and you’re going to tell them that you’re pregnant’ (Britney, 17, Individual Interview).

Although it could be assumed that having a close relationship with someone was important before a person could feel sufficiently comfortable to talk to them, this was not always the case. One participant found it easier to talk to people she did not know when looking for support.

‘I feel like I can talk to them about how I feel and all that....I think its cause.....I don’t really know them that well, I can talk to people that I don’t know’ (Alexis, 17, Individual Interview).

In addition to those providing a source of support taking the time to listen, participants chose people whom they felt were helpful, and whom they liked and thought were really 'nice'. Having a person to talk to was really important to many participants and when it was not available, there seemed to be an emptiness and longing for it. Rochelle explained that a lot of her relatives had passed away and she did not have any aunts or uncles with whom to talk. Occasions did arise when she could speak to her mother about certain issues but there were other matters that she did not feel comfortable discussing. Rochelle's comments about being reluctant to discuss issues with a parent are also echoed in Hight and Jamieson's (2007) study. As some of Rochelle's issues were not school related she did not feel it was appropriate to share these with her guidance teacher nor was it a matter to be discussed with a health professional.

Two participants had chosen a mix of professionals and family members as their sources of support. Their reasons for choosing these people were that they were 'the only people who would do it' or who were physically there and available. Other people within their sources of support were chosen because of the practical and solution-focused approach that they provided.

'I think they would listen more than a stranger would. I know a stranger would listen but I think people more close to you listen to what you've got to say and support you if you needed help or try and find a solution for your problems' (Britney, 17, Individual Interview).

Participants were attracted to the people among their sources of support for a variety of different reasons. These cut across a wide range of areas such as: ability; strength of character; trustworthiness; truthfulness; personal attributes and values. It would appear that there was no reciprocal relationship whereby participants would as Sahlins (1972) states be willing 'to give for that which is received' (p158). Those who have better resources are better equipped to take part in and trade services as they have more to contribute (Hansen, 2005). Schoolgirl mothers/mothers-to-be without resources can be restricted in using these interdependent relationships as they may have little to contribute in terms of reciprocity. The choice of people within their sources of support were, therefore, based on a set of principles other than reciprocity.

### *Other sources of help*

During the interviews, participants were asked where they would go, or what else they would do, if they could not get help from the people they had listed in their formal and informal sources of support. Responses to this question varied as each participant had her own thoughts about which particular aspect of help or support she might potentially need help with.

Six participants (aged 14-16) said that they felt very confident in the existing people they had listed as their means of support and would not need to seek help outside this network. Being able to think of any other support outwith this circle was quite difficult for these particular schoolgirl mothers/mothers-to-be. This was not due to a lack of knowledge about other potential sources of support but, rather, because the participants viewed their networks as being capable of meeting any needs or answering any questions they might have. Alternatively, they would know whom to contact for help. These sources of support excluded any potential medical problems. However, family members (usually the schoolgirl's mother) were the first point of contact and source of support regardless of the issue.

Sourcing help and support for three participants (aged 14, 15, 17) appeared to refer specifically to childcare when asked where they would go to or what else they would do if they needed help. Their response to this question was that they would forget about where they had originally planned to go and would stay in and get on with other things. For these three participants, as with the above group, family members were identified as a first point of contact.

Over a third of the participants (37%) across the different age ranges of 15-18 years old responded very quickly that they would source information via the internet search engine 'Google' if their sources of support could not help. For these participants, 'Google' was perceived to be the gateway not just to every answer, no matter what the question, but also to a very wide range of potential answers. Collating an extensive range of opinions and answers from different people and sources was really important for many participants. Decisions regarding any problems were only made after



obtaining this wide range of opinions which then enabled them to make an informed choice.

The vast array of online perspectives and opinions was particularly important for one participant and she used it to answer a variety of her questions. This participant also used the internet to try to 'self-diagnose' potential health problems because she did not like asking awkward and 'silly' questions to a professional in the first instance. The confidentiality and anonymity aspects of searching for information on the internet was also an appealing attribute as it provided reassurance that the questions would not be repeated to anyone else. Some dubiety existed for another participant on the authenticity, trustworthiness and dependability of potential responses from the internet but it seemed the only alternative option she had outside of her sources of support. In any case, this participant had confidence that her sources of support would definitely be able to help in the first instance. Internet responses provided some reassurance and confirmation regarding the information being offered by those in this participant's network and sources of support.

Obtaining information and help through an online baby forum or social media was viewed by two other participants as being really useful because the people online were in a similar situation. Talking to these parents online was easier not only because they were strangers but also due to the entirely objective opinion they provided given their remoteness from the situation and family circumstances.

Only a small proportion of participants (3 in total) (aged 15-17) did not know or comment on where else they would seek help if they had to go outside their sources of support. Two of these participants had not been in that situation because the people within their network (generally parents) had always been able to provide the help and support required. These participants described family as being their first point of contact for help and advice.

Contacting professionals such as a social worker, family nurse, staff at school/nursery or the doctor in the first instance was attractive to six participants (aged 15-17).

Placing trust in the internet was not so attractive for these participants and they preferred to talk face to face with a professional. Four participants commented that family was their first point of contact for advice and support, whilst another commented that she preferred to seek multiple opinions in her search for help.

Other schoolgirl mothers/mothers-to-be (either the same age or older) were viewed by participants as being a good source of support in regard to issues surrounding the baby, both during and after pregnancy. Sometimes this could be schoolgirl mothers/mothers-to-be who were in the same school, service provision, flexible learning unit or Young Mothers group. The advice and opinions of other schoolgirl mothers/mothers-to-be were valued more highly by each other than those of friends (or their peer group) because of their experience in having had or about to have a baby. Good friends of the same age were perceived by some participants as 'not knowing what they were talking about' or as being too immature and so the views of other schoolgirl mothers/mothers-to-be received more respect and were of greater value. Support and advice from friends, meanwhile was appreciated in other areas such as relationships or emotional help.

Family was, for many participants, viewed as being a first point of contact for help and support. Reasons given for this varied but included the family being viewed in higher esteem because they had lived through the experience (sometimes a similar experience) and because they had been through so many other issues in their own lives. This was in comparison to professionals who possibly had not personally lived through a similar situation and could only offer their best advice rather than professional advice based on experience.

Obtaining support from other sources was for two participants something which had to be sought out rather than a form of help which would automatically come to them. These two participants viewed it as their role to go and seek help by speaking to somebody who would be knowledgeable and this would, in turn, lead them eventually to find an answer. This meant that family was not always the first point of contact.

Only one participant did not view herself as being the type of person to seek help and support from others. This was not because of a lack of confidence or knowledge about whom to approach but rather because she did not want to 'bother anyone'. Instead, this participant stated that she kept everything to herself and worried about it. This did not include having to seek medical advice. Any information and advice that this participant did seek from others, required to be clarified by a professional such as a social worker to satisfy her that it was correct. More trust was placed in professionals (mostly medical) than other people, including her own family.

All participants were asked whether anyone else within their family had been a schoolgirl mother. Those who responded positively to this question were then asked whether this had been a source of support to them and if it had helped in any way. Thirty-five participants responded that they had at least one member of their immediate family who had been a schoolgirl mother. Seven participants said they had been the first schoolgirl mother in their family and one did not comment.

Seven participants advised that only their mother had had a baby during her teenage years. The remaining twenty-eight participants commented that there had been more than one schoolgirl mother (including themselves) within their family. These relatives were either sisters, aunts, grandmothers or cousins. Approximately half of the participants involved in this study were aged fourteen or fifteen when they had had their baby and the other half were aged sixteen to eighteen. The majority of relatives had been either the same age as participants (or older) when they had their baby. Only a small number advised that their relatives had been one or two years younger than them when they had had their baby.

Twenty of the thirty-five participants whose relatives were schoolgirl mothers, advised that they were a particularly good source of support. Being a second or third generation schoolgirl mother was viewed as an advantage because it was not a new experience or a shock to the family. Coping mechanisms had already been tested, tried and established through the generations, albeit life was now different compared to previous times. The remaining fifteen participants felt that having a relative who was

a schoolgirl mother had either helped a little or not at all. One participant stated that the information she had received from her relative had had the opposite effect and, instead of helping her, it had frightened her slightly about what she might encounter in the future.

The support from relatives, as described by the participants, covered a range of topics. Some of the topics covered were in relation to the different stages of pregnancy, labour and early motherhood. This support had come in the format of ongoing information and advice during these three stages. The information had been valued for many reasons including simply being able to have someone there to talk to about concerns as and when they arose. One participant commented that she had found it easier to tell her mother that she was pregnant and to talk to her afterwards. Any advice and information from parents or relatives had been regarded as more reputable and attractive because they had personally been through the same situation. Some family members had had two babies during their teenage years. Information and advice to participants was not imparted all at once but on a 'drip feed' basis, as and when help was asked for.

Participants talked about having had discussions with their family and relatives about potentially negative responses to their pregnancy from others and in particular, what to expect along with possible options for the future. Being able to talk these through had not only helped to prepare participants psychologically for future comments from others but had also provided them with practical suggestions and support on how to cope with negative responses. Reassurance had been given by family members to participants that things would be difficult for a while, that they might feel as if they were on a daily 'emotional rollercoaster' where some days would be better than others, their ability to cope might fluctuate but everything would be alright.

Opinions and views sought from family members and relatives by participants were not necessarily sought in order to get someone to take their side but rather to get an objective perspective from someone they trusted but who was also slightly distanced from the situation. These opinions were highly valued by participants for this reason

and also because they felt that their relatives had matured in age and experience. The schoolgirl mothers' grandparents were on occasion viewed as being a trustworthy and dependable source of information, advice and support not least because they were slightly removed from the close proximity of the situation and would provide an objective opinion. Talking to grandparents was often perceived to be easier than talking to mothers. For a small minority of participants their mother or father was either not in their life at that time or had passed away. Grandparents were therefore the closest alternative to parents.

Emotional support from family extended to cover boyfriend problems. For one schoolgirl mother, her boyfriend had not wanted anything to do with her or the baby when she had told him she was pregnant. On talking this through with her mother, she had found that her own father's initial reaction to the news about their pregnancy had been that he too did not want anything to do with it. The father of this schoolgirl mother-to-be had later come to terms with the pregnancy, had got a job, and a house, and they had all been a family unit since then. This particular schoolgirl mother-to-be gained empathy and emotional support from her mother.

In one case, emotional support came in a slightly negative form where a close relative, who had been a schoolgirl mother, started to cry when she found out this participant was pregnant. This negative reaction had quite an impact and had caused shock to the participant even though she knew it was unintentional. The relative explained that she had been upset because she had not wanted her to go through everything that she had gone through as a schoolgirl mother. Although this response to the news about her pregnancy had not angered or annoyed the participant, she had felt it had really hit home the message about the potential difficulties and hard times ahead.

Practical suggestions and support were given to participants from family members. A few participants commented that they were encouraged to take responsibility for their baby and not let others take over. Allowing others to care for the baby and do everything would result in them, as the baby's mother, not learning but also not feeling that it was their child. One participant commented that advice given to her had been

that the ability to cope with a baby was not dependent on age. It depended on whether she could deal with the baby crying, and whether she could change its nappy and feed it. If she could cope with all these, then she would be able to manage.

Support was not always in the form of practical advice, information or emotional and psychological help. For many participants, support came in the form of role modelling. Seeing family members coping with a baby and continuing in education or higher education then moving on to employment was not only reassuring but, indeed, inspirational. Understanding the potential difficulties, being provided with support mechanisms and realising that it was ‘not the end of one’s life’ confirmed the path ahead that participants wanted to take and instilled a new determination in them to succeed. The support provided to the young mother to help her continue in education, in the form of role modelling, was backed by practical help in providing childcare.

### **8.3 Conclusion**

This chapter has drawn on the accounts of participants to explore the sources of support that schoolgirl mothers/mothers-to-be had identified were available to them while continuing in education. Where relevant, data from school staff and health visitors have also been included to provide insight into the support available to schoolgirl mothers/mothers-to-be. The four topic areas discussed were ‘formal sources of support’, ‘informal sources of support’, ‘type of help requested, reasons for choice of professionals and people’, and ‘other sources of help’.

A large number of participants had contacted their key worker, guidance teacher, health visitor or midwife for support during their pregnancy and the early stages of motherhood. Within school, the key worker or guidance teacher had been the main contact person for participants who lived in the local authorities which had a service provision. The majority of participants valued having a key worker or guidance teacher as a main point of contact for themselves and their family although a minority thought that it had singled them out a little. Participants in other local authorities described different teaching staff whom they had used as a main contact person.

The support that school staff provided to schoolgirl mothers/mothers-to-be was described as representing different levels of intensity throughout pregnancy and after participants returned to education. These fell into three categories of short, medium or longer term support and extended across a variety of topics including arranging meetings, providing practical support, providing tuition, changing timetables, helping participants to manage relationships, and organising childcare and transport. School staff on occasion, had had to help colleagues as well as participants on how to support pregnant schoolgirls.

A large number of participants knew their school had a school nurse but they had not approached her. Those who had approached the school nurse had valued this relationship and the support she had provided. The role of the family nurse partnership was also valued by all the participants who had been allocated this service.

There is no standardised procedure for midwives to hand over their caseloads to health visitors regardless of the age of the mother. Caseload handovers might involve the transferring of files and paperwork, or a telephone conversation, or a message left on an answering machine but rarely a face-to-face discussion. The information shared during the caseload handover did not differ for schoolgirl mothers as compared to other mothers who were not schoolgirls. Health visitors had not contacted school staff regarding the schoolgirl mothers on their caseload.

Participants had described their parents as the first people they would initially speak to for help. Relationships between the participant and her mother had, in some instances always been good. Other participants described their relationship with their mothers as being good while they had been growing up, turbulent during the teenage years and then good or really close once again from pregnancy onwards. The majority of participants did not comment about the relationship they had had with their father.

Participants aged 15-17 requested more help from professionals and family or friends than those in any other age range. Schoolgirl mothers/mothers-to-be in this age range had asked professionals for advice about their pregnancy, the baby or school related

matters. The type of help and support requested from family had ranged across wider areas such as housing, money, seeking someone to talk to, seeking practical and/or emotional support, love, school and family issues. Participants had required support from professionals, family members and their friends which was specifically tailored to their needs. The data from this project show that support for schoolgirl mothers/mothers-to-be needs to be sustained over a long period of time while the young mother is continuing in education and in some cases, beyond this timescale, rather than a one-off intervention of support.

It is unclear from the data how participants arrived at their decision regarding which professionals they should approach for support. The quality of relationship and empathy would appear to be key in participants' decision-making process in this regard. Some participants had not felt properly supported or cared for during pregnancy nor during the early stages of motherhood, by health staff. This was attributed by participants to the judgemental attitudes they received from health professionals. Such responses seem to have influenced participants' decisions when considering whom to approach for support.

Trust was the main reason that participants gave for approaching people within their informal sources of support. Participants did not expand on their thoughts about trust or where this had emerged from but it was prevalent throughout all responses.

A minority of participants felt confident in the existing people within their network and did not think they had required additional help outwith. The internet was identified by several participants as an extremely valuable source of information because of the extensive opinions it had presented and the range of data available from which they could make an informed choice. Some participants viewed other schoolgirl mothers/mothers-to-be as a good source of support. Overall and without exception, schoolgirl mothers/mothers-to-be had described family members as their first point of contact for help and support during pregnancy and the early days of motherhood.



## CHAPTER 9

### CONCLUSION

‘It is about us as a community wrapping ourselves round these youngsters and them feeling like they have got opportunities to go to places’.

(School, 3)

#### 9.1 Introduction

This concluding chapter draws together the substantive findings which have been presented in Chapters Five to Eight and situates these in the literature that was identified at the outset of the study. The chapter begins with an overview of the study before going on to discuss the deficit model characterising schoolgirl mothers/mothers-to-be and to critically assess the existing research literature. In section 9.3, data from the questionnaires and interviews with research participants, school staff and health visitors are used to address the three research questions.

The aim of this study is to answer the question ‘What experiences and challenges do Schoolgirl Mothers/Mothers-to-be face when continuing in education?’ The existing literature on the experiences and challenges of schoolgirl mothers/mothers-to-be when continuing in education is limited and the voice of schoolgirl mothers/mothers-to-be is missing in research and Government agendas/policies. Furthermore, the need for research on the role of professionals in supporting schoolgirl mothers/mothers-to-be and their influence has already been highlighted by some academics (Macvarish and Billings, 2007). This study has focused on the experiences of schoolgirl mothers/mothers-to-be and the way these are shaped by the social organisation of schooling as well as interacting policies and practices aimed at young mothers. Additionally, the study has considered the role of health and education professionals in the life of a schoolgirl mother/mother-to-be. By doing so, the study contributes to the existing research within sociology but also adds to social policy and education policy literature.

Policies have been produced by the Scottish Government to address health, education and socio-economic inequalities. It was important at the outset of this study to explore the range of policies which refer to schoolgirl mothers/mothers-to-be with a view to identifying any potential areas for future development. In order to meet the research objective, it was necessary to carry out a review across all thirty-two local authorities in Scotland to obtain data on the different approaches taken to support schoolgirl mothers/mothers-to-be while continuing in education and to consider the advantages and disadvantages of these.

Forty-three schoolgirl mothers/mothers-to-be participated in this research. Participants attended schools within eleven local authorities across Scotland. Prior to the interview, participants were given a questionnaire to complete. An individual or group interview was held with participants and a follow-up interview was carried out 9-12 months later. Twenty-nine schools or alternative provisions were included in this research. An interview was held with seventeen members of staff from schools or an alternative provision that participants attended. Five health visitors from five NHS Boards across Scotland (that the identified local authorities fell within) were also interviewed.

## **9.2 Deficit model characterising schoolgirl mothers/mothers-to-be**

In Chapter Five the deficit model characterising schoolgirl mothers/mothers-to-be and the existing research literature was discussed. Assumptions surrounding schoolgirl mothers/mothers-to-be were: lack of knowledge about sexual activity and contraception; health outcomes; maturity and confidence; poverty and financial dependency.

The experiences of participants in this study often did not fit with the deficit model that characterises schoolgirl mothers/mothers-to-be in popular accounts about young mothers. Similar to previous studies, schoolgirl mothers/mothers-to-be did not plan their pregnancy. Contrary to Macvarish and Billing's (2010) study the majority of participants did not connect their unplanned pregnancy to a lack of knowledge about

sexual activity and contraception although participants who attended a Catholic school did highlight the need for information on sexual activity and contraception to be allowed into their school. The evidence from schoolgirl mothers/mothers-to-be suggest that the quality of information on sexual activity and contraception is not yet provided consistently for all pupils regardless of which type of school they attend in Scotland. It also suggests that this is not a main reason for teenage pregnancy. These findings concur with Duncan et al's (2010) study in that there is insufficient evidence to suggest a lack of knowledge causes pregnancy or increased knowledge prevents it.

