

Launch
HOUSING

IT'S TIME TO END
HOMELESSNESS

Pregnancy and Homelessness: Service responses

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About Launch Housing

Launch Housing is a Melbourne based, secular and independent community agency formed in July 2015. Launch Housing's mission is to end homelessness. With a combined history of over 75 years serving Melbourne's community, Launch Housing provides high quality housing, support, education and employment services to thousands of people across 14 sites in metropolitan Melbourne. Launch Housing also drives social policy change, advocacy, research and innovation.

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List of Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
DHHS	Department of Health and Human Services
FSP	(Family violence) Flexible Support Packages
SACSN	Salvation Army and Crisis Support Network
THM	Transitional Housing Management
VI-SPDAT	Vulnerability Index – Service Prioritisation Decision Assistance Tool
WADS	(Royal Women’s Hospital) Women’s Alcohol and Drug Service

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Executive Summary and Recommendations

This research originated from concerns expressed by senior staff at Launch Housing and the Royal Women's Hospital that pregnant homeless women are not receiving the level of support warranted, given their circumstances and that of their unborn child. While individual Victorian homelessness services work with pregnant homeless women, there is currently no systemic response to this group, nor is there reliable information on how many women among the homeless population are pregnant. These gaps in the service system, and in the collection of data, contribute to lost opportunities for intervention to provide the best possible support to women and infants.

The research had two key elements, reflected in the following two research questions:

- What is the estimated number of pregnant women in Victoria's homeless population and how might data collection processes be put in place that better identify and enumerate this group?
- In what ways do Victorian homelessness and related services work with a pregnant homeless woman, and how might this occur in better ways for both the woman and her baby?

The research was undertaken using a qualitative approach and comprised a literature review and interviews and focus groups with 41 staff from 27 homelessness and pregnancy support agencies that have expertise in the policy and practice of working with pregnant homeless women.

The research found that while some homelessness services collect data on pregnancy, typically, it is not readily accessible. Specialist women's homelessness services, including family violence services, are the most likely to collect such information. Health and hospital services are also likely to routinely collect information regarding housing and pregnancy. However, there are no known means of aggregation between and across these sectors. Not having accurate data on the number of women who are pregnant and homeless in Victoria, and their circumstances, is a significant impediment to improving services and providing the best possible responses to this group of women and their children.

The lack of data about the incidence of pregnancy and homelessness in Australia is a significant gap in knowledge that could be used to inform social and health policy and service delivery. While homelessness can have dire consequences for both mothers and infants, pregnancy can be a turning point for homeless women, which supports the need for strong system responses to this group. However, in the absence of such data, service provision has

occurred ad hoc in response to local need. While there are examples of innovative programs and good practice, the research confirmed there is no coordinated, system-wide response to pregnant homeless women.

The research found that, like all homeless people, pregnant homeless women experience difficulty in accessing housing support due to the overwhelming demand for these services. Moreover, even when accessing housing support services, pregnant homeless women may not receive responses to their additional support needs, in part because some homelessness services do not take pregnancy into account as a risk factor for determining access to support until late in the pregnancy. In a housing crisis, women may be referred to rooming houses or to stay with family or friends, which is likely to be unsustainable or become unsuitable once the baby is born. Aboriginal women and young women may access homelessness services that provide specialist support but there are fewer available than are required. Many pregnant homeless women have experienced family violence but, due to an overburdened service system, they may not receive a family violence specialist response. Women aged 25 years and over are the least likely to receive a specialist response; however, a new initiative based on intensively supported transitional accommodation offers great promise for this neglected group. Yet, access to long-term housing is highly limited. Critical shortages in safe, stable and affordable housing constrain the capacity of homelessness services to support pregnant homeless women.

It was also evident that housing and homelessness service workers may not have the skills to work with pregnant homeless women. Training is needed in sensitively collecting information about pregnancy status and improving practice with this client group to produce the best possible outcomes for the woman and her child.

Service providers reported the need for specialist health support for homeless pregnant women, as well as for mainstream health services, to be well-informed of the needs and circumstances of this group of women. Highly regarded specialist health programs exist, including those that respond to women with complex needs. Service providers identified the key elements of these programs as wraparound provision of services, continuity of care and outreach. Peer support was identified as particularly important for young women and there is the potential to further develop such initiatives for pregnant homeless women of all ages. Long-term support, while often needed, was limited. Ongoing collaboration and further integration among and between specialist health and homelessness services were seen as a means of improving responses to pregnant homeless women.

Recommendations

Data collection

- Review Australian Institute of Health and Welfare data collection to include a mandatory check box or other means of readily identifying pregnancy status

- Develop practice in relation to 'pregnancy-friendly' approaches to sensitively collect information about pregnancy status among homeless women
- Investigate means of aggregating data across health and homelessness sectors to better enumerate the total population of pregnant homeless women

Research

- Conduct further research to illuminate the number and circumstances of pregnant homeless women to better inform current policy and practice, including through researching directly with pregnant homeless women themselves

Long-term housing

- Increase access to social housing for pregnant homeless women in a range of dwelling types and suitable locations that maximise women and children's stability, safety and wellbeing including access to supportive networks and services
- Resource the A Place to Call Home program by restocking transitional housing dwellings when tenancies are transferred to permanent public housing
- Ensure private rental and other brokerage arrangements are available that suit the circumstances of pregnant and newly parenting women in terms of affordability and location
- Increase provision of housing-led programs so pregnant women can access permanent housing and obtain stability early in their pregnancy

Intensively supported transitional accommodation

- Drawing on good practice examples for young women and a new initiative for women aged 25 years and over, provide additional intensively supported transitional accommodation for pregnant homeless women

Crisis accommodation

- In situations where long-term, stable and sustainable housing or supported transitional accommodation are not immediately available, increase and improve access to suitable crisis accommodation for pregnant homeless women
- Provide flexibility in the length of time crisis accommodation is available to avoid pregnant homeless women exiting with nowhere to live
- Review access to family violence crisis support to ensure pregnant homeless women with complex needs are not disadvantaged

Support

- Locate specialist housing support workers in hospital settings to assist pregnant homeless women with accessing housing support
- Ensure homelessness and health services are aware of the family violence Flexible

Support Packages and the ways that they can provide support to pregnant homeless women experiencing family violence

- Promote homelessness, health and other services working together to provide long-term support to women during pregnancy and early parenting
- Enable services to provide relevant good practice elements of continuity of care, outreach, wraparound provision of services and peer support
- Raise awareness of the needs of women who seek a termination rather than continue with a pregnancy
- Underpin service provision by trauma-informed care

Training and education

- Develop and implement a training package that assists housing and homelessness services staff to collect information about pregnancy status
- Build on current good practice and develop and implement specialised training for homelessness and housing service workers in relation to homelessness and pregnancy
- Promote understanding of the circumstances and needs of pregnant homeless women through education of generalist staff

Networks and integration

- Re-institute network meetings between specialist workers to share information and provide peer support regarding pregnant homeless women
- Initiate state-wide forums to further integration of system responses to pregnant homeless women
- Map services available to pregnant homeless women across Victoria to identify gaps in an effort to improve system responses

Chapter 1: Introduction

1.1 Background

Launch Housing is an independent Melbourne-based community organisation that was formed from the merger of Hanover Welfare Services and HomeGround Services in 2015, and brings a combined 75 years' experience of working with people at risk of or experiencing homelessness. Launch Housing's mission is to end homelessness. As one of Victoria's largest providers of housing and homelessness support services, Launch Housing operates across 14 sites and 13 local government areas. Launch Housing provides flexible, specialist services that directly assist thousands of individuals, couples and families every year. The organisation also undertakes research into homelessness and uses the evidence to inform policy development and to advocate strongly for measures to improve affordable housing. Launch Housing commissioned this research as a way of responding to homeless women who are pregnant—a group of clients of particular concern.

While Victorian homelessness services such as Launch Housing work with pregnant homeless women, there is currently no systemic response to this group. This gap in the service system produces a lost opportunity for intervention to provide the best possible support to women and infants. There is also no reliable information on how many homeless women are pregnant. Moreover, due to a perception that they may receive restricted access to services or simply that they feel vulnerable about their pregnancy, some women do not disclose their pregnancy to homelessness services. Not all homelessness services are alert to the situation faced by pregnant women and workers do not always know how best to respond. Consequently, workers may not be inquiring about pregnancy or following up the additional needs of pregnant homeless women appropriately.

1.2 Policy context

Two key policy areas informed this research: housing and homelessness, and family violence. The housing system in Australia has increasingly failed to meet the needs of a growing proportion of low-income Australians. Currently, Australia has no coherent national framework to tackle this lack of affordable housing, which has long been identified as a critical issue for vulnerable people in the community. Typically, private rental costs are unaffordable for people on pensions and benefits or who receive low incomes, particularly in cities, including Melbourne (Anglicare Australia, 2017; Milligan, Pawson, Williams, & Yates,

2015; Toohey, 2014). At the same time, it is well established that there is a shortage of social housing in Victoria and more broadly across Australia (National Housing Supply Council, 2012). The proportion of Australian households living in social housing decreased from 7 per cent of all households in 1991 to 4.2 per cent in 2016 (Australian Housing and Urban Research Institute, 2017). This stemmed from the withdrawal of government investment in social housing (interrupted briefly between 2008 and 2012) and an overall long-term decrease in the share of social rental housing compared to population growth (Milligan et al., 2015; Toohey, 2014). Growing demand within the community combined with decreasing government investment has meant that there were 164,000 people on the public housing waiting list in 2012 with a wait time of up to 15 years in some areas (Toohey, 2014). Australia requires an investment of \$67.4 billion to build enough accommodation for those on social housing waiting lists, or \$90 billion to meet the housing needs of low-income households (Toohey, 2014). The majority of the social housing stock in Victoria is public housing, with this state having less public housing per capita than the national average (State of Victoria, 2016). Turnover in public housing is thus slow, and waiting times are a key cause of blockages in the homelessness service system (State of Victoria, 2016). These pressures create obstacles for women and their children attempting to find housing and who want to exit specialist homelessness services. They also prevent others from accessing this specialist support.

Recent policy developments in Victoria have signalled a renewed commitment to tackling housing affordability and homelessness. The Andrews-led Labor government's housing and homelessness policy, *Homes for Victorians*, commits to a range of initiatives designed to increase housing supply, including increasing the supply of social housing and improving housing services for Victorians in need (Victoria State Government, 2017). The Council to Homeless Persons (2017) commended this policy on the basis that it would deliver '6,000 social housing dwellings over five years, which will have a positive impact on homelessness'. The policy also documents commitments to improve housing and homelessness services through investments designed to increase rapid re-housing and improved access to permanent housing for those sleeping rough. It is particularly targeted at young people, rough sleepers and women and children experiencing family violence; however, there is no mention of pregnant homeless women (Victoria State Government, 2017).

Family violence is a key reason why women seek homelessness support. In Victoria in 2016–17, 40 per cent of clients (or nearly 115,000 people) seeking assistance from homelessness services were experiencing family violence. Of these, over a third (35%) were aged under 18 years and over a fifth (22%) were under 9 years. Females made up 91 per cent of the adult population seeking assistance in relation to family violence from homelessness services (Australian Institute of Health and Welfare (AIHW), 2017a). In response to the findings of the Victorian Royal Commission into Family Violence, the Victorian Government's *Ending Family Violence: Victoria's Plan to Change* (Victoria State Government, 2016a) includes a range of strategies broadly grouped under the following areas: prevention of family violence

through universal strategies designed to tackle gender inequality; service systems reform designed to expand, better resource and integrate early intervention; specialist family violence and mainstream services including a substantial re-design of the service system to include support and safety hubs; reform of laws and services to make perpetrators more accountable; and reform of governance and laws to improve information sharing, workforce capacity and accountability. In particular, in relation to housing, the Victorian Government allocated over \$150 million for a 'housing blitz' and a further \$109 million for the redevelopment of women's refuges, rapid housing assistance and the expansion of the family violence flexible support packages (FSPs) initiative. Also instigated from the findings of the Victorian Royal Commission on Family Violence, the Victorian Government's Roadmap to Reform: Strong Families, Safe Children (Victoria State Government, 2016b) combines a range of service responses, including child protection, family violence and homelessness, and focuses on prevention, early intervention, integration of services, wraparound support and continuity of care.

