Health, Social Care and Sport Committee

1st Meeting, 2022 (Session 6), Tuesday, 11 January 2022

Inquiry on health and wellbeing of children and young people

Introduction

1. At its meeting today, the Health, Social Care and Sport Committee will take evidence from stakeholders as part of its inquiry into the health and wellbeing of children and young people.

2. This session will focus on general health and wellbeing issues and experiences.

Background

3. At its work programme discussion on 5 October 2021, the Health, Social Care and Sport Committee agreed to hold an inquiry into the health and wellbeing of children and young people.

4. The Committee subsequently agreed that the aim of the inquiry was to address key issues affecting the health and wellbeing of children and young people including:

    - Child poverty (including the Scottish Government's current child poverty delivery plan), inequality and adverse childhood experiences;
    - Issues affecting care experienced young people;
    - Mental health, access to Child and Adolescent Mental Health Services and the importance of early intervention; and
    - Health and wellbeing in schools

Structure of the inquiry

5. Given the relevance of the health and wellbeing of children and young people to a number of committees, it was agreed that the Convener could write to other relevant committees requesting an update on any planned work in this area of policy. Formal responses were received from the Public Audit Committee and the Social Justice and Social Security Committee. These responses are included at Annexe A.

6. The Equalities, Human Rights and Civil Justice Committee contacted us to advise it has no relevant work currently planned.

7. The Committee issued a call for evidence on 2 November 2021 which closed on 7 December 2021. The Committee sought views on:

    - What are the key issues around health and wellbeing for children and young people in Scotland?
    - What are the current challenges with improving the health and wellbeing of children and young people over the next 5 years?
    - What offers the best opportunity for improving the health and wellbeing of children and young people over the next 5 years?
    - How does addressing poverty lead to improved health and social care outcomes?

8. The Committee received 96 responses which can be viewed here: Published responses for Inquiry into the Health And Wellbeing of Children And Young People - Scottish Parliament - Citizen Space

9. Supporting documents, to be read in conjunction with Citizen Space responses, were received from various stakeholders and are included at Annexe B.

10. Following the closure of the call for views, word clouds have been produced from the responses to each of the four questions. These can be viewed at Annexe C.

11. The Committee's inquiry consists of five sessions in January and early February 2022:

11 January 2022	Panel 1: Evidence session with stakeholders
18 January 2022	Panel 2: Evidence session with stakeholders Panel 3: Evidence session with stakeholders
25 January 2022	Panel 4: Evidence session with stakeholders
1 February 2022	Evidence session with the Scottish Government

Clerks to the Committee

7 January 2022

Annexe A

Letter from Public Audit Committee dated 2 December 2021

Dear Gillian,

Thank you for your letter of 3 November outlining your Committee's plans to undertake an inquiry into the Health and Wellbeing of Children and Young People.

The Public Audit Committee welcomes this important and very timely piece of work. So far in this session of Parliament, our Committee has taken evidence on a range of reports and online outputs published by the Auditor General for Scotland (AGS) relevant to the scope of your inquiry work. I outline some of the key messages from our work below.

Improving outcomes for young people through school education

The Improving outcomes for young people through school education report, published by the Auditor General for Scotland and the Accounts Commission in March 2021, recognises the important role of the school education system, together with other sectors, "to tackle issues which affect young people's life chances and outcomes, such as child poverty and health and wellbeing".

The report highlights that many young people have reported that their mental health has been affected by the impact of the Covid-19 pandemic. Audit Scotland welcomes the increased focus on supporting and monitoring wellbeing during the pandemic but cautions that this needs to continue. It also raises concerns that there is insufficient national data on some of the wider outcomes of school education, such as health and wellbeing.

The report also highlights that school education in Scotland is about more than just exam results. While there has been an increase in the types of opportunities, awards and qualifications available to children and young people, Audit Scotland reports that better data is needed to understand whether other outcomes, like wellbeing and confidence are improving.

The issue of insufficient data to measure outcomes is a consistent theme heard by our Committee. We would therefore encourage your Committee to consider what work is ongoing to develop better data on the health, wellbeing and confidence of children and young people as part of your inquiry.

As you will be all too aware, the Covid-19 pandemic has disrupted the life of every child and young person in Scotland. The report recognises that the impact of Covid-19 on outcomes for children and young people is influenced by their circumstances including their experience of poverty and deprivation. The report goes on to state that—

> "*Pupils living in very challenging circumstances have been most affected by the impact of school closures. These pupils were particularly affected by*

> *access to digital resources. The Scottish Government and its partners have taken action to address the digital gap, but it has taken time to implement these measures*".

Scotland's Colleges 2020

This "digital gap" was an issue drawn to the Committee's attention during its scrutiny of the AGS's blog on Scotland's Colleges 2020. During a roundtable evidence session in September 2021, the Committee heard directly from the President of the National Union of Students (NUS) Scotland, who stated—

> *"A striking moment this year was the realisation of just how many students were in digital poverty, particularly early in the pandemic, and struggled to access the laptops, equipment and internet connection that they needed to take part in their studies. The Government made some investment in the sector last year, which helped incredibly. It was not necessarily enough money, in that colleges were often topping up that investment from the Government. However, we still see digital poverty as an issue that is facing students this year".*

NUS Scotland also highlighted that students "are a demographic and a population that tend to struggle more with their mental health at that stage in life". They also highlighted the wider benefits of students attending college, including gaining confidence and building their social skills, which was significantly impeded by the pandemic.

We would therefore encourage your Committee to consider how students within the college system are being supported with their mental health, as well as the issue of digital poverty in schools and other education settings, and the funding available to narrow the digital gap.

In October 2021, our Committee took evidence from a range of stakeholders on the provision of child and adolescent mental health services (CAMHS) in Scotland. This session was prompted by the publication of a blog on this issue by Audit Scotland.

The evidence session provided the Committee with an up-to-date position on how CAMHS are operating in Scotland. The Committee heard compelling evidence that limited progress had been made to address the significant concerns raised in Audit Scotland's report on Children and young people's mental health, published in 2018. Indeed, rejected referral rates, waiting times for CAMHS treatment and the availability of robust data on mental health services for children and young people appear to be as much of an issue today as they were three years ago. It is clear that the Covid-19 pandemic has clearly exacerbated a system that was already under significant pressure.

Following the evidence session, the Committee agreed to write to the Director-General for Health & Social Care and Chief Executive of NHS Scotland to—

- seek further information about the significant variation in CAMHS waiting times across Scotland;

- establish how good practice is being shared to improve CAMHS across Scotland;
- provide a breakdown of the actions that have been taken against each of the 29 recommendations made by the Scottish Association for Mental Health and NHS NSS Information Services Division in its "Rejected referrals to child and adolescent mental health services audit", published in 2018.
- provide further information on work the Scottish Government is progressing with Public Health Scotland to improve the quality and scope of data on the provision of mental health services for children and young people.

The Committee also agreed to write to the AGS to stress its view that urgent action is required to address the systemic issues, as abovementioned, and to encourage him to consider how Audit Scotland may seek to review its work programme in light of the evidence heard.

Responses have been received from the Director-General for Health & Social Care and Chief Executive of NHS Scotland and the AGS.

As regards the correspondence from the Director-General, the Committee was concerned by the limited level of detail provided on the action taken by the Scottish Government against the 29 recommendations of the "Rejected referrals to child and adolescent mental health services audit". The Committee therefore invites your committee to consider this area in more detail as part of your inquiry work, if time permits.

The Committee also noted concerns recently expressed by the Scottish Association for Mental Health in the media about plans to replace the term "rejected referrals" by the Scottish Government. The Committee is of the view that the current term should be maintained until there is clear evidence that children and young people are able to access the support that they need for their mental health. The Committee wishes to draw this to your attention, should you wish to follow it up as part of your inquiry work.

As you will note, the AGS has no immediate plans to do any further audit work on CAMHS. Instead, he plans to undertake audit work on adult mental health services, while closely monitoring the progress on the actions being taken by the Scottish Government on CAMHS, to inform future audit work in this area.

While the Committee is disappointed that further audit work on CAMHS is not in the scope of the AGS's work programme in the short term, it is encouraged that your inquiry on the health and wellbeing of children and young people will continue to shine a light on this important policy area.

We hope that this information is helpful to inform your inquiry work.

Yours sincerely,

Richard Leonard MSP
Convener

Letter from Social Justice and Social Security Committee dated 29 November 2021

Dear Gillian

Thank you for your letter of 3 November advising the Committee of your inquiry into the key issues impacting the health and wellbeing of children and young people.

You sought an update on any related work the Social Justice and Social Security Committee is planning to undertake in this area to allow the clerks to factor this information into your inquiry planning.

In the first instance the Committee would like to draw the Health, Social Care and Sport Committee's attention to recent work it has conducted relevant to child poverty.

The Committee's central theme for its pre-budget 2022-23 scrutiny is the Scottish Government's progress in meeting the interim child poverty targets for 2023. A wide range of evidence was gathered on 16 September and 7 October 2021 that could be useful for your Committee's purposes. The Committee's letter of 29 October 2021 sets out our conclusions and areas where the Committee has either asked the Scottish Government for more information, proposed taking a different approach, or asked for specific actions to be prioritised. The Committee will, like other committees, be continuing its 2022-23 budget scrutiny following publication of the budget.