Participants were generally healthy, they had healthy babies, and positive relationships with health professionals. From the accounts of participants (including those with concealed pregnancies), the experience of ante-natal care was enjoyed and valued. Babies born to schoolgirl mothers/mothers-to-be in this study generally had really good birth weights. Health visitors confirmed that babies born to young mothers normally have good birth weights and that what happens in practice now, differs to previous research. These findings challenge suggestions by Arai (2009) and Daguerre and Nativel (2006) that adverse outcomes for young mothers are linked with a lack of ante-natal care. Given the improvement in maternal and child health as acknowledged by UNICEF (2013), further research is required on whether the health outcomes of schoolgirl mothers and their babies is changing. If the Scottish Government's aim is to engage with families who are at a higher risk of poor outcomes as stated in the 'Framework for Maternity Services in Scotland' (2011), the delivery of ante-natal care could be taken to where young mothers are located (schools), rather than simply 'strengthening ante-natal care'.

The discourse on teenage pregnancy suggests that being young and a mother is a bad combination for mental health. The testimonies of participants in this research indicate that background family circumstances and the responses received to the news about their pregnancy impact the mental health outcomes of schoolgirl mothers/mothers-to-be. These findings are opposed to Macvarish and Billing's (2010) study which suggests schoolgirl mothers/mothers-to-be are 'naturally' more prone to post-natal depression because of their age. In terms of participants' competency to be a mother,

the findings did not highlight any distinctive difficulties which are not already discussed in existing motherhood literature.

Practitioners who work with young mothers require further understanding of the experiences and challenges they face. The review of local authority policies and discussions with practitioners in this study indicates that a lack of knowledge of the experiences and challenges of schoolgirl mothers/mothers-to-be has at times unintentionally exacerbated difficulties in their situation especially in terms of their mental health. Through an in-depth knowledge of young mothers' experiences and challenges, practitioners can begin to build relationships with them. Research participants approached professionals they felt able to talk to and who they thought would understand their situation. Positive engagement with schoolgirl mothers/mothers-to-be is not always sufficient on its own without understanding their experiences and challenges, and can be counterproductive. Achieving improved mental health outcomes and targets for schoolgirl mothers/mothers-to-be may be more successful for the Scottish Government if professionals have the necessary skills to help them support this vulnerable group.

This study did not find any single or standard means or life experience which participants felt contributed to them attaining sufficient capacities and competencies to feel confident effective adults. Judging the maturity or confidence levels of participants prior to becoming pregnant or the process and pace of change is not possible. From participants' testimonies, increased confidence and maturity for them started in pregnancy and took place unconsciously step-by-step. This coincides with Christensen and James' (2008) comments that children and young people are on a journey to 'mature, rational, responsible, autonomous, adult competence' (p15).

No participant in this study, expressed regret about having a baby but rather the majority talked in the interviews about how it had positively influenced and changed the direction of their life. Becoming a mother resulted in some participants taking school and their education more seriously even though they had to overcome disruptions and difficulties while on their journey. A motivating factor for participants

to continue in education and obtain a good job was to avoid being accused of being dependent on benefits. If pregnancy amongst schoolgirls increases the desire for educational qualifications and employment opportunities, then this presents an opportunity for the Scottish Government and professionals to take advantage of this motivation to raise attainment, improve training and employment opportunities, potentially reduce poverty and break the cycle of deprivation.

### **9.3 Research questions**

*What experiences and challenges do schoolgirl mothers and mothers-to-be (aged 18 and under) living in Scotland face when continuing in education?*

Chapter Six considered participants' reflections about their educational experiences in school before becoming pregnant, experiences of 'coming out' as pregnant, the people and professionals they approached and their reactions to the pregnancy. Lastly, the chapter discussed participants' (dis)engagement with education and the impacts of deviating from 'normative pathways'.

Data from the interviews indicates that contrary to a key finding in Alldred and David's (2007) study, research participants did not have a bad school experience before becoming pregnant. Many participants had a 'really good' or 'good' school attendance and pregnancy was not an escape route away from a negative experience of life and school. These findings differ from studies by Cater and Coleman (2006) and Hosie and Selman (2006). Participants were 'distracted' by different family circumstances rather than 'disengaged' from education. Only by fully understanding the distractions can progress be made to provide effective support to schoolgirl mothers/mothers-to-be while they continue in education.

Schoolgirl mothers/mothers-to-be faced difficult decisions after finding out they were pregnant. Family members urged participants to continue with their pregnancy while some professionals promoted termination as an option. From the data, schoolgirl mothers-to-be came to their own decision about the pregnancy and very often this was

influenced by the ante-natal scan. Good practice for professionals would be to provide information and advice to pregnant schoolgirls on all options available and allow them to come to their own decision.

The data from the interviews with participants suggests that schoolgirl mothers/mothers-to-be made a purposeful choice about which professional to approach for help regarding their pregnancy but it does not indicate any consistent theme over why certain professionals were chosen over another. From the interview data, individual and personal choices about professionals were made by participants based on an 'expectation of reaction'. Unsupportive, judgemental and inflexible approaches along with a lack of practical help discouraged participants from continuing in education. Added stress was placed on participants when teaching staff did not make any comment to the news about their pregnancy and when they had to manage their own information regarding their pregnancy. The findings in Hosie's (2007) study suggests that young mothers are less likely to access professional services. From participants' accounts, judgemental attitudes may have influenced which health professionals were approached and their decision to actually access professional services.

Data from the interviews provides information on the experiences and challenges participants encountered during pregnancy and early motherhood which at times made it difficult to continue in education. Chapter Seven explored participants' health challenges during the first trimester of pregnancy, emerging practical difficulties of continuing at school during pregnancy, participants feelings about returning to education and challenges over childcare. Morning sickness was a significant challenge for participants at school and greater flexibility in timetabling, freedom of movement and consumption of food and drink are required for pregnant schoolgirls if they are to overcome this challenge.

Many pregnant schoolgirls talked during the interviews about having to wear school uniform during pregnancy even though this was not practically possible, financially viable or in compliance with the Equality Act (2010). The enforcement of school

uniform came at a time when some schoolgirl mothers-to-be were already emotionally struggling with their changing and growing body shape and image during the second and third trimesters of pregnancy (Thomson et al, 2011). Education practitioners require further information about the Equality Act (2010) and they should ensure that alternative arrangements regarding school uniform are made for pregnant schoolgirls.

Different, inconsistent transport arrangements were put in place by staff in schools for schoolgirl mothers/mothers-to-be across Scotland. Many participants were not offered transport assistance of any kind. Participants described a range of difficulties in trying to get to school during pregnancy and the early stages of motherhood. The attendance and attainment of schoolgirl mothers/mothers-to-be at school could be improved if transport was provided to allow them to more easily continue in education. The Scottish Government has provided the necessary legislation such as the Additional Support for Learning Act (2004, 2009) and the Equality Act (2010) to support local authorities in making arrangements for the provision of suitable education at school or alternative provision, for schoolgirl mothers/mothers-to-be. Local authorities are not applying this legislation consistently and therefore schoolgirl mothers/mothers-to-be across Scotland are receiving a patchy service which has resulted in reduced opportunities to gain qualifications and continue in education.

The age and design of school buildings made it difficult for some participants to continue in education during pregnancy. This combined with the volume of pupils in school contributed to participants feeling unsafe in the crowds. Pregnant schoolgirls were not consistently provided with a lift key and this made movements between classes more difficult. The layout of the school building made it challenging for participants to access toilet facilities quickly. This was exacerbated when teachers had not been informed that a schoolgirl was pregnant and so they were reluctant to let them out of class.

Returning to school one week after delivery was emotionally challenging for schoolgirl mothers as they had to leave their baby with someone else. Having available and suitable childcare was difficult for several participants when returning to

education. Although school was a familiar routine, returning after having a baby was hard as participants had to get themselves and the baby ready and be at school on time. Schoolgirl mothers were unable to breastfeed their baby during the early stages of motherhood. Many participants returned to school quickly and the organisation of the school environment did not facilitate breastfeeding neither were babies located within the school building.

Changing schools was a positive experience for some participants but daunting for others. Reactions from participants' peer group to their pregnancy either made the decision to move school easier or more difficult. Being pregnant at school altered the relationship between some participants and their peer group. More interest and attention was given to the unborn baby than the pregnant schoolgirl. Many participants experienced a loss of eye-contact with their peer group and this provoked feelings of annoyance and frustration at the loss of friendship and support. Additionally, participants who moved schools generally struggled with the loss of 'connectedness' and familiarity of their previous school environment.

The emotional demands along with the experiences and challenges that participants outlined above are far removed from suggestions in Hosie and Selman's (2006) study that schoolgirl mothers/mothers-to-be make a choice to 'drop out' of school. Instead the evidence from this research strongly highlights participants' struggle to manage the conflicting legal demand to remain in education versus the emotional demand and responsibilities as a parent to care for their baby. The decision to return to school might be easier for schoolgirl mothers if alterations (relaxing school uniform, easier toilet access, providing a lift key) and provisions (childcare and transport) were made.

*What are the different approaches taken by local authorities in supporting schoolgirl mothers/mothers-to-be whilst at school?*

A significant proportion of local authorities did not have a policy in place regarding schoolgirl mothers/mothers-to-be. The review of approaches revealed that staff in many schools responded to schoolgirl pregnancies on an ad hoc basis. The lack of a



protocol caused concern amongst some staff as there was the potential for inconsistency when providing support or to forget about procedures that had to be followed. Alternatively, having a policy document did not always provide sufficient flexibility to be able to treat each case individually. 'Getting it right for every child' (GIRFEC) provided the opportunity to consider a young person's needs holistically but this approach was not sufficient without funding to provide childcare assistance and transport costs. Practice across local authorities varied greatly and schoolgirl mothers/mothers-to-be could experience very different levels of being supported or were lacking support.

Part-time timetables were used in many local authorities as a means of supporting schoolgirl mothers/mothers-to-be to continue in education. Continuing with the maximum number of course subjects during pregnancy or after having a baby was difficult and participants welcomed a reduced timetable. Study time was built into some participants' timetable but this was not everyone's experience. Participants who did have study time had the advantage of being able to spend the rest of the evening with their baby rather than trying to complete homework and care for the baby.

Transport assistance was not provided in every local authority for schoolgirl mothers/mothers-to-be. Schools within the service provision approach provided transport for the schoolgirl mother and her baby. One participant whose local authority took a GIRFEC approach was receiving transport but this was not consistent across the same local authority or in another local authority with the same approach.

Childcare assistance was provided for participants in the local authorities that took a service provision approach. A further two participants (GIRFEC and Policy approach) talked about receiving childcare assistance but this was not consistent across participants in the same local authorities. Participants in the service provision approach valued having a member of staff in the nursery who was dedicated to them and was a good source of support on a daily basis.

Some participants were offered the option of attending a flexible learning unit or staying in their own school. Childcare assistance was not provided for these participants but they were transported to and from the unit. Flexible learning units were not consistently viewed as being as much fun or interactive compared to school. It was not possible to do proper group work in the flexible learning units because of the smaller number of pupils. One participant who stayed in her own school was unable to get a baby place in the local nursery because of the age restriction at the time of intake (child had to be at least one year old) and she had to find alternative childcare arrangements to allow her to continue in education.

Links between school staff and other services such as health were viewed as a particular strength to help support schoolgirl mothers/mothers-to-be. External partner agencies could be used to provide parenting programmes or support for schoolgirl mothers/mothers-to-be when continuing in education. External agencies offered support to schoolgirl mothers after they left school.

Staff in the four different approaches taken by local authorities often felt frustrated about the limited resources they had in terms of time and being able to sufficiently address the needs or be able to fully follow through on their pupils who were schoolgirl mothers/mothers-to-be. School staff would have liked to be more flexible with timetables and have more access to colleges and work experience.

*How do education and health professionals (school staff, health visitors) in schools and the National Health Service (NHS) support schoolgirl mothers/mothers-to-be while continuing in education during pregnancy and the early stages of motherhood?*

All participants were allocated a main contact person within school depending on their personal preference, their involvement with other agencies (i.e. social work) or the member of staff with pastoral care responsibilities in their remit. School staff categorised the support they provided to schoolgirl mothers as falling into short, medium and longer term support. This support could increase or decrease in intensity

during pregnancy and after the baby was born. Support given to participants required to be tailored according to their needs at the time. Having a guidance teacher or key worker as a main contact person was an effective source of support to schoolgirl mothers/mothers-to-be and their families but it required to be sustained across a longer period of time and not a one-off intervention.

Several participants were able to identify a range of extended professionals they approached for support (i.e. health). These findings are contrary to previous studies (Hosie 2007, McNulty 2008) which state that schoolgirl mothers/mothers-to-be do not know who to approach for support and are unable to ask for this. Choices made by participants when approaching staff were based on the quality of relationship they had developed with professionals. The most common theme participants gave as their reason for approaching professionals, family or friends, was trust. Seligman (1997) describes trust as being vital in interpersonal relationships. Trust in talking to another person was a key finding in Highet and Jamieson's (2007) study.

In addition to trust, professionals who were willing to listen, easy to talk to, approachable, willing and able to plan for the future made it easier for schoolgirl mothers/mothers-to-be to approach them for help and feel confident that the necessary steps were being taken in preparation for the baby's arrival and forthcoming examinations. Positive responses to the news about the pregnancy encouraged participants to stay in education but this had to be followed through with adaptations to the curriculum where necessary. An understanding attitude and knowledge about the challenges that participants faced was needed as well as continued positive reassurance. Professionals who were judgemental, opinionated or provided a 'nil' response to the information about their pregnancy did not appear to have the same respect from participants. For the schoolgirl mothers who received cards and gifts from teaching staff after their baby was born, these were greatly appreciated. Participants also welcomed staff checking with them that everything was going well and if not, then helping them to address any concerns. Schoolgirl mothers-to-be liked to look forward and talk about their plans and things that would happen when the baby arrived.

Participants in the service provision approach described feeling a sense of ‘hope’ for them and their baby through the support provided by their local authority. Staff in a service provision showed ‘respect to participants as the mother’ and they were ‘really good with the baby’ which helped schoolgirl mothers/mothers-to-be to settle into their new school. Participants liked being able to spend time with their baby during breaks and to have staff who were available, approachable, willing to listen and talk to them about any concerns.

## **9.4 Concluding thoughts**

Without a specific directive, local authorities have implemented Scottish Government policies differently and many did not have a policy in place to provide guidance to staff who support schoolgirl mothers/mothers-to-be. This has resulted in an inconsistent and patchy approach towards supporting schoolgirl mothers/mothers-to-be and many found it difficult to continue in education. Only a minority of participants were given the opportunity of a flexible tailored curriculum to attend school and college.

Exploring the different approaches taken by local authorities has provided insight into the different ways that Scottish Government policies have been translated into practice and the varying approaches taken to support schoolgirl mothers/mothers-to-be. If the Scottish Government is to meet its aspirations for Scotland to be the best place in the world to grow up, a place to provide opportunities for all to flourish, for young people to have ‘More Choices, More Chances’ with ‘flexible opportunities tailored to individual need and clear pathways from school to learning post-16, with appropriate support throughout’ and have a special focus on the most vulnerable young people to ensure ‘their longer term employability and contribution to society’ then the support offered should be consistent regardless of where the schoolgirl mother/mother-to-be lives in Scotland (Achieving our Potential, 2008, p7).

Measuring success in supporting schoolgirl mothers/mothers-to-be who continue in education was described by school staff in local authorities across Scotland through a

range of indicators. These measures of success were identified as schoolgirl mothers: having positive destinations with a clear pathway which is sustainable and supports them for future; being happy and healthy; having a happy and healthy baby; being resilient; having the life skills to manage; having achieved qualifications; being able to parent their baby effectively; valuing education; feeling happy about school; having positive experiences; being able to take their baby into school to show to staff; being well-adjusted, able to speak to staff; regularly attending school; involved in extra-curricular activities; and having positive relationships.

The role played by education and health professionals in the life of young mothers and the relationship built up and established between them is key in being able to help schoolgirl mothers/mothers-to-be overcome whatever experiences and challenges they face when continuing in education. Schoolgirl mothers/mothers-to-be require a range of support from professionals over a sustained period of time to allow them to more easily continue in education during pregnancy and the early stages of motherhood. Data from this study complements that of Vincent's (2012) study in that the 'more supportive schools achieve good outcomes' (p69). One member of school staff in this study commented that the service provision approach was 'designed for schoolgirl mothers/mothers-to-be' (School, 2).

Dawson and Hosie's (2005) study sought to identify what factors and forms of provision determined academic and broader success in returning to or continuing in education. The study suggested that schools required a willingness to accommodate the changing needs of schoolgirl mothers/mothers-to-be (Dawson and Hosie, 2005). Many schoolgirl mothers/mothers-to-be in this study could have had a completely different experience of education during pregnancy and after returning to education if a range of supports and provisions had been provided which was tailored to meet their individual needs. It is recognised that schoolgirl mothers/mothers-to-be do not all have the same needs or require the same level of help and support. However, support and provisions need to be consistent across Scotland and should not be dependent on where a schoolgirl mother/mother-to-be lives.

## 9.5 Implications of the study

This thesis has discussed the experiences and challenges encountered by schoolgirl mothers/mothers-to-be while continuing in Scottish education in the 21<sup>st</sup> century. These perspectives have not previously been gathered, therefore they have important implications for current and future: professionals who work with this vulnerable group; policymakers; researchers; and schoolgirl mothers/mothers-to-be. Publications in appropriate formats for different audiences is imperative if the findings of this study are to address the experiences and challenges of schoolgirl mothers/mothers-to-be which make it difficult to continue in education.

*Professionals* - The review of local authority policies and discussions with health and education professionals involved in this study indicated that a lack of knowledge of the experiences and challenges of schoolgirl mothers/mothers-to-be has at times unintentionally exacerbated their difficulties. Professionals can now benefit through hearing directly from a vulnerable group for whom they are responsible. Schoolgirl mothers/mothers-to-be praised professionals who built relationships with them, and who were approachable, understanding, flexible, and accommodating to their individual complex and diverse family backgrounds and circumstances. If the personalisation of approaches and tailored support by professionals makes schoolgirl mothers/mothers-to-be more positive about continuing in education, it is likely to improve short and longer term outcomes. Challenges remain for professionals who work with very small numbers of schoolgirl mothers/mothers-to-be on a yearly basis and have limited experience and opportunity to support them.

*Policymakers* – can now benefit from hearing directly from a vulnerable group that they are pledged to support. Policymakers can also address the deficit model which characterises schoolgirl mothers/mothers-to-be whilst also influencing current and future Government agendas/policies. Challenges exist in trying to overcome longstanding cultural, moral, value-based judgements and attitudes regarding early parenting to take advantage of the increased educational motivation of some mothers and mothers-to-be, in ways that raise attainment, improve training and employment opportunities, and reduce the likelihood of future poverty and deprivation.