1.3 Research design

The research had two key elements, reflected in the following two research questions:

- What is the estimated number of pregnant women in Victoria's homeless population and how might data collection processes be put in place that better identify and enumerate this group?
- In what ways do Victorian homelessness and related services work with a pregnant homeless woman, and how might this occur in better ways for both the woman and her baby?

The researchers, Professor Suellen Murray and Dr Juliet Watson from RMIT University and Dr Jacqui Theobald from La Trobe University, worked with a reference group including senior staff from Launch Housing, the Royal Women's Hospital and other community and government organisations. The reference group was involved in the development of the project and provided expert guidance in matters such as the recruitment of research participants, analysis of the data and presentation of the findings. Ethics approval was gained from Launch Housing and the RMIT University Human Research Ethics Committee.

The research was undertaken using a qualitative approach and comprised a literature review and interviews and focus groups with key stakeholders who have expertise in the policy and practice of working with pregnant homeless women. Recruitment of key stakeholders occurred through the professional networks of the reference group members.

Interviews and focus groups were conducted for up to an hour each during which time policymakers and practitioners were consulted regarding:

- An estimate of the number of pregnant homeless women seen by their service and the method by which this figure was determined
- Ways to improve data collection, including what to collect, how, when and by whom
- The ways in which services are currently provided to this group
- Issues of concern and examples of good practice
- Possible improvements to service responses

There are three limitations to the research. First, the research did not involve participation from women who are or have been pregnant and homeless. This is a significant limitation and was due to the constraints of funding and project timing. To address this, while limited, literature was sought that focused on women's experiences of homelessness and pregnancy to inform the analysis. This lack of research regarding the experiences of pregnant homeless women is a major gap in Australian homelessness research. Second, the research intentionally paid primary attention to policy and practice in relation to pregnant homeless women. While this report acknowledges the impact of homelessness on the unborn child and infant, further research could be conducted that focuses on service responses to these specific groups. Third, access to housing was viewed through the lens of the homelessness service system. It is acknowledged that there are other forms of supported housing such as that provided through residential detoxification facilities for alcohol and other drugs. These forms of supported housing were not included in the research and further investigation could be undertaken to determine the extent to which they meet the needs of pregnant homeless women who are dealing with alcohol and drug misuse. Moreover, the management of alcohol and drug misuse during pregnancy, while recognised as a significant reason for pregnant women's homelessness, was also not a focus of the research.

1.4 Summary of data collection

Twenty-seven services participated in the research, comprising:

- Eighteen homelessness services
- Two hospital-based health services
- Five community-based health services
- One community-based specialist support service
- One government agency

The research involved 41 participants, including 19 individual interviews and eight group interviews/focus groups.

All services were located in Victoria except for one, with five services in rural or regional areas and a number of state-wide services. The one interstate service was included as it had been identified as an example of good practice service provision to young women.

The services included generalist homelessness and health services as well as specialist services for women (including family violence services); Aboriginal people, Aboriginal women and Aboriginal young women; young people and young women; people of culturally and linguistically diverse backgrounds; and pregnant and parenting women.

1.5 Key concepts

In undertaking the research, a number of key conceptual issues became evident and they are discussed here to provide further background to the report. These issues relate to the definitions of homelessness and pregnancy, the nature of housing and homelessness services and the level of support required by pregnant homeless women.

In this report, homelessness is defined in relation to a lack of suitable housing or being at risk of homelessness due to the inadequacy of the dwelling, and a lack of tenure and control and access to space for social relations (Australian Bureau of Statistics (ABS), 2012a). In relation to pregnancy, 'suitable housing' relates to both the woman and her unborn baby and, in time, her newborn baby. In other words, housing that may be suitable for a pregnant homeless woman may not be suitable for a newborn baby. For convenience, this report refers to 'pregnant homeless women', which includes women who are homeless, those who are at risk of homelessness and those who are in unsuitable housing for herself or the newborn.

Among the service providers, there was no single timeframe that was used to determine pregnancy as a factor in the receipt of support; this could span from any unverified time during pregnancy to a minimum of seven months into the pregnancy as verified by a medical certificate, to full-term.

In this report, homelessness services, such as those provided specifically for Aboriginal and Torres Strait Islander women (henceforth in this report named 'Aboriginal women' and 'Aboriginal services'), young women and women who have experienced family violence, are identified as 'specialist homelessness services'. All homelessness services including those that are entry points and others that target single men and families are termed 'homelessness services'. In the homelessness service system, there is an important differentiation between a 'single' pregnant woman (who may have children but they are not accompanying her) and a pregnant woman with accompanying children as the latter will be considered as a 'family' but the former is not, depending on the timeframe at which the pregnancy is registered as a risk factor. The level of support a pregnant woman receives is thus influenced by whether she has other accompanying children and the way pregnancy is defined by the service.

It is acknowledged that the level of support required varies depending on the circumstances of the women. For example, a pregnant homeless woman may be dealing with an acute housing crisis, or she may be experiencing longer-term disadvantage or marginalisation. This report is largely concerned with the needs of the latter group.

1.6 Structure of the report

This chapter has outlined the background and research design. Chapter 2 is a summary of the international academic and grey literature concerned with pregnancy and homelessness, with a particular focus on its significance, incidence and experience. Chapter 3 addresses data collection and identifies ways in which this could be improved. Chapters 4 and 5 discuss current Victorian responses to homelessness and pregnancy from the perspectives of housing and pregnancy support services, respectively, identifying gaps in policy and service delivery, as well as good practice. Chapter 6 presents the report's conclusion and recommendations.

Chapter 2:

Literature review

2.1 Introduction

Women who are pregnant and homeless may have a number of co-occurring factors, including alcohol and drug misuse, domestic and family violence, mental health issues and socio-economic disadvantage (Cutts et al., 2015; Greunert & Tsantefski, 2012; Taplin, Richmond, & McArthur, 2014). Some will be young women and, characteristic of the wider homelessness population, there will be those who spent time in out-of-home care as children (Esen, 2017; Shaw & Willard, 2016). All these factors compound the difficulties that being homeless during pregnancy presents. Importantly:

The homeless and pregnant constitute a mixed group of women ranging from adolescents and teenagers with no children to adult women with one or more children, all with different pathways to homelessness ranging from adolescents running away from home to adult women fleeing domestic violence, all with different needs apart from the pregnancy. (Esen, 2017, p. 2116)

There is a range of literature that is broadly concerned with homelessness and pregnancy, including:

- the nature, definition and incidence of homelessness and responses to it, specifically in relation to women and young women (e.g. Chamberlain, Johnson, & Robinson, 2014; Esen, 2017; Thompson, Begun, & Bender, 2016)
- pregnancy and parenting, particularly in relation to young women (e.g. Boulden, 2016; Keys, 2007; Kuskoff & Mallett, 2016; Loxton, Williams, & Adamson, 2007; Thompson et al., 2016)
- the nature and incidence of alcohol and drug misuse and pregnancy and responses to it (e.g. Burns & Breen, 2013; Scobie & Woodman, 2017; Taplin et al., 2014).

While considering the range of co-occurring factors, this literature review specifically addresses:

- the impact of homelessness on pregnancy
- the incidence of pregnancy during homelessness
- women's experiences of pregnancy during homelessness
- service responses to pregnancy during homelessness

The literature studied includes both academic and grey literature from Australia as well as internationally, including that from New Zealand, the United Kingdom (UK), the United States (US) and Canada.

2.2 Impact of homelessness on pregnancy

The significance of this research topic is evident by the impact of homelessness on pregnancy. Mothers' health can be affected, including inadequate weight gain, anaemia, bleeding problems and other acute and chronic health problems (Bloom et al., 2004; Thompson et al., 2016). More generally, homeless people are known to experience more mental and physical ill health than the wider population (Esen, 2017) and pre-existing co-occurring mental illness and alcohol and drug misuse further affect women's health. Practical issues such as a lack of storage and refrigeration can restrict a homeless pregnant woman's ability to maintain a healthy diet (Moore, 2014).

Pregnant homeless women are less likely than other pregnant women to attend antenatal care (Bloom et al., 2004). Barriers to accessing healthcare services include concern by the mothers that their babies will be taken from them, the cost of services, lack of transport, wait times to receive services, unsatisfactory personal relationships with care providers and a lack of knowledge of the importance of prenatal care (Bloom et al., 2004; Cutts et al., 2015; Esen, 2017; Fleming, Callaghan, Strauss, Brawer, & Plumb, 2017).

Pregnant homeless women are at risk in terms of their own health and also that of their unborn infant (Allen, Feinberg & Mitchell, 2014; Murphy, Mill, Fordham, & Gorman, 2013; Richards, Merrill & Baksh, 2011). As noted by Moore, Arefadib, Deery, Keyes, and West (2017, p. 2) from conception, 'the developing foetus and infant are at their most adaptable, but also their most vulnerable'. According to Shaw and Willard (2016, p. 4), 'experiences of prenatal homelessness were associated with disproportionately higher rates of risk factors for poor perinatal outcomes'. Low birth weight and increased risk of preterm birth are two key medical impacts of homelessness on pregnancy (Esen, 2017; Cutts et al., 2015; Little et al., 2005; Moore et al., 2017). Babies born under these circumstances were found to have increased risk of time in a neonatal intensive care unit and were less likely to have received infant health care and be breastfed (Cutts et al., 2015).

The unborn child can also be negatively affected by their mother's experience of violence, where pregnancy is known to be a risk factor for the onset or increase in domestic violence, and there can be long-lasting emotional, behavioural and neurological effects for children and into adulthood (Moore et al., 2017). Moreover,

Compared with children from low-income families who have never been homeless, children from homeless families are twice as likely to be hospitalised and make

significantly more visits to hospital emergency departments. A higher incidence of asthma and other respiratory problems, infectious diseases, trauma related injuries, lead poisoning, chronic diarrhoea, visual and neurological deficits, delayed immunisations, tooth decay, ear and skin infections, conjunctivitis, and mental health problems and behavioural disorders have also been found. (Moore et al., 2017, p. 20)

Homelessness, then, can have serious health consequences for a woman and her newborn baby, which can impact on their life chances. This early period of life is critical for ensuring healthy development and highlights the need for early intervention and prevention responses, as well as timely support and safe, stable and sustainable housing.

2.3 Incidence of pregnancy during homelessness

In Australia, estimates of the incidence of pregnancy during homelessness were not found in the literature. While 44 per cent of homeless people in Australia in 2011 were women, it is not known what percentage of this group were pregnant (ABS, 2012b). In contrast, in the US and the UK, more attention has been given to enumerating the population of pregnant homeless women. In the US, one in five homeless women were estimated to be pregnant, almost twice the rate of the general population, with the highest incidence among young homeless women aged 16 to 19 years (Bloom et al., 2004). In other research, these rates were higher for homeless women, i.e. whereas 10 per cent of women in the US were pregnant in 2009, 50 to 60 per cent of homeless women were pregnant (Cronley, Hohn, & Nahar, 2017).

From over 11,000 women studied in the US Pregnancy Risk Assessment Monitoring System between 2000 and 2007, 4 per cent were found to be homeless in the year prior to the birth of their child (Richards et al., 2011). In Pennsylvania, specifically, the rate of prenatal homelessness has decreased over time, from 4.5 per cent of all mothers in 2007 to 1.8 per cent in 2011 (Shaw & Willard, 2016). In the UK, in 1990, it was estimated that 2 per cent of all births were to homeless women (Paterson & Roderick, 1990, as cited in Esen, 2017); this figure is likely to be higher three decades later (Esen, 2017).