Your letter references the Scottish Government's current Tackling Child Poverty Delivery Plan. You may wish to note that the Scottish Government wrote to the Social Justice and Social Security Committee on 19 October seeking our views on the second Tackling Child Poverty Delivery Plan 2022-26. We responded on 22 November 2021 drawing out relevant points form the Committee's pre-budget work and highlighting other work the Committee has undertaken around homelessness.

Other specific points we raised with the Scottish Government were, who had been consulted, how the effectiveness of policies included in the new delivery plan will be monitored, how the new delivery plan will incorporate the Social Renewal Advisory Board's recommendations, and what the funding comparison is between the first and second child poverty delivery plans.

On poverty and debt more generally, the Committee held an informal evidence gathering session on 18 November where it heard from people with lived experience. A note from this session will be available shortly on the Committee's webpage.

As well as this work, the Committee has considered some relevant pieces of subordinate legislation, which you may wish to take account of in your planning. These are:

The Welfare Foods (Best Start Foods) (Scotland) Amendment Regulations 2021 (2 September 2021)

- Best Start Foods is money to spend on healthy foods, for pregnant women and families with very young children. These regulations increased the

amount provided. The Committee wrote asking for clarification whether the scheme would be extended to those with no recourse to public funds, mirroring developments in the UK equivalent scheme.

The Winter Heating Assistance for Children and Young People (Scotland) Amendment Regulations 2021 (28 October 2021)

- Provides annual payment to families with severely disabled children recognising their additional requirement for heating. These Regulations remove the requirement to pay the benefit by a certain date and extend eligibility to include young people in receipt of Personal Independence Payment.

Regarding future Committee work in relation to the health and wellbeing of children and young people, we are still in the process of finalising our work programme for early 2022. The Committee is holding a series of one-off sessions to establish its priorities. As such, the Committee is not able to provide information on relevant planned work at this stage, however, we do note your inquiry and have asked the clerks to keep in touch should there be some subject cross-over.

Yours sincerely

Neil Gray MSP
Convener of the Social Justice and Social Security Committee

Annexe B

Accounts Commission and the Auditor General for Scotland additional submission: Health and wellbeing of children and young people inquiry

Exhibit 1

Factors affecting the mental health and wellbeing of children and young people

Some children and young people are more likely to be affected by poor mental health and wellbeing.

Gender

44%

of 15-year-old females in Scotland show signs of emotional problems.[1]

Additional support needs

36%

of children and young people with learning disabilities have a diagnosable psychiatric disorder.[2]

Looked after children

45%

of looked after children in Scotland aged between 5-17 were assessed as having at least one mental disorder.[3]

Young carers

33%

of young carers report problems around eating and self-harming or having suicidal thoughts.[4]

LGBT

40%

of LGBT young people consider themselves to have a mental health problem compared with 25 per cent of all young people in Scotland.[5]

Young offenders

95%

of 16 to 20-year-olds in custody have at least one mental health problem.[6]

Deprivation

3x

Children living in low income households are three times more likely to suffer mental health problems than their more affluent peers.[7]

Sources:

1. *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2015: Mental Wellbeing Report,* Scottish Government, 2017.
2. *Children and Young People with Learning Disabilities – Understanding their mental health,* BOND, Department of Education, 2015.
3. *The mental health of young people looked after by local authorities in Scotland,* Office for National Statistics, 2004.
4. 'Worries and problems of young carers: Issues for Mental Health' in *Child and Family Social Work,* Cree, V.E. Volume 8, 2003, p.301.
5. *Life in Scotland for LGBT Young People: Health Report,* LGBT Youth Scotland, 2013.
6. *Psychiatric morbidity amongst young offenders in England and Wales,* Lader, D. et al, London: Office for National Statistics, 2000.
7. *The Mental Health of Children and Adolescents in Great Britain,* Meltzer, H et al, London: The Stationery Office, 2000.

NHS Education for Scotland additional submission: Health and wellbeing of children and young people inquiry

The NES Programme of work to support Children and Young People's Health and Wellbeing:

A comprehensive programme of education, training and implementation support is provided, by NES, for the children and families workforce, that focuses on evidence-based / informed prevention, early intervention and treatment approaches that have been designed to improve the mental health and wellbeing of children and young people, build strong parent-child relationships, and support the promotion of resilience among children, young people, and families. This work spans the perinatal period, through infancy, childhood, adolescence, and young adulthood.

Training covers the four practice levels:

- INFORMED- all staff working in health, social care and third sector settings
- SKILLED- staff who have direct and/or substantial contact with infants, children, young people and their families.
- ENHANCED- staff who have more regular and intense contact with infants, children, young people and their families who are at risk of, or are experiencing mental health and wellbeing concerns
- SPECIALIST- staff who, by virtue of their role and practice setting, provide an expert specialist role in the assessment, care, treatment and support of infants, children, young people and their families who are at risk of, or are experiencing mental health and wellbeing concerns

Several key themes cut across this work:

- Infant, child, adolescent, and family development, including neurodiversity
- Engaging with children, young people, and families
- Assessment, formulation, and diagnosis of difficulties including neurodevelopmental diversity
- Evidence based interventions aimed at strengthening attachment, parenting and family relationship
- Trauma- Informed Practice

4.1 Psychology of Parenting Project (PoPP)

The Psychology of Parenting Project (PoPP) is aimed at improving the availability of high-quality evidence-based parenting approaches (the Incredible Years Preschool Basic and Level 4 Group Triple P interventions) for families with children aged 3-6 years who have elevated levels of behaviour problems. Since January 2013, 806 practitioners have been trained to deliver these interventions and 988 PoPP groups have been delivered (or are currently being delivered) to 6,063 families. Outcome

data (in the form of pre and post group Strength and Difficulties Questionnaires) has been collected on 3,244 children; over the years 81% of children have demonstrated an improvement, with 61% of children who started in the clinical range moving out of this high-risk range by the time that their parents had completed a group. In response to the pandemic, Triple P Online was also made available to families. 147 families have taken part in this online intervention and are experiencing similar positive outcomes to the PoPP groups, and given these outcomes, Triple P Online will remain a continued offer available for families. PoPP is also now expanding to support families of older primary school age children (7-12 years) to take part in either a Triple P or Incredible Years group for parents, and for parents of teenagers (12-16 years) to take part in a Teen Triple P group. It is anticipated that these new interventions will commence in spring/summer 2022.

4.2 Infant Mental Health

In 2014, NES initiated a cascade of training in the Solihull Approach, to make basic Infant Mental Health (IMH) training more widely available across Scotland. 1,521 practitioners and 160 Solihull trainers have now been trained in this approach, across every health board area in Scotland. In response to the pandemic, since May 2020, the Solihull Approach Online has been made freely available to every family in Scotland. Since that time, it has had 12,390 participants register to use the online courses. From 2017, NES has supported additional mental health training; since 2019, 223 practitioners have been trained in an online training in IMH developed by Warwick University, with a further 60 practitioners about to commence their training in January 2022. Additionally, 35 practitioners have received training and for many of these, post-training supervision in Video Interaction Guidance, with a further 8 practitioners due to be trained in December 2021.

Ten practitioners from across Scotland and from a range of professional backgrounds commenced the MSc in Psychoanalytic Observation and Reflective Practice, a three-year Master's level qualification in January 2021.Plans for further training and support in evidence based IMH interventions is planned for 2022-26.

4.3 Early Intervention Framework for CYP's Mental Health and Wellbeing

NES have developed a digital, web-based resource, specifically applicable to the Scottish context, in response to Action 3 of the Mental Health Strategy, The Early Intervention Framework. The resource allows comparison of evidence-based prevention and early intervention approaches that have been designed to improve the mental health and wellbeing of children and young people. This resource was launched in March 2021 and draws upon the work of the National Implementation Research Network (NIRN), and specifically the Hexagon Exploration Tool (Metz & Louison, 2018). Further promotion and training events to support services to use the resource are planned for early 2022.

4.4 Training in Psychological Skills – Early Interventions for Children (TIPS-EIC)

https://www.nes.scot.nhs.uk/our-work/training-in-psychological-skills-early-intervention-for-children-tips-eic/

This training has been developed for qualified multi-disciplinary staff across agencies who work with children and young people, e.g., in school settings.

The resources are evidence and competency-based and aligned to the NES child and adolescent mental health service (CAMHS) MATRIX. The training, delivered by NES-funded TIPS-EIC local psychologists, presently embedded in 11 Health Board areas, aims to equip staff to deliver psychologically informed practices and interventions to children and young people who have elevated levels of distress but who would not meet the criteria for a referral to tier three CAMHS.

We are guided by the principles of implementation science, which tell us that on-the-job support is required to embed new skills into practice; all our training is accompanied by 'Application to Practice' groups or coaching sessions delivered by an expert in the technique / intervention. Evidence-based interventions are offered for common mental health issues such as, anxiety, low mood, and trauma as well as training to upskill staff in psychologically informed ways of working.

The 'Let's Introduce Anxiety Management' (LIAM) intervention has good traction and over the past year we have implemented an intervention to address low mood / depression, brief Behavioural Activation (brief BA) which has been well received and is ready to grow. These interventions are ideal to address Covid-19 related distress and are delivered by staff such as School Nurses and Pupil Support Officers with coaching provided by local NES-funded psychology staff to translate new skills into practice and ensure clinical governance and care pathways are managed consistent with the CAMHS Service Specification and the Community Services Framework.

Response to Covid-19

At the start of the first Covid-19 lockdown we translated all training materials to allow remote delivery of training. Our feedback data show that remote training is just as effective as face-to-face training at increasing the knowledge and confidence ratings of attendees and this offers exciting scope to reach colleagues in remote and rural areas. We have succeeded in engaging NHS Shetland, NHS Orkney, NHS Western Isles and NHS Dumfries and Galloway since we changed to a remote training / coaching model.