*Researchers* - This thesis provides a starting point for further research on schoolgirl mothers/mothers-to-be in Scotland by identifying gaps that other researchers might be able to fill. Future research could consider gathering a more holistic picture of schoolgirl mothers/mothers-to-be and early parenting by involving a wider range of practitioners, including midwives, who have responsibilities for this vulnerable group as well as family members. The account of the research process also alerts future researchers to the challenges in obtaining access to participants which include several layers of gatekeepers and sometimes means that schoolgirl mothers/mothers-to-be do not get the opportunity to make their own decision over whether or not they wish to share their experiences and challenges of continuing in education when pregnant or after having a baby.

*Current and future schoolgirl mothers/mothers-to-be* – could benefit from the findings of this research through future publication of the experiences and challenges that participants in this study have encountered whilst pregnant or after having a baby and continuing in education. The findings of this study could help schoolgirl mothers/mothers-to-be both now and in the future to be: better informed and prepared for the kind of experiences and challenges they might encounter; know what sort of help to ask for and what they are entitled to; be able to know who to ask for help or where to access help but also be confident to do so; be reassured that it is possible to continue in education during pregnancy or after having a baby, gain parenting skills, qualifications or continue on to a positive destination such as employment or further education. Challenges exist for schoolgirl mothers/mothers-to-be not least because of the power disparity in relationships between themselves and professionals but also because of the cultural, moral, value-based judgements and attitudes that they can at times encounter.

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## APPENDICES

### Appendix 1 – Profile of participants

#### Geographical location

According to the description of the school catchment areas as provided by the member of school staff, twenty participants (56%) lived in a city or a suburb of the city. Eight participants (22%) were in a more rural area. The remaining eight participants (22%) lived in a mixed area but with either some surrounding urban or coastal areas.

#### Places / Accommodation

Schoolgirl Mothers/Mothers-to-be were asked to describe the place that they grew up in as either: a city, town, village, in the country, or other. They were also requested to state the type of property that they lived in.

#### Chart 2 – Accommodation

Description of place growing up							
Property type	City	Town	Town & City	Town & village	Village	Blank	Total
House					1		1
Bungalow		1					1
Cottage		1					1
Detached	1	2	2		1		6
Flat	6	6			1		13
Flat & semi-detached		2					2
Semi-detached	1	5		1	2		9
Terraced	2	3					5
Not known	1	1				3	5
<b>Total</b>	<b>11</b>	<b>21</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>3</b>	<b>43</b>

#### Living arrangements

Participants were asked to outline the people that they currently live with. One participant advised that she was living with a parent, step parent and six siblings. Only two participants mentioned that they did not have their own room. Sixty seven percent of participants commented that they were not planning to move from their current accommodation. Three participants advised that they had their own accommodation.

**Chart 3 - Living Arrangements**

Person/People Living With	Total	Own Room		Planning to move		
		Yes	No	Yes	No	Don't know
Boyfriend	3	3			3	
Boyfriend's parents & boyfriend	1	1		1		
Dad	1	1				1
Dad, Sister	1	1			1	
Don't know	1	1				1
Foster care	2	2		1	1	
Grandparent	3	3			2	1
Mum	2	2			2	
Mum, own boyfriend	1	1		1		
Mum, 1 sibling	3	3			3	
Mum, 1+ siblings	2	1	1		2	
Mum, dad	3	3		1	2	
Mum, dad, 1 sibling	3	3		1	1	1
Mum, dad 1+ siblings	8	7	1	1	7	
Mum, relative, 1 sibling	1		1	1		
Mum, step dad, 1 sibling	2	1	1		2	
Mum, step dad, 1+ siblings	1	1		1		
Siblings & their partners	2	1	1		2	
Own place	3	3			2	1
<b>TOTALS</b>	<b>43</b>	<b>38</b>	<b>5</b>	<b>8</b>	<b>30</b>	<b>5</b>



**Scottish Educational Research Association  
Ethical Guidelines for Educational  
Research  
2005**

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## **Foreword**

*SERA's Code of Practice in Educational Research published in 1997 provided useful guidance for the conduct of educational research in Scotland. It set out the responsibilities of researchers, funding bodies and host institutions and the role of SERA. Since publication of the SERA Code, there has been heightened concern in society about human rights in general, for example, with respect to freedom of information and the right to privacy. With regard to children's rights there is particular concern with protecting them from harm and ensuring their active participation in decision making. Educational legislation, in the form of the Standards in Scotland's Schools etc. Act 2000, has set a new context for the Scottish education system and hence for educational research. These changes present new challenges to the research community to work in partnership with all stakeholders in education, with learners of all ages, professional bodies, government agencies, voluntary bodies and other interest groups towards the aim of enhancing the quality of life in our society. The Executive Committee of SERA reached the decision in 2002 that the Existing Code of Practice should be revised to take account of these changes in the context of Scottish education. The present document is intended to provide comprehensive guidelines for the ethical conduct of educational research in Scotland. It is expected that membership of SERA entails a commitment to the ethical standards set out below.*

*Research in education is often directed at children and other vulnerable populations. A main objective of this code is, therefore, to remind us that as educational researchers we should strive to protect these populations and to maintain the integrity of our research, of our research community and of all those with whom we have professional relations. We should pledge ourselves to do this by maintaining our own competence and that of colleagues we induct into the field by continually evaluating our research for its ethical and scientific adequacy and by conducting our internal and external relations according to the highest ethical standards. The standards that follow remind us that we are involved not only in research but in education. It is, therefore, essential that we continually reflect on our research to be sure that it is not only rigorously conducted, but that it also makes a worthwhile contribution to the quality of education in our society.*

**March 2005**



## Acknowledgements

The SERA Ethical Guidelines have drawn heavily from other published ethical codes of practice for educational research including the BERA Revised Ethical Guidelines for Educational Research 2004 and the Ethical Standards of AERA. In particular, the SERA Executive Committee is grateful to the Executive Council of BERA for its permission substantially to adopt and adapt the text of the BERA Revised Ethical Guidelines for Educational Research (2004).



## **Scottish Educational Research Association**

### **Ethical Guidelines for Educational Research**

#### **Preamble**

1. The SERA Ethical Guidelines are a set of standards designed to guide the proper conduct of the research activities of members of SERA. Since education has the fundamental ethical purpose of improving the lives of individuals, communities and society, ethical considerations must lie at the core of educational research. SERA strongly asserts the view that giving due attention to such ethical considerations should not be seen as constraining or limiting research but rather as enhancing the quality of educational research in the widest sense. Since educational research often involves children and other vulnerable groups, a key purpose of these Guidelines is to remind SERA members that educational researchers should be aware of the potential influence of a power differential inherent in their relationship with research participants and that they must at all times strive to protect and safeguard the interests of participants in research. The Guidelines are also aimed at ensuring that SERA members do their utmost to maintain the integrity of their research, of the research community, and of all those with whom they have professional relations. In order to achieve these aims, SERA members should be prepared to maintain and enhance their own competence by critically evaluating their research activities in relation to the ethical standards set out in the following pages.
2. This set of Ethical Guidelines replaces the SERA Code of Practice published in 1997 and takes into account developments in legislation and research governance, which have taken place since then. The Children (Scotland) Act 1995 and its requirements, implemented in 1997, the Human Rights Act 1998 and the Data Protection Act 1998 must all be taken into account in the conduct of research activity. In all fields of research involving human beings, the importance of ethical considerations has now been widely acknowledged. It is important that educational research is conducted in accordance with ethical standards shared across disciplinary boundaries. In this context, SERA acknowledges that educational research is a diverse field of inquiry, is informed by a number of disciplines, drawing upon a range of theoretical frameworks and employing a variety of research methodologies. SERA recognises that its members may already be guided by other codes of practice reflecting their different disciplinary backgrounds and the interests and requirements of the institutions and organisations to which they are affiliated. However, this set of ethical guidelines is designed to be sufficiently robust and comprehensive to incorporate the key ethical considerations to be addressed across the whole field of educational research.
3. Membership of SERA entails individual responsibility to adhere to the Ethical Guidelines and Code of Practice in the proper conduct of research. SERA recommends that educational researchers should join with others in their

institutions, organisations or agencies to form local ethics committees which should use the guidelines to inform their deliberations on the ethical conduct of research activity and the process of formal approval of research proposals.

4. Educational research is conducted in complex social settings. Decisions about the conduct of research require professional judgement on the part of researchers. These ethical guidelines cannot and should not aim to provide a 'formula' or simple blueprint for research. Rather they set out key principles and provide advice which should inform the process of decision-making about research in ways which will allow the resulting research activity to be carried out in a sound, justifiable and ethically acceptable manner.

### **Guiding Principles**

5. SERA shares with colleagues in the wider UK and international community of educational researchers, represented by such bodies as BERA and AERA, a number of fundamental principles which underpin this set of Ethical Guidelines. These are represented by a commitment to an ethic of respect for:
  - the person;
  - knowledge;
  - democratic values;
  - justice and equity;
  - the quality of educational research; and
  - academic freedomBERA<sup>1</sup>

6. These guiding principles are applied to four key areas of responsibility on the part of educational researchers, namely:
  - responsibilities to participants in research;
  - responsibilities to sponsors and other stakeholders in educational research;
  - responsibilities to the field of educational research; and
  - responsibilities to the community of educational researchers.

## **GUIDELINES**

### **Responsibilities to Participants**

7. Participants in research are taken to include all those involved in the research activity either directly or indirectly and either passively, such as when part of an educational context being observed, or actively, such as when taking part in an interview procedure.
8. SERA expects educational researchers to demonstrate respect for participants in research regardless of their age, gender, race, religion, political beliefs, lifestyle or any other source of potential discrimination. Particular care should be taken in the use of non-discriminatory language in all research

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<sup>1</sup> BERA (2004) *Revised Ethical Guidelines for Educational Research*. Southwell: BERA (p. 4).

communications, in the construction of research instruments and in the reporting of research.

### *Voluntary Informed Consent*

*The essence of the principle of informed consent is that the human subjects of research should be allowed to agree or refuse to participate in the light of comprehensive information concerning the nature and purpose of the research<sup>2</sup>*

9. Researchers must ensure that participation in research is on the basis of voluntary informed consent. Participants in a research study have the right to be informed about the aims of the investigation, the processes in which they will be engaged, the likely risks involved in the research and any potential consequences for them. Participants also have the right to know in advance why their participation is necessary, how the information gathered will be used and how and to whom the results will be reported. They must have the opportunity to give their informed consent before participating in the research. Consent to participate should never be given under any kind of duress.
10. Obtaining informed consent is a continuing obligation rather than a once-and-for-all step in the research process. Educational researchers should ensure that they inform participants about any significant changes in the programme of research. It is essential that participants are made aware that they are free to withdraw their consent at any time and for any, or no reason. It is important to stress that giving informed consent must be an active process. It is inappropriate to assume consent is given by virtue of the fact that an opportunity provided to “opt-out” of participating has *not* been taken up.
11. However, there are circumstances, where it may be impracticable or unduly restrictive to obtain informed consent from all participants, for example, in observational studies where the observed activity, such as playground games, is non-specific to individuals. In some participant observation research, it is important that the researcher's role is not made evident. In all such cases, the circumstances must be carefully and thoroughly considered and clear reasons recorded before any decision is taken not to obtain informed consent. Where such research activity is intended, researchers should seek the approval of their local ethics committee.

### *The Rights of Children, Vulnerable Young People and Vulnerable Adults*

12. Educational researchers must conduct their research in accordance with the United Nations Convention on the Rights of the Child and relevant subsequent legislation based on the principles of the UN Convention, including the Children (Scotland) Act 1995.

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<sup>2</sup> Homan, R. (1991). *The ethics of social research*. London: Longman (p. 69).

13. In particular, researchers must comply with the stipulation of the Children (Scotland) Act 1995, which extends Article 3 of the UN Convention by asserting that the best interests of the child must be the *paramount* concern in all decisions and actions affecting the child. In addition, researchers must comply with Article 12 of the Convention which requires that children must be given the opportunity to express their views freely in all matters affecting them, commensurate with their age and maturity, and that these views must be listened to. This is particularly relevant to the issue of obtaining informed consent. Every effort must be taken by researchers to facilitate children's right to give their own informed consent to participation in research. This should be done on the basis of an initial assumption of children's competence to do so.
14. Researchers should operate in the spirit of Articles 3 and 12 of the UN Convention on the Rights of the Child where the research involves vulnerable young people and vulnerable adults<sup>3</sup>.
15. In the case of participants whose age, intellectual capability or other vulnerable circumstances may limit the extent to which they can be expected to understand or agree voluntarily to undertake their role, researchers must fully explore alternative ways in which they can be enabled to make authentic responses. In such circumstances, researchers must also seek the collaboration and approval of those who act in guardianship (i.e. parents) or as 'responsible others' (i.e. those who have responsibility for the welfare and well-being of the participants i.e. social workers).
16. Researchers must make every effort to ensure that they meet all relevant legislation governing work of any kind with children, vulnerable young people or vulnerable adults.

*Avoidance of any detrimental effects on participants in research*

17. Researchers must recognise that participants may experience distress or discomfort in the research process and must take all necessary steps to reduce the sense of intrusion and to put them at their ease. They must desist immediately from any actions ensuing from the research process that cause emotional or other distress.
18. Researchers must recognise concerns relating to the 'bureaucratic burden' of much research, especially survey research, and must seek to minimize the impact of their research on the normal working and workloads of participants. They should adhere to the ethic of 'minimal intrusion', and only ask those questions that provide the data required to address current research questions.
19. Researchers must make known to the participants (or their guardians or responsible others) any predictable detriment arising from the process or findings of the research. In addition, researchers must discuss any predicted

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<sup>3</sup> Paras 14-16 are based on BERA (2004) *Revised Ethical Guidelines for Educational Research* (p.6)

detriment with their local ethics committee before embarking on a research project. Any unexpected detriment to participants, which arises during the research, must be brought immediately to their attention or to the attention of their guardians or responsible others as appropriate. Researchers must take steps to minimise the effects of designs that advantage or are perceived to advantage one group of participants over others, i.e. in an experimental or quasi-experimental study in which the treatment is viewed as a desirable intervention and which by definition is not available to the control or comparison group.

#### *Offering Incentives for Participation*

20. Researchers' use of incentives to encourage participation must be commensurate with good sense and must avoid choices which in themselves have undesirable effects (i.e. the health aspects of offering cigarettes to young offenders or sweets to school-children). They must also acknowledge that the use of incentives in the design and reporting of the research may be problematic; for example where their use has the potential to create a bias in sampling or in participant responses. In general, the use of incentives for participation should be the exception rather than the norm in educational research and where incentives are being proposed, the case for this should be considered by a local ethics committee.

#### *Privacy, Confidentiality and Anonymity<sup>4</sup>*

21. The confidential and anonymous treatment of participants' data is considered the norm for the conduct of research. Researchers must recognise the participants' entitlement to privacy and must accord them their rights to confidentiality and anonymity, unless they or their guardians or responsible others, specifically and willingly waive that right. In such circumstances it is in the researchers' interests to have such a waiver in writing. Conversely, researchers must also recognise participants' rights to be identified with any publication of their original works or other inputs, if they so wish. In some contexts it will be the expectation of participants to be so identified. However, caution must be applied in any situation where an individual waiving the right to confidentiality could lead to others being identified or where an individual is representing the views of an institution or organisation. It is inadvisable for the researcher to assume that the participant is entitled to put the confidentiality of others at risk or waive it on behalf of their institution or organisation.

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<sup>4</sup> Paras 22 and 24-30 are adopted from BERA (2004) Revised Ethical Guidelines for Educational Research (pp 7-9).

22. It is possible to draw a distinction between the extent to which confidentiality and anonymity can be guaranteed. It is possible to provide anonymity to participants by taking clear steps to ensure that the identity of any participant is not discernible to any other party in any research database or research report. However, since researchers have certain duties of disclosure discussed below in Paragraphs 28 and 29, it is not always possible to guarantee confidentiality.

#### *Data Protection*

23. Researchers must comply with the legal requirements in relation to the storage and use of personal data as set down by the Data Protection Act (1998) and any subsequent similar acts. In essence people are entitled to know how and why their personal data are being stored, to what uses it is being put and to whom it may be made available.
24. Researchers must have participants' permission to disclose personal information to third parties and researchers must ensure that participants have given their agreement to any such third parties being permitted to have access to the information. They are also required independently to confirm the identity of such persons and must keep a record of any disclosures. Disclosure may be written, electronic, verbal or any visual means.
25. The Data Protection Act also confers the right to private citizens to have access to any personal data that are stored in relation to them. Researchers seeking to exploit legal exclusions to these rights must have a clear justification for so doing, which should be submitted for approval to a local ethics committee. Researchers should also be aware of obligations under the Freedom of Information Act 2005.
26. Researchers must ensure that data are kept securely and that the form of any publication, including publication on the Internet, does not directly or indirectly lead to a breach of agreed confidentiality and anonymity.

#### *Disclosure*

27. Researchers who judge that the agreements reached about confidentiality and anonymity may allow illegal behaviour to continue, must carefully consider making disclosure to the appropriate authorities. If the behaviour is likely to be harmful to the participants or to others, the researchers must also consider disclosure. Insofar as it does not undermine or obviate the disclosure, researchers must apprise the participants or their guardians or responsible others of their intentions and reasons for disclosure.
28. At all times the decision to override agreements on confidentiality and anonymity must be taken after careful and thorough deliberation. In such circumstances it is in the researchers' interests to make contemporaneous notes on decisions and the reasoning behind them, in case a misconduct complaint or other serious consequence arises.

### *Providing feedback to participants*

29. All research participants are entitled to receive feedback on the outcomes of the research. It is good practice for researchers to debrief participants at the conclusion of the research and to provide them with copies of any reports or other publications arising from their participation. Where the scale of the research makes such a consideration impractical, alternative means such as a website should be used to ensure participants are informed of the outcomes.

### **Responsibilities to Sponsors of Research<sup>5</sup>**

30. A sponsor of research is considered to be any person or body that funds research (i.e. a research charity or government body) or facilitates it by allowing and enabling access to data and participants (i.e. an examinations body or a local authority education department). All sponsors should be made aware of these Ethical Guidelines.
31. In the context of school-based research, the Scottish Local Authorities have a key role in granting permission to researchers to approach schools and other educational establishments. The researcher should take appropriate steps to consult with Local Authorities when negotiating access for research purposes.
32. The relationship between researchers and sponsors should be defined by a written agreement in the case of funded or commissioned research. Such agreement should minimally cover the purpose of the research, the research methods to be used, any conditions of access to data or participants, ownership of data, the researchers' right to publish, requirements for reporting and dissemination, deadlines for completion of the work and the accounting for the use of funds. In recognition of the dynamics of research, agreements should also include provision for negotiating changes sought by either the researchers or the sponsors.
33. Researchers must fulfil their responsibilities to sponsors to the highest possible standards. It is in the researchers' interest that respective responsibilities and entitlements should be agreed with the sponsors at the outset of the research. Where the sponsor acts essentially as a host or facilitator for research, researchers must, out of courtesy, inform them of the work they propose to undertake i.e. a group of teachers engaging in a process of action research as part of curriculum renewal should inform the school management of their intentions.