Rates of pregnancy among young homeless women are five times more likely than their housed peers, with between 30 and 60 per cent of this population reporting past or current pregnancy in a number of US studies (Thompson et al., 2016). A study in London found that nearly a quarter (24%) of young homeless women were pregnant, although not all continued with their pregnancy (Gorton, 2000, as cited in Esen, 2017).

Reasons for this higher rate of pregnancy for homeless women compared to housed women include reduced use of contraception and sexual victimisation (Cronley et al., 2017; Esen, 2017; Thompson et al., 2016). As noted by Cronley et al. (2017, p. 1), homeless women 'report

experiencing higher rates of reproductive health-related traumas, including unplanned pregnancies, miscarriage and abortion, compared to their non-homeless peers’.

2.4 Women’s experiences of pregnancy during homelessness

This research project involved participation from service providers and policy makers and not women who are or have been homeless and pregnant. This is a significant limitation of the research. To address this, literature was sought that focused on women’s experiences of homelessness and pregnancy. According to Moore (2013, p. 144), there is ‘a dearth of qualitative studies that examine the daily lived experience or illuminate the voices of pregnant homeless women’. Having said that, a number of more recent studies were found, as were two older Australian research projects that provide useful insights into this population from their own perspectives. The following three key themes were identified: pregnancy as a turning point, gaps in the service systems and the importance of stable housing.

In a study in an urban community in Texas, 20 women recruited from homelessness services participated in semi-structured interviews concerned with their experiences of pregnancy during homelessness (Cronley et al., 2017). Among this group, pregnancy was typically unintended and was characterised by a loss of control over reproductive health. The news of their pregnancy was received with mixed feelings; some were dismayed, others excited and pregnancy ‘transformed their lives overnight, and frequently not in a positive way’ (Cronley et al., 2017, p. 7). For some, this meant that at that time their educational and vocational goals were dashed. Moreover, the women disclosed reproductive health traumas such as miscarriage, infections, involuntary sterilisation and difficult births. The women’s reflections indicated that pregnancy was a turning point, with participants noting that they ‘looked forward to a life characterized by possibilities rather than disappointment’ (Cronley et al., 2017, p. 9).

In Watson’s (2018) research with young homeless women, she also found that pregnancy could be a turning point. For one of her research participants, ‘becoming a mother and recognising the impact of intimate partner violence on her son precipitated her decision to leave an abusive relationship’ (p. 141). In another Australian study, Keys (2007) found that becoming a mother was a catalyst for change for young women in a number of ways, including in relation to their sense of identity, relationships, health and housing. Keys (2007) conducted interviews with service providers as well as 24 women aged between 17 and 26 years who had experienced homelessness. The research identified gaps in the service system including weak links between the health and homelessness services, and a lack of recognition of the needs of young people in family services, and pregnancy and parenting in youth services.

In another US study, in Philadelphia, the focus of the research was on homeless pregnant

women's experiences of prenatal care (Fleming et al., 2017). Nine women were recruited from women's shelters who were pregnant at the time or had been homeless and pregnant in the previous six months. The most common themes identified by the women were the lack of social support, access to care affected by location or transportation, lack of control of their day-to-day life in the shelter and concern for their personal safety (Fleming et al., 2017).

A number of studies noted the importance of secure housing. Moore's (2013) UK study focusing on the experiences of one pregnant homeless woman identified the stress caused by housing instability and the associated lack of control, especially when the woman was temporarily housed in a location where she was socially isolated and had no family support. It was evident from this research, and in another UK study (Hogg, Haynes, Baradon, & Cuthbert, 2015), that housing policy impacted negatively on homeless pregnant women. In particular, women reported that they had moved between poor-quality accommodation, which subsequently reduced their access to prenatal care and affected their mental health. Research with young drug-dependent homeless pregnant women in Australia found that the following two interventions were critical: drug treatment and suitable accommodation (Bessant, 2003). Using an ethnographic approach, participants in this research explained the ways in which stable housing increased the likelihood of a healthy pregnancy and enhanced their access to drug treatment.

2.5 Service responses to pregnancy during homelessness

Key features of approaches to addressing the needs of homeless pregnant women identified in the literature include the prioritisation of stable housing (Bessant, 2003; Cutts et al., 2015; Little et al., 2005) and supporting young women to transition to independent housing (Holtschneider, 2016). Another feature is coordination of responses (Esen, 2017; Hogg et al., 2015; Scally, Waxman, & Gourevitch, 2017), which Esen (2017, p. 2116) identifies as 'multifaceted and multi-agency'. Scally et al. (2017) describe Boston's 'citywide approach' in which health and housing authorities partnered to better understand and respond to the intersections of health and housing with local universities providing evaluation support. A further feature is the use of trauma-informed approaches. As noted by Cronley et al. (2017, p. 12):

All service providers working with this population require sensitivity regarding potential past trauma and ability to use trauma-informed models of care. The latter are particularly critical, because they encourage practitioners to recognize the psychological impact of health-related traumas, and the need to engage patients in vulnerable situations through empowering strategies that stress patient autonomy.

Existing programs include specialist obstetric providers (Tsantefski, Humphreys, & Jackson,

2014; Tsantefski, Jackson, & Humphreys, 2015) or other means of providing specialist care to pregnant homeless women such as a Canadian team of public health nurses providing a direct client service via outreach in partnership with collaborative networks of other service providers (Murphy et al., 2013). In settings where women could access universal services, Fleming et al. (2017) found that the provision of transportation to access prenatal care was important and a group model of prenatal care was preferred by women.

In Boston, a partnership between local health and housing authorities and universities has resulted in a number of significant public health programs. From 2011, the 'Healthy Start in Housing' initiative prioritised pregnant homeless women to gain secure and stable housing through the Boston Housing Authority. Women are provided with assistance to apply for housing and, once successful, receive intensive case management support, including that provided by public health nurses, for up to three years (Allen et al., 2014; Scally et al., 2017). In an evaluation of the program, there were statistically significant improvements in the mental health of participants (Feinburg & Vieira, 2016, as cited in Scally et al., 2017).

Particular attention has been given to pregnant homeless young women and homeless young mothers. Services for these groups typically include supported housing, education programs and antenatal outreach services or supported access to antenatal care. In Australia and New Zealand, there are a number of such services (e.g. Anchor, 2017; Gonzalez & Hussein, 2011; Karinya Young Women's Service, 2011, 2017; St John of God, 2016; Lachlan, Rosmini & Araki, 2015; Nelson, 2012; Russell & Thorpe, 2007; Young, Hunt & Sullivan, 2008).

Models of service and good practice with homeless pregnant women may also be informed by programs such as one-to-one peer support for women experiencing mental ill health (McLeish & Redshaw, 2017), community support groups for women from 'impoverished' communities (Gabbe et al., 2017) and support for young mothers (e.g. Connections Uniting Care, 2015).

2.6 Conclusion

A lack of data regarding the incidence of pregnancy and homelessness in Australia is a significant gap in knowledge that could be used to inform social and health policy and service delivery. While homelessness can have dire consequences for both mothers and infants, pregnancy can be a turning point for homeless women, thus supporting the need for strong system responses to this group. The literature suggests that the key elements of such an approach include the availability of stable long-term housing, coordination of health and housing responses, and the use of trauma-informed care.

Chapter 3:

Data collection

'There needs to be a mandatory tick box.'
(Specialist housing support worker)

3.1 Introduction

In 2015, over 304,000 women gave birth in Australia, with a rate of 62 per 1000 (6.2%) among women of reproductive age (15 to 44 years) (AIHW, 2017b). It is unknown how many of these women were homeless during their pregnancy. However, we do know that the majority of people who accessed homelessness services in 2015–16 in Australia were women (59.4%, over 165,000 women) and of these nearly two-thirds (62.9%) were of child-bearing age (15 to 44 years) (AIHW, 2016a).

There is very little data on pregnancy and homelessness that is readily available and consequently in the present research it was not possible to accurately estimate the incidence of pregnancy among homeless women in Victoria. As there is no routine data collection of pregnancy during homelessness, the evidence presented here is ad hoc and is from agencies that could readily access this information and were willing to submit it to the researchers. Launch Housing also organised a two-week snapshot survey to provide evidence of the incidence of pregnancy and homelessness.

Homelessness services funded by the state and federal governments are required to contribute to a Specialist Homelessness Services National Minimum Data Set. This data is provided to AIHW, which in turn sends it to the Victorian Department of Health and Human Services (DHHS). According to AIHW (2017c), 'data collection includes basic socio-demographic information and the services required by and provided to each client'. However, pregnancy is not included as part of the collection of socio-demographic information. The national minimum data set data collection software was not designed to routinely collect data on pregnancy and there is no box to check that indicates that a client is pregnant when opening (or during) a support period.

There is a reference to pregnancy otherwise as 'information [that] is obtained about the client circumstances before, during and after receiving support' (AIHW, 2017c). 'Pregnancy assistance', which refers to 'advice, support and assistance relating to pregnancy issues',

can be recorded as clients' specialised services activity types that are 'needed', 'provided' or 'referral arranged'. (Note that there have been changes to the data set from July 2017 but these do not substantially affect data collection regarding pregnancy support.)

3.2 Sources of data and data collection

3.2.1 Homelessness services

Due to the lack of a field in the minimum data set, homelessness services may not collect any data on women and pregnancy. Some agencies collect additional data for organisational purposes and include a field for pregnancy, which is then readily extractable. Other homelessness services may seek information concerning pregnancy but only record this information via case notes; therefore, it is not easily accessible. Some services noted that this was the case but did not have the staff resources to extract this information from case notes for the purposes of this research. Consequently, there is no consistency across the homelessness service system for the collection of data regarding pregnancy.

In 2015–2016, 0.8 per cent of Victorian homelessness services clients (839 clients) were identified as needing 'pregnancy support'; of these, 55.3 per cent had services provided in response to this need (AIHW, 2016b). However, advice from support workers suggests that,

In general, a question on pregnancy is not routinely asked, so it can be assumed that the AIHW figures are under-reported, and do rely on women disclosing that they are pregnant. But, a question about children is routinely asked at intake (whether someone presents with children or not) and this may prompt a client to disclose they are pregnant. (Launch Housing, email correspondence, 2017)

In contrast, it was noted that homelessness services that specialise in supporting women and young families routinely ask about pregnancy.

To support this research, Launch Housing and the Salvation Army and Crisis Services Network (SACSN) conducted a snapshot survey over a two-week period, from the 21 November to 4 December 2017 (Launch Housing, 2017b). The survey targeted workers who had clients that they were actively case managing with a 41 per cent response rate at Launch Housing (of 131 workers) and an 87 per cent response rate at SACSN (of 23 workers). The survey questions sought to determine the number of clients the agencies worked with during the data collection period and, among these, how many were female, pregnant and linked in with antenatal services. Table 1 shows that during this two-week period in these two homelessness agencies, 6.4 per cent of female clients were pregnant. Of these, nearly three-quarters (72.2%) were receiving antenatal care at the time (Launch Housing, 2017b).

Table 1: Launch Housing and Salvation Army and Crisis Services Network Snapshot Survey
(Source: Launch Housing, 2017b)

	Launch Housing	Salvation Army & Crisis Services Network	Total
Number of completed surveys	53	20	73
Estimated number of clients	539	180	719
Estimated number of female clients	422 78.3%	143 79.4%	565 78.6%
Number of female clients reported as pregnant	31 (7.3%)	5 (3.5%)	36 (6.4%)
Number of pregnant clients receiving antenatal support	22 (71%)	4 (80%)	26 (72.2%)

In addition, Launch Housing analysed data collected from their use of the Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) data collection. The VI-SPDAT has a specific question about pregnancy. Commencing in March 2017 at three Launch Housing access points, the VI-SPDAT had by mid-December 2017 been completed for 1,768 people, 674 (38.1%) of whom were women. Table 2 shows that, across a random selection of two-week intervals, including the snapshot survey collection period, 7.7 per cent (52) of all women reported being pregnant (Launch Housing, 2017b).