Training Delivered

TIPS-EIC trainers have delivered training to1342 staff (school nurses, pupil support officers, pastoral care staff, third sector staff, social workers, and educational psychologists). 1824 training places have been delivered in total.

Some staff have been trained in several things as part of a learning and skill development journey. For example, 294 people were trained in psychological skills modules and a proportion of those then trained in LIAM (half day awareness raising session 619 / full two-day LIAM training with follow-up coaching 987). A proportion of the LIAM workers have been trained in Risk Management (94) and Brief BA (Behavioural Activation) (94). The trauma modules were designed for delivery to social work staff and school staff at the 'skilled' level and have been delivered to 77 staff.

Results and Outcomes

Staff rate the quality of the follow-up coaching delivered by NES-funded Clinical Psychology staff very highly. They say coaching translates the new skills into changed work practices, is containing, maintains the momentum of the implementation and builds staff confidence. Coaching prevents therapeutic drift, improves consistency, and ensures safe delivery of the interventions.

Clinical outcomes are measured for every child or young person who receives LIAM whenever possible. Anxiety, low mood / distress, and risk are measured via the RCADS (Revised Child Anxiety & Depression Scale) and the Young People - Clinical Outcomes in Routine Evaluation (YP-CORE) scales, respectively. Children and young people set their own goals for the LIAM intervention using Goal Based Outcomes. The Experience of Service Questionnaire is given at the end of the intervention.

NES has collected a sample of clinical outcome data from across Scotland for 435 children and young people who received the LIAM intervention. Analyses reveal highly statistically significant reductions in anxiety, low mood and distress and highly statistically significant progress towards the children's own therapy goals, for example:

'Feeling more confident to speak out in class,' 'having less worries and fears and sleeping better,' 'worry less about exams,' 'be kinder to myself,' 'go on sleepovers,' 'reduce anxiety about coming to school.'

The TIPS-EIC model of service delivery solves several problems:

a) Children and young people can be seen locally enabling effective communication about their care to happen within their daily setting and across agencies. This is consistent with GIRFEC (Getting It Right for Every Child), the Community Services Framework and the CAMHS Service Specification.

b) Delivery in school settings by school-based staff allows children who are distressed but not yet presenting with moderate to severe mental health problems requiring specialist CAMHS, to be offered an early intervention. NES maintains oversight of sessions provided and numbers trained via quarterly meetings of NES-funded staff and tracker data. We also collect Routine Outcome Measures for children and young people seen wherever possible. We provide ring-fenced delivery of evidence-based, early interventions which make a measurable difference to children and young people's mental health.

c) The model allows Specialist CAMHS psychology staff to support staff in schools to deliver evidence-based, high quality psychological interventions with good clinical governance and risk management usually resolving problems before they become entrenched. It also allows those small numbers of children and young people who require specialist tier three care to be referred to CAMHS appropriately when needed.

d) Our aspiration is for those school staff who become expert in the delivery of an intervention to be trained, by the NES-funded psychology staff, to become coaches in that intervention. This cascade model allows us to scale up delivery and reach more children and young people. We have some notable examples of this working in practice, for example, the Wellbeing Academy in NHS Lothian.

e) This work aligns closely with the Enhanced Psychological Practice (EPP-CYP) Programme and connecting these two strands of work will be mutually beneficial. We will explore the contribution that the TIPS-EIC Psychologists can make to the supervision and training of EPP (Enhanced Psychological Practitioner) trainees.

f) There will be opportunities to further expand capacity to deliver early psychological interventions across child agencies in Scotland while maintaining care pathways and clinical governance (e.g., future support for qualified Enhanced Practitioners to become coaches).

4.5 CAMHS

NES CAMHS has focused on supporting the quality and future sustainability of evidence based psychological interventions through providing a programme of therapy and supervision training for the multidisciplinary specialist CAMHS workforce. We link with each health board via our network of CAMHS Learning Co-ordinators (CLCs) who have some limited time funded by NES. We have four broad types of educational work which we plan to continue going forward:

1. Provision of long (one year or more) courses in evidence based psychological therapies for children, young people and families. NES CAMHS commissions and funds learners' places on the courses and contributes towards backfill of clinical time. We offer:

1a. Cognitive Behavioural Therapy (CBT) at certificate and diploma level including NES CBT tutor support

Since Sept 2015

CBT certificate - completed N=64 ongoing N=20

CBT diploma – completed N=34 ongoing N=6

Past analysis of clinical outcomes of children/young people seen by the CAMHS CBT trainees during training showed a highly significant improvement in pre and post measures of anxiety and depression (RCADS), with 76% of those cases presenting in the borderline or clinical range before treatment falling below the borderline range at completion of treatment.

1b.IPT (Interpersonal Psychotherapy) both at practitioner and supervisor level

Since Sept 2016

IPT practitioner – completed N=13, ongoing N=9

IPT supervisor – completed N=7

1c. Systemic Family Therapy, at Foundation, Intermediate, Masters and Supervisor

Since Jan 16

Foundation year – completed N=55

Intermediate year – completed N=30, ongoing N=7

Masters 2 years – completed N=6, ongoing N=3

Supervision – completed N=10

1d. Family Based Therapy (FBT: a treatment for Anorexia Nervosa) at introductory, practitioner and supervisor level. We are building a group of Scottish Adjunct FBT Supervisors in Scotland to help sustain this model going forward.

Since Sept 2016

Introductory level (2-day course)- completed N=83

Year long FBT certified practitioner level- completed N=9, ongoing N=4

Year long FBT supervisor level – completed N=6, ongoing N=5 (6 now granted adjunct supervisor status although one now left for adult mental health post)

Prior to covid, regional analysis reported that the implementation of FBT coincided with a reduction in admissions to the inpatient units for children/young people with eating disorders. The National Eating Disorder Review (2021) highlighted the increase in CYP presenting with Eating Disorders in the past 7 years, and referrals have accelerated markedly during the covid pandemic period with some health boards reporting a 200-300% increase in referrals of cyp presenting with Eating Disorders.

2. Provision of short courses at the enhanced level for experienced clinicians. We offer:

CBT for Eating disorders -completed N= 69 since Sept 17, and N=25 places for Jan 22.

Trauma focussed CBT – completed N= 138 since Sept 2015, and N=20 ongoing due to complete March 22

CBT supervision – completed N= 145

We also deliver train the trainer courses for cbt based interventions such Behaviour Activation. In November 21 we delivered a Train-the-trainers

course in trauma for camhs for the first time (N=10 trained), and there are repeats planned in the new year.

3. E learning based programmes :

Essential CAMHS Refreshed in 2019 and hosted on TURAS, the Essential CAMHS resource is comprised of 5 eLearning modules with associated evidence portfolios, supported by supervision. The first three modules provide a foundation of knowledge relevant to all professionals working with children and young people. Modules 4 and 5 introduce clinical assessment and therapeutic intervention and can be accessed by all staff working within specialist CAMHS services. To support the role out, we offer Essential CAMHS supervision training to experienced staff.

Forensic CAMHS

Related to the new inpatient forensic CAMHS provision, we commissioned and now host an e-learning module on Turas Learn for staff new to working in the forensic CAMHS field. This resource is being promoted across agencies and will be targeted at the staff of the new inpatient forensic CAMHS provision when they are employed.

4. The 1-year development plan. In 2019/20 we ran the first cohort of the "1 year development plan" to support the training of staff new to CAMHS recruited as part of the workforce expansion. This was a series of specialist level trainings including essential CAMHS completion and additional face to face or Microsoft teams training in: introducing trauma skilled practice, working with learning disabilities, introduction to positive behavioural support, systemic practice, parenting and physical health monitoring in CAMHS. There is a high level of demand for this training due to the number of new staff starting in camhs, and level of staff turnover, and since 2019 we have run the training with 3 further cohorts. Further repeats of the training are planned in the new year.

Total numbers trained are 104

cohort 1: N=48, Sept 19 to March 20

cohort 2 N=28 Sept 20 to June 21

cohort 3 N=28 April 21 to Dec 21)

Total numbers currently in training are N=26 after 4 withdrawals (Sept 21 to June 22)

4.6 Children and young people's mental health & wellbeing: a knowledge and skills framework for the Scottish workforce

https://learn.nes.nhs.scot/49346/children-and-young-people-s-mental-health-and-wellbeing/children-and-young-people-s-mental-health-and-wellbeing-a-knowledge-and-skills-framework-for-the-scottish-workforce/children-and-young-people-s-mental-health-wellbeing-a-knowledge-and-skills-framework-for-the-scottish-workforce

This framework sets out the levels of knowledge and skills required by staff, across agencies, to deliver wellbeing and mental health supports and interventions within the framework of Getting it right for every child (GIRFEC). It takes a right's-respecting approach that upholds the United Nations Convention on the Rights of the Child as well as the European Convention on Human Rights. We hope this framework will be useful for all staff who work with children, young people, and their families. It is intended to inform workforce planning and commissioners of training, for educationalists to design training courses, to inform the professional learning and development plans of staff and to help to standardise mental health and wellbeing language.

In response to stakeholder request and as a further deliverable to the CAMHS Programme Board, NES, along with a multi-agency stakeholder group, is progressing a quality assurance and mapping of training available to the multi-agency workforce in Scotland. This map will signpost to high quality, evidence-based training resources that cover all the knowledge and skills set out in the Framework. It is intended to guide commissioners of training as well as those seeking to enhance their knowledge and skills via professional learning.