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<sup>5</sup> Paras 31, 33 and 34 are based on BERA (2004) Revised Ethical Guidelines for Educational Research (p. 9).



## **Responsibilities to the field of Educational Research<sup>6</sup>**

34. Educational researchers should conduct their professional lives in such a way that they do not jeopardise future opportunities for research, the public standing of the field, or the integrity of the discipline's research results.
35. Educational researchers must not fabricate, falsify, or misrepresent authorship, evidence, data, findings, or conclusions. They must not 'sensationalise' findings in a manner that sacrifices intellectual capital for maximum public exposure.
36. Educational researchers must not knowingly or negligently use their professional roles for fraudulent purposes.
37. Researchers must employ methods that are fit for the purpose of the research they are undertaking. Those researchers who prefer or promote specific methods, theories or philosophies of research must have knowledge of alternative approaches sufficient to assure sponsors that they have considered these and that the research needs are being properly addressed. Sponsors should be offered a full, honest and amenable justification on the final choice of methods.
38. Researchers must, within the context and boundaries of their chosen methods, theories and philosophies of research, communicate the extent to which their data collection and analysis techniques, and the inferences to be drawn from their findings, are reliable, valid and generalisable.
39. Educational researchers should report research conceptions, procedures, results, and analyses accurately and sufficiently in detail to allow knowledgeable, trained researchers to understand and interpret them.
40. Educational researchers' reports to the public should be written straightforwardly to communicate the practical significance for policy, including limits in effectiveness and in generalisability to situations, problems, and contexts. In writing for or communicating with non-researchers, educational researchers must take care not to misrepresent the practical or policy implications of their research or the research of others.

### *Reporting and publishing findings of research*

41. The right of researchers to publish the findings of their research under their own names is considered the norm for sponsored research. However, there are conditions under which this right might not hold including circumstances in which:

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<sup>6</sup> Adapted from AERA (2000) *Ethical Standards of AERA*. American Educational Research Association. <http://www.aera.net/about/policy/ethics.htm>

- researchers have waived this right in writing;
  - publication would contravene the law (i.e. in the area of libel or race relations);
  - the work that has been commissioned specifically to produce a confidential report i.e. consultancy reports that are based on research activity;
  - undertakings have been given to participants concerning confidentiality and the intention to avoid causing unnecessary harm to those affected by the research findings;
  - the researchers have failed to comply with contractual obligations;
  - the researchers have failed, without reasonable justification, to report findings in a manner consistent with these ethical guidelines i.e. failure to report findings honestly and accurately.
42. Researchers have the right to dissociate themselves publicly from accounts of the research that they consider misleading or unduly selective. Sponsors enjoy a similar right. It is in the interests of researchers and sponsors alike to prevent this situation arising by agreements on publication or, if necessary, through arbitration.

### **Responsibilities to Colleagues and to the Community of Educational Researchers<sup>7</sup>**

43. The community of educational researchers is considered to mean all those engaged in educational research including academics, professionals (from private or public bodies), full-time research staff, teachers and students.
44. Researchers must protect the rights and interests of research colleagues and research staff contracted to carry out research activities. Researchers must ensure that they carefully assess and strive to minimise any risks to staff in conducting research activity. For instance, it is inadvisable for a researcher to go unaccompanied to an unknown research participant's home for the purpose of conducting an interview procedure.
45. All educational researchers must protect the integrity and reputation of the educational research community by ensuring they conduct their research to the highest standards. Researchers must therefore not bring the educational research community into disrepute by, for example:
- criticising other researchers in a defamatory or unprofessional manner;
  - exploiting the conditions of work and roles of contract research staff;
  - undertaking work for which they are perceived to have a conflict of interest or where self-interest or commercial gain might be perceived to compromise the objectivity of the research;
  - undertaking work for which they are not competent;
  - using work carried out with co-researchers as the basis of individual outputs without the agreement of the co-researchers concerned;

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<sup>7</sup> Adapted from AERA (2000) *Ethical Standards of AERA*. American Educational Research Association. <http://www.aera.net/about/policy/ethics.htm>

- mis-representing, falsifying, distorting or sensationalising research findings.
46. Where researchers become aware of examples of malpractice or potential malpractice they must present their concerns, in the first instance, to the researchers involved. If their concerns are proven correct and if the researchers in question do not move to correct the situation, the matter must be reported to the Association's Academic Secretary. With due consideration to the important principle of the public's right to know, researchers should avoid bringing the community into disrepute through public accusations or allegations.
  47. Subject to any limitations imposed by agreements to protect confidentiality and anonymity, researchers must make their data and methods amenable to reasonable external scrutiny. The assessment of the quality of the evidence supporting any inferences is an especially important feature of any research and must be open to scrutiny. Where sponsors initiate the request for scrutiny, and disclosure of aspects of the data may be injurious to participants, researchers should consider assuring the sponsor of the integrity of the work through the scrutiny of a mutually acceptable third-party, who is also bound by the non-disclosure agreements.
  48. Researchers must accord due respect to all methodologies and related methods. They must contribute to the community spirit of critical analysis and constructive criticism that generates improvement in practice and enhancement of knowledge.

### *Authorship*

49. Authorship should be determined based on the following guidelines, which are not intended to stifle collaboration, but rather to clarify the credit appropriately due for various contributions to research.
  - All those, regardless of status, who have made substantive creative contribution to the generation of an intellectual product are entitled to be listed as authors of that product.
  - First authorship and order of authorship should be the consequence of relative creative leadership and creative contribution. Examples of creative contributions are: writing first drafts or substantial portions; significant rewriting or substantive editing; and contributing generative ideas or basic conceptual schemes or analytic categories, collecting data which require significant interpretation or judgement, and interpreting data.
  - Clerical or mechanical contributions to an intellectual product are not grounds for ascribing authorship. Examples of such technical contributions are: typing, routine data collection or analysis, routine editing, and participation in staff meetings.
  - Authorship and first authorship are not warranted by legal or contractual responsibility for or authority over the project or process that generates an

intellectual product. It is improper to enter into contractual arrangements that preclude the proper assignment of authorship.

- Anyone listed as author must have given his/her consent to be so listed.
- The work of those who have contributed to the production of an intellectual product in ways short of these requirements for authorship should be appropriately acknowledged within the product.
- Acknowledgement of other work significantly relied on in the development of an intellectual product is required. However, so long as such work is not plagiarised or otherwise inappropriately used, such reliance is not ground for authorship or ownership.
- It is improper to use positions of authority to appropriate the work of others or claim credit for it. In hierarchical relationships, educational researchers should take care to ensure that those in subordinate positions receive fair and appropriate authorship credit.
- In cases where writing relies on a thesis or data collected by a student, the authorship in the publication of work arising from theses and dissertations is determined by creative intellectual contributions as in other cases. An explicit agreement should be negotiated in each case. Research teams or academic staff involved in sustained co-working with students should agree an authorship policy at the beginning of the research process.
- Authors should disclose the publication history of articles they submit for publication; that is, if the present article is substantially similar in content and form to one previously published, that fact should be noted and the place of publication cited.

### **Note on Practitioner Research**

Paragraphs 7 to 30 of the SERA Ethical Guidelines aimed at protecting the rights of participants should *not* be interpreted as inhibiting practitioner research and enquiry and/or other forms of action research as long as the following conditions are met:

- the data are those that could be derived from normal teaching/learning processes;
- confidentiality is maintained;
- the safety and welfare of participants are protected;
- informed consent is obtained when appropriate; and
- the use of the information obtained is primarily intended for the benefit of those receiving instruction in that setting.

## References

BERA (2004) *Revised Ethical Guidelines for Educational Research*. Southwell: British Educational Research Association.

AERA (2000) *Ethical Standards of AERA*. American Educational Research Association. <http://www.aera.net/about/policy/ethics.htm>

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## Historical Note

During his term of office as President, Donald Christie took responsibility for revising the 1997 SERA Code of Practice in Educational Research and produced an initial draft of a much more substantial document in 2004, 'Scottish Educational Research Association Ethical Guidelines for Educational Research'. Following this, a small working group composed of SERA Executive members Donald Christie, George Head, Fran Payne, Christine Stephen and Allen Thurston discussed and made several revisions to the draft. Subsequent to this process, a 'final' draft was sent to all SERA members in October 2004 for consultation. It was also posted on the SERA website and responses invited. The consultative draft document was an item on the agenda of the Annual General Meeting in November. It was approved subject to amendments proposed by members as a result of the consultation. Further minor amendments were submitted by members and taken account of by the Executive working group. The new ethical guidelines were formally adopted by the SERA Executive in December 2004.

Fran Payne  
*President*  
March 2005

## Appendix 3 – Letter to Directors of Education

School of Social and Political Sciences,  
The University of Edinburgh,  
15a George Square,  
Edinburgh,  
EH8 9LD.

Tel: 07702 349790

[Date]

Director of Education

Dear....

### **Research Project - Schoolgirl Mothers and Mothers-to-be**

I am a 3<sup>rd</sup> year (part-time) student at The University of Edinburgh and am doing a research project for my postgraduate degree (PhD) on schoolgirl mothers and mothers-to-be who are still attending secondary school. There are many schoolgirls across Scotland who have had a baby while still attending school but we do not know very much about their experiences.

In addition to this, I also work for Falkirk Council and have recently been in contact with some members of your staff about a recently conducted survey. This survey asked all Local Authorities across Scotland if they had a service provision or a policy/guidance/pathway concerning schoolgirl mothers and mothers-to-be within their schools. Analysing the results from all Local Authorities has helped to identify the authorities from which I would like, if possible, to recruit participants for this research.

I am seeking permission to carry out research within your Local Authority and to see if you would be able to suggest a school(s) for me to contact regarding potential participants. I would like to hold a group interview session with 3-4 schoolgirl mothers and mothers-to-be. The group interview would last between 1-2 hours maximum.

In addition to this, I would also like to meet with a relevant member of staff within one of your schools who deals with or helps to support schoolgirl mothers and mothers-to-be such as a Guidance Teacher, Pastoral Teacher or a member of staff from Learning Support.

After completing the research project, I will send you a copy of a generic and anonymised report that I will write for all Local Authorities about the experiences and views of schoolgirl mothers and mothers-to-be. This may indicate how to improve services for schoolgirl mothers, their baby and their families.

I have a lot of experience in working with parents and young people and am currently carrying out research with schoolgirl mothers and mothers-to-be within my own Local Authority (Falkirk Council). The purpose of the research within Falkirk Council is to assist us in writing our own Policy Guidance and pathway for staff in schools on how to support schoolgirl mothers and mothers-to-be. Please find enclosed, copy of a letter from my own Director of Education in support of the work I am carrying out both within Falkirk Council and for my postgraduate degree. Should you need to speak to my Director of Education (Julia Swan) for clarification on any matter, she can be contacted on Tel No: 01324 506681 or by e-mailing: [julia.swan@falkirk.gov.uk](mailto:julia.swan@falkirk.gov.uk).

The names and contact details of my supervisors at The University of Edinburgh are as follows:

Professor Lynn Jamieson, Tel: 0131 650 4002, E-mail: [l.jamieson@ed.ac.uk](mailto:l.jamieson@ed.ac.uk)  
Professor John MacInnes, Tel: 0131 651 3867, E-mail: [john.macinnes@ed.ac.uk](mailto:john.macinnes@ed.ac.uk)

If you are able to reply to me by E-mail on [s0792637@sms.ed.ac.uk](mailto:s0792637@sms.ed.ac.uk) to advise if you are agreeable to me carrying out research within your Local Authority and with the name(s) of any school(s) that you think I should contact, I would be very grateful.

I look forward to hearing from you.

Yours sincerely,

**Beverley Ferguson**  
**PhD Student**

Enc.

**Julia Swan: Director of Education**

Sealock House

2 Inchyra Road Grangemouth FK3 9XB

Phone:01324 506600 Fax:01324 506601 Email:julia.swan@falkirk.gov.uk



**Falkirk Council**  
Education Services

Date: 7 October 2011

Dear

**Research Project - Schoolgirl Mothers and Mothers to Be  
Beverley Ferguson**

I am writing to introduce one of my members of staff to you.

Beverley is the Parents Officer within Falkirk Council Education Services. She is currently the lead officer on a multi-agency working group who are developing a pathway and policy guidance for staff in our secondary schools on how to handle and support pregnant schoolgirls within Falkirk Council. Research with pregnant schoolgirls themselves is currently underway in Falkirk and a lot of other background work has already been carried out on this as well. After this is complete, Beverley will be working with the multi-agency group to finalise the pathway to develop the policy guidance. This piece of work is very important to Falkirk Council to enable us to develop documentation that will help support our schoolgirl mothers.

In addition to her role as Parents Officer, Beverley is also a part-time PhD student at Edinburgh University. Her research project is almost an extension of the work that she is currently doing within Falkirk Council. She has worked for several years with parents and young people in Education Services and I can highly commend her to you. I know Beverley will be writing to you requesting your permission to carry out research with pregnant schoolgirls within your local authority and if you are able to assist with this, it would be much appreciated.

Should you require any further information or clarification regarding the above, please do not hesitate to contact me.

Yours sincerely

Julia Swan  
Director of Education

Our Ref: JS/AN

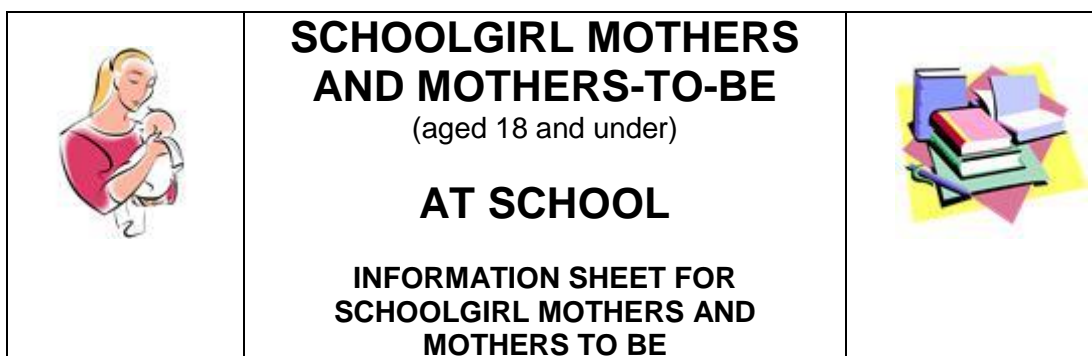


*Director: Julia Swan*

Sealock House,  
2 Inchyra Road, Grangemouth FK3 9XB LP3 Falkirk-2  
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Fax: 01324 506601  
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## Appendix 4 – Information sheets and consent forms for schoolgirl mothers/mothers-to-be and their parent(s)



### Who am I?



Hi, my name is Beverley Ferguson and I'm a student at the University of Edinburgh. I am doing a research project for my postgraduate degree (PhD) which is looking at young people who are pregnant and are still attending secondary school. I have a lot of experience in working with parents and young people.

There are many schoolgirls across Scotland who have had a baby while still attending school but we do not know very much about their experiences.

I hope that by writing a report about the views of schoolgirl mothers and mothers-to-be for local councils, this will help to improve services for young people, their baby and their families.

### What does it involve?

I would like to come along and talk to you and other young people who are pregnant and are still at school. I will explain fully what the project is about and you will have the opportunity to ask me questions.

If you are interested in being involved in my project which will be looking at the experiences of schoolgirl mothers and mothers-to-be, I would like to meet with you and other young people in a group interview for about 1-2 hours either at your school or another school in the area on a day and time that suits everyone.

### Is this a school initiative?

No. This project has nothing to do with your school.

### Do I have to be involved?

No. You are welcome to read this information sheet and learn about the project but if you do not wish to take part afterwards that's fine.

**What happens next?**

You will receive this information sheet, a consent form and some further information that you can take home and discuss with your parent/carer. For any young person who is under 16, I will need your parent/carer to agree to you being involved in the research and for them to sign a consent form as well.

If after reading the information provided, you and your parent/carer are happy about being involved I would then like to meet with you for about 1-2 hours as part of a group interview session. Our meeting would be either at your school or another school in the area on a day and time that suits everyone.

**Anything else?**

After the group interview session, I would like to talk with you again briefly in the next 9-12 months to see how both you and your baby are getting on. This would only be for a short while and is likely to be by telephone.

After our group interview session, I will send you a short report on the main points I have learned about your experiences.

**Will the things I say be kept confidential?**

Everything you say will be kept confidential unless you advise me of either yourself or another person being hurt or in immediate danger. I will respect all the views that you bring to our conversations. I will take some notes and may use a digital recorder to help remind me of the valuable points that are raised but I will always ask for permission before I do this. If there are points that you do not want me to record then I will switch the machine off.

I would like to use some of the words that you say. If you would like to continue with the research, you can choose a name, or a code name that I can use when I write. This way no-one will know that it was actually you that said it. All my notes and recordings of our conversations will be looked after very carefully.

I will send all the schoolgirl mothers and mothers-to-be involved in the project, a short report about the things I have learned from them.

**What do I do next if I want to be involved?**

If you would like to be involved in the project, please return the attached consent form to your Guidance Teacher / Pastoral Teacher / Learning Support Teacher so that I know which days and times suits you best to meet. I will then arrange a date and time to come along and meet with you and the group. For any young person who is under 16, I will need the consent of your parent/carer as well for you to be involved in the project.

**What if I need more information?**

Should you or your parent/carer wish to talk to me more about the project or need further information before making a decision, you can call me on 07702 349790, or e-mail me on [s0792637@sms.ed.ac.uk](mailto:s0792637@sms.ed.ac.uk).

Thank you for taking the time to read this.



**PARENTAL CONSENT FORM  
FOR QUALITATIVE RESEARCH INTERVIEWS**

**What experiences and challenges do schoolgirl mothers and mothers-to-be (aged 18 and under) living in Scotland encounter whilst still attending school?**

1. I agree for my daughter to be interviewed for the purposes of the above project. Yes  No
2. I understand that the interview will be electronically recorded and that any personal details will be anonymised. Yes  No
3. I understand that anonymised quotations (using a code name) from my daughter's interview may be used. Yes  No
4. I understand that my daughter can withdraw at any time. Yes  No

**Contact Information:**



Beverley Ferguson,  
School of Social and Political Sciences,  
The University of Edinburgh,  
15a George Square,  
Edinburgh,  
EH8 9LD.