Table 2: Launch Housing Analysis of VI-SPDAT data (Source: Launch Housing, 2017b)

	01/05/2017 - 15/05/2017	03/07/2017 - 17/07/2017	04/09/2017 - 18/09/2017	21/11/2017 - 4/12/2017*	01/03/2017 - 14/12/2017**
Number of VI-SPDAT completed	107	94	95	93	1,768
Number of women with VI-SPDAT	45	33	36	32	674
Number recorded on VI-SPDAT as pregnant	2 (4.4%)	2 (6.1%)	5 (13.9%)	2 (6.3%)	52 (7.7%)

* 2 week data collection pregnancy snapshot
** Nine months since VI-SPDAT implemented at Launch Housing Access Points

These two measures are of those women who accessed homelessness services and who were pregnant; however, many do not access services. It is also possible that this sample of agencies underrepresents young women's services and consequently the number of young women accessing homelessness services. As the literature review highlighted, young women are over-represented among pregnant homeless women (Bloom et al., 2004). Given these caveats, and noting that they are lower than the rates found internationally, these two measurements derived from Launch Housing and SACS (6.4%) and Launch Housing's VI-SPDAT (7.7%) are slightly higher than the national rate of 6.2 per cent.

3.2.2 Specialist homelessness services

Specialist homelessness services reported that they routinely collect data on pregnancy. It may be the case that these services target pregnant or parenting women, or because pregnancy is an issue that is considered a risk factor for women who have disclosed family violence. The data, however, could be embedded in case notes, and thus not be readily accessible. Alternatively, these services may use a pregnancy field in their organisational dataset.

Among the specialist homelessness services that participated in the research, some provided information about the incidence of pregnant homeless women among their client groups. For example, the Salvation Army's SalvoConnect Ballarat programs, Mothers and Children (MaC) and Young Families Connected (YFC) provide medium-term accommodation and target clients who are aged under 25 years. The MaC program is for single mothers and the YFC program is for coupled parents. Over a 12-month period from November 2016, these two services worked with 29 mothers. Over a quarter (27.2%) were pregnant, including five who presented as pregnant at the commencement of their support period and three who became pregnant while they were being supported by the agency. All other clients had children, including nine who came to the service with a newborn baby aged under six months (SalvoConnect Ballarat, email correspondence, 2017). Another of SalvoConnect Ballarat's programs provides emergency accommodation for single mothers aged over 25 years. Over a 12-month period from November 2016, this program supported 35 mothers of whom five (14%) accessed the service while they were pregnant and another five clients had a newborn baby with them (SalvoConnect Ballarat, email correspondence, 2017).

The BOOST enhanced refuge response of the Hope Street Youth and Family Services targets young people aged 16 to 25 years who are homeless or at risk of homelessness and in crisis with a particular focus on young people with complex needs. An evaluation of this service noted that one of the key target groups is pregnant young women but they did not provide data on the number of pregnant young women (for the period November 2012 to June 2013) (Jones & Costello, 2013). More recently, from January to mid-November 2017, seven of 132 BOOST clients were pregnant young women. During this period, no pregnant young women were supported in either the Hope Street youth refuge, which provides support and crisis

accommodation, or their Youth Support Service (Hope Street Youth and Family Services, email correspondence, 2017).

Safe Steps Family Violence Response Centre is Victoria's state-wide first response service for women, young people and children experiencing family violence. In 2016–2017, 2,760 women completed risk assessments with Safe Steps and, of those, 478 (17.3%) had pregnancy or new birth identified as a risk factor. Among this group, 306 women (64%) received accommodation support during this period and most of them (95% or 453 women) had a safety plan (Safe Steps, email correspondence, 2017).

3.2.3 Hospital and health services

Specialist pregnancy support services are likely to routinely collect data on a pregnant woman's housing situation as this has a bearing on the circumstances for the newborn. Among clients who attended the Royal Women's Hospital's Women's Alcohol and Drugs Service (WADS) in 2016, 50 per cent (34 women) were homeless or living in unsuitable housing (WADS, 2017).

3.2.4 Collecting data

In the research, it was acknowledged that there were particular difficulties in collecting data about pregnant homeless women. For example, a housing support worker referred to the way that hidden homelessness could make this group invisible and hard to find and count:

There's a real hidden homelessness population I think specific to pregnant women – the women I saw would do anything to stay off the street and the majority of them are so motivated by their pregnancy and motivated to have this child in their care that they will remain in like very dangerous situations with violent men, they'll couch surf, they'll sex work, they'll do all kinds of different things just to make sure that they're not on the street. So it's going to be very hard to get a true sense of how many women in Melbourne are pregnant and experiencing homelessness at any given time.

Typically, health services routinely ask women if they are pregnant with one health support worker observing that 'some people are probably better at asking than others'. It was acknowledged that some women would volunteer information about their pregnancy status in the context of their concern about being pregnant while homeless. Service providers reported that women may be more likely to disclose a pregnancy due to a belief that this would increase their chance of being offered accommodation. In contrast, it was also noted that some women avoided disclosing pregnancy for fear that they would be less likely to be housed.

Specialist family violence services noted that staff routinely and directly ask about pregnancy as part of their intake process as pregnancy is identified as a family violence risk factor.

Others observed that it was important to use an indirect and conversational approach to allow women to disclose their pregnancy in their own way and time. The importance of rapport was noted by an Aboriginal service in assisting women to disclose. This then has implications for when information is likely to be collected about pregnancy as there may not be the time or opportunity during the first contact but rather this would occur in a later more detailed assessment if she was referred to support services. This approach, however, does not allow for the need to identify pregnancy early, thereby counteracting this as a means of ensuring women receive the best possible service response. This range of responses from service providers suggests the need for further investigation of 'pregnancy-friendly' approaches to sensitively collect this information and staff training to upgrade skills in doing so.

3.3 Conclusion and recommendations

3.3.1 Conclusion

Anecdotally, and to the limited extent that this research has allowed, it is known that there is a significant population of women who experience pregnancy during homelessness. While some homelessness services collect data on pregnancy, typically it is not readily accessible. Health and hospital services are likely to routinely collect this information, as well as some specialist homelessness services including family violence services, but there are no known means of aggregation. Not having accurate data on the number of women who are pregnant and homeless in Victoria, and their circumstances, is a significant impediment to improving services and providing the best possible responses to this group of women and their children. There is a pressing need to review the data collection to ensure all relevant demographic and other information is available to inform this analysis of client needs and service provision.

3.3.2 Recommendations

Data collection

- Review AIHW data collection to include a mandatory check box regarding pregnancy status
- Develop practice in relation to 'pregnancy-friendly' approaches to sensitively collect information about pregnancy status among homeless women
- Investigate means of aggregating data across health and homelessness sectors to better enumerate the total population of pregnant homeless women

Research

- Conduct further research to illuminate the number and circumstances of pregnant

homeless women to better inform current policy and practice, including through researching directly with pregnant homeless women themselves

Training and education

- Develop and implement a training package that assists housing and homelessness service staff to collect information about pregnancy status

Chapter 4: Housing support

'There's really just a complete and utter lack of options for homeless pregnant women.'

(Homelessness support worker)

4.1 Introduction

In Victoria, homelessness services provide housing and support to homeless women, including those who are pregnant. Like Australia more broadly, Victorian homelessness responses are largely crisis-based and provide short-term crisis accommodation options in the form of independent units and rooms in larger facilities with shared amenities and funding for short-term motel accommodation. Medium-term supported accommodation options include transitional housing properties (often referred to as THMs in Victoria) and other forms of community housing. When residing in supported accommodation, homeless pregnant women are also assisted with accessing a range of social care services including those dealing with income support, debt, antenatal care, mental health, material aid, drug and alcohol use, counselling and parenting support.

Homelessness services also support homeless women to obtain long-term housing such as public and social housing and private rental; however, most commonly, the provision of support does not continue once people are housed. In recent years, there has been growing international interest in Housing First, which involves providing immediate access to permanent, supported housing for chronically homeless people. This model of housing is underpinned by values including a human right to housing as well as the principle that housing provision should not be dependent upon behavioural change. The Housing First approach prioritises permanent tenancies followed by the provision of a multidisciplinary team of support services (Johnson, Parkinson, & Parsell, 2012). Pregnant homeless women are not necessarily chronically homeless and therefore may not meet the criteria and measures of Housing First; however, the housing-led and targeted intensive support aspects that are central to Housing First could be particularly suited to them. Certainly, a housing-led approach is critical in providing stability and ongoing support for both a pregnant woman and, later, her newborn baby. An alternative approach is intensively supported transitional housing that provides assistance for extended periods of time that may be particularly suited

to first-time pregnant women who are homeless. To date, the evidence from the present research suggests this model has been used most successfully with young women.

Pregnant homeless women access homelessness and housing services, including specialist programs. These specialist programs are targeted to young women, Aboriginal women and women experiencing family violence. There are also some limited accommodation and support options designed specifically for pregnant homeless women. Overwhelmingly, there are not enough housing and support options to meet the specific needs of pregnant homeless women in the short-, medium- and long-term, and there are particular gaps for some groups. As noted in the introduction to this report, there is an acknowledged ongoing need for increased public and community housing to enable people to exit homelessness (Chamberlain et al., 2014). Private rental brokerage programs have expanded considerably over the past several years; however, there continues to be challenges in relation to long-term sustainability, particularly because of low income and rental affordability issues. Therefore, the turnover in crisis accommodation is slow and, while pregnant homeless women may be accorded priority on the basis of their vulnerability, others with complex support needs are also prioritised, resulting in many pregnant homeless women not obtaining the housing and support services they require.

4.2 Responses to specific groups of pregnant homeless women

Given the lack of reliable data about pregnant homeless women, service responses have been established in ad hoc ways and in response to local need. Consequently, in Victoria, there is a limited range of responses to pregnant homeless women. There are identifiable specific responses to Aboriginal women, young women under 25 years and women experiencing family violence. Women aged 25 years and over receive more limited responses.

4.2.1 Aboriginal women

Specialist homelessness services for Aboriginal women provide emergency accommodation and outreach support, and include women's services and a young women's service. There are three Aboriginal women's refuges in Victoria with two more planned to be built by the Victorian Government by 2020. This much-needed expansion is consistent with the view that 'Aboriginal people need Aboriginal services'; however, service providers also acknowledged that some Aboriginal women prefer mainstream services.

A specialist homelessness worker noted that 'most Aboriginal women are homeless due to family violence'. Elizabeth Morgan House provides a specialist family violence response but also works flexibly with women whose primary presenting issue is homelessness:

Our core business is family violence but we all know that [when] someone comes in as family violence or they come as homelessness ... they always have both ... so

we'll work with women regardless. (Specialist Aboriginal family violence support worker)

While funding bodies require that women's refuges 'move people on at the end of six to thirteen weeks', Elizabeth Morgan House extends stays where possible if no housing option is found and avoids 'putting somebody back out in the homelessness sector when we've got a unit sitting there' (Specialist Aboriginal family violence support worker).

Margaret Tucker Hostel provides crisis accommodation and support for young Aboriginal women between the ages of 15 and 18 years. Young pregnant women access their service and one bed is targeted to women with babies under six months of age; therefore, if a woman is pregnant, she can give birth to her baby and return to the service and stay in their bungalow. Margaret Tucker House receives referrals from Child Protection when there are gaps in residential care options or a placement breaks down and/or a young woman requires respite from residential care or sleeping rough. Young women may come to Margaret Tucker House due to being forced out of home because of overcrowding or on exiting the juvenile justice system.

Family violence is a key issue facing Aboriginal young women accessing the services. Margaret Tucker House meets an important gap because the women are often too young to enter a family violence refuge and they play a role in connecting young women to family and culture. This flexible model of support works well for young women who are unable to manage 'strict rules' in residential care. Similar to Elizabeth Morgan House, Margaret Tucker House does not evict women into homelessness and some women have stayed for up to one year despite the service being funded for six-week support periods.