4.7 Autism and Neurodiversity

https://learn.nes.nhs.scot/9948/autism-and-neurodiversity-across-the-lifespan

NES delivers a programme of training, across the practice levels, for those who support children, young people and their families who are affected by Autism and Neurodiversity. Consistent with the Scottish Strategy for Autism https://www.gov.scot/publications/scottish-strategy-autism/ and the Neurodevelopmental Service Specification https://www.gov.scot/publications/national-neurodevelopmental-specification-children-young-people-principles-standards-care/ NES offers training in recognition, assessment (e.g., we have trained 75 health professionals to use the ADOS-2 (Autism diagnostic observation schedule 2) over the past year), diagnoses and individual formulation as well as support, education and evidence-based interventions (such as CBT and Mindfulness).

4.8 Enhanced Psychological Practice- Children and Young People (EPP-CYP)

A new certificate level training scheme is being developed to create a new workforce of psychological practitioners capable of delivering high-quality, evidence-based interventions for mild to moderate mental health and wellbeing difficulties in a way that can be efficiently brought to scale. This approach to aims to make effective use of the large cohorts of graduates in Psychology and related disciplines – as well as those with equivalent training and experience - to deliver and support, under supervision, brief, outcome-focused evidence-based interventions for children and young people's mental health difficulties. They will be trained to deliver psychological interventions at the Enhanced level of practice with children, young people, and their families for common mental health problems (anxiety, low mood, and parenting). Enhanced Psychological Practitioners will provide a defined clinical service, working under supervision, within wider children's services delivering mental health and

wellbeing interventions. There are likely to be multiple services within which this new workforce works, including within CAMHS, schools and primary care settings. The first intake of practitioners on this new course are anticipated to commence in April 2022.

The Promise additional submission: Health and wellbeing of children and young people inquiry

Dear Committee Members,

Thank you for the invitation to respond to your inquiry for all who have an interest in the health and wellbeing of children and young people in Scotland.

You may be aware that The Promise Scotland was created in March 2021 as an independent organisation tasked with supporting and monitoring the implementation of The Independent Care Review's conclusions by 2030.

The Independent Care Review published its conclusions on 5 February 2020 with cross party support. That has continued into 2021 manifesto commitments from all parties and is evidenced with how Members across the Scottish Parliament engage with the issues impacting children and families who come into contact with Scotland's 'care system'.

On 31 March 2021, The Promise Scotland published Plan 21-24, outlining the priorities and what must happen by 2024. It contains very specific outcomes surrounding A Good Childhood that are directly relevant to your inquiry. There is a short #KeepthePromise briefing on health and wellbeing that summarises the headline themes for the sector. You may also find this poverty briefing useful during your inquiry.

Plan 21-24 and the supporting Change Programme ONE published in June this year, highlight the crucial work that is needed to ensure A Good Childhood, including support to ensure that health needs are met. At present the assessment is that work is underway - but it does not yet appear sufficient.

A summary of the issues the Committee would wish to review has been provide to your call for views. May I request that it links with other Parliamentary Committees to ensure the whole of Parliament is well sighted on the work to #KeepThePromise. My hope is that this alignment will lead to an opportunity for me to attend the Conveners Group, to allow The Promise Scotland to inform how Parliamentary Committees can, individually and collectively, fulfil their scrutiny function to #KeepThePromise.

With best wishes
Fiona Duncan
Chair, The Promise Scotland

Who Cares? Scotland additional submission: Health and wellbeing of children and young people inquiry

Contents

Summary

This year, 55 Care Experienced people shared their views with us on sexual and reproductive health as part of our Annual Participation Programme 2021-22. We found out about a range of experiences and views they have about sexual and reproductive health and we worked with members of our National Representative Body to develop recommendations for change.

Learning about sexual and reproductive health

- School was the main way Care Experienced people learnt about sexual and reproductive health. Low school attendance, problems at home and placement moves however, led to learning through older relatives, self-research, or through direct experience.
- Experiences of learning from other people – carers, family, and friends - was mixed. For those in kinship care, particularly those who lived with grandparents, their experience of learning about sexual health could be more challenging due to the older age of carers.
- Often members ended up learning about sexual and reproductive health by 'trial and error' through their own experiences. The most frequently mentioned learning experiences were pregnancy and parenthood, childhood trauma, or lack of understanding due to being a young age.

Feeling informed and making choices

- Many Care Experienced people told us they felt well-informed about sexual and reproductive health. However, when it came to making an active decision about their sexual and reproductive health, the picture was slightly less positive. They shared how decisions they made could seem like the right thing to do at the time but then later, this changed.
- An important theme in our evidence centred around either having or not having, a sense of control and autonomy in decision-making about sexual and reproductive health. Over half of those who answered the survey said they felt in complete control when making decisions about sexual and reproductive health, while others said they did not feel in control to some degree.
- This feeling of control was often because they had a trusted individual with them. Others explained that a sense of control was felt because their sexual and reproductive health was something they could decide on for themselves, even if other aspects of their lives felt out of control.
- Members also told us about how they could feel out of control when making choices, due to a lack of information and autonomy to make decisions. This could also be impacted by abusive relationships or because they did not feel listened to by adults and professionals in their lives. Experience of services

- The most common service accessed was for contraceptives, while just under 1 in 5 had not accessed any of the services listed. Having choices available and being fully informed were seen to be the biggest factors which contributed to feeling supported when accessing services.

- For those who felt services were not helpful, we heard that this could be due to the awkwardness of professionals and carers, accessing services which were not traumainformed, or who gave bad advice, and were not felt to be transparent enough.
- The biggest theme was the feeling of being judged, stigmatised or 'othered' by professionals and adults. Being care experienced could impact negatively on the way people felt they were treated when accessing services – over half of survey respondents believed that this has impacted their experience. Care Experienced people also shared issues about being stigmatised due to different parts of their identity, such as their young age or being part of the LGBTQ+ community.

What needs to happen now?

Care Experienced people told us about the changes they'd now like to see in sexual and reproductive health. We shared these views confidentially with members of our National Representative Body, who helped create different recommendations for change on 12 different areas of policy and practice. These will be shared with different organisations and policymakers, to make sure change happens, including the Scottish Government, Corporate Parents and with The Promise.

1. Empowerment through learning in schools
2. Upholding the right to inclusive education
3. Supporting carers and families
4. Bridging the generational gap in kinship care
5. Training the workforce
6. Honest and open conversations with carers and families
7. Access to period products
8. Questioning sexual experience as a learning method
9. Trauma-informed services
10. Accessibility of confidential resources and services
11. LGBTQ+ inclusivity
12. Understanding care experience and harmful prejudices

Why talk about sexual and reproductive health?

The topic of sexual and reproductive health was identified as a key theme in Who Cares? Scotland's Annual Participation Programme 2021-22. This programme creates different opportunities for Care Experienced members of Who Cares? Scotland to be involved in influencing work on areas we know are important to them and it allows members to choose what they get involved with and how they participate.

As a provider of professional, independent advocacy services, we support Care Experienced children, young people and adults to navigate different issues and challenges which they may

be experiencing. From the data we collect about our advocacy work, we have evidence that Care Experienced young people often require advocacy support to access health professionals and services they need. However, we did not have the depth of data required to understand what those challenges look like in detail and particularly, the issues specific to sexual and reproductive health that Care Experienced people may need further support with.
Current available research also does not yet provide enough insight into the experiences of people with care experience in relation to sexual and reproductive health. Commonly accepted risk factors for poor sexual and reproductive health include suffering from mental ill health, substance misuse, being exposed to criminal activity, and having low educational attainment or being disengaged from school.[1] This indicates that some Care Experienced people may be significantly impacted by health inequalities due to existing statistics in Scotland on poorer outcomes across a range of areas such as education, health and employment.[2] We also know that sexual and reproductive health problems disproportionately affect people from more marginalised communities, for examples, pregnancies in under 18s are more common in areas of deprivation, which also have lower rates of abortion.[2]

Currently, we also know that Care Experienced children can have less access to consistent sources of sex and relationship education and advice.[3] This could be due to the fact Care Experienced children may have interrupted or low attendance at school, and many will have more than one placement with different carers.
By carrying out this work, we have gained further insight into the experiences of people who have been in care, particularly in relation to how they learn about sexual and reproductive health, and in how they have experienced and accessed a variety of specialist services. We also have 12 recommendations for change, which show how different areas of sexual and reproductive health can be improved. To create these, we shared the findings from our membership with members of Who Cares? Scotland's National Representative Body, who worked with us to create these clear calls to action.

Who did we speak to?

A total of 55 responses were received, the majority (78%) of which came via online survey, with the remainder made up of focus group and interview participation. 43 Care Experienced people took part in the survey, of which 72% were aged between 15 and 24. Six people over the age of 35 took part in the survey.

