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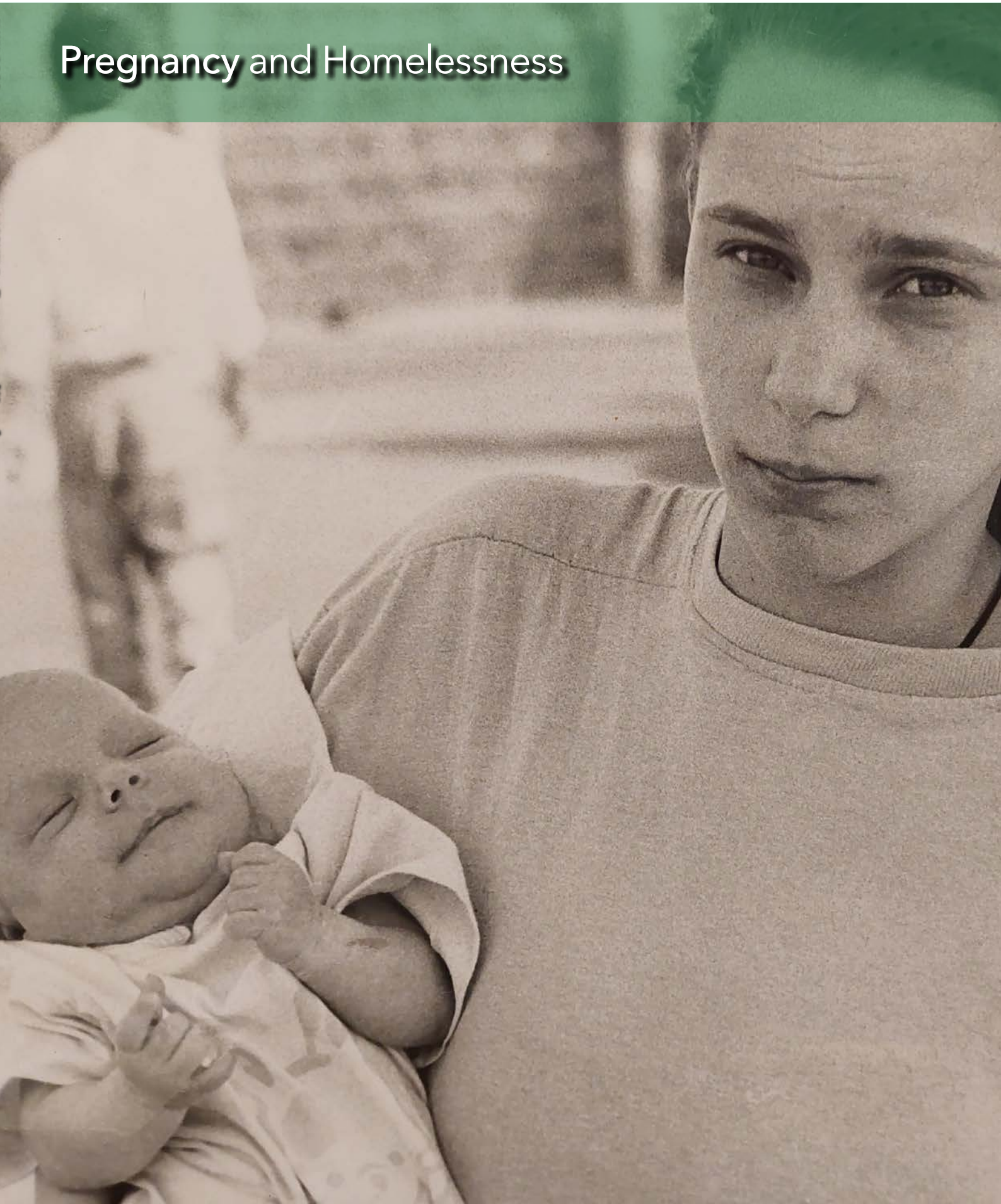
Council to Homeless Persons

Pregnancy and Homelessness



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Parity
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Contributions to *Parity* are welcome. Each issue of *Parity* has a central focus or theme. However, prospective contributors should not feel restricted by this as *Parity* seeks to discuss the whole range of issues connected with homelessness and the provision of housing and services to people experiencing homelessness. Where necessary, contributions will be edited. Where possible this will be done in consultation with the contributor. Contributions can be emailed to ***parity@chp.org.au*** in Microsoft Word or rtf format. If this option is not possible, contributions can be mailed to CHP at the above address.

Proposed 2022 *Parity* Publication Schedule

August: Working Together: The Future of South Australian Homelessness and Domestic Violence Services
September: The Victorian Response to Homelessness
October: Towards a New National Homelessness Strategy
November: The Role of Information Technology in Responding to Homelessness
December: Homelessness and the Law Revisited

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Cover image courtesy of Kids Under Cover.

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Opinions

Foreword

A message from the Hon. Natalie Hutchins, Minister for Women and Minister for Education

Ensuring every woman has access to the support they need to prepare for the arrival of their baby is a core part of our work towards gender equality in Victoria.

We know the impact a safe and secure home makes on the health and wellbeing of every Victorian.

It is why the Victorian Government is committed to working alongside a visionary and dedicated sector to improve women's access to safe housing as a core building block of a healthy pregnancy.