Aboriginal women's housing services provide a holistic and flexible range of supports to women, which include assistance with longer-term housing. Support for women who are pregnant involves linking them with health supports and facilitating access to appointments by providing transport. It is common for their clients not to have engaged with medical care during their pregnancy, or planned for the birth and ongoing care. These services work with women to plan ahead and ensure they have material goods by linking them into programs such as St Kilda Mums. Maternal and child health nurses also visit the services to provide care. Margaret Tucker House will support a young woman who has just given birth with developing her care skills such as feeding and bathing her baby, and intentionally substituting the roles of mothers and kinship networks.

These Aboriginal women's services also provide medium- to longer-term accommodation in the form of transitional housing. Similar to other service providers, Margaret Tucker House reports that other forms of long-term housing for young single women are difficult to obtain, and that in the past three years they had only one person access public housing prioritised for Aboriginal people. Indeed, Aboriginal services rely heavily on accessing properties from mainstream providers that are over-stretched and unable to meet demand. A specialist

Aboriginal housing worker noted that there are particular housing challenges facing single Aboriginal women including those who are pregnant: 'A single woman is never going to be housed basically, you're going to be put in a rooming house' and trying to find housing for young Aboriginal women that were pregnant was a 'nightmare'.

Those with multiple children also face challenges with obtaining housing. As noted by a specialist Aboriginal housing support worker, there is a lack of suitable housing options such as an adequate number of bedrooms resulting in women 'sitting in THMs for two years because there is no exits for them'. Aboriginal women can also experience discrimination in the private rental market, resulting in long periods of time in crisis accommodation: 'we've had a woman in our refuge for six months because there is no exit at the moment apart from private rental which we've tried for but people don't want to lease their property to a woman with six kids and another on the way' (Specialist Aboriginal housing support worker).

4.2.2 Young women

A specialist homelessness support worker reported that in Victoria there is 'good specialist knowledge about young women' and this is reflected in there being a number of specialist services for young women including for those who are pregnant and homeless. Indeed, services for homeless young women are more prevalent than for homeless women aged 25 years and older, which is indicative of wider concerns regarding youth, pregnancy and parenting. Short-term crisis accommodation and support options for young women include youth refuges and outreach programs in various locations across the state. However, service providers reported that demand for these services continues to exceed supply. A Melbourne inner south service reported that: 'for every referral we're getting for a family vacancy we're getting about 14, 15 applications'. In response, the service has redirected existing resources by designating two of their refuge units for homeless pregnant women: 'We're starting to see an emerging trend of young mums, eight months' pregnant couch surfing or sleeping in cars. So, there was a real need to actually put another service in place'.

Various initiatives have attempted to respond to the need for crisis accommodation for young, pregnant homeless women. For example, in the eastern region of Melbourne, five crisis accommodation units have been made available to young women (and their partners) who are pregnant or parenting. This provides a diversion from motel accommodation, which is seen as particularly high-risk for this group. However, while these units were intended as a crisis response, due to the lack of exit points, young women have remained in these properties for much longer periods.

Specialist homelessness services also provide medium- and longer-term supported accommodation in the form of transitional housing to young homeless women, including those that are pregnant. Some services such as the Salvation Army outreach program in the inner south target young women specifically, and also have the flexibility to provide support to young women that are still transient.

Key features of support provided by specialist homelessness services to young, pregnant homeless women are intensive case management and advocacy in relation to long-term housing, as well as facilitating access to other relevant support needs including health and antenatal care. Peer support was identified as an important means by which assistance was provided to young pregnant women and their newborn babies and children. The Family Access Network in Melbourne's eastern region has run a young mothers' support group for over 20 years, which links in with antenatal and parenting services and provides life skills, pregnancy and parenting education as well as social support. This group has enabled young women to engage with long-term support beyond the more intensive and time-limited case-managed support of crisis accommodation and transitional housing.

A small number of organisations provide intensive residential support for young pregnant women. For example, using a 'therapeutic family model of care', the Lighthouse Foundation provides supported accommodation for up to three young women aged between 15 and 22 years in each of its three houses. Two live-in carers are present in each home providing 'round the clock support, just like a parent or grandparent' with access to other staff including psychologists and counsellors. The young women and their babies can stay until 'they are ready to leave' (Lighthouse Foundation, 2016). Hazel Hams Homes, a part of Anchor, was opened in 2017 and provides seven three-bedroom homes for pregnant and parenting young women who are at risk of homelessness. The homes operate in partnerships with maternal and child health services, hospitals and a range of other services (Anchor, 2017).

4.2.3 Women experiencing family violence

Given the evidence that the risk of violence can escalate with pregnancy and childbirth, attention to this group of homeless women is warranted (ABS, 2013). However, while many service providers reported that family violence was the main cause of homelessness for women accessing their service, some women do not make their way to specialist family violence services, or were unable to meet the threshold to receive a family violence response.

Women experiencing homelessness with complex needs can face barriers accessing women's refuges—particularly when family violence is not an immediate presenting issue but has been in the past or was the cause of their homelessness. As explained by a specialist housing support worker:

I have never got anyone into a domestic violence refuge ... they discriminate against our client group [particularly] if women [have complex needs], have significant drug and alcohol, they're experiencing homelessness, they might have some challenging behaviours ... I had situations at the Women's Hospital where women had been attacked by their partners, were heavily pregnant. We know obviously that's a very high-risk group and Safe Steps would at the very most give them seven nights in a motel but never did they get accommodated in a domestic violence refuge ...

As noted above, Aboriginal women's refuges tend to have more flexible entry criteria and this housing support worker reported that she had managed 'to get a couple of Aboriginal women into Aboriginal-specific domestic violence refuges and I can only imagine that's because they're a little bit more flexible around the complex needs that our client group face'. The redevelopment of women's refuges to core and cluster models (rather than communal houses) that is currently underway in Victoria is intended to support the entry of women with complex needs to these services.

According to a specialist service working with asylum seekers, single pregnant women are mostly homeless because they are escaping family violence. Without permanent residency, women seeking asylum cannot easily access support from family violence (or other) services as typically they do not have an income to pay for ongoing accommodation and risk remaining long-term in emergency accommodation or a refuge. They can also fear that they will need to meet healthcare and other costs for themselves and their baby.

There are different pathways into support from family violence. For those women who identify the problem as homelessness rather than family violence, the newly developing safety and support hubs should provide entry points into specialist family violence assistance. It was noted, however, that often women were not ready to engage with service providers around family violence. This could be due to a prioritisation of other problems, a violent partner being the woman's only support or prior negative experiences with family violence service responses.

Family violence FSPs of up to \$7000 are available in Victoria to women experiencing family violence to assist them 'to access support, move out of crisis, stabilise and improve their safety, well-being and independence' (DHHS, 2016). FSPs are provided in the context of a case management plan; however, women engaging with homelessness services and others who do not meet the threshold to receive family violence support may miss out on access to this support. Such support could be invaluable in providing assistance to pregnant homeless women who have experienced family violence. It is unclear to what extent this support is offered to this group.

Most refuges are set up for families comprised of a woman and her child/children rather than single women. However, it is possible for a single pregnant woman who has experienced family violence and has heightened vulnerability to access a refuge depending on the availability of rooms, given the intention of refuges to prioritise safety. If a woman is able to access a family violence refuge, she would undergo a thorough assessment, be offered intensive support and be linked in with services: although, typically, these services would be distant from her local area having been moved for safety reasons. Depending on where she obtains longer-term housing, she may then need to re-engage with prenatal care and support services in another location. The ongoing redevelopment of Victorian women's refuges into core and cluster models lends itself to improved service provision allowing for

greater capacity for wraparound responses with health support workers coming into the refuge and greater continuity of care.

4.2.4 Women 25 years and over

There are very few crisis accommodation options for homeless women aged 25 years and over, other than specialist family violence services. However, the limited data that is available suggests that this group is certainly among those who are homeless and pregnant. For example, in 2016, the average age of WADS' clients was 32 years, with a range of 15 to 43 years (WADS, 2017). Those services that provide crisis accommodation to this group, such as Launch Housing, offer some supported short-term crisis accommodation for families and single women. Until recently, there were no accommodation options specifically targeted to pregnant homeless women in this age group; therefore, according to one housing support worker, pregnant women 'fall in between families and singles'.

A metropolitan Melbourne regional homelessness service worker reported that despite the risks associated with pregnancy, a pregnant homeless woman would struggle to receive an adequate service response. For example, a single, pregnant homeless woman without accompanying children would 'rarely' be funded to receive crisis accommodation in a motel:

We just don't have the money to do that ... with single women it is really, really difficult because the vast majority of single men that we see we will place in a rooming house. There are no female rooming houses in the [region]... [or] few that are registered that we are prepared to use.

Most crisis options are available to women with children in their care. Families with children, especially young children, are prioritised, as explained by this specialist housing support worker:

If we have someone who is three or four months pregnant and someone else who has children alive in their care then we are going to prioritise those. We've always got more families ... than we're actually able to place and so we have to prioritise people who have children in their care at the time.

Due to insufficient resources and a lack of prioritisation of pregnancy, this service provider reported that a pregnant homeless woman would typically be offered food and/or food vouchers and be advised to seek accommodation by couch surfing with friends or relatives. However, this is unlikely to be a long-term solution once the baby is born. Likewise, if the woman was referred to a rooming house it would not be possible to continue living there once the baby was born. At this regional homelessness service, a pregnant homeless single woman can only apply for a THM when she is at least seven months pregnant and has a medical certificate. Previously, THMs were only available to families with children; access to single women who were at least seven months pregnant was negotiated more recently as an exception to this policy.

A well-regarded service provided by Launch Housing includes outreach case management support to pregnant women over the age of 18 years without accompanying children who are homeless or living in insecure or unsafe housing. This service also provides secondary consultations to others as well as an outreach post to pregnant women accessing other crisis accommodation services provided by Launch Housing.

A new model of supported housing targeting homeless women who are pregnant and/or have children is currently being developed by Port Phillip Housing in partnership with Launch Housing and Unison Housing in consultation with the Royal Women's Hospital. The model is based on intensive support while living in transitional housing and with a commitment that no clients will be exited into homelessness. The service will provide up to 50 self-contained accommodation units across three buildings, and one of these will be purpose-built with self-contained units for pregnant women and women with children. The service will provide short- and medium-term length of stays, and each tenant will have a support worker. Clients will be provided with material aid upon arrival and a comprehensive range of services will be delivered onsite, including child and maternal health care.

4.3 Long-term housing and support

4.3.1 Long-term housing

There are significant barriers for pregnant homeless women to obtain long-term housing, not the least of which are affordability, sustainability and availability. The lack of available housing undermines the homelessness service system because many women stay longer in short- and medium-term supported accommodation facilities in an effort to avoid exiting into homelessness, and hence reduce the possibility of others receiving this support. However, homeless women can also be exited from crisis accommodation and transitional housing services into homelessness without their long-term housing situation being resolved. They may be exited into unstable and unsuitable accommodation such as rooming houses and couch surfing. Although, as we have seen, Aboriginal women's services resist this practice, and are increasingly more likely to be flexible by extending the length of accommodation stays and providing greater support. Several other services also reported that they would not exit clients into homelessness, or they were becoming more flexible in that regard, particularly when the client was engaging in support services or was deemed to be acutely vulnerable. There is now a growing emphasis on giving priority to outcomes rather than outputs, reflecting in part changes in state government policy.

Pregnant homeless women can be required to move after giving birth if the service is not funded or designed to cater for children. They may also be excluded from access to short-term crisis properties because they will need to move when their baby is born (which explains why some women avoid disclosing their pregnancy). Those in the early stages of pregnancy who are single are also often excluded from access to medium-term housing options such as transitional housing until late in their pregnancy, and 'might have to wait until they're

literally birthing to get that' (Specialist housing support worker). Service providers noted this is largely an issue because of the lack of supply and the associated concern of THM providers to maximise the bedroom usage of their properties. The lack of options for stabilising women in housing early in their pregnancy undermines the relationship between mother and baby during the critical early stages: 'So this is having huge implications on the women's ability to bond with this baby, to get excited, to get ready' (Specialist housing support worker).