Mob: 07702 349790  
E-Mail: s0792637@sms.ed.ac.uk

Name of Participant: \_\_\_\_\_

Parental Signature: \_\_\_\_\_

Date: \_\_\_\_\_

	<p><b>SCHOOLGIRL MOTHERS AND MOTHERS-TO-BE</b> (aged 18 and under)</p> <p><b>AT SCHOOL</b></p> <p><b>INFORMATION SHEET FOR PARENT(S)/CARER(S)</b></p>	
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**Who am I?**



Hi, my name is Beverley Ferguson and I'm a student at the University of Edinburgh. I am doing a research project for my postgraduate degree (PhD) which is looking at young people who are pregnant and are still attending secondary school. I have a lot of experience in working with parents and young people.

There are many schoolgirls across Scotland who have had a baby while still attending school but we do not know very much about their experiences.

I hope that by writing a report about the views of schoolgirl mothers and mothers-to-be for local councils, this will help to improve services for young people, their baby and their families.

**What does it involve?**

I am inviting your daughter to come along and hear more about my project on the experiences of schoolgirl mothers and mothers-to-be who are still at school. I will explain fully what the project is about and she will have the opportunity to ask me questions.

If your daughter is interested in being involved in my project which will be looking at the experiences of schoolgirl mothers and mothers-to-be, I would like to meet with her and other young people in a group interview session for about 1-2 hours either at her school or another school in the area on a day and time that suits everyone. Being involved in this project is entirely voluntary and she does not have to attend if she doesn't want to.

**What if my daughter meets with you but doesn't want to continue?**

After learning about the project, if your daughter does not want to participate in the group interview session, that's absolutely fine.

**Is this a school initiative?**

No. This project has nothing to do with your daughter's school.

**What happens next?**

Your daughter has been given an information sheet and a consent form. Should she wish to be involved in the research project, she should sign the consent form and return this either to her school (Guidance Teacher / Pastoral Teacher / Learning Support

Teacher) and/or let me know. For any young person who is under 16, I will need your consent as a parent/carer (as well as your daughter's) for her to be involved in the project.

Attached to this information sheet is a Parental Consent Form and I would be obliged if you would be able to complete this to say that you are happy with her participating in this research. The forms can be handed to your daughter's Guidance Teacher / Pastoral Teacher / Learning Support Teacher, or she can bring this with her to our meeting.

**Anything else?**

After the group interview session, I would like to talk to your daughter again briefly in the next 9-12 months to see how both she and the baby are getting on. This would only be for a short while and is likely to be by telephone.

**Will the things she says be kept confidential?**

Everything your daughter says will be kept confidential unless I am advised of her or another person being hurt or in immediate danger. I will respect all the views that your daughter will bring to our conversations. I will take some notes and may use a digital recorder to help remind me of the valuable points that are raised but I will always ask for permission before I do this. If there are points that your daughter does not want me to record then I will switch the machine off.

I would like to use some of the words that your daughter says. If she would like to continue with the research, she can choose a name, or a code name that I can use when I write. This way no-one will know that it was actually her that said it. All my notes and recordings of our conversations will be looked after very carefully.

I will send all the young people involved in the project, a short report about the things I have learned from them.

**What if I need more information?**

Should you as her parent/carer wish to talk to me more about the project or need further information before making a decision, you can call me on 07702 349790, or e-mail me on [s0792637@sms.ed.ac.uk](mailto:s0792637@sms.ed.ac.uk).

Thank you for taking the time to read this.

	<p><b>SCHOOLGIRL MOTHERS AND MOTHERS-TO-BE</b> (aged 18 and under)</p> <p><b>AT SCHOOL</b></p>	
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**PARENTAL CONSENT FORM  
FOR QUALITATIVE RESEARCH INTERVIEWS**

**What experiences and challenges do schoolgirl mothers and mothers-to-be (aged 18 and under) living in Scotland encounter whilst still attending school?**

1. I agree for my daughter to be interviewed for the purposes of the above project. Yes  No
2. I understand that the interview will be electronically recorded and that any personal details will be anonymised. Yes  No
3. I understand that anonymised quotations (using a code name) from my daughter's interview may be used. Yes  No
4. I understand that my daughter can withdraw at any time. Yes  No

**Contact Information:**

Beverley Ferguson,  
School of Social and Political Sciences,  
The University of Edinburgh,  
15a George Square,  
Edinburgh,  
EH8 9LD.

Mob: 07702 349790  
E-Mail: s0792637@sms.ed.ac.uk

Name of Participant: \_\_\_\_\_

Parental Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix 5 – Questionnaire for schoolgirl mothers/mothers-to-be

My name is: \_\_\_\_\_ but I would like my code name to be: \_\_\_\_\_

My date of birth	
------------------	--

<b>My current age is:</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>
(Please tick)						

When is your baby due or when was your baby born?		If pregnant, how many weeks pregnant are you just now?	
---	--	--	--

**I would describe the place(s) I grew up in as being (please tick all that apply):**

<b>In a town</b>	<input type="checkbox"/>	<b>In a city</b>	<input type="checkbox"/>	<b>In a village</b>	<input type="checkbox"/>	<b>In the country</b>	<input type="checkbox"/>	<b>Other (please state)</b>	
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<b>Flat</b>	<input type="checkbox"/>	<b>Semi-detached</b>	<input type="checkbox"/>	<b>Cottage</b>	<input type="checkbox"/>	<b>Detached</b>	<input type="checkbox"/>	<b>Farmhouse</b>	<input type="checkbox"/>	<b>Other (please state)</b>	
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**At present I live with (please tick):**

Parent(s)/Carer				One or more Brother/Sister	Friend(s)	Boyfriend	Someone else (please specify i.e. grandparent, foster carer)
Mum	<input type="checkbox"/>	Dad	<input type="checkbox"/>				
Step mum	<input type="checkbox"/>	Step dad	<input type="checkbox"/>				
Relative	<input type="checkbox"/>	Non-relative	<input type="checkbox"/>				

Do you have your own room?	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
Are you planning to move from the above accommodation after the baby is born?	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>

**Parents**

I would describe my (birth) parent(s) current job title as (eg: nurse, clerical assistant, manager, student):

<b>Mum</b>	
<b>Dad</b>	

Please describe which area of work their job title, as mentioned above, falls within (eg Education, NHS, Manufacturing, Agriculture, Retail)







<b>Mum</b>	
<b>Dad</b>	

**The first person/people I told about being pregnant was my** (please tick):

Parents/Carer				Brother/Sister	Friend	Boyfriend	Someone else (please specify i.e. grandparent, foster carer)
Mum	<input type="checkbox"/>	Dad	<input type="checkbox"/>				
Step mum	<input type="checkbox"/>	Step dad	<input type="checkbox"/>				
Relative	<input type="checkbox"/>	Non-relative	<input type="checkbox"/>				







I was \_\_\_\_\_ weeks pregnant when I told the above person. I was \_\_\_\_\_ weeks pregnant when my school was advised.

**My feelings when I found out I was pregnant were** (please tick as many as describe your feelings):







					
<b>Scared</b>	<b>Pleased</b>	<b>Tearful</b>	<b>Angry</b>	<b>Frustrated</b>	<b>Surprised</b>
<b>Any other feelings not mentioned above?</b>					



When my mother first knew I was pregnant, she was (please tick as many as you need):

					
<b>Scared</b>	<b>Pleased</b>	<b>Tearful</b>	<b>Angry</b>	<b>Frustrated</b>	<b>Surprised</b>
<b>Tick here if you do not know→</b>		<b>Any other feelings not mentioned above? Write in →</b>			

When my father first knew I was pregnant, he was (please tick as many as you need):

					
<b>Scared</b>	<b>Pleased</b>	<b>Tearful</b>	<b>Angry</b>	<b>Frustrated</b>	<b>Surprised</b>
<b>Tick here if you do not know→</b>		<b>Any other feelings not mentioned above? Write in →</b>			

Were you planning to have a baby?

Yes

No

If yes, can you say in a few words why you wanted to have a baby?

<b>Did you consider any other options such as:</b>				<b>Did anyone or anything influence your decisions?</b>			
Adoption	Yes		No				
Termination	Yes		No				
Other? (please specify)	Yes		No				

<b>Do you feel you lacked any information or knowledge from classes at school (eg Personal Social Education (PSE)) about things like relationships, contraception, sexual activity that contributed to you becoming pregnant?</b>				Yes		No	
<b>If yes, what information could have been better?</b>							

**During my pregnancy I am or I was:**

Seriously unwell with lots of complications	Very sick/unwell at times	Just normal i.e. morning sickness	Rarely sick or unwell	No sickness or complications at all
<b>If you have or had any major health concerns during pregnancy, what are/were these?</b>				

<b>Do you have any concerns about money and being able to look after your baby and yourself in future?</b>				Yes		No	
<b>If yes, what are your concerns?</b>							

<b>Are you confident that you know about the benefits you are entitled to?</b>				Yes		No	
<b>If no, do you know who to contact about this?</b>				Yes		No	
<b>If you are aged 16 or over, do you currently receive Education Maintenance Allowance?</b>				Yes		No	

<b>Are you planning to stay on in education after the baby is born / have you returned to education since having your baby?</b>	<b>Yes</b>		<b>No</b>	
<b>If yes, what would be an ideal number of weeks after the baby is born to return to school or college?</b>				

**If yes, who will look after your baby while you are at school/college? (tick all that apply)**

Parents/carers	<input type="checkbox"/>	Professional childcare/child-minder	<input type="checkbox"/>	I chose this person/these people because:
Extended family	<input type="checkbox"/>	Neighbours	<input type="checkbox"/>	
Friends	<input type="checkbox"/>	Mixture of the above	<input type="checkbox"/>	
Other people in the community	<input type="checkbox"/>	Others?	<input type="checkbox"/>	

**Can you write in a few words, your feelings and thoughts just now on the following?**

<b>Leaving my baby with someone else</b>

**If you are not planning to return to school/college, can you identify any reasons for not going back i.e. childcare / no other options?**

<b>Do you think you will return to college/education in a few years time when the baby is older?</b>	<b>Yes</b>		<b>No</b>	

**I would describe myself as fitting into the following category**

1	I do not want to return to school/college after having my baby, and would not even if I have someone to look after my baby	
2	I plan to return to school/college after having my baby and have someone to look after my baby	
3	I would like to return to school/college but have no-one to look after my baby	
4	I have plans to return to school/college, I have someone to look after my baby, but worry that it will be too hard to manage having a baby and school/college	
5	I would find it too hard to leave my baby with someone else while I'm at school/college	

**In a few words, can you describe how and/or where you see yourself in the next year?**

**What about the next 5 years?**

**Do you think this picture would look any different if you did not have a baby? If yes, can you give any reasons why it might be different?**

**Could you describe in a few words or a phrase, how you think being pregnant has or has not changed how you see yourself at this time?**

**Do you have any feelings about the way your body is or has changed shape during/after pregnancy?**

## Appendix 6 – Individual/group interview questions for schoolgirl mothers/mothers-to-be

<b>Activity</b>	<b>5 mins</b>	Introductions, icebreaker
<b>Discussion</b>	<b>15 mins</b>	<b>Experiences</b> <ul style="list-style-type: none"> <li>• What was school like before you became pregnant – good experience? What about the teachers?</li> <li>• Attendance at school before pregnancy? Attendance at school during pregnancy?</li> <li>• Anyone been excluded from school? What was this for?</li> <li>• Who did you tell at school that you were pregnant? Why did you pick them? How did they react?</li> <li>• How did other teachers react?</li> <li>• What kind of support has been put in place for you?</li> <li>• Who is the main person in school that you speak to now?</li> <li>• Has the teachers' reactions influenced your decision on whether to return to school? Any judgemental attitudes?</li> <li>• Is the decision to stay on or leave school a hard one? Were you asked to leave school? Encouraged to stay on?</li> <li>• Are you pleased / disappointed with the way the school has reacted to your pregnancy?</li> </ul>
<b>Activity / Discussion</b>	<b>10 mins</b>	<b>Friends</b> <ul style="list-style-type: none"> <li>• Can you think of up to 5 people who were your best friends before you became pregnant? Did you go to primary school with them? Do they live near you? Do you see them outside of school?</li> <li>• Think of up to 5 who are currently your friends. Has any names changed since becoming pregnant?</li> <li>• What was their reaction to you being pregnant?</li> <li>• For those who are still your friends, what makes them good friends?</li> <li>• What happened to those who are not your friends now – their reaction? Nothing in common anymore?</li> <li>• Did any of your friends tell the school/your parents that you were pregnant? Discuss feelings about this.</li> <li>• Any bullying before / during pregnancy?</li> </ul>
<b>Discussion</b>	<b>10 mins</b>	<b>Challenges</b> <ul style="list-style-type: none"> <li>• Any difficulties – school uniform, stairs, crowded corridors, lift passes, toilet passes, physically uncomfortable?</li> <li>• Who do you speak to at school about concerns? Have these things helped or made things worse – singled out?</li> <li>• Are special arrangements being put in place for exams?</li> <li>• If you are returning will you be on a part-time timetable?</li> <li>• Do you speak to the school nurse about any concerns about being pregnant / having a baby?</li> <li>• Any changes in identity / self-esteem / confidence?</li> <li>• Thoughts on what being a mum will be like?</li> </ul>
<b>BREAK (5 mins)</b>		

<b>Activity</b>	<b>10 mins</b>	<p><b>Sources of Support (small piece of paper, do not need to show to anyone)</b>  Draw a map of the people you would normally ask for help i.e. mothers, fathers, family members, extended family, community, school.</p> <ul style="list-style-type: none"> <li>• List what kind of help or information you would ask them for i.e. practical, financial, emotional, housing, transport, clothes, baby equipment?</li> <li>• Why did you choose these people – age, location, trust?</li> <li>• Is family the first point of contact? Does it depend on what it is for? Whose advice would you listen to most? Would you speak to them first?</li> <li>• Relationship with parents (especially mother)?</li> <li>• If you could not get help or information from the people listed, what would you do or where would you go i.e. internet, other professionals, friends.</li> <li>• Anyone else in your family been a teenage mother? Has it helped you in any way? How?</li> </ul>
<b>Discussion</b>	<b>10 mins</b>	<p><b>Professionals (health)</b>  <b>Ante-natal care</b></p> <ul style="list-style-type: none"> <li>• Appointments - How many weeks pregnant were you when you contacted the doctors/health clinic? If delayed, any specific reasons? Attend regular appointments with midwife/doctor to check health &amp; development of baby?</li> <li>• Screening (tests that assess whether unborn baby is at risk of certain conditions or abnormalities) - Attendance?</li> <li>• Classes (classes and workshops to prepare mother / partner for birth of baby) – Attendance. Why not – timing, location, staff, disruption to school work, mobility, older mothers.</li> <li>• Feeding programmes - why not?</li> </ul> <p><b>Support Groups</b></p> <ul style="list-style-type: none"> <li>• Views about groups i.e. location, timing, mobility, staffing, older mothers, how you will be perceived (bad parent)?</li> </ul> <p><b>Professionals</b></p> <ul style="list-style-type: none"> <li>• Location, accessible, available when needed, timing, transport? How do they treat/support you? When would you contact them? Any frustrations? If you do not attend is this through choice?</li> <li>• Contact with any other professionals for help and support? How was that?</li> <li>• Deliberate choice over who to contact for help?</li> </ul>
<b>Discussion</b>	<b>15 mins</b>	<p><b>Conclusion</b></p> <ul style="list-style-type: none"> <li>• Brainstorming session – good and bad things about the way the school is supporting you through your pregnancy.</li> <li>• What kind of support would you like or do you need?</li> </ul> <p><b>Keeping in touch over the next 9-12 months</b></p> <ul style="list-style-type: none"> <li>• Would like to contact you in the next 9-12 months to see how you are getting on. Any suggestions on doing this?</li> <li>• Feedback / thoughts on the session</li> </ul>

## Appendix 7 – Interview questions for school staff

<b>School:</b>				<b>Local Authority:</b>		
<b>Method:</b>	Service Provision					
	Ad hoc Schools Based Approach					
	GIRFEC					
	Policy					
	Other					
<b>Policy:</b>	Yes		No	<b>Member of staff / Position:</b>	Guidance Teacher	
					Pastoral Teacher	
<b>Participants attend this school?</b>	Yes		No		Support for Learning Teacher / Pupil Support	
					Other:	

<b>Background</b>	
	<ul style="list-style-type: none"> <li>• Number of pupils in full school</li> <li>• Number of feeder primaries</li> <li>• Type of communities – socio-economic – mix?</li> <li>• Rural/urban location / catchment areas</li> </ul>
	How many schoolgirl mothers (under 18) would the school have per academic year? How many of these would you deal with?
	In the cases that you have dealt with, did the schoolgirls tell you themselves that they were pregnant?
	In the cases that you have dealt with, what stage in their pregnancy did the girls advise the school? <ul style="list-style-type: none"> <li>• 0-3 months / 3-6 months / 6-9 months</li> </ul>
	Thinking about the cases that you know of, have the schoolgirls been from different social class backgrounds?
	From the cases you are aware of, are the girls from all levels of attainment?

	In these specific cases, would the girls' own parents' employment be: <ul style="list-style-type: none"> <li>Professional / managerial-technical / skilled (non-manual/manual) / partly skilled, unskilled, other?</li> </ul>
	Information is passed from primary schools to secondary schools during the transition stage. Thinking about the cases you have dealt with, did any of the information refer to the relationship between the schoolgirl and her parents?

<b>Support</b>	
	What sort of support would schoolgirl mothers-to-be, be offered and by whom?
	In the cases you can think of: <ul style="list-style-type: none"> <li>Have the schoolgirl mothers-to-be and/or their family asked school staff for any kind of support or help?</li> <li>Was this at the time of advising you about the pregnancy or later on during the pregnancy?</li> <li>Do you have any evidence or hunch about whether the schoolgirl mothers-to-be, or her family feel, that they make a choice of who to ask for help and which professional services they will access?</li> <li>Do you have any evidence or hunch about whether the schoolgirl mothers-to-be are confident in asking for help and know who to approach for help?</li> <li>Do you have any evidence or hunch about whether the schoolgirl mothers-to-be, or her family, trust staff with this kind of sensitive information?</li> <li>Are they more likely to opt for informal sources of support i.e. family/friends rather than professional services?</li> </ul>
	Would schoolgirl mothers and mothers-to-be, be allocated a key person to deal with any problems or do these all go through guidance teachers / pastoral staff? <ul style="list-style-type: none"> <li>Is the relationship between one key member of staff and the schoolgirl important or is it just necessary that they have a range of staff they can speak to?</li> </ul>
	Would a member of school staff sit with the girl and carry out any form of assessment or needs analysis or risk assessment re: <ul style="list-style-type: none"> <li>Access to a lead professional to co-ordinate support and review their progress?</li> <li>Discuss additional needs in confidence</li> <li>Look at childcare</li> <li>A focus on educational needs to plan and tailor their transition back into learning and employment</li> <li>A focus specifically on maintaining school attendance and how to make this easier</li> </ul>
	Are there any support programmes or parenting programmes run either within school or through multi-agency partners who provide training or support sessions?