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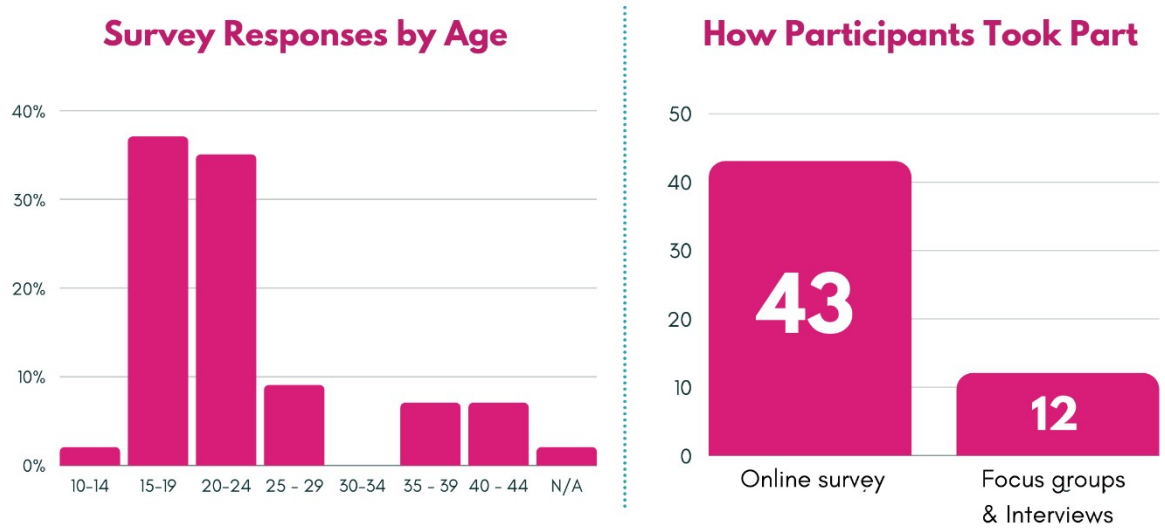
[1] *https://www.isdscotland.org/health-topics/maternity-and-births/teenage-pregnancy/* [2] *https://www.whocaresscotland.org/who-we-are/media-centre/statistics/*

[2] *Ibid.*

[3] *https://www.scie.org.uk/publications/briefings/briefing09/*



Responses to the survey were received from 18 of the 32 Local Authority areas in Scotland. Most responses were received from Glasgow (16%), Shetland (12%), Dundee and West Dunbartonshire (both 9%).

What did we find out?

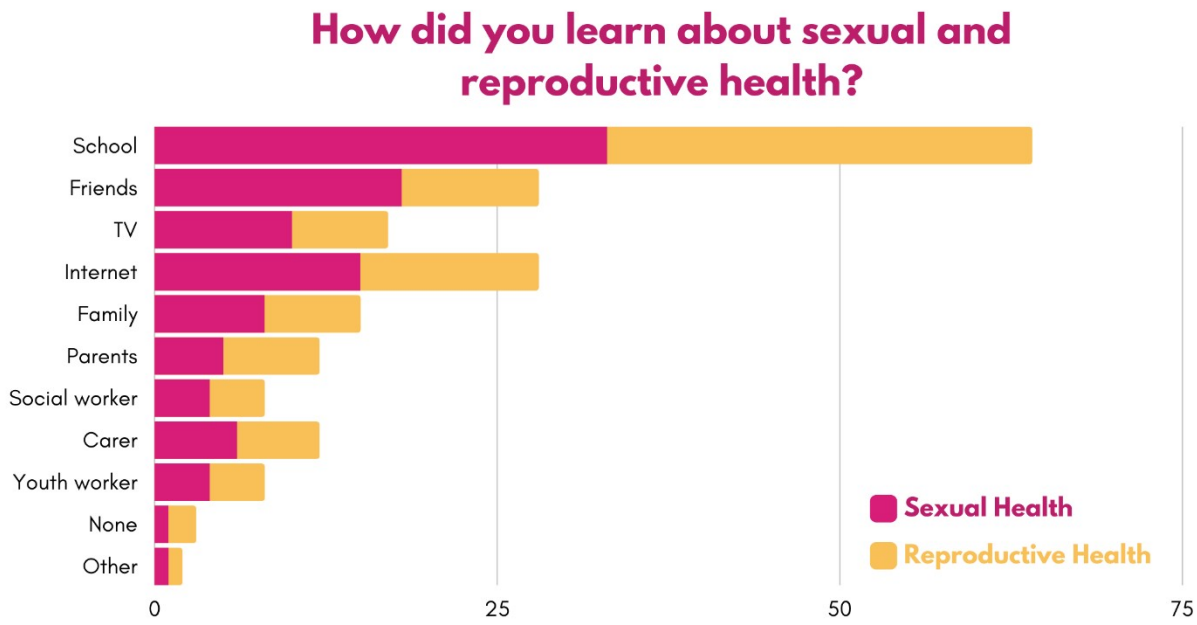
Across surveys, focus groups and interviews, we heard about Care Experienced people's views and experience of sexual and reproductive health across three key themes:

1. Learning about sexual and reproductive health 2. Making choices 3. Experience of services

1. Learning about sexual and reproductive health

We asked our members questions about how they first learned about sexual and reproductive health, and how this has impacted them. Although school was identified as the main information source for Care Experienced people, many told us that low school attendance,

problems at home and placement moves can lead to reliance on learning through older relatives, self-research, or through experience.



In school

School was by far the most cited source of learning on sexual and reproductive health for participants, followed by friends and the internet. However, we heard evidence that learning in school could be inaccurate, vague and incomplete, leaving some to learn via other sources:

> *'I had a pretty bad experience with schools teaching reproductive health, I had an hour lesson in primary school which was filled with misconceptions.'*

> *'We learned about periods and stuff in primary school - but really vague, like a 15minute discussion one time. [Learning about] sexual health was more like from my friends.'*

> *'[Learning in] school only focused on what not to do.'*

For Care Experienced people, placement moves and difficult circumstances at home can also mean they are more likely to miss school and miss out on any of this learning:

> *'Because of my circumstances when I was young, I wasn't able to go to school much, so I missed out on a lot of information about [sexual and reproductive health].'*

> *'I think placement moves mean that people don't know who to go to.'*

> *'I didn't go to school long, and they didn't teach much apart from how to put a condom on.'*

Further, we heard evidence that teachers were at times not seen as the best people to be teaching this kind of subject matter:

> *'Teachers just feel awkward, they don't want to talk about it.'*

One participant shared that she felt there was too much emphasis in her school on personal responsibility and not enough on 'rights education'. She explained that as a victim of abuse by a family member, she was not aware of what was happening until she was much older.

> *'They only told us what we shouldn't do… Nobody ever told me 'If this happens, you should get help'…I didn't know it was wrong until it exploded- everything came bad.'*

Family and carers

Evidence about learning from other people – carers, family and friends - was mixed. Many of the comments we received from people with experience of fostering or residential care were positive, where carers and staff would give helpful information and be at hand to answer questions:

> *'Whenever I moved, every carer I had would give me the talk and explain everything to me and how to be safe so I knew.'*

> *'Due to the care givers I had whilst in care, I was informed well enough with any questions I had.'*

However, one participant shared that they had found interactions with carers more difficult when accessing information and practical products too:

> *'I wasn't given the resources to get help or information about other things. I only had staff to take me period shopping and this was uncomfortable. It would be better if there was an abundance of products in the bathroom so I didn't have to ask. Anything else I learned was online.'*

For those who experienced kinship care, particularly those who lived with grandparents, their experience of learning about sexual health was often more challenging:

> *'[What I was told] wasnae accurate - I was raised by my grandmother...I grew up with really warped - not warped but not healthy views. So when I had sex, it led to underage pregnancy.'*

> *'When you have kinship carers raising young people - when you have grandparents, older generations, there aren't as many opportunities to have those discussions.'*

> *'I lived with my grandparents and found it awkward to have those conversations with them.'*

Self-research and learning from experience

Many of the Care Experienced people we spoke to told us that, in the absence of any other quality or reliable information source, their main source of learning was either self-research on the internet or, in many cases, learning through their own experiences.

> *'I did have to find out a lot of things online but I think that meant I had access to more information than I would've been given at school.'*

> *'I looked at everything on the Internet and asked my resi workers anything I didn't understand after I was taken into care.'*

While internet self-research can be a first step, many explained the problems with this approach:

> *'Social media is a double-edged sword. It's really powerful tool for people to get information and learn. It shouldn't be the only source of information though.'*

Although our online survey did not specify it as a possible learning source, a frequently mentioned theme was that members ended up learning about sexual and reproductive health by 'trial and error' through their own experiences. The most frequently mentioned experiences here were pregnancy and parenthood, childhood trauma, or simply age:

> *'[Being a Care Experienced parent] You know from your own experiences what you didn't want to do. But not what you had to do.'*

'I'm a mother, so reproductive and sexual health I have had to learn through experiences.'

'Fully versed [in sexual and reproductive health] due to childhood traumatic sexual experiences.'

'Due to age and experiences now, I am more aware however I wish I had known what I know now when it was important.'

2. Feeling informed and making choices

Linked to the process of learning about sexual and reproductive health is how that learning is put into action when making choices. We asked our membership how informed and in control they felt in relation to their sexual and reproductive health and found that although the evidence was mixed, control and bodily autonomy when making decisions is very important for Care Experienced people.