Further, access to transitional housing for homeless pregnant women requires them to be engaged in support relationships and tackling their presenting issues before they are eligible for this housing because providers want evidence that the housing will be sustained, clients will continue to work towards exiting into other long-term accommodation and, in the case of allocating a two-bedroom property, that their baby will remain in their care. Therefore, pregnant homeless women with particularly complex needs face compounded barriers to accessing supported accommodation because of the difficulties associated with meeting these requirements while homeless. They also face similar expectations from Child Protection workers. But the challenges of supporting homeless women to manage various presenting problems including pregnancy while transient and without housing was raised by participants as a particular dilemma: 'pregnancy isn't at the forefront of their mind because there's so much going on for them' (Housing support worker).

These challenges have led some services to argue for a housing-led approach informed by Housing First to meet the specific needs of some pregnant homeless women. As noted above, this model is underpinned by the idea that people who are homeless must first obtain stable, permanent housing and only once this is secured can other issues be appropriately tackled:

We need some supported accommodation for very complex women who are experiencing homelessness and also pregnancy so that we can actually get them accommodated and then stabilise them instead of expecting them to stabilise and then we'll accommodate them. (Specialist housing support worker)

Pregnant homeless women are also often unable to access longer-term social housing such as community rooming houses, in part because their income is often not adequate to cover the requirements. This is a particular issue for young homeless women whose income support is often inadequate—particularly if they receive youth allowance—or is non-existent. Community rooming houses are also identified as not being suitable to the needs of women with babies and small children.

One government initiative designed to provide housing stability for women and children is the Commonwealth program A Place to Call Home (Department of Social Services, 2014). For those fortunate enough to gain access to a transitional housing property, the program enables them to remain in their property while the tenancy is transferred to

permanent public housing, rather than having to move again. Initiated in 2008, A Place to Call Home was highly successful but has been undermined by limited turnover. The program has been unable to deal with the overwhelming demand and there has been no increase in transitional housing stock.

Pregnant homeless women can also find it very difficult to access private rental accommodation because it is unaffordable on a government support payment and some face issues of discrimination. Service providers explained, for example, that Aboriginal women often experience stigma and discrimination from real estate agencies, particularly those with several children in their care. This is also a particular barrier facing pregnant women without other children in their care because there is a delay in their ability to receive Centrelink parenting payments until their baby is three weeks old, which further exacerbates their ability to enter the private rental market. Some youth services have been able to bridge this gap with the use of brokerage funds.

The transient nature of homelessness means that public housing applications can become out of date and inaccurate, in particular, bedroom requirements for pregnant women. Applicants can also be placed at the bottom of the list if information requirements and contacts are not maintained. This is exacerbated by women changing their phone numbers, which many do to manage their safety from perpetrators in the context of family violence.

There are examples of innovative approaches to long-term housing including HomeShare, which is a new model being developed by Launch Housing where women are matched to the homes of people that have spare rooms and are willing to actively support the placement. This approach was supported by a specialist health worker who favoured 'shared care and mentoring' and was identified as a particularly useful for women who had experienced institutionalisation and had no role modelling or positive parenting experiences. Lead tenant arrangements for young women can also provide supported long-term housing.

4.3.2 Long-term support

Few services are funded to provide long-term holistic support to women, particularly once they move out of homelessness services into longer-term housing, including private rental and public housing. Participants identified that long-term support was needed for homeless pregnant women, including after they have given birth, to ensure their housing remains stable and support needs are met.

In particular, service providers consistently identified the need for intensive support to be provided with housing to ensure that homeless women with complex needs are provided with every opportunity to be able to tackle the range of issues they were dealing with including keeping their children in their care. This incorporated the opportunity for women to be housed early in their pregnancy to avoid them 'floating around the system where they don't have that continuity of care where they're probably at their most vulnerable' (Specialist

housing support worker). As noted above, a housing-led approach that is accompanied by multidisciplinary support services is likely to assist in resolving these concerns or, alternatively, where women are intensively supported for up to extended periods of time in transitional housing and not exited into homelessness. Another initiative worth exploring draws on the peer support model undertaken successfully with young women, expanding this further to embrace women of all ages in age-specific cohorts.

Mother and baby units that provide intensive onsite support were also identified as needed, particularly for younger women and women with complex needs:

We would identify enormous amounts of young women – and particularly that younger cohort who are pregnant – [who] have no capacity to manage themselves let alone manage a child ... what's really required for most of our younger age mums is mother baby-type units with intensive guided support ... There's a real dearth of those sort of options available so there was no other reality than that these young mums will lose their children without that sort of support. (Housing support worker)

Elizabeth Morgan House has advocated recently for the need to respond in a holistic and therapeutic manner to the accommodation and support needs of young pregnant and parenting Aboriginal women (Elizabeth Morgan House, 2017). Key elements of the proposed model include the provision of culturally appropriate care in partnership with other services to provide therapeutic care as well as pre and postnatal care. It is designed to prevent Aboriginal families from entering the Child Protection and out-of-home care systems, and to tackle issues associated with family violence. This is particularly important because Aboriginal women become pregnant and have children at younger ages than non-Aboriginal women: 15 per cent of Aboriginal mothers are teenagers when they become pregnant compared to 2 per cent of non-Aboriginal women (AIHW, 2017b).

In relation to young Aboriginal women, a specialist Aboriginal housing support worker argued that:

wraparound services, that's what they need. You can't just say "oh you're homeless, you need a place to stay, we found something for you, there you go, bye-bye" because we've housed plenty of girls and outreach to them has gone anywhere from ... a week or two ... others will be calling on a weekly basis or dropping by or still needing that help and support so we could go up to three months still working with somebody who has been exited but needing so much help and support in their new place.

Similarly, a specialist health worker noted that the need for support does not end once someone is housed:

You can get somebody housed into public housing, it's great, you've got somebody

housed. Talk to them three months later ... isolated, "I've got a baby, what do I do?" ... there's a lot of women out there who do get housed, have the baby and think – "I'm lonely, I'm sad, I've got no friends".

Service providers also noted the particular issues and ongoing support needs for women who have had children removed from their care, and the associated trauma that continues for women when they are pregnant and after they have other children. Long-term support would assist in identifying and supporting women experiencing family violence, as well as its long-term consequences on their health and wellbeing, because women do not always want to disclose this information in the short-term, which is related to the fear that revealing family violence would result in the removal of their child by Child Protection.

4.4 Specialist housing support workers

Specialist housing support workers were identified as a crucial element of a strong system response. As noted earlier, Launch Housing has a sole worker providing outreach case management to pregnant women without accompanying children that are homeless or living in insecure or unsafe housing. This came about from resources being redirected from one of their housing support programs but demand exceeds capacity.

The need for housing workers in hospitals was also identified, particularly at the WADS clinic. Previously, such a position had been funded philanthropically for 10 months at the Royal Women's Hospital but resources have not been able to be obtained for it to continue. This service was highly regarded although there were particular challenges with the role; most notably, the worker could not access systems available to specialist housing workers. This hampered the work that could be undertaken and outcomes relied on favours and relationships. One solution proposed was having a housing worker located at WADS. It was also reported that family violence services require the services of specialist housing workers.

4.5 Conclusion and recommendations

4.5.1 Conclusion

Homelessness support workers reported significant gaps in the system response to pregnant homeless women. Like all homeless people, pregnant homeless women experience difficulty in accessing housing support due to the overwhelming demand for these services. Moreover, pregnant homeless women may not have their additional housing support needs taken into account, at least partly because some services do not adequately recognise pregnancy as a risk factor for determining access to support until late in the pregnancy. While young women

and Aboriginal women may be able to access services that provide specialist support—and there are good practice examples of these—there are fewer available than are required. Women aged 25 years and over are least likely to receive a specialist response; however, the creation of a new, targeted initiative based around intensively supported transitional housing offers great promise for this neglected group. In a housing crisis, women may be referred to unsafe rooming houses or to stay with family or friends, which are likely to be unsustainable or become unsuitable in the longer term. There are significant barriers for pregnant homeless women to obtain long-term safe, stable and sustainable housing, and there is a need for programs that provide long-term support.

4.5.2 Recommendations

Long-term housing

- Increase access to social housing for pregnant homeless women in a range of dwelling types and suitable locations that maximise women and children’s stability, safety and wellbeing including access to supportive networks and services
- Resource the A Place to Call Home program by restocking a transitional housing dwelling when a woman’s tenancy is transferred to permanent public housing
- Ensure private rental and other brokerage arrangements are available that suit the circumstances of pregnant and newly parenting women in terms of affordability and location
- Increase provision of housing-led programs so pregnant women can access permanent housing and stabilise early in their pregnancy

Intensively supported transitional accommodation

- Drawing on good practice examples for young women and a new initiative for women aged 25 years and over, provide additional intensively supported transitional accommodation for pregnant homeless women

Crisis accommodation

- In situations where long-term, stable and sustainable housing or supported transitional accommodation are not immediately available, increase and improve access to suitable crisis accommodation for pregnant homeless women
- Provide flexibility in the length of time crisis accommodation is available to avoid pregnant homeless women exiting with nowhere to live
- Review access to family violence crisis support to ensure pregnant homeless women with complex needs are not disadvantaged

Support

- Locate specialist housing support workers in hospital settings to assist pregnant

homeless women to access housing support

- Ensure homelessness and health services are aware of the family violence FSPs and the ways that they can provide support to pregnant homeless women experiencing family violence
- Promote homelessness, health and other services working together to provide long-term support to women during pregnancy and early parenting

Chapter 5: Pregnancy support

'Pregnancy and homelessness ... it's a diabolical mix.'

(Specialist health support worker)

5.1 Introduction

While it is acknowledged that the level of support women need varies depending on circumstances, this research showed that there are many women for whom pregnancy during homelessness is highly complex and, as a housing support worker commented, 'it's very rare for me to pick up support for somebody where all they need help with is housing'. Overwhelmingly, service providers reported the need for specialist service provision for pregnant homeless women. This, however, does not mean that mainstream services should not have this specialist knowledge. Concern was raised that generalist health services, particularly midwives, were often not cognisant of the difficulties faced by homeless women and how they were often accompanied by other factors such as family violence, complex trauma, and alcohol and drug misuse. This could manifest in midwives being unsure of how to work with these clients or, at worst, being judgemental due to a lack of understanding of women's circumstances.

5.2 Responding to complex needs

Pregnant homeless women may have complex needs associated with social and economic disadvantage, mental ill health, hazardous alcohol and other drug use, and family violence. For example, the use of alcohol and other drugs can contribute to women not engaging with pregnancy care in a timely manner. This can be due to the alcohol and drug use making their lives chaotic as well as fear of Child Protection involvement. Alcohol and drug use can cause complications for pregnancy. Abuse of the illicit drug ice, in particular, was viewed as making it difficult for services to engage with women:

It seems as though the ice is really making people come very late to pregnancy care or just turning up in labour not having any antenatal care. And all the outcomes are much, much worse if they don't have any antenatal care, particularly for the baby around prematurity and having to go to special care nursery. (Specialist health

support workers)

Of the 70 women who attended the WADS clinic in 2016, 23 had no antenatal care. Most of these women had obstetric complications with the most common being the baby's prematurity for 14 of them (61%). Compared to mothers who attended WADS and received antenatal care, the mothers who did not have antenatal care had babies with lower birth weights (mean birth weight of 2.3 kg compared to 3 kg) and fewer were breastfed (42% compared to 61%) (WADS, 2017).