<b>Attendance</b>	
	<p>How does the school record attendance – SEEMIS?</p> <ul style="list-style-type: none"> <li>• Would anyone monitor or analyse the attendance of the schoolgirl mothers?</li> <li>• What process is used to record pastoral notes – On The Button?</li> </ul>
	In the cases that you have dealt with, what is the attendance of the girls like?
	If the attendance of the girls deteriorates either during pregnancy or after returning to school what happens regarding attendance (a legal requirement)? Flexible arrangements?
	<p>From the cases that you have dealt with:</p> <ul style="list-style-type: none"> <li>• What year were the schoolgirl mothers-to-be in when they left school?</li> <li>• Were they close to the school leaving age?</li> <li>• Did most of the young people you know of sit their exams or leave without qualifications?</li> <li>• Would they normally leave with qualifications or achievements of some form?</li> <li>• Would their educational achievements and qualifications have been any different had they not been pregnant/had a baby?</li> </ul>
	<ul style="list-style-type: none"> <li>• Are you aware of any cases when the schoolgirl mother did not return to school/education?</li> <li>• For those that did not return, do you have any evidence about why they did not return?</li> </ul> <p>Would it be because they:</p> <ul style="list-style-type: none"> <li>• They did not want to return to school/college after having the baby, and would not even if they had someone to look after the baby</li> <li>• Would have liked to return to school/college but had no-one to look after my baby</li> <li>• Had plans to return to school/college, have childcare but they worry that it would be too hard to manage having a baby and school/college</li> <li>• They found it too hard to leave the baby with someone else while they were at school/college</li> </ul>
	Are you aware of cases when the girl did return? If the girls decide to return to school/education, when would this be i.e. 6 weeks?
	Local authorities and schools are responsible for planning and supporting young people to make successful transitions to young adulthood and the world of work. What happens in terms of planning a successful transition for schoolgirl mothers and mothers-to-be?

<b>Professionals/Schools</b>	
	Does your school have a nurse based on site?
	Do schoolgirl mothers and mothers-to-be access the school nurse? <ul style="list-style-type: none"> <li>• What kind of things would this be for?</li> <li>• Would they do this instead of accessing support from health professionals at local clinics?</li> </ul>
	What happens when the young person needs to attend ante-natal classes, does a member of staff accompany them? Are the antenatal classes run in the school?
	Does the school have a link health visitor?
	Would health professionals external to the school notify you of teenage pregnancies or share information with you?

<b>Experiences</b>	
	In cases you now, would you say that most girls were or were not disengaged from school before becoming pregnant? <ul style="list-style-type: none"> <li>• Is there anything that the disengagement could be specifically linked to i.e. <ul style="list-style-type: none"> <li>○ a bad educational experience</li> <li>○ relationships with peer group/friends / bullying</li> <li>○ deviation from normal education pathway</li> <li>○ changing identities</li> <li>○ influenced by teachers / lack of encouragement / judgemental attitudes</li> </ul> </li> </ul>

<b>Challenges</b>	
	Are there any practical obstacles that the young people face while pregnant and attending school i.e. toilet passes, negotiating stairs, desks, chairs uncomfortable? How are these addressed?
	What about wearing school uniform during pregnancy? Flexible arrangements?
	Are there any special arrangements put in place for examinations?
	If the schoolgirl mothers return, would they follow a full timetable?
	Young people quite like to be seen as fitting in, treated normally: <ul style="list-style-type: none"> <li>• Do they comment that special arrangements single them out?</li> <li>• Could the special arrangements contribute to their engagement or disengagement from education?</li> </ul>
	Would you record or log schoolgirl pregnancies as a child protection issue?
	For the young mothers that stay on in school, and are aged 16, would any claim EMA or ask about benefits?
	Any cases where there has been noticeable changes in the schoolgirl mothers/mothers-to-be in terms of their identity, self-esteem, confidence?

<b>Health</b>	
	What is the health like of the girls during pregnancy? What about when they return?
	What about the health of the babies?
	What about the mental health of the girls before / after having the baby?

<b>Other</b>	
	Teachers' reactions?
	Are there any particular advantages or disadvantages to the way the school responds to schoolgirl mothers and mothers-to-be?
	How would the school measure success of the way the school responds to schoolgirl mothers and mothers-to-be?

## Appendix 8 – Letter to NHS health visitors, consent form, questions for interviews

School of Social and Political Sciences,  
The University of Edinburgh,  
15a George Square,  
Edinburgh,  
EH8 9LD.

Tel: 07702 349790

[Date]

To: NHS Health Visitors

### **Letter of Invitation Research Project - Schoolgirl Mothers and Mothers-to-be**

I am a 3<sup>rd</sup> year (part-time) student at The University of Edinburgh and am doing a research project for my postgraduate degree (PhD) on schoolgirl mothers and mothers-to-be who are still attending secondary school. There are many schoolgirls across Scotland who have had a baby while still attending school but we do not know very much about their experiences.

As part of my research, I would like to interview one Health Visitor from each of the NHS Boards listed above. The purpose of the interview is for me to learn about the existing practical and supporting role of NHS Health Visitors to schoolgirl mothers. After completing the interviews, I will send you a transcript that you will be able to check over for accuracy.

I have a lot of experience in working with parents and young people and am currently carrying out research with schoolgirl mothers and mothers-to-be within my own Local Authority (Falkirk Council). The purpose of the research within Falkirk Council is to assist us in writing our own Policy Guidance and Pathway for staff in schools on how to support schoolgirl mothers and mothers-to-be.

The names and contact details of my supervisors at The University of Edinburgh are as follows:

Professor Lynn Jamieson, Tel: 0131 650 4002, E-mail: [l.jamieson@ed.ac.uk](mailto:l.jamieson@ed.ac.uk)  
Professor John MacInnes, Tel: 0131 651 3867, E-mail: [john.macinnes@ed.ac.uk](mailto:john.macinnes@ed.ac.uk)

If you are able to reply to me by E-mail on [B.E.Ferguson@sms.ed.ac.uk](mailto:B.E.Ferguson@sms.ed.ac.uk) to advise if you would like further information about the project and/or if you are willing to be involved in an interview with myself, I would be very grateful. The interview would last approximately one hour.

I look forward to hearing from you.

Yours sincerely,

**Beverley Ferguson  
PhD Student**

	<p><b>SCHOOLGIRL MOTHERS AND MOTHERS TO BE</b> (aged 18 and under)</p> <p><b>AT SCHOOL</b></p>	
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Participant's Study Identification Number:

**CONSENT FORM FOR QUALITATIVE RESEARCH INTERVIEWS WITH  
HEALTH VISITORS**

**What experiences and challenges do schoolgirl mothers and mothers-to-be (aged 18 and under) living in Scotland encounter whilst still attending school?**

I ..... would like to be involved in this project and am happy to meet with you to talk further about this.

My contact details are:.....Tel. No: ..... E-mail: .....

*Please initial  
box*

- |   |   |
|---|---|
| 1. I confirm that I have read and understand the Participant Information Sheet dated..... (Version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input style="width: 80px; height: 30px;" type="text"/> |
| 2. I agree to be interviewed for the purposes of the above project.   | <input style="width: 80px; height: 30px;" type="text"/> |
| 3. I agree that the interview will be electronically recorded and that any personal details will be anonymised.   | <input style="width: 80px; height: 30px;" type="text"/> |
| 4. I understand that anonymised quotations (using my code name) from my interview may be used.  | <input style="width: 80px; height: 30px;" type="text"/> |
| 5. I understand that I can withdraw at any time.  | <input style="width: 80px; height: 30px;" type="text"/> |

I am available to meet with you on:  Monday  Tuesday  Wednesday  
 Thursday  Friday  Saturday

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

**Contact Information:**  
 Beverley Ferguson, School of Social and Political Sciences, The University of Edinburgh, 15a George Square, Edinburgh, EH8 9LD. Tel: 01324 506694 / Mob: 07702 349790 / E-Mail: B.E.Ferguson@sms.ed.ac.uk

## Appendix 9 – Interview questions for health visitors

<b>Health Board:</b>		<b>Local Authority:</b>		
<b>Member of Staff / Position:</b>				

<b>Background</b>	
	<ul style="list-style-type: none"> <li>• How many Health Visitors would be in your team?</li> <li>• Is there a set number of cases that you are allocated?</li> <li>• Type of community – socio-economic mix?</li> <li>• Rural/urban location</li> </ul>
	<ul style="list-style-type: none"> <li>• How many schoolgirl mothers (under 18) would there be per year? How many of these would you deal with?</li> </ul>
	Thinking about the cases you know of, would you know what stage the girls advised professionals about their pregnancy? <ul style="list-style-type: none"> <li>• 0-3 months</li> <li>• 3-6 months</li> <li>• 6-9 months</li> </ul>
	<ul style="list-style-type: none"> <li>• Thinking about the cases that you know of, have the schoolgirls been from different social class backgrounds?</li> </ul>

<b>Information on Ante-natal care</b>	
	Health Visitors normally take over from midwife around day 10. I'm interested in the ante-natal care prior to the Health Visitor taking over: <ul style="list-style-type: none"> <li>• Would you be aware of what ante-natal care would be provided during pregnancy?</li> <li>• Would the ante-natal care for schoolgirl mothers-to-be, be any different?</li> </ul>
	From the cases you are aware of, do schoolgirl mothers attend their ante-natal appointments? <ul style="list-style-type: none"> <li>• Any evidence or hunches about why they did/did not attend?</li> </ul>
	If schoolgirl mothers did want to attend but can't for a particular reason ie transport, is there any assistance provided by health service?
	From the case you know of, did the schoolgirl mothers who did attend, come on their own or bring someone with them?
	When would ante-natal appointments run i.e. during the day? Are there any flexible appointments or evening appointments?
	Would separate ante-natal classes be offered and held for schoolgirl mothers-to-be?

<b>Health Visitor Role</b>	
	After the schoolgirls have delivered their baby, do you meet with the midwife for a handover? <ul style="list-style-type: none"> <li>• What kind of information would be shared?</li> <li>• Would the information shared for young mothers be any different to the information shared for other women?</li> </ul>
	Is there a procedure for reporting/referring teenage pregnancies to Health Visitors? <ul style="list-style-type: none"> <li>• Would you contact schools / local authority / social work / police?</li> </ul>

	What would the role of the Health Visitor be when they are assigned a case with a schoolgirl mother? <ul style="list-style-type: none"> <li>• General practical role?</li> <li>• Supporting role?</li> <li>• Regular visits</li> <li>• Is this any different to other women?</li> </ul>
	How long do Health Visitors support young mothers after they have had their baby?

	<p>Would Health Visitors carry out any form of assessment on the young mother i.e. to provide:</p> <ul style="list-style-type: none"> <li>• Access to a lead professional to co-ordinate support and review their progress?</li> <li>• An opportunity to discuss additional needs in confidence</li> <li>• A range of support including childcare to meet their assessed needs</li> </ul>
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<b>Health of young mother/baby</b>	
	<p>Would you be aware of the general health of a schoolgirl mother or any particular health issues for her during pregnancy?</p> <ul style="list-style-type: none"> <li>• What about after they have delivered?</li> </ul>
	<p>From the cases you have dealt with, what has the health of the babies been like?</p> <ul style="list-style-type: none"> <li>• Has this improved or deteriorated in recent years?</li> </ul>
	<p>What about the mental health of the girls before/after having the baby?</p>
	<p>From the cases you have dealt with, has a negative response to their pregnancy impacted on their mental health and wellbeing?</p>
	<p>In the cases you have dealt with, have there been specific things that have determined a positive or negative health outcome?</p> <ul style="list-style-type: none"> <li>• Age of schoolgirl?</li> <li>• Poverty?</li> <li>• Lack of ante-natal care</li> </ul>
	<p>Thinking about the cases you have dealt with, is there any reason to think that schoolgirl mothers are more or less prone to post-natal depression than older mothers?</p> <ul style="list-style-type: none"> <li>• Is there a pattern to when this occurs i.e. a few weeks after the baby is born?</li> </ul>
	<p>In the cases you are aware of, has there been any particular adverse effects of becoming a mother during the teenage years?</p>

<b>School</b>	
	<p>Would Health Visitors meet with:</p> <ul style="list-style-type: none"> <li>• School nurses to discuss any issues regarding the schoolgirl mother/baby?</li> <li>• School staff to discuss any issues regarding the schoolgirl mother/baby?</li> </ul>
	<p>Do Health Visitors provide any guidance to schoolgirls about when they should return to school/college after having a baby?</p>
	<p>What would be an ideal time for them to return to school/college if they are going to return?</p>
	<p>Would school staff raise any concerns with health professionals about pupils being off school and away from their lessons?</p>



	<p>If the girls do return to school/college, do you notice any changes/differences in any way?</p> <ul style="list-style-type: none"> <li>• Health?</li> <li>• Maturity?</li> <li>• Confidence?</li> <li>• Identity?</li> <li>• Self-esteem?</li> </ul>
	Do schools have a link Health Visitor?
	Would school staff notify health professionals of any teenage pregnancies or share information with you?

<b>Support/programmes</b>	
	What sort of support would schoolgirls mothers be offered and by whom?
	<p>In the cases you can think of, have the girls:</p> <ul style="list-style-type: none"> <li>• Contacted you or asked you for advice and support / finance? What stage was this at ie just after the birth?</li> <li>• What kind of things would this be for?</li> <li>• Do you have any evidence or hunch about whether they make a choice of who to ask for help and which professional services they will access?</li> <li>• Do you have any evidence or hunch about whether the schoolgirls or her family are confident in asking for help and know who to approach for help?</li> <li>• Do you have any evidence or hunch about whether the schoolgirl mothers or her family trust professionals with this kind of sensitive information?</li> <li>• Are they more likely to opt for informal sources of support i.e. family/friends rather than professional services?</li> </ul>
	Schoolgirls are allocated a Health Visitor, if that person was unavailable, could the girls approach another Health Visitor or member of the team?
	Would Health Visitors organise support groups for young mothers? Have any been arranged in this area?

	<p>Are there any parenting programmes being run in the area?</p> <ul style="list-style-type: none"> <li>• Do young mothers attend these? If not, do you have any evidence or hunches about why they do not attend?</li> <li>• Could it make them think that they are not good at parenting?</li> </ul>
	<p>Are there any particular issues in the community over young mothers being unable to access programmes/support i.e. transport issues, geographical issues?</p>

<b>Relationships</b>	
	<p>From the cases that you have dealt with, what is the relationship like between the schoolgirl and the Health Visitor?</p> <ul style="list-style-type: none"> <li>• How did the schoolgirls react to the Health Visitor's involvement?</li> </ul>
	<p>Would you build up a relationship with the schoolgirl's wider family or just with them?</p>
	<p>What is the attachment and bonding like between schoolgirl mothers and their babies?</p>

<b>Other</b>	
	<p>Reactions by health professionals?</p>
	<p>Are there any particular advantages or disadvantages to the way Health Visitors respond to schoolgirl mothers?</p>
	<p>Would the role of Health Visitors in general alter if the Family Nurse Partnership was rolled out across all Health Boards?</p> <ul style="list-style-type: none"> <li>• How would you see this changing?</li> </ul>
	<p>How would Health Visitors measure success in the way they respond to schoolgirls?</p>

## Appendix 10 – Review of Scottish Government policies relating to schoolgirl mothers/mothers-to-be

The following review of policies has been organised into five themes. These are health, poverty and financial dependence, early years, integrated services for children and other relevant policies.

### *Health – Reducing Inequalities in Scotland*

#### **A Framework for Maternity Services in Scotland (2001) / A Refreshed Framework for Maternity Care in Scotland (2011)**

Shortly after the longitudinal scoping study had been commissioned in 2000, the Scottish Government produced a document called ‘A Framework for Maternity Services in Scotland’ (2001). This document set out the vision for Scotland’s maternity services including the provision of quality parent education services which would meet the needs of all parents. The aim of the framework was to work in partnership with individuals, communities and service providers to ensure that children across Scotland got the best possible start in life.

The framework recognised that having a baby was a major life event. It also noted that early influences could have life-long health consequences even before the birth of the baby. The Scottish Executive decided to focus and invest in supporting parents, children and families. Maternity services were seen as playing a vital role in providing care and support for women, their partners and their babies during this time.

There were several principles set out in the framework which was aimed at all women of reproductive age. The purpose of the framework was to empower and encourage women to be as healthy as possible. In addition to this, NHS trusts in partnership with local authorities were to ensure that ‘the specific needs of pregnant schoolgirls are met and that all professionals have the skills to support this vulnerable group’ (2001, p63).

Social influences before, during and after pregnancy were viewed as impacting on the child and the mother’s health. Key target areas for resources to be deployed were identified as childcare, education, employment and health. Educating children on the importance of a healthy pregnancy was to start in school where life skills and lifestyles were to be a core part of personal and social development. It was the role of maternity services to ensure that women’s circumstances were assessed holistically and any social and psychological needs were to be identified and managed accordingly. At a local level, NHS Trusts were to make sure that ‘all professionals received training in monitoring and supporting women with particular needs such as pregnant schoolgirls’ (2001, p44).

In January 2011, the framework was re-launched under the title ‘A Refreshed Framework for Maternity Care in Scotland’. This revised document was designed to address the care provided from conception through pregnancy and during the postnatal phase. Some of the key drivers were to measure improved access, care and the

experiences for all women. It was also to ensure that women and their babies were cared for by the right team of people who had the right skills in the right place. The need to use women's experiences of maternity care in order to drive service improvements was acknowledged. Investing in early intervention, prevention and support was viewed as a significant saving in the longer term for public services. Reaching women who were in the higher risk groups during the antenatal period would further strengthen the NHS's capacity to promote healthier pregnancies. In essence, getting maternity care right for all women was viewed as a vital part of giving Scotland's children the best possible start in life.

Strengthening antenatal care in order to get better engagement with those families at a higher risk of poor outcomes was viewed as being very important. Particular attention was to be paid to schoolgirl mothers-to-be as they traditionally did not attend antenatal classes and had less engagement with the NHS.

This refreshed framework identified other public services as having a key part to play in areas such as pre-conceptual health and the delivery of personal, social and health education elements. For this reason, the revised framework was to be viewed as part of the wider health improvement agenda.