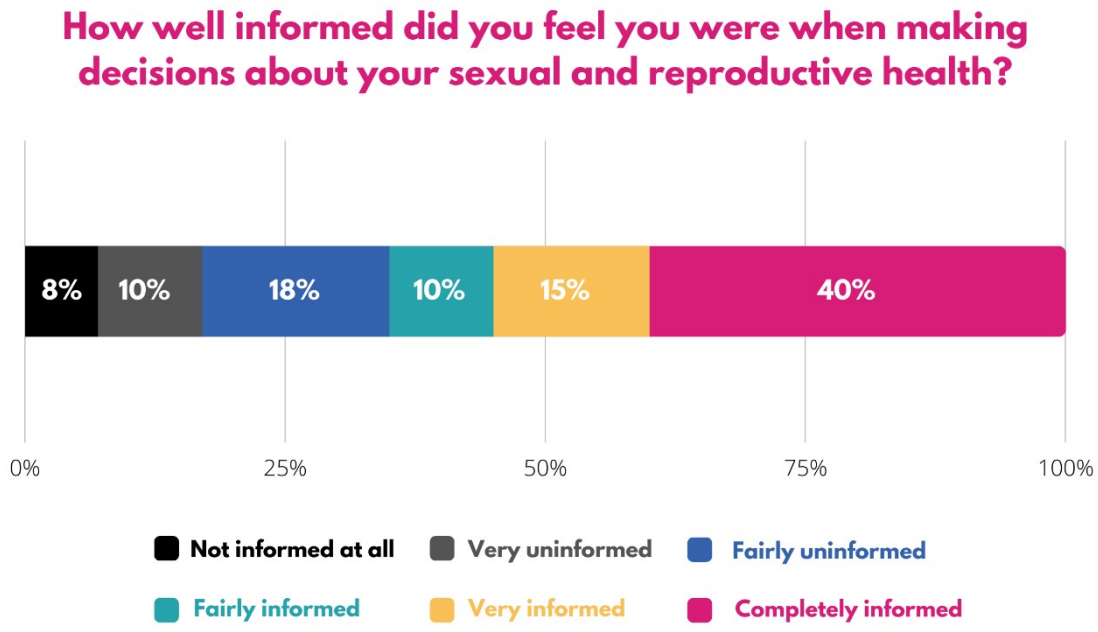
Informed decisions

Many Care Experienced people told us they did feel well-informed about sexual and reproductive health, with 72% saying they felt either very informed or extremely informed in the survey. The reasons given for this ranged from good experiences of family conversations about sexual health and that being in care can lead to more access to information for some:

'Although I missed school sex ed, sexual health was a pretty open conversation in my family. I feel confident that I know my body and what is normal for me and what is something I should speak to a doctor about. I also feel confident in knowing my rights and responsibilities in regards to sex and relationships.'

'[In care] people have a responsibility to make sure you are safe and so you are given lots of information that is useful. It has impacted on me positively.'

However, when it came to making an active decision about their sexual and reproductive health, the picture was slightly less positive. Around two thirds (65%) told us they felt informed to make decisions to some degree, however 18% said that they felt either very uninformed or not informed at all.



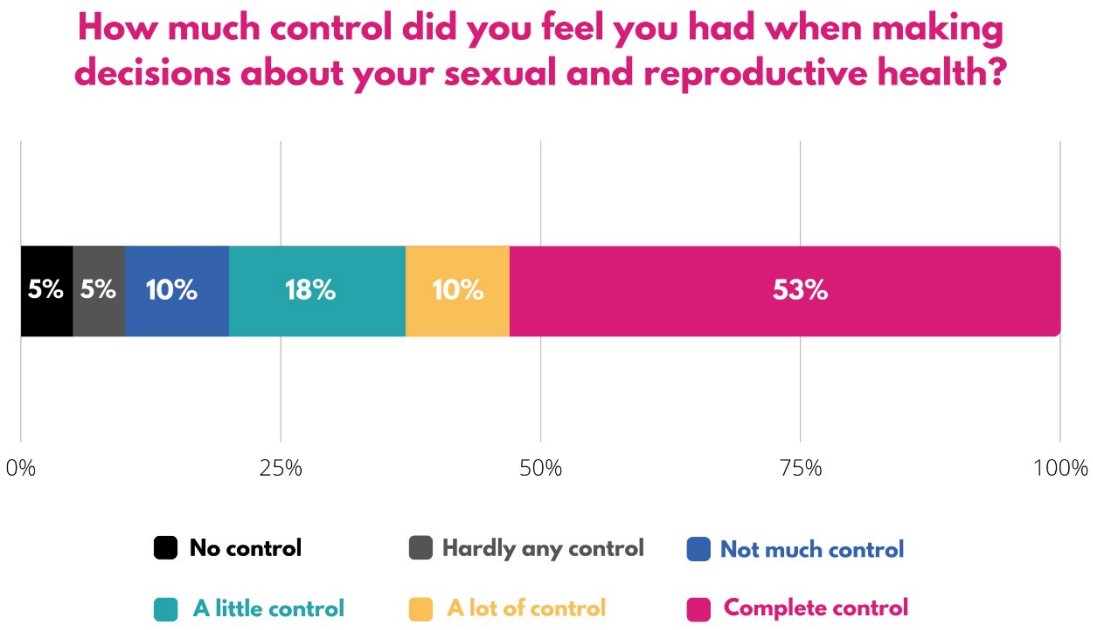
Care Experienced people shared how decisions they made could seem like the right thing to do at the time but then later, this changed:

'I thought I was well informed, but have recently discovered an abundance of awful side effects from the implant. I now need to decide whether or not to get it removed and it seems I will have bad side effects either way.'

'I wish I was told more about the dangers of becoming sexually active.'

Control and autonomy

An important theme in our evidence centred around either having or not having, a sense of control and autonomy in decision-making about sexual and reproductive health. Over half of those who answered the survey said they felt in complete control when making decisions about sexual and reproductive health, with one in five saying they did not feel in control to some degree.



Care Experienced people explained that their feelings of control can come from a myriad of factors. Some of the most prominent ones we heard about were the ideas of free will, independence and bodily autonomy; being able to control something at a time when many other things felt out of control:

'I knew what I wanted, I knew what I needed. [My sexual health and identity] was the only thing I had any control over... [the same] with my body. It is all you've got - well, it isn't, but it carries you.'

'[As a Care Experienced young person] you're subjected to a lot of things that might harm you, harm your body. So you have to take control over your body.'

'If you don't have care-givers - or good relationships with them - you kind of become your own person, your own advocate - not necessarily always in a good way... People with Care Experience are so used to doing things for themselves.'

Another important reason given for how Care Experienced people could feel in control was if they had the support of a trusted individual, be that a family member, carer, partner, or medical professional:

'I felt like I had a lot of control but I think that's because I had my aunty with me. She wouldn't take any shit.'

'[My carers] took me along to the right places that I needed be to make informed/ confidential decisions and supported me on the decisions I made.'

'Doctor talked me through [my choices] and I felt I had made the right decision.'

However, participants also told us about how they could feel out of control when making choices, and this often manifested due to a lack of information and autonomy to make decisions:

'I wasn't given the necessary education to make an informed choice. I could only go on small pieces of information such as knowing that pads and tampons existed but I wasn't taught about alternatives.'

'I would've liked to have been given more information on my options, rather than feeling like I didn't have a choice what I did with my body.'

'I felt like I was slightly forced into being on birth control by my foster carer, felt like my relationships were constantly over scrutinised and expected to be perfect in the eyes of my social workers and foster carers.'

In one instance, we learned that having no control over reproductive health at an early age had devasting and lasting repercussions in adulthood. One young woman explained that as a teenager *'no one [teachers, carers, parents] wanted to sign the forms for my HPV vaccine'* resulting in her missing out. At the age of 21 she was diagnosed with cervical cancer. She recalls having to face her diagnosis face alone, during a global pandemic, often relying on foodbanks for support.

"Nobody asked- do you have a family. Nobody asked. They just assumed I'd get help."

Living alone on a 3rd floor flat, she only realised the day before her operation that she would likely be unable to make it up the stairs. It was only then that she called a colleague, explained her situation, and asked if she could stay with them.
She is now cancer-free but traces the probable chance of infertility to the lack of decisions made on her behalf when she was in care.

'No one took an interest in me. Everyone was more concerned over who was the right person to sign the form rather than what was right for me.'

Other participants shared more reasons for not feeling in control of decisions about sexual and reproductive health including circumstances related to abusive relationships or from not feeling listened to:

'I ended up in an abusive relationship and I thought it was normal because no-one spoke about same sex relationships or abusive relationships and what to look for.'