If there has been little or no contact with a woman prior to giving birth, and she has disclosed drug use, the baby may be put in the special care nursery for observation for any problems even if none are immediately obvious. Service providers particularly praised the WADS' model of care for women who needed additional support due to alcohol and other drug use. This unique model provides continuity of care for each woman with a midwife and a social worker or specialist counsellor for the duration of the pregnancy and shortly after the birth. The clinic operates as a 'one-stop shop' where women are able to access support from an obstetrician, a psychiatrist, a dietician and a physiotherapist. It was recommended that this model of care be available through other hospitals that provide maternity care.

Women who are sleeping rough were identified as more often having challenging behaviours that can make it difficult for them to engage with pregnancy care services. These women were described as having complex needs, on top of which they were expected to engage with a complex service system:

It's the [pregnant] rough sleepers that probably do the worst and they're the ones that we find very hard to get into care and (they) may be just sleeping somewhere, they're in a violent relationship and very sexually exploited and it just really is ... quite a tragic set of circumstances in that context. (Specialist health support worker)

Some pregnant homeless women have challenges with literacy, which is not widely acknowledged. Shame and stigma prevent women from alerting agencies such as Centrelink and Child Protection. Difficulty with reading and writing influences many aspects of the support needed by these women, which affects their understanding of the pregnancy care they require and later the care of their newborn baby, as well as their capacity to sign forms (including consent forms) for service providers such as Centrelink, hospitals, Child Protection, mental health services and housing organisations. Similarly, services such as Centrelink ask clients to use computers to fill out forms online, which some women are unable to do. Services like the Bolton Clarke Homeless Persons Program (formerly Royal District Nursing Service) work with women in these circumstances and will support them to provide informed consent, and to complete paperwork for matters such as income support entitlements and registering the birth of children. Birth registration has implications for a woman being able to obtain appropriate benefits in relation to income and housing, and other supports for herself and her baby.

Women who have come from countries with different health systems than Australia may avoid pregnancy care due to fear of the cost, expecting that they will be asked to pay for their health care and associated costs. This is particularly pronounced for women seeking asylum and women without permanent residency as they do not have access to Medicare and neither does the newborn baby.

Homeless women may not have a support person they can depend on during their pregnancies. They may be relying on a partner or family member with whom there is tension and who may not remain for the duration of the pregnancy. This means that not only are women attending appointments on their own, they may also give birth alone. As a consequence, some service providers will provide a level of support above and beyond what they are funded to do. As one homelessness outreach worker stated: 'I don't want a woman sitting in bed miscarrying on her own when she's got nobody. It's incredibly sad and especially what she's going through'.

Not all homeless women choose to continue with their pregnancies. Indeed, it is being homeless that can become 'a make or break in ... decision-making for women' (Specialist health support worker). Women may choose to terminate a pregnancy due to homelessness; alternatively, women may make this choice because they know that continuing with the pregnancy will make them homeless due to living in unsuitable accommodation for a baby or being told to leave home by their family. Women can feel pressured into having a termination by Child Protection, especially young women, as there is the concern that the baby will be removed from their care. However, terminating a wanted pregnancy has ramifications for a woman's mental health:

Women's choice to be parents could be interrupted by this ... such a basic human right that they could not find housing. And to see how it would impact on women who were absolutely distraught because they would have to have a termination because of poverty and homelessness, it was pretty hard to bear. (Specialist health support worker)

Homeless women seeking to terminate a pregnancy have limited options. There is only one public hospital in Victoria that offers terminations; otherwise, women need to access private providers that attract fees that homeless women are unlikely to be able to afford. Homeless women living in rural areas are further disadvantaged as they are required to come to Melbourne if they choose to have a termination. There is currently no prioritisation of crisis accommodation for women who have been discharged following a termination meaning that some will be sleeping rough immediately after. However, as noted below, Aboriginal health services provide unique wraparound maternity support for pregnant homeless women, including those accessing termination services. Furthermore, due to many factors associated with homelessness such as poor physical and mental health, alcohol and drug use, and a lack of continuity in medical care, many women may not realise

they are pregnant until it is too late to have a termination.

Service providers emphasised that being homeless meant women had little time to contemplate their futures as mothers. Not having a home makes it impossible to even imagine the home that will be created for a family:

They're not going to do all that preparation, that nice fluffy stuff that we all want to think that all mothers are doing, preparing mentally for what kind of parent am I going to be? And how is my baby going to be? How am I going to be towards my baby? And how am I going to form this attachment and bond that's really going to give my baby a secure attachment and the best start in life? You know all these things ... they're just so far in the background. (Specialist health support worker)

Support for becoming a parent was particularly important because many women had not experienced a positive modelling of parenting themselves. A peer support group for young mothers was one space that was considered to offer an opportunity for women to connect with their babies:

These women really don't get the chance to ... really connect with their baby as much as... other women might so (the group leaders) spend a lot of time ... talking about the importance of ... talking to the baby ... It's a good time for them just to connect with (the baby) – hold their bump. (Young mothers' support worker)

But even then, there could be more complex issues influencing the pregnancy:

Once you've decided you're having the baby and you're following through with the pregnancy, you're already a mother in a sense ... If the reason the woman is experiencing homelessness is related to trauma or family violence there's also lots of other psychosocial issues which stop them connecting with the baby. (Service manager)

As this participant stated, it is important to have someone in the woman's life to assist her to connect with her baby and realise that she has the capacity to be a mother and to identify that: 'all of the challenges she had been through were what actually gave her the strength to birth and mother ... rather than those experiences being a barrier'.

While not specifically targeting homeless women, the Healthy Mothers, Healthy Babies program runs out of a number of Victorian local government areas through community health centres. The program links women with existing services and, in particular, provides outreach to pregnant women with complex needs. It provides community-based support for women to engage with clinical antenatal care providers and maternal and child health nurses from pregnancy until four to six weeks after birth (DHHS, 2017).

5.3 Responding to diversity

Young women, Aboriginal women, and migrant, refugee and asylum-seeking women have particular needs or circumstances that may warrant extra support. Young women can be stigmatised due to their age because, while all women may struggle after their first child, younger mothers are judged harshly due to their inexperience:

Some midwives, I have seen it happen, they're just a bit disrespectful, particularly after the baby's born, and they're kind of raising all these red flags ... of course it's important to ... manage risk but ... no-one knows what they're doing at the start.
(Young mothers' support worker)

Similarly, service providers who work with young women said that the social stigma of being young and pregnant means that young women do not feel comfortable accessing mainstream childbirth education and other hospital services. This factor can be a deterrent for young women seeking pregnancy care or voicing their concerns in consultations. A number of services run young women's support groups that offer peer support and pregnancy education. Zoe Support in Mildura, for example, has a focus on life skills and social connectedness and engaging young women with education and employment. The Cradle to Kinder and Aboriginal Cradle to Kinder programs target young women under 25 years and provide intensive antenatal and postnatal support until the child reaches four years of age. Child Protection involvement or the heightened vulnerability of the child are precursors to involvement in the Cradle to Kinder programs (DHHS, 2015).

Aboriginal women are more likely to have premature labour, babies needing stays in neonatal intensive care units and babies with low birth weights than non-Aboriginal women (AIHW, 2017b). They are also more likely to have experienced homelessness and family violence. Aboriginal women may feel stigmatised when attending clinic days at particular hospitals as 'they don't want to be labelled as disadvantaged' and may not necessarily want to attend with other Aboriginal women due to wanting anonymity in their community. Some services also noted that there was a lack of communication between Child Protection services regarding notifications and child removal, particularly for Aboriginal women, who may not understand why they have had a notification made about them when pregnant.

A particular issue noted for Aboriginal women was not getting the support they required in hospital to register the birth of their children (Castan & Gerber, 2015). The long-term effects of this are that women may be on the incorrect Centrelink income payments, which exacerbates longer-term housing issues. Elizabeth Morgan House was involved in registering 12 births in the past six months of children aged three and four years.

Where a woman is not proficient in the English language, she may miss out on receiving information about pregnancy and birth provided by health professionals. This makes it essential that these women have access to interpreters. Due to the difficulties involved

in booking interpreters, and the limited time that doctors and midwives in mainstream services often have with women, this can result in interpreters only being called in when the clinical staff need to explain a medical issue or procedure, or to provide the date of the next appointment. Moreover, opportunities to explain a woman's individual circumstances can be lost as noted by a specialist support worker:

I recently had an experience where a woman who was fleeing DV [domestic violence] and pregnant tried to access crisis housing through an entry point and they didn't use an interpreter and then said that she didn't say "yes" to anything and so no referrals or services were provided ... if they had just communicated in a language that she understood she probably would have had a much different response.

There are specific issues for pregnant women who do not have access to entitlements, such as income support and healthcare services. This is commonly due to women being on a spousal visa or women on visas who are seeking asylum. For these women, their situations are further complicated if they leave their partners because they are usually included on a family application for asylum. Obtaining housing support and pregnancy care for this group is challenging. Few services will work with women without citizen entitlements because of the concern for the long-term implications as they have 'nowhere to move people on [to]' (Specialist health support worker). Bolton Clarke Homeless Persons Program supports many women from culturally and linguistically diverse backgrounds and will work with women to ensure they are managing access to their health and social care needs. They also spend time educating women on their income support entitlements and assisting them with living skills such as budgeting.

5.4 Towards good practice

Specialist health support workers identified key elements of good practice that were based around the provision of continuity of care, wraparound services, outreach and trauma-informed care.

Continuity of care was raised by many service providers as being essential for pregnant homeless women. Early identification of pregnancy and referral to pregnancy care makes it more likely that women will receive continuity of care. Unfortunately, this does not occur routinely due to the complexity of women's lives. A woman may not realise she is pregnant for some time, she may be worried that if she engages with pregnancy services Child Protection will become involved and she will have her child removed from her care, or she might not be asked about pregnancy by housing or other support services and therefore not receive an appropriate referral. By not attending a pregnancy care service early enough (and this may mean as early as six weeks), homeless women are automatically shut out of continuous care services before even knowing what they provide. A suggestion was made that these

services keep a certain number of spots available for women with complex needs, including homelessness.

Birth for Humankind offers continuity of care to homeless women throughout their pregnancy and immediately after birth through the provision of a doula service. The woman is matched with a doula who will provide a range of services such as travel passes, attendance at pregnancy care appointments, pregnancy and childbirth education, and attendance at the birth. The doula is able to follow the woman if she moves around and changes to a different pregnancy care program. The doula is also able to advocate for the woman in the birthing suite and maternity ward if necessary. In addition, the doula is able to offer emotional support, something that is often missing due to the clinical focus of pregnancy care, and is particularly important if the woman is alone.

Access Health in St Kilda offers a unique model of wraparound care that is client centred, and has a great deal of flexibility associated with meeting the long-term support needs of their clients. According to Access Health's support workers, they 'fill the gaps in between services to make it more seamless for the client'. In addition to providing a range of primary healthcare needs, the service provides outreach programs and group work. They work with particularly vulnerable women with complex needs including pregnant women experiencing primary homelessness, drug and alcohol use, and mental illness. The philosophy of the service is informed by non-judgemental and harm minimisation principles as well as a 'no wrong door' response and they will provide some response regardless of the client's needs. This approach means that clients who might otherwise be hard to engage—such as Aboriginal people who make up a quarter of their clients—connect with the service instead of avoiding contact with services altogether due to their concerns about Child Protection involvement. Specific support for pregnant homeless women includes providing sexual health care, and they also provide housing assistance by actively linking them to local homelessness services. They work in close partnership with WADS and other local services such as Sacred Heart Mission to ensure that women are accessing services, which includes transporting them to appointments and, particularly in the late stages of pregnancy, searching the streets for women if they have missed appointments to ensure they are safe and accessing care. Vitally important is Access Health's capacity to provide long-term continuity of care and support a woman with her choices, when most other services have time-limited support capacity.