### **Better Health, Better Care: Action Plan (December 2007)**

A document produced by the Scottish Executive called 'Building a Health Service: Fit for the Future,' (2005) identified the challenges that the National Health Service were facing. In 2005 the Scottish Executive felt that they needed a new and different approach for the National Health Service (NHS). A revised strategic vision was drawn up called 'Better Health, Better Care: Action Plan' (2007). In order for the vision to succeed, the Executive felt that patients' experience of care had to improve, everyone should take responsibility for their own health and wellbeing, health inequalities should remain a focal point, partnership working was essential and early intervention and prevention was crucial. The vision was based on a shift which viewed people as patients or service users, to seeing the Scottish people and NHS staff as partners or co-owners (in the NHS) and who had real involvement, representation and a voice that was heard. The document and their implementation plans showed how early years could contribute to addressing health outcomes.

The Action Plan acknowledges that many 'teenage girls experience unintended or unwanted pregnancies. While pregnancy and parenthood are positive choices for some young people, for others unintended pregnancies and parenthood are associated with negative social and psychological consequences such as incomplete education, poverty, social isolation and low self-esteem' (2007, p27).

Scotland's NHS antenatal services felt that they were uniquely placed to develop relationships early on with families and to identify risks but also provide a preventative approach to health care. In order to do this, the NHS felt that they needed to 'strengthen antenatal care so that we get better engagement with families who are at higher risk of poor outcomes, paying particular attention to the needs of teenage mothers who have traditionally started antenatal support later' (2007, p28).

The Better Health, Better Care Action plan promised to promote infant nutrition with the new Food and Health Delivery Plan. It also wanted to improve breastfeeding rates and appoint an Infant Nutrition Co-ordinator.

### **Respect and Responsibility (2005 & 2008-11)**

Scotland's national Sexual Health Strategy 'Respect and Responsibility', was launched in January 2005 with the aim of (amongst other things) reducing the number of unintended schoolgirl pregnancies throughout Scotland. Success of this was noted as being dependent on involving parents, carers, young people and partners along with key clinical services. The subject of sexual health was acknowledged as being a controversial subject with deeply held views on moral issues along with cultural and lifestyle differences. The Ministerial Foreword at the beginning of the document states that 'it would be easier to focus our public health efforts elsewhere. But with schoolgirl pregnancy rates amongst the highest in Europe and rising rates of diagnosed sexually transmitted infections across all ages, such an approach would not be responsible' (2005, piii).

The key messages and values of 'respect' and 'responsibility', as noted in the title of the document, are strongly identified as being part of a parent's and/or the family's role to pass on to their children and to help shape their lives. The Scottish Executive clearly stated that it supported the approach of abstinence of sexual activity which it sees as being a legitimate choice, or delaying sexual activity until a mature, loving relationship is established and this is believed to be a positive choice.

In addition to the roles and responsibilities placed on parents, schools too were identified as having a crucial role to play. The role of schools was in 'fostering healthy attitudes towards relationships, sex and sexuality in young people. All schools are expected to provide sex and relationships education' in an objective, balanced but sensitive manner which is consistent with the principles and aims of national guidance (2005, p8).

The role of the media in portraying sexual images across many aspects of modern society as well as being used to sell products, was not overlooked. The messages arising from the media images were acknowledged as leading not only to pressure but also to confusion over the realities of relationships. This was seen as particularly influencing young people on the idea that casual attitudes to sexual issues were not only acceptable but free of risk.

The Scottish Executive proposed to use the same powerful tool of the media to provide positive information about sexual health. Work with the media would look to supporting action to improve sexual health through accurate but balanced reporting but also to relay the message that abstinence and delayed sexual activity in young people was a socially acceptable choice.

Revised outcomes for the Sexual Health Strategy was produced and covered a three year period from 2008-2011. The revised document outlined plans for all young people to 'receive evidence informed, age appropriate sex and relationships education

and have access to a linked local drop-in service which provides as a minimum, general health advice, chlamydia testing, pregnancy testing and free condoms'. In addition to this, there was to be an 'increased confidence and competence of education, nursing, community learning, social work, voluntary and community sector staff leading to provision of relevant interventions which meet young people's needs' (2008-11, p10).

### **Equally Well (2008)**

The first significant Scottish Government document to be produced after the first research report on sweep 1 of the findings from the Growing Up in Scotland survey, was called 'Equally Well' (June, 2008). This document was a report of the Ministerial Task Force on health inequalities and it contained a number of important key findings. Firstly, the children born to parents in the lowest income quintile were much more likely than others to have been affected by a number of things including having an unmarried schoolgirl mother. Prior to the policy being produced, the Scottish Executive (now Scottish Government) had set national targets in 2004 to reduce health inequalities through increasing the rate of improvement across a range of indicators for the most deprived communities (Equally Well, 2008).

These targets were to 'improve the health and quality of life of the people of Scotland and to deliver integrated health and community care services making sure there is support and protection for those members of society who are in greatest need' (p24). Out of the six indicators set, each one was described in the document as being on track to meet their target apart from the one selected regarding schoolgirl pregnancies amongst 13-15 year olds. The Equally Well document goes on to highlight that 'a reduction in health inequalities, by improving the health of those most deprived, is likely to result in a reduction of costs to the NHS and society as a whole' (p26). The exact amount of possible savings, was described as hard to estimate due to the range of inequalities that existed.

Outcomes for children of schoolgirl mothers were reported in 'Equally Well' as being poorer. The inequalities amongst schoolgirl mothers appeared in pregnancy and the early years. Young mothers were also reported as being less likely to attend ante-natal classes, to breastfeed their baby or to know who to ask for help.

'Equally Well' highlighted some caveats in that some areas of the research evidence had come from the United States where health, welfare and the education systems were all different. It emphasised the need to test some of the evidence and assumptions in a Scottish context and to engage a wider range of stakeholders in order to develop the Early Years Framework document.

Despite the findings listed above and the clear acknowledgement that further evidence in a Scottish context was necessary, there was no research conducted nor policy guidance devised which endeavoured to consider schoolgirl pregnancies in any shape or form.

## **Convention of Scottish Local Authorities (COSLA) paper (within Equally Well)**

The Convention of Scottish Local Authorities submitted a paper to the Joint Ministerial Task Force on health inequalities. The paper discusses two main questions, ‘how do we tackle the causes of health inequalities?’ and ‘how do we respond to the consequences of health inequalities?’ Public Services within the paper are seen as being well equipped to deal with the manifestation of health inequalities but it is recognised that they need to become better at dealing with the causes.

The key to success in tackling the causes of health inequalities is viewed as ‘effective targeted intervention during the early years of a child’s development’ (p27). A holistic approach which links health inequalities to the development of an early years strategy was stated as being the best way forward.

In order to understand what works in tackling the causes of health inequalities, the suggestion was made that ‘knowledge sharing networks should be established to ensure that practitioners have the tools, skills and resources to make an impact on health inequalities’ (p27). Being in the role of providing education, regeneration, housing (amongst other things), local government viewed themselves as being a key player in helping to ‘tackle the consequences of health inequalities’ (p27). COSLA stated that they are ‘committed to maintaining and improving these crucial services, thus improving the health and well-being of all members of the community, but particularly those living in disadvantage’ (p27).

The need for central and local government to consider how best to fund the transition from reactive crisis management to proactive early intervention and prevention was raised. COSLA’s proposed way forward was to propose a long-term twin track approach to resourcing the change. Firstly, investment would need to be made in the capacity to respond to crisis and secondly, to prevent it from happening in the first place. Making a real impact on the health inequalities agenda was, according to COSLA, dependent on strategic and political buy in. Single Outcome Agreements were identified as the vehicle to deliver change at the strategic level. These agreements contain a range of indicators and outcomes which would relate to the health inequalities agenda.

The Scottish Government’s Joint Ministerial Task Force was tasked with looking at health inequalities with its main aim being to agree priorities for cross-cutting government activity which would achieve measurable outcomes in reducing health inequalities. Two of the key priorities highlighted from the work already carried out at that time were firstly that children’s very early years, where inequalities first arose, may influence the rest of people’s lives and secondly because there was a high economic, social and health burden imposed by mental illness, there was a requirement to improve mental wellbeing.

As a way forward, it was agreed that the Scottish Government and COSLA would work together to develop an Early Years Strategy. It was identified that there was a need to become ‘more successful at providing services to children and parents who are hardest to reach, in order to ensure that the physical, emotional and mental wellbeing

of the child is nurtured and protected’ (p33). The Early Years Strategy aspirations and work on health inequalities was to be carried out in line with the ‘Getting it right for every child’ agenda. In order to make an impact on health inequalities, COSLA identified that they needed to ensure that there was a ‘more concerted effort to deliver pro-active services and that intervention was targeted at high risk families’ (p37).

The evidence available to COSLA suggested that ‘child-focused, goal-directed, well-structured interventions have the best outcomes’ and that it might involve ‘developing intensive support mechanisms for high-risk families until the child reaches school age’ (p29). Wrap around care was seen as an option to reduce the impact of ‘chaotic environment in the early years’ (p29). The Equally Well (2008) document refers to a review carried out by the Centre on the Developing Child at Harvard University on ‘A Science-Based Framework for Early Childhood Policy’ (2007). The Harvard review identifies a number of effective approaches to reduce inequalities in the early years. One of these is ‘targeted interventions/programmes for children at particularly high risk and effective risk management’ (p37).

Difficulties in engaging hard to reach families who were unsure of statutory services were acknowledged along with the challenges that partner agencies like Sure Start had experience in trying to do so. Understanding the causes of health inequalities was agreed as becoming clearer but there was still less understanding around what worked in tackling the causes of these inequalities.

As a way forward COSLA proposed to commit to the health inequalities agenda through five key principles. These were: universal service provision tailored to individual need; effective early intervention; shared learning to help understand what works in tackling health inequalities; strategic approach to partnership working through Single Outcome Agreements; and a longer term twin track approach to resourcing change.

### **Improving Maternal and Infant Nutrition Framework (2011)**

The Improving Maternal and Infant Nutrition Framework (2011) was based on the principles outlined above in ‘Better Health, Better Care’ (2007) and ‘Getting it right for every child’ (2008). The Scottish Government recognised that international and national work over a number of years had focused on promoting and supporting breastfeeding but there had not been the same focus on improving the nutrition of mothers during pregnancy and beyond mild feeding. This Framework stresses the ‘importance of concentrating efforts on the early years and targeting those in need, to ensure that health outcomes for children are improved and health inequalities reduced (2011, p4). The document is aimed at policymakers in organisations and frontline staff and volunteers.

The framework states that ‘younger mothers, those living on a low income or in areas of deprivation and those with fewer education qualifications are less likely to take the recommended nutritional supplements prior to pregnancy and have a good diet during pregnancy’ (2011, p7). Nutritional health in women prior to conception and the early weeks after conception are recognised as being really important to influence the



growth and development of the unborn baby. These critical periods can also influence longer term health outcomes.

One of the appendices in the framework makes reference to Public Health Guidance produced by NICE on research recommendations. These recommendations state that research commissioners and funders should commission research into ‘effective ways of improving the nutritional status of pre-conceptual women’ (2011, p91). It should also identify ‘effective ways of engaging with women both before and during pregnancy’ and pay ‘particular attention to teenage parents’ (2011, p91). The framework has estimated that up to 50% of all pregnancies are unplanned but those who do plan their pregnancy are more likely to have taken folic acid supplements prior to conception.

Younger mothers are also ‘less likely to breastfeed and more likely to introduce complementary foods earlier than recommended’ (2011, p7).

### **Sexual Health and Blood Borne Viruses Framework (2011)**

Sexual health and blood borne viruses are recorded as being a high priority for the Scottish Government. As a result of this, the Government launched a Framework during 2011 with an ambitious vision for these key public health challenges and it marked the first time that they had been placed alongside each other.

Within the document, local authorities are identified as having the ‘lead role at a local level in delivering national strategies which address disadvantage in Scotland and breaking the intergenerational cycle of inequalities’ (2011, p9). The local authority in partnership with the NHS, third sector and other local partners, is also tasked with taking an ‘assumed’ leadership role to reduce schoolgirl pregnancies and if relevant ensure that an indicator (relating to schoolgirl pregnancy) is identified in the Single Outcome Agreement.

The framework highlights that targeted interventions for young people known to be most at risk are more effective and cost effective. High risk groups are identified as including young people under 25 and young people not in school. Although pregnancy and parenthood are acknowledged as being positive choices and experiences for some, others may be at risk of harm as a result of unintended pregnancy and they require this targeted supportive and preventative action. A more targeted approach with multi-agency partners working together is the Scottish Government’s desired way forward within the document.

In addition to having a lead role to deliver national strategies and reduce schoolgirl pregnancies, local authorities are also responsible for ensuring that ‘relationships, sexual health and parenthood education is delivered to all young people both in school and wherever learning is taking place’ (2011, p11), within the Health and Wellbeing component of the curriculum. This is seen as an ideal opportunity for links to be made with other health improvement issues and risk-taking behaviours. Parents too are viewed as having an essential role to play in providing age appropriate information on

relationships, sexual health and parenthood. Local authorities must support and facilitate parents to discuss these issues with their children and young people.

### **Mental Health Strategy 2012-15**

‘Mental illness is one of the top public health challenges in Europe’ (Mental Health Strategy, 2012-15, p3). In August 2012, the Scottish Government launched its Mental Health Strategy for Scotland. The document brings the ‘mental health improvement work’ and ‘work to improve mental health services’ together for the first time under one single strategy. It sets out the Government’s plans to work together with partner agencies to respond to the continuous challenges of improving mental health whilst endeavouring to improve services and outcomes for individuals and communities.

Within the document there are 36 key commitments across the full spectrum of mental health improvement. The key commitments are to demonstrate the Scottish Government’s desire to increase the pace of change and focus on key future changes and improvements within an accountability framework (Mental Health Strategy, 2012). The strategic objective is to help people sustain and improve their health, especially in disadvantaged communities ensuring better, local and faster access to health care.

This strategy document has a range of themes to help improve mental health services. These themes are set in the context of a Quality Strategy and they focus on working with people and communities to produce better outcomes. In addition to this there are three quality ambitions for Scotland whereby health and care is to be ‘person centred, safe and effective’. The person centred approach is to develop mutually ‘beneficial partnerships between patients, their families and those delivering healthcare services’ whilst also respecting ‘individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making’ (Mental Health Strategy, 2012, p13). This approach requires change in how the NHS and its partners actually develop and then deliver services while also giving people more control and engagement. Work is ongoing with service users to understand how they experience and understand their health and to ensure that they are involved in their own healthcare experience.

Lastly, another quality ambition is ‘effective’ and this is to ensure that the most appropriate treatments, interventions, support and services is provided at the right time to everyone who will benefit.

The first key area for change is in child and adolescent mental health. The strategy recognises that the period between pregnancy and three years of age is seen as a critical time in shaping the life chances of children. This is based on evidence of brain formation, communication and language development along with the impact of relationships being formed during this period on mental health (Mental Health Strategy, 2012). The early period of a child’s life is also viewed as being a critical opportunity for intervention in order to break the cycle of poor outcomes.

Within the strategy a set of national mental health indicators have been established for children and young people. These indicators cover the state of mental health and the associated contextual factors. For the first time, this provides a means of assessing and monitoring the mental health of children and young people in Scotland over a period of time thus allowing the development of a national mental health profile for children and young people from pre-birth to age seventeen. The profile is to be updated every four years and will provide a greater understanding of the current and changing picture of mental health in children and young people and the factors which influence it.

The second key area of change is to rethink how common mental health problems are responded to. Commitments outlined in the strategy promise that more therapies will be available along with a wider range of responses, social prescribing, self-help and peer to peer work. The notion exists that more and more people are able to self-refer to services or search out support themselves and this is viewed as building capacity, making choices and is in itself health producing because of the degree of control that it brings. Previously the model used was that doctors would diagnose and then treat an illness. Under the new changes, people will identify problems themselves, seek help and take action but this also includes and recognises that families and friends are also able to offer support. It is accepted that these new ways of working will not be for everyone either through personal choice or because of illness. Services and approaches are requested through the strategy to adapt quickly to this new change.

### *Poverty and Financial Dependency - Reduction*

#### **Achieving our Potential (2008)**

‘Achieving our Potential’ framework was launched in November 2008 and it is aimed at tackling poverty and income inequalities in Scotland.

The Scottish Government’s purpose in and through this document is to create a ‘wealthier and fairer’ Scotland. It is also to ‘provide the opportunities and incentives for all to contribute to Scotland’s sustainable economic growth’ (p3). Single Outcome Agreements were made between the Scottish Government and Community Planning Partnerships and their purpose was to provide the means of describing how poverty was being addressed at a local level.

The framework while aiming to provide a balanced approach, encouraged people to work and it aspired to remove barriers to employment. It also aimed to continue supporting those who could not work and to provide opportunities for ‘all people to flourish and to work with others to tackle the injustice of poverty in modern Scotland’ (p1). The difficulties and disadvantages that families with caring responsibilities can face in accessing and sustaining employment is recognised in the framework. Balancing care and work is also acknowledged as is losing confidence after having been out of the labour market when caring for their family. The framework sees ‘a lack of high quality reliable childcare’ as discouraging people from seeking or moving towards employability.

Young people are encouraged in the framework to stay in learning post-16. This was to be achieved through support from the 'More Choices, More Chances' (2006) Strategy whereby the new 'Curriculum for Excellence' would provide 'flexible opportunities tailored to individual need and clear pathways from school to learning, post-16, with appropriate support throughout' (p7). This new model would ensure that 'every young person has an appropriate, relevant, attractive offer of learning made to them, well in advance of their school leaving date' (p14). This was expected, by the Scottish Government, to be a universal offer across Scotland by 2010 and it was anticipated that a 'special focus will be needed by local authorities and their partners on the most vulnerable young people' (p14). Staying in education is viewed by the Scottish Government as 'the best way of ensuring their (young people) long-term employability and contribution to society' (p7). To assist in this policy objective, access and participation in further and higher education was widened to address student hardship and provide grants for part-time learners in higher education.

One area of change which is viewed in the framework as being of vital importance is the new relationship and way of working with local authorities. This has seen a 'move away from micro-management' at the Scottish Government and 'one size fits all' national solution approach to provide local authorities with the autonomy to make effective and decisive actions at a local level (p7).

'Achieving our Potential' intimated the Government's plans to introduce an 'Early Years framework' to address the root causes of disadvantage. This was to be achieved through focusing on 'supporting parents and communities to provide the nurturing and stimulating environment for children' (p14). It also called for a shift in policy from crisis intervention to prevention and early intervention.

Community Planning Partnerships (CPPs) help public agencies work with the community to plan and deliver better services that make a real difference in people's lives (Achieving our Potential, 2008). In consultation with the Scottish Government, Community Planning Partnerships were clear that they needed guidance on how to tackle poverty and income inequality in their local areas. Indicators were therefore set at a national level and Community Planning Partners subsequently adopted local indicators in order to tackle poverty and income inequality in Scotland. These indicators were also to observe progress and drive change. One of the local indicators set by Community Planning Partnerships was to reduce the number of under 16 pregnancies per 1000.