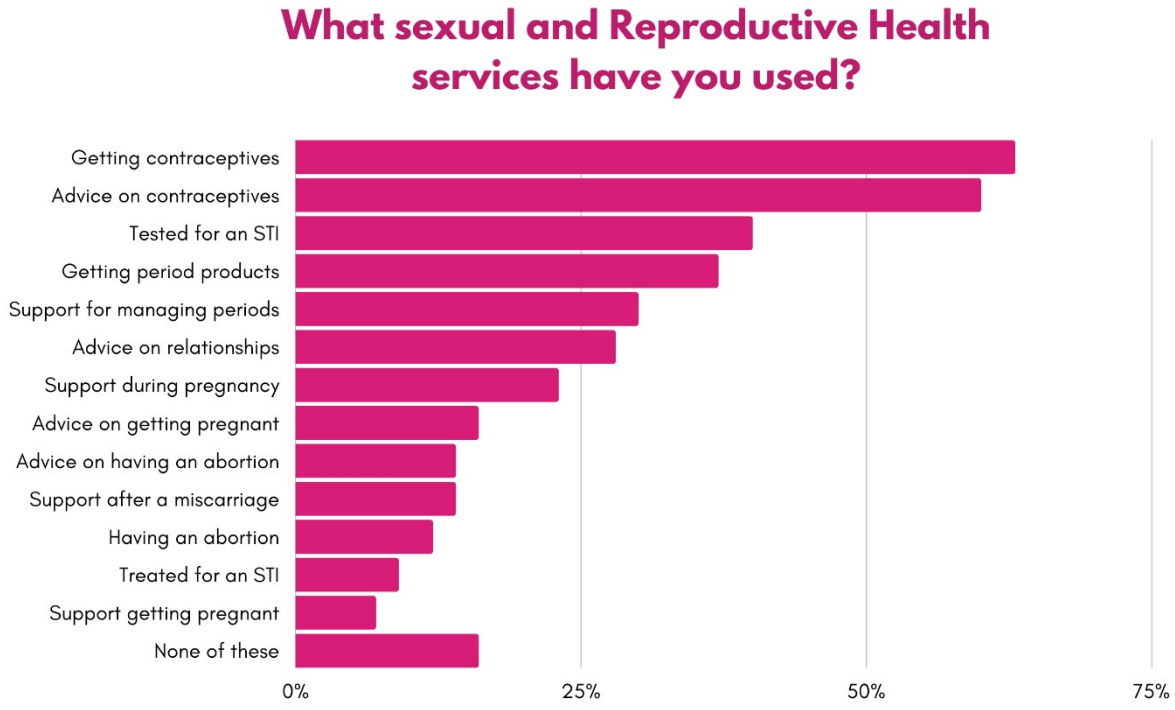
'The support during miscarriage was awful. It was cold and felt like a production line. No choices and none of what I wanted was respected. When choosing contraception, I was often ridiculed for questioning because I was not qualified.'

3. Experience of services

Care Experienced people also shared theirs views on sexual and reproductive health services. Our evidence suggests that services are seen helpful on the whole, however there are issues around awkwardness, not always being trauma-informed, and a lack of transparency. Care Experienced people also shared issues with being stigmatised due to different parts of their identity, such as their young age or being part of the LGBTQ+ community.

Access and provision

The most common service accessed was for contraceptives, while just under one in five had not accessed any of the main sexual or reproductive health services listed.



Of those who had accessed at least one, around three quarters (77%) found them to be helpful to some degree. Having choices available and being fully informed were seen to be the biggest factors which contributed to feeling supported when accessing services.

'Having the support there was very helpful and services knew what to do.'

'Felt reasonably comfortable and happy enough with everything.'

For those who felt services were not helpful, we heard evidence that suggested this was because of the awkwardness of professionals and carers, services which were not trauma-informed, gave bad advice, or were not transparent enough.

One participant explained that when she was going through a gynaecological exam, she asked to be 'put under' to avoid the trauma of remembering past abuse. The doctors thought she was worried about the pain and simply explained it would not hurt.

"They didn't ask if I had a history of sexual trauma".

Similarly, another young woman shared her negative experience from services after being sexually assaulted. She explains that she had to wait two days before she could shower as, due to her history of abuse, she had requested a female doctor to conduct the exam. They were unable to find a female doctor qualified to conduct the exam for two days. When she

did see a doctor, she explains that to avoid traumatic questions, she did not correct the doctor's assumption that the colleagues she was with were her parents.

After the exam, she recalls being given a leaflet and asked by the nurse if she wanted follow-up therapy which she refused. *"It was a tick box."* She later struggled with severe mental health issues. She now reflects that she wished the nurse had been better trauma-informed.

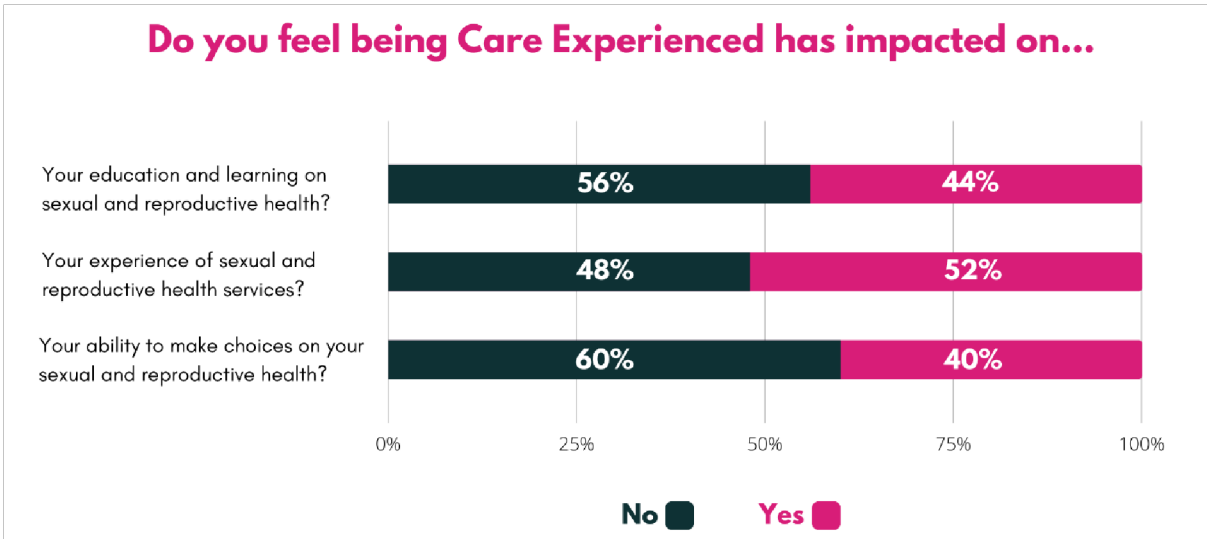
Feeling judged and stigmatised

When it came to the negative experiences of services we heard about, there is one key theme above all others which was mentioned as a driver for this – the feeling of being stigmatised, 'othered' and judged by professionals and other adults.

> *'The overall feelings I get when I have accessed services - I have felt judged. I had to get a procedure done and I had it done quite a few times - and this woman was just looking at my notes, and she was just tutting. It's worse when you don't have parental figures there to make you feel better.'*

> *'After leaving care I would have been embarrassed and felt stigmatised accessing services due to being a care leaver.'*

We learnt that being Care Experienced could impact negatively on the way people felt they were treated when accessing services – over half of survey respondents believed that this has impacted their experience.



Experience of care was not the only demographic which was mentioned as a reason for othering and that a person's age also impacted how they were viewed:

> *'Young people aren't taken seriously.'*

> *'I definitely feel when I was in hospital with my eldest - he was born at 27 weeks - I felt like I was treated a certain way 'cause of my age. I had an emergency c-section and when my stitches burst – I kept telling them I was bleeding they just dismissed me. I had to wait for when my social worker came and she told them and they took me into theatre immediately.'*

Being part of the LGBTQ+ community was also identified as a way individuals experience discrimination. This could be when learning about sexual health as well as when accessing

services and resources. More than half of our survey respondents identified as belonging to the LGBTQ+ community, and spoke about the impact this had on them:

> *'I tried to get support for birth control but being a trans man no-one really knew what to do or say.'*

> *'There's a big focus on [heterosexual] couples. There's not much information given to young people in how to stay safe when having sex with someone of the same gender. There's also no focus on being trans and the support available to trans young people.'*

> *'[About the impact of identifying as LGBTQ+] Double labels, double scrutiny, double discrimination.'*

For many who we spoke to, they felt there were a combination of ways they were stigmatised in trying to access services resulting, in many instances, of avoiding them altogether:

> *'I haven't accessed services 'cause of the stigma. I was so scared of what people would think.'*

What needs to happen now?

We worked with members of our National Representative Body to come up with a clear list of recommendations to improve the experiences of Care Experienced people in relation to sexual and reproductive health. These provide a call to action for different corporate parents, and other adults and professionals working to support Care Experienced people.

1. Empowerment through learning in schools

Sexual and reproductive health education needs to be taught by confident and understanding teachers, in an inclusive and empowering way. Members spoke about how education at school could be vague, patchy and awkward – with teachers potentially bringing their own views into how the subject is taught, especially on LGBTQ+ issues. School is a vital source of learning for Care Experienced children and young people, who may not always have family or support at home to learn about sexual and reproductive health.

2. Upholding the right to inclusive education

If a child in care is missing school or experiences disruption to their learning, pro-active efforts must be made to ensure they learn about sexual and reproductive health as an essential part of their right to education. It is also vital that sexual and reproductive health education is not overly gendered, and that all Care Experienced people learn about the full range of sexual and reproductive health information, regardless of gender identity.

3. Supporting carers and families

Carers and families must be equipped with the information and skills to support Care Experienced people to feel informed and confident about their choices in relation to sexual and reproductive health. This should be viewed as a fundamental part of a parental and caring role. Education and proactive conversations should start at home, in a person-centred and non-judgemental way, meeting the individual where they are at in terms of knowledge and comfort.

4. Bridging the generational gap in kinship care

There must be better support for children and young people living in kinship care and further understanding of how to provide appropriate information and support to older kinship carers on sexual and reproductive health education. The older age of carers is an important factor in how children in care may feel able or not to discuss their sexual health at home.

5. Training the workforce

There must be robust training offers for the social care workforce on sexual and reproductive health and normalisation around leading out conversations about sexual health in a

supportive and nonjudgemental way. This is a specific skillset and needs support to get the right approach for Care Experienced people. This is especially important for carers.

6. Honest and open conversations with carers and families

Carers and families must understand the power they have to influence attitudes and behaviours of care experienced people's sexual and reproductive health. Honesty and trust are extremely important in creating open conversations about sexual activity, rather than a solely disciplinary approach.