Some service providers were particularly attuned to advocating for the rights of women. This could involve working with other services to explain what needed to be changed to support women, such as being flexible around missed appointments. It also included building strong, collegial and collaborative relationships that occurred within a framework of consent, confidentiality and dignity for women. Some service providers noted that, when working with women, it was crucial to recognise them as individuals with individual needs and, therefore, they require individualised care. This further supports the need for continuity of care so that a woman's circumstances could be regularly reassessed:

It all comes down to women just wanting to feel respected and they want to feel supported. They don't want to feel alone when they're navigating pregnancy and the system ... All women experience the same thing and there are different factors that stop them accessing the system and the system needs to be aware of that. (Service manager)

Maternity services at the Aboriginal Health Co-ops were suggested by service providers to offer high-quality services. The Co-ops offer a wraparound model of service delivery with various services on site such as general practitioners, midwives, housing and family violence support workers, counsellors and mental health practitioners. The Co-ops work with women holistically and assist them according to their specific needs. In addition to the above services, this could include providing transportation to appointments and procedures (including termination of pregnancy), arranging childcare, and providing overnight accommodation if a rural woman needed to attend an appointment in the city.

The Bolton Clarke Homeless Persons Program was identified as delivering an excellent service to women. This program was credited with being able to build ongoing relationships with women, including those who were sleeping rough, whereby they could refer them to a hospital for pregnancy care or they would offer this themselves. Similar to the Access Health services, a key aspect of their success was offering services in a non-judgemental manner. Some services noted positive outcomes they were able to achieve for their clients as a consequence of having long-term support relationships. A youth service support worker observed that: 'all the young mums that have lived with us have actually maintained contact with their children so it's been a real commitment from us to work towards achieving that'. Launch Housing reported that 95 per cent of babies born to mothers supported by the outreach program remained in their mother's care.

A key aspect of working effectively with pregnant homeless women is recognising and identifying their complex needs. As noted, these may include, among others, mental health problems, past and ongoing trauma, exposure to violence (including gendered violence) and alcohol and drug issues. These problems do not exist in isolation and can have a compounded effect. Pregnant women may also have been exposed to discrimination by services that intensify the difficulties they are experiencing. Therefore, it is crucial that services provide a model of care that is trauma-informed. A trauma-informed approach acknowledges the influence of trauma of a woman's life and how it affects her current decision making. In doing so, this approach recognises that there is an important correlation between the impact of trauma and other difficulties such as alcohol and drug misuse and mental health problems, and it is these difficulties that can prevent women from engaging with services. As such, a trauma-informed approach works with women on all areas in which she might require support, not only housing. It therefore targets intervention to the stage a woman is at in her recovery from trauma (Clark, Classen, Fourt, & Shetty, 2015). A specialist youth services support worker described their approach to trauma-informed practice as recognising the

relationship between trauma and other issues:

[I]f their behaviours are acting out or just a bit chaotic ... they're responded to from a trauma-informed practice which is about managing self-soothing ... and creating a calm environment and making sure it's a non-violent and safe and respectful environment.

5.5 Integration of responses

While some good practice examples of service integration and coordination of responses were evident, it was apparent that much more is needed to support pregnant homeless women. This situation is complicated by women often being involved with multiple services and having to navigate a service system that was described by an outreach worker as 'complex and challenging'. Some homeless women are dealing with a range of complex issues in addition to their lack of housing, as described by this specialist health worker who works with:

Many women who have got mental health, family violence, drug and alcohol, a child with Child Protection, they're homeless, they've got debts, they might have a warrant out against them for prison. And their Centrelink is not there, they don't have any ID and it just goes on and on. That's a really common client for me, you know?

But, according to the outreach worker, 'mental health will do their thing, drug and alcohol will do their thing, family violence will do their thing and no-one's talking to each other', with these siloed responses leading to confusion for the clients.

Further to this are the challenges of providing support to women who have obtained housing but require assistance with a range of other services to maintain it but do not have the support of specialist housing services. As noted by a specialist outreach worker: 'if you're with a program you'll be fine but if you're not with a program you struggle'. In effect, this inconsistency of responses means that specialist health workers can spend a lot of time advocating for their clients in an effort to get women established in their new home.

One outreach worker emphasised how important professional networks were to her ability to successfully advocate for clients; similarly, a specialist health worker explained that their success was due to their partnership-based approach. There was considerable value seen in establishing memorandum of understandings and networks among services. Specialist workers had previously met as a network but this good practice had fallen away in more recent times.

A key element of integrated responses to pregnant homeless women is the involvement

of Child Protection, and their work with other services. The complex needs of homeless women mean that often a notification will be made. With young women, the complexities of youth and inexperience in parenting can lead to a notification, with which their support services may not agree:

I think it can really cause problems for young people in terms of just forgetting the fact that they're actually a new parent ... (Child Protection) are looking at all the things they're doing wrong rather than the things they're doing right ... (Young mothers' support worker)

In circumstances where Child Protection requires women to leave their violent partner or risk having their children removed, there may be little support for the woman to leave safely. Women can be torn between wanting to remain living with their partners who are violent and having to leave if they want to retain custody of their newborn baby. Women seeking asylum and women without permanent residency have the added vulnerability of being without an income and therefore to leave a violent partner means they are without their financial provider. Integrated responses in such circumstances would ensure the safety of the women and the best possible outcomes for their children. For example, Aboriginal women's refuges highlighted how they had been successful in advocating for Child Protection to close cases where they are supporting women and consider them to be managing well.

Sometimes 'in-utero' notifications are made when homelessness is a known issue:

One of the main reasons why I see Child Protection involved with the women that I support is because they're flagged by the hospital because of their housing and ... there's not somewhere safe and stable for them to return to with the baby. (Specialist housing support worker)

This is a particular issue of concern for some service providers, particularly those working with pregnant Aboriginal women who see a disproportionate amount of notifications made in relation to that group. An Aboriginal specialist housing support worker, for example, considered that notifications may be unnecessary when women are acting protectively: 'They might be homeless but they're turning up to their appointments, they're making sure their antenatal is done or prenatal, all that stuff but yet they're still getting notifications done on them'. An example of good practice in this regard is the policy adopted by Access Health who make notifications to Child Protection based on their assessment of risk rather than as a matter of course in relation to homelessness and pregnancy.

As a specialist health support worker observed:

There has to actually be constant collaboration and monitoring and building of the relationships ... It's not just building them, it's actually sticking at them and persisting and that includes persisting with Child Protection. So the good outcomes are when Child Protection is involved, mental health has been provided, housing

services are provided, outreach services are provided, maternal and child health nurses actually come on board early.

It was noted that it would be more effective to further invest in existing services so that they could have more time to work with women rather than developing new programs that only have short-term funding.

Part of an integrated approach to service provision is shared understandings of the circumstances of pregnant homeless women. As a number of stakeholders noted, not all those involved appreciate the complexities of these women's lives:

Getting the student midwives before they're even in the hospital (and) talking to them about the things to look out for ... because a lot of the midwifery courses ... and the doula course as well – focus really on how to help the average woman ... it's about making sure that the service providers think about a woman in a more holistic sense rather than just making an appointment and thinking, "Why didn't she turn up?" (Service manager)

Support was expressed for homelessness services to provide education to midwifery students, similar to what Launch Housing have done at La Trobe University.

5.6 Conclusion and recommendations

5.6.1 Conclusion

Highly regarded specialist programs exist for pregnant homeless women, including those that respond to women who have complex needs. Overwhelmingly, the need for wraparound services, continuity of care and outreach were reported. Women also require holistic responses that recognise their rights and advocate for them as individuals and care that is trauma informed. Ongoing collaboration and integration of services are required to meet the long-term needs of homeless women. Service providers reported the need for specialist support for pregnant homeless women, as well as for mainstream services to be well-informed of the needs and circumstances of this group of women.

5.6.2 Recommendations

Support

- Enable services to provide relevant good practice elements of continuity of care, outreach, wraparound provision of services and peer support
- Raise awareness of the needs of women who seek a termination rather than continue with a pregnancy
- Underpin service provision by trauma-informed care

Training and education

- Promote understanding of the circumstances and needs of pregnant homeless women through the education of generalist staff

Networks and integration

- Re-institute network meetings between specialist workers to share information and provide peer support regarding pregnant homeless women
- Initiate state-wide forums for further integration of system responses to pregnant homeless women
- Map services available to pregnant homeless women across Victoria to identify gaps in an effort to improve system responses

Chapter 6: Conclusion and recommendations

6.1 Conclusion

This research clearly indicates that pregnant homeless women have specific needs that require greater attention and resources. While there is innovative and collaborative work being conducted in this field, there is room for improvement. This needs to involve the enumeration and better understanding of the circumstances of this cohort through data collection and analysis. This would assist with highlighting the scale of the issue and would emphasise the complexity of the challenges faced by pregnant homeless women.

There are significant barriers for pregnant homeless women to obtain long-term safe, stable and sustainable housing. Pregnant homeless women experience difficulty in accessing housing support due to the overwhelming demand for these services. Moreover, they may not have their additional housing support needs considered because some services do not adequately recognise the need for support until late in their pregnancy. There are well-regarded specialist homelessness support services for Aboriginal women and young women, and a new program is being developed for women aged 25 years and over, with these services providing useful models for further development of service provision in this field.

Among health services, there are highly regarded specialist programs including those that respond to pregnant homeless women who have complex needs. Key elements of good practice were identified in the research and include wraparound services, continuity of care, outreach, peer support and trauma-informed care. Further collaboration and integration of homelessness and pregnancy support services is a means of improving responses to pregnant homeless women.

6.2 Recommendations

Data collection

- Review AIHW data collection to include a mandatory check box or other means of readily identifying pregnancy status
- Develop practice in relation to 'pregnancy-friendly' approaches to sensitively collect information about pregnancy status among homeless women
- Investigate means of aggregating data across health and homelessness sectors to better enumerate the total population of pregnant homeless women

Research

- Conduct further research to illuminate the number and circumstances of pregnant homeless women to better inform current policy and practice, including through researching directly with pregnant homeless women themselves

Long-term housing

- Increase access to social housing for pregnant homeless women in a range of dwelling types and suitable locations that maximise women and children's stability, safety and wellbeing including access to support networks and services
- Resource the A Place to Call Home program by restocking transitional housing dwellings when tenancies are transferred to permanent public housing
- Ensure private rental and other brokerage arrangements are available that suit the circumstances of pregnant and newly parenting women in terms of affordability and location
- Increase provision of housing-led programs so pregnant women can access permanent housing and stabilise early in their pregnancy

Intensively supported transitional accommodation

- Drawing on good practice examples for young women and a new initiative for women aged 25 years and over, provide additional intensively supported transitional accommodation for pregnant homeless women

Crisis accommodation

- In situations where long-term, stable and sustainable housing or supported transitional accommodation are not immediately available, increase and improve access to suitable crisis accommodation for pregnant homeless women
- Provide flexibility in the length of time that crisis accommodation is available to avoid pregnant homeless women exiting with nowhere to live
- Review access to family violence crisis support to ensure pregnant homeless women with complex needs are not disadvantaged

Support

- Locate specialist housing support workers in hospital settings to assist pregnant homeless women to access housing support
- Ensure homelessness and health services are aware of the family violence FSPs and the ways that they can provide support to pregnant homeless women experiencing family violence
- Promote homelessness, health and other services working together to provide long-

term support to women during pregnancy and early parenting

- Enable services to provide relevant good practice elements of continuity of care, outreach, wraparound provision of services and peer support
- Raise awareness of the needs of women who seek a termination rather than continue with a pregnancy
- Underpin service provision by trauma-informed care

Training and education

- Develop and implement a training package that assists housing and homelessness services staff to collect information about pregnancy status
- Build on current good practice, develop and implement specialised training for homelessness and housing service workers in relation to homelessness and pregnancy
- Promote understanding of the circumstances and needs of pregnant homeless women through education of generalist staff

Networks and integration

- Re-instigate network meetings between specialist workers to share information and provide peer support regarding pregnant homeless women
- Initiate state-wide forums to further integration of system responses to pregnant homeless women
- Map services available to pregnant homeless women across Victoria to identify gaps in an effort to improve system responses

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