### *Children's Early Years – New Emphasis*

#### **Early Years Framework (2008)**

A third document produced in 2008 was the 'Early Years Framework'. This document aims to 'maximise positive opportunities for children to get the start in life that will provide a strong platform for the future success of Scotland' (p1). The framework seeks to have investment in the early years which is focused on building success and reducing the costs of failure. The costs of failure were considered too high and a shift

away from crisis intervention to prevention and early intervention was deemed necessary.

The document also seeks to address the needs of the children whose lives, opportunities and ambitions are hindered because of poor health, poverty, attainment and unemployment. Early years is defined in the framework as pre-birth to eight years old but it also recognises that many aspects of it are also relevant to children over eight.

At the heart of the framework is an approach ‘which recognises the right of all young children to high quality relationships, environments and services which offer a holistic approach to meeting their needs’ (p3). The approach in the framework is seen as being of particular benefit to those children and families requiring higher levels of support. Four principles of early intervention were identified as: everyone to have the same outcomes and opportunities; identifying those at risk of not achieving those outcomes and taking steps to prevent that risk of materialising; where the risk has materialised, take effective action; work to help parents, families and communities develop their own solutions using accessible, high quality public services. The vision was that all children should be able to achieve positive outcomes regardless of their race, disability or their social background.

The document carries a strong message and focuses on years 0-3 as being the period of a child’s development which shapes future outcomes. This is backed up by reference to another policy document called ‘Skills for Scotland: A lifelong Skills Strategy’ (2007) and reference to Scotland’s Chief Medical Officer’s Annual Report on Health in Scotland 2006.

### **Skills for Scotland: A lifelong Skills Strategy (2007)**

The Skills for Scotland strategy covers specific target groups starting from early years through to adulthood. The document starts off by stating that it will be Equality Impact Assessed across the areas of (race, disability, gender, sexual orientation, age and religion/faith) and monitored to ensure that it is appropriate and alleviates any potential negative impact as well as being as effective as possible for as many people as possible.

Early years are viewed in the strategy as being ‘the time when we can lay a solid foundation for skills’ (p15). Compulsory education provides the ‘chance to encourage and influence attitudes to the importance of skills and the world of work’ and this is viewed as being ‘highly relevant to shaping their life chances’ (p15). The aim of the document is to develop a unique Scottish approach to acquiring skills whilst also balancing the needs of employers and individuals and also making those individuals the central focus point of learning and skills development.

The Strategy which contains several priorities for action had emerged whilst trying to develop the workforce but also tackle the skills deficits which are barriers to employability and employment (p44). These priorities were to: ‘develop a distinctively Scottish approach to skills acquisition, balance the needs of employers/individuals, align employment/skills and place the individual at the centre of learning and skills development’; develop a coherent funding system for individuals

of all ages, in all forms of education and training that encourages participation in learning and work. This was to include support for individuals to increase control and choice over their learning and skills development; ensure that the strategy promoted equal access to and participation in skills and learning for everyone, along with equality of opportunity to those trapped by persistent disadvantage' (p44).

The new 'Curriculum for Excellence' was seen as being an ideal way to encourage schools to provide pupils with 'increased opportunities to build work related knowledge, experience and skills through a range of routes' including school-college partnerships (p16). This transition for young people from school to adulthood and the world of work was highlighted as being particularly important. Clear pathways and support which provided opportunities for all young people to engage in learning were to be arranged. Effective processes to quickly identify any young person who would be unlikely to secure and sustain training and employment would be put in place. Focused work with these young people to help identify a suitable pathway based on their motivations, aspirations and needs would be carried out. The most important thing was that young people were to be encouraged to 'retain an enthusiasm for learning'.

#### **Health in Scotland 2006, Annual Report of the Chief Medical Officer (November 2007)**

This Annual Report by the Chief Medical Officer identifies pregnancy, parenting and the first years of life as having 'a huge influence on the future mental health of the child and future adult' (p15). It goes on to explain that 'adverse events during this time can lead to irreversible problems for future ability to cope with everyday life and increase the probability of future poor mental and physical health' (p15). A parent's interaction with their child during the early years of their life is seen as 'critical to child development both within the family and in society' but also to prepare the foundations for positive physical and mental health development (p15). As these issues were likely to run through generations, the Chief Medical Officer stated the importance of 'recognising the need to invest in the health of infants, young people and children' not least because of the substantial 'long-term rewards for our future child and adult populations' (p15). Improving early years support was therefore viewed as a central part of the strategy and to help break the cycle of poor outcomes which can be associated with schoolgirl pregnancy.

In terms of what interventions work to improve a child and their family's outcomes, the Chief Medical Officer believes that 'child focused, goal directed, well-structured interventions have the best outcomes. Such interventions are cost effective. No one approach suits all infants or families and several interventions targeted at high risk families are often necessary' (p14).

## *Other Relevant Policies*

### **Reducing Teenage Pregnancy. Guidance and Self-Assessment Tool (2010)**

This guidance recognises that there are many policy documents, guides and resources that provide advice to support the reduction of schoolgirl pregnancies in Scotland. The document aims to bring together the range of current evidence and advice on partnership working, strategies and interventions which need to be in place locally if schoolgirl pregnancy rates are to be reduced.

The document also outlines the Scottish Government's overarching purpose to 'create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth' (2010, p7). Preventing schoolgirl pregnancy is identified as a strong economic argument as 'teenage mothers (and their children) are more likely than older mothers to require extensive support, placing a significant burden on local and wider public services, as well as the NHS' (2010, p17). Although the guidance and self-assessment tool is focused on the prevention of schoolgirl pregnancies, it highlights the need to ensure that provision is made for young women who do become pregnant at an early age but there is no mention of who should take this role on or what provision should be made.

The guidance was designed primarily to be used by local multi-agency sexual health strategy groups and individuals working within those groups at Health Board and local authority level who have responsibility for sexual health and reducing schoolgirl pregnancies.

Within the document, the overview on the key characteristics of successful programmes suggests that there are clearly defined roles for sexual health leads in Health Boards and local authorities. Leadership development opportunities are also available to those in a lead role and local sexual health strategies are to outline how they will ensure a competent and confident workforce (2010). Local authorities are identified as key partners in reducing schoolgirl pregnancies and in delivering training around comprehensive sex and relationship education programmes.

### **Under-Age Sexual Activity: Meeting the Needs of Children and Young People and Identifying Child Protection Concerns (2010)**

The Sexual Offences (Scotland) Act 2009 stipulates that the age of consent for sexual activity is age sixteen. Any sexual activity between an adult and a child or young person constitutes a criminal offence. Sexual intercourse and/or oral sex between children and young people who are under the age of sixteen is also unlawful.

This national guidance (Under-Age Sexual Activity, 2010) looks at how protocols can be developed to ensure that there is early identification and support for children and young people who may be at risk of significant harm as a result of under-age sexual activity. Even when there may not necessarily be a child protection issue, this guidance tries to ensure that the needs of children and young people involved in under-age sexual activity are still met appropriately.

Under the guidance, when practitioners and ‘anyone working with children and young people become aware of situations where under-age sexual activity has taken place, they have a duty to consider the impact that this has had on them and whether the behaviour is indicative of a wider child protection concern’ (2010, p1). The Under Age-Sexual Activity document provides guidance to agencies and practitioners on how they should respond to such information and aims to assist their decision-making process. The guidance is not specific about the processes that are required to be put in place locally. It does stipulate that local areas need (on an inter-agency basis) to develop their own protocols that outline how the Under-age Sexual Activity guidance is going to be implemented and put into practice.

Acknowledgement is given to the fact that ‘different individual agencies and professionals have different roles and responsibilities in relation to protecting the well-being of the individual involved in under-age sexual activity’ (2010, p2). Advice is not to be given nor ‘services provided or assessments made unless staff are appropriately qualified and trained’ and professions are to be ‘aware of the relevant local services and protocols in order to give advice’ (2010, p3). Emphasis is placed on children and young people being offered ‘a consistent and joined-up approach from every service with whom they come into contact’ (2010, p3).

Local areas are encouraged in the document to develop protocols which should include courses of action that may be followed and routes through local processes such as a flowchart. In forming the basis of a response to a case where there has been under-age sexual activity, consideration is to be given to the five GIRFEC questions which are:

- What is getting in the way of this child or young person's well-being?
- Do I have all the information I need to help this child and young person?
- What can I now do to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?

This national guidance does not specifically mention schoolgirl mothers/mothers-to-be but for those who are under the age of sixteen it automatically applies.

### *Most recent Political aspirations and Subsequent Policies*

#### **SNP Manifesto (2011)**

The SNP Manifesto in 2011 promised to deliver changes on a range of topics to the people of Scotland. The first of these which is relevant to schoolgirl mothers is the Sure Start Fund. The SNP promised to provide £50m for the early years’ initiative through the Sure Start Fund. This is designed to help deliver real change in the life chances of children in the most deprived communities. The money is to act as a change fund to support projects which will deliver effective early intervention in a child’s life. Investment was also to be made for pathfinder projects and a new generation of Children and Family Centres across Scotland which offered a range of services including childcare (SNP, 2011).



In addition to this, the SNP believe they are working to ensure Scotland has the education and training system it needs to succeed. For this reason the SNP are planning new training opportunities and flexible approaches to training. An announcement was also made that the family nurse partnership programme, currently running in NHS Lothian, would be extended to include Tayside and Glasgow with proposals to roll this out across Scotland in future. This programme is intended to provide support for teenage mothers.

Promises were also given to place greater focus on the early years and the commitment of every local authority to this agenda would be reflected in each authority's Single Outcome Agreement. The Children (Scotland) Act 1995 would also be brought up to date and new legislation would be created which would place an obligation on local authorities, the health service and Government to deliver early years services and to see early years education as an essential part of the learning journey (SNP, 2011). Efforts were to be focused on those from the most deprived backgrounds and those families who need it, would get help with parenting and access to high quality childcare.

Another priority for the SNP Government was the development of a National Parenting Strategy which would encourage agencies to work together and support all parents to allow them to develop their parenting skills. The desire of the Scottish Government in creating a National Parenting Strategy for all parents would be to try to de-stigmatise or normalise support and portray the message that everyone in a parental role needs help at some point with issues no matter how big or small.

Childcare was recognised as one of the biggest barriers to changing the circumstances of a family. Childcare for all was to be put at the centre of the SNP's ambitions for families in Scotland. The steps needed to increase childcare support in Scotland, to match the best elsewhere in Europe, were to be set out. Lastly, the SNP recognised that Government can all too often offer a one size fits all approach when sometimes a more localised and personal solution is needed (SNP, 2011).

### **Family Nurse Partnership**

The family nurse partnership programme is an intensive home visiting programme which is delivered by specially trained nurses to schoolgirl mothers aged nineteen and under. The family nurse visits the teenager every one or two weeks during pregnancy and throughout the first two years of their baby's life. It relies on developing a supportive therapeutic relationship between the Nurse and the family.

The family nurse works intensively with families and offers guidance on a range of issues including, child development, parenting skills, eating and living healthily, breastfeeding, child nutrition, future pregnancy planning, and financial planning. They also support mothers who choose to take up education or employment opportunities. The programme is not only about changing health behaviours but also about developing capacity to make choices that will improve outcomes for the schoolgirl and her baby.

## **National Parenting Strategy**

In October 2012, the Scottish Government launched its new National Parenting Strategy. The purpose of this document is ‘to act as a vehicle for valuing, equipping and supporting parents to be the best that they can be so that they in turn can give the children and young people of Scotland the best start in life’ (National Parenting Strategy, 2012, p7). This strategy seeks to turn the Scottish Government’s aspiration for Scotland to be the best place in the world for children and young people to grow up, into practical action. The process for making this happen is through championing the importance of parenting and strengthening the support on offer to parents and to make it much easier for them to actually access the support they need. A focus on supporting parents to be competent and confident in their endeavours to build strong attachments with their babies and young children is also a key theme.

Such a strategy builds on existing policies and key drivers for change such as the revised guidance on Maternity Care, Improving Health Services in the early years, the Early Years Framework and the revised Child Protection Procedures.

## **Children and Young People (Scotland) Bill**

Consultation on the Children and Young People (Scotland) Bill was undertaken by the Scottish Government during 2012. The Bill was debated in Parliament and passed on the 19<sup>th</sup> February, 2014.

The aim of the Bill is to further the Scottish Government’s ambition for Scotland to be the best place to grow up. This is to be achieved by putting children and young people at the heart of planning and services but also to ensure that their rights are respected across the public sector. A duty is placed on Scottish Ministers under the Bill to take steps to further the rights of children and young people, to promote and raise awareness and understanding of the United Nations Convention on the Rights of the Child (UNCRC).

The wider public sector are also accountable in the Bill for their efforts to take forward the realisation of rights which are set out in the UNCRC and they are required to report on what actions they are taking to progress it. Additionally, Scotland’s Commissioner for Children and Young People would have a key responsibility to take on an investigative role on behalf of individual children and young people.

Realising these rights is viewed by the Scottish Government as being essential if children and young people are to achieve what is outlined in the new Curriculum for Excellence – successful learners, confident individuals, effective contributors and responsible citizens. Through the valuing of children’s rights, policies and approaches are to be developed so that the child is placed at the centre of these. This is with a view to making certain that the child’s best interests are at the forefront of everything but also that the voice of the child is listened to when decisions are being made that could affect them.

The Bill lays out a range of proposals to take forward the Scottish Government's ambitions for services as well as for Children's rights. It will in effect set a strategic direction for the way in which Scottish Public Services should be delivered and will assist public bodies in their endeavours to improve the life chances of children and young people. In order to ensure that this happens and to remove any barriers that would prevent public bodies from delivering services effectively, the Scottish Government is proposing to make whatever changes in legislation are required to achieve this. Such complex and difficult problems are to be taken forward through a separate Children's Services Bill to provide time to develop effective solutions with stakeholders which really work.

Implementation of the 'Getting it right for every child' approach is viewed in the Bill as benefiting all children and young people. Within the legislation all children and young people from birth to leaving school are to have access to a 'named person'. To improve the way services work to support children, young people and their families, duties are placed on public bodies to co-ordinate the planning, design and delivery of services (for children and young people) with a focus on improving wellbeing outcomes. This is also with a view to making the process easier for families without having to repeatedly provide similar information to a range of agencies.

Within the Bill, the role of early years support is to be strengthened by increasing the amount and flexibility of free early learning and childcare by one hundred and twenty-five hours per year (to six hundred hours) for three and four year olds as well as two year olds who are or have been looked after or subject to a kinship care order.

### **A Pathway of Care for Vulnerable Families (0-3)**

The Scottish Government wanted to develop a national multi-agency, multi-disciplinary programme of work which would support vulnerable children and families from conception to age three. This would be part of the implementation of the Early Years Framework. The Government asked NHS Quality Improvement Scotland (NHS QIS) to lead on this.

The guidance which was finally produced draws upon key Scottish Government publications which were released during 2008-2011 to reinforce key messages about reducing inequalities, building capacity in individuals, families and communities but also taking a holistic approach to meet the needs of all children (Pathway of Care, 2011). The overarching aim of the guidance was to ensure that vulnerable children and families across Scotland would receive support that was equitable, proportionate, effective and timely.

The aims of 'A Pathway of Care for Vulnerable Families' is threefold: to support a consistent approach to meeting the needs of pregnant women, children and families; to enhance local pathways for vulnerable children and families; and to support implementation of the 'Getting it right for every child' (GIRFEC) approach. Guidance on this is presented in the document under three main sections: the universal journey; guidance and approaches within the antenatal period to enhance the universal pathway;

and guidance on approaches to enhance the universal pathway in the immediate postnatal period up to age three.

The guidance also poses a series of questions and issues that professionals from all agencies may wish to consider as they look at potential concerns with children and families throughout the stages of the universal pathway (Pathway of Care, 2011). It is also aimed at equipping and supporting professionals to think about the kinds of issues which are important to women, children and families, to use the prompts provided in the document to enable them to identify those who are at higher risk of poor outcomes and then to use their professional judgement to decide how many needs can be met when working with the family and through engagement with other professionals.

Examples of higher risk groups are identified as those under the age of twenty. Reference is made to the NICE (2010) document - Pregnancy and Complex Social Factors. This document states that pregnant woman with complex social factors may need additional support.

### **Child Poverty Act (2010)/Child Poverty Strategy for Scotland (2011)**

The Child Poverty Act was launched in 2010 and this laid out the UK wide targets regarding eradicating child poverty. These specific targets which refer to levels of child poverty are to be met by April 2020. The Act also stipulated that the UK Government was to produce a Child Poverty Strategy. This applies to Scotland as well for policy matters which have been devolved to the Scottish Parliament/Ministers.

As a result of the Child Poverty Act (2010), the Scottish Government set out its vision for a Scotland where ‘no children are disadvantaged by poverty’ (p1). Growing up in poverty is viewed by the Government as impacting on children’s outcomes. Material deprivation was seen as not purely being an issue of exclusion from experiences because of a lack of material resources, but as something which contains a wide range of interconnected issues like stress and poor health.

Although poverty is seen as being complex, multi-dimensional and something that demands a range of interventions and responses, these were not to address the symptoms but required to go deeper and look at the causes. Investment in eradicating child poverty and reducing inequality remains vitally important to the Scottish Government. Failure to do so brings a great cost to society and is something which the economy cannot afford to pay. Therein lies the Government’s case and argument to shift resources into early intervention and prevention with the first few years of a child’s life being a key starting point.

The main aim of the Child Poverty Strategy in Scotland is to maximise household resources (income poverty and material deprivation) and to improve children’s wellbeing and life chances (breaking inter-generational cycles of poverty/inequality/deprivation). According to the Scottish Government, such an approach requires to focus on tackling underlying social and economic determinants of poverty and to improve the circumstances in which children grow up, especially during the early years.

Recognition is given to the fact that this approach is a long-term one. To achieve it, the strategy has three underpinning principles. These are: early intervention and prevention, building on the assets of individuals and communities and ensuring that the needs of children and families are at the centre of service design and delivery. These principles are taken from the main social policies which the Government has already put in place to address child poverty (Achieving our Potential, 2008; Early Years Framework 2008; Equally Well, 2008).

All three of these social frameworks promote an assets based approach whereby the capacity of individuals and families is built upon to enable them to manage their way out of poverty. Great importance is placed on policy makers and delivery agents to ensure that attention is not solely placed on looking at the barriers on their own nor should assumptions be made that people lack capacity for anything other than a 'passive acceptance of the circumstances in which they live' (Child Poverty Strategy, 2011, p9). Previously the state has taken the approach of trying to 'fix people' and any alteration requires a shift in the normal relationship between vulnerable individuals and the state. The asset based approach not only invites both individuals and communities to manage positive changes to their circumstances by assisting in the production of the interventions that will help support them out of poverty. Under this approach professionals also must recognise that individuals and communities are able to become 'a resource which co-designs services' rather than being simply consumers of services (Child Poverty Strategy, 2011, p9).