7. Access to period products

Every child in care must have access to the period products they need, in a way which suits them. Confidential advice and support should be available from carers and families alongside this on how to use these products and on wider questions about reproductive health.

8. Questioning sexual experience as a learning method

There must be a clearer understanding from all adults and professionals working with Care Experienced people, that sexual experience does not equate to someone having access to safe, positive sources of information about sexual and reproductive health. Many members told us how they learnt through experience, but that this could be negative or something that with hindsight they wish they had more information about first. There needs to be a supportive approach taken to understanding and exploring how an individual has learnt the behaviours they normalise when it comes to sexual activity and health.

9. All services must be trauma-informed

Trauma-informed practice must be essential and embedded in the way sexual and reproductive health education and services are designed and delivered. Conversations about sexual experience are essential for safety and information but may trigger trauma-responses for those who have had traumatic sexual experiences at any point in their life. Trauma-informed practice should also include the ability to choose a specific gender of doctor or professional when accessing services.

10. Accessibility of confidential resources and services

Information about sexual health services must be obvious and easy to find for all Care Experienced people. It was identified that secrecy, shame, and stigma could prevent understanding about which services are available and how to access these easily. This should include pro-active signposting to confidential, anonymous access to services where an individual can be honest about sexual activity they may have already engaged in.

11. LGBTQ+ inclusivity

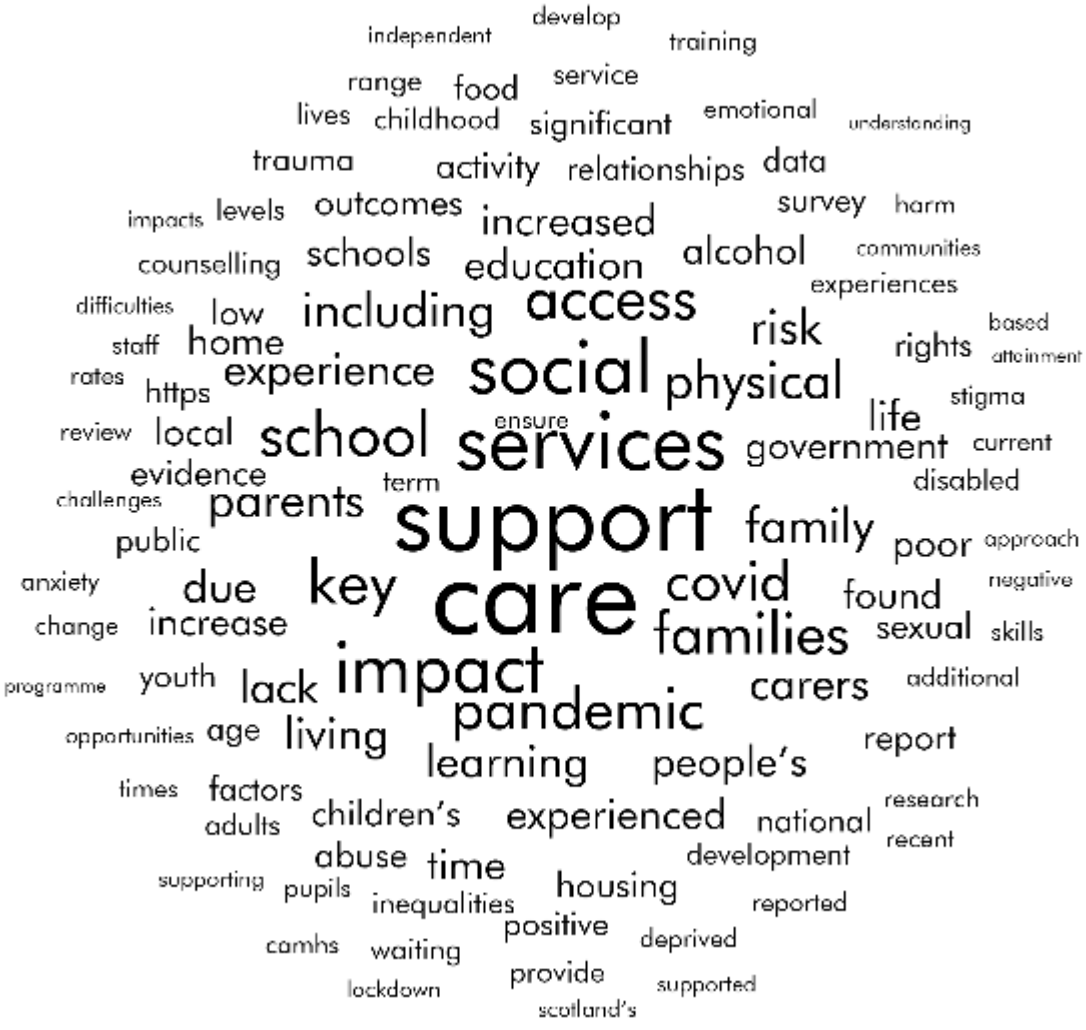
LGBTQ+ inclusive sexual and reproductive health must be viewed as essential for all Care Experienced people, ensuring all information and education provided is sensitive to an individual's sexuality and gender identity. There should be a diverse workforce delivering sexual health services who can understand and relate to LGBTQ+ experiences.

12. Understanding care experience and harmful prejudices

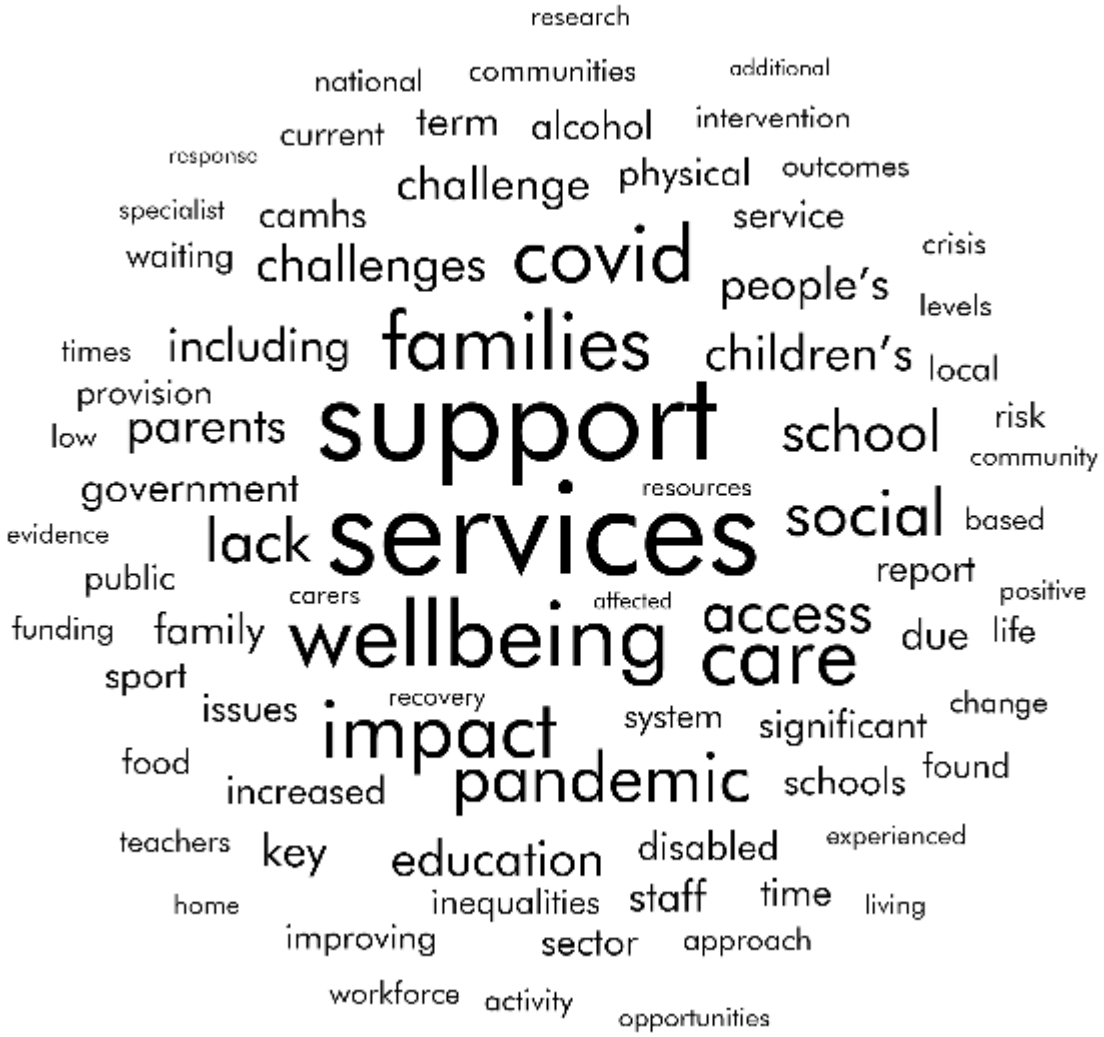
Professionals working across the health sector must have a better understanding of care experience and ensure they do not judge an individual's ability to have a family or make other choices about their sexual and reproductive health due to being in or having been in care.

Annexe C

Word cloud 1: What are the key issues around health and wellbeing for children and young people in Scotland?



Word cloud 2: What are the current challenges with improving the health and wellbeing of children and young people over the next 5 years?



Word cloud 3: What offers the best opportunity for improving the health and wellbeing of children and young people over the next 5 years?

Word cloud 4: How does addressing poverty lead to improved health and social care outcomes?