We're proud to support the ground-breaking Cornelia Program, the first collaboration of its kind in Australia that provides safe and secure accommodation for pregnant women and new mums.

The program focusses on keeping mothers and babies together and creating pathways to safe, long-term accommodation, with easy access to specialised healthcare and social support from program partners, the Royal Women's Hospital, Launch Housing and HousingFirst.

This crucial service is now fully funded to operate for the next five years, with a $3.1 million Victorian Government investment. This is alongside the $13 million contributed for the redevelopment of the 36 apartments.

The opening of Viv's Place, in Dandenong, in May 2022 was another Australian-first.

Delivered by Launch Housing and Uniting Victoria Tasmania and supported by the Victorian Government's $13 million contribution, Viv's Place is a vibrant and connected community.

Viv's Place — named after Launch Housing's first social worker, Vivienne McCutcheon — will permanently house up to 200 mothers and their children escaping family violence or at risk of experiencing homelessness in trauma-informed accommodation.

Family and intimate partner violence is the single leading cause of women's homelessness in Australia, and we know that women are at an increased risk of experiencing this violence during pregnancy.

As a result, our efforts to create safe and accessible housing options for pregnant women experiencing homelessness continue to go hand in hand with our work to end family violence in Victoria.

This year, we announced a $240 million investment over four years to build on our progress to break the cycle of family violence and violence against women in our communities.

Of this, $69 million will go towards ensuring women can find safe accommodation when they need it by delivering two new core and cluster refuges, supporting the refurbishment and operation of existing facilities, and purchasing six new accommodation properties that will each house individual families.

We have also almost completed the rollout of the statewide Orange Door Network which provides easier access to family violence services and services to support the wellbeing of children and young people.

The Orange Door is operating in 15 areas across the state, with the final two remaining areas to be opened by the end of 2022.

These are just some examples of initiatives which represent the incredible vision and collaboration shown across Victoria's housing, family violence and health sectors to support pregnant women and new mums experiencing homelessness to thrive in safe and secure housing.

I commend Council to Homeless Persons and all contributors to this Pregnancy and Homelessness edition of *Parity* for their work and advocacy in this space towards a safe and equal future for every Victorian woman.

Editorial

Jenny Smith, Chief Executive Officer, Council to Homeless Persons

Safeguarding Motherhood — Pregnant and Without a Home

As we turn our minds to the circumstances of women who are pregnant and without a home, we see at least two vulnerable people in scope; and we are reminded about the lack of safe, stable and affordable housing options available. We also become aware of the shortage of services with the specialist skills to provide the critical support that is needed.

When pregnant women are in crisis and needing a service response, we see them living in their cars or placed in circumstances that likely only increase their vulnerability, such as rooming houses or couch surfing. These circumstances make it more likely that these vulnerable women will not disclose the pregnancy, as being without a home brings with it a reasonable fear of child removal. These are all circumstances that place at risk both mother and child's health and safety, both pre- and post-nataly.

In our contemporary community, we would expect to have prioritised for this group, wrap-around human and health services with targeted and prioritised continuity of care which includes longer-term outreach and post-natal care.

Family Violence is the major contributor to women being without a home, and specialist family violence support services are also overburdened, which only increases the risk of vulnerable pregnant women returning to the unsafe housing they left.

First nations people for over 65,000 years have been caring for their infants in culturally appropriate ways. Culturally appropriate parenting can be seen as quite different to a western approach to motherhood and can be misjudged accordingly.

Aboriginal and Torres Strait Islander peoples are significantly over-represented in our services. Access to the right mix of culturally safe aboriginal and specialist homelessness services is what is needed, but at present not often to be found.

Young people face a different set of circumstances where the combination of risk taking, mental health issues, unsafe housing, substance use, trauma, violence and family violence hinder their ability to fully appreciate the choices that underpin their decisions. While developmentally ongoing parenting is needed they may choose to not involve family and friends given the trauma times associated with those relationships.

Poor rental histories, generational poverty and experience of being without a home can be barriers to finding and securing safe housing. Also being without a fixed address limits access to health and human services, as often these are geographically connected.

Women without a home who are pregnant face health challenges due to poor nutrition, dental care wrap around health care, in turn that impacts on an unborn child's birth weight, nutrient supply and a mother's ability to feed her infant once born.

We should understand that it is not just a compassionate, but it is a cost-effective community investment to do our best to safeguard both vulnerable life stages. This first edition of *Parity* on pregnancy and homelessness shows that currently, this is far from the case.

The description of our current approach to homelessness and pregnancy provided by this edition, is framed by accounts of the lived experience of being pregnant without having a home. The edition is underpinned by the efforts of a voluntary network of practitioners and researchers, who bring together an outline of what is being done and of what should be done, to wrap support around women who are both pregnant and without a home.

Acknowledgements

The Council to Homeless Persons would like to acknowledge and thank all those involved in the development and preparation of this edition. In particular all the members of the Pregnancy and Homelessness Network and especially its Convenor, Dr Theresa Lynch.

Likewise, CHP would like to give special thanks to Launch Housing for being the main sponsor of the edition. Without the support of Launch Housing, this edition would not have happened. Many thanks also to our other sponsors Safe and Equal, The Royal Women's Hospital, Housing First and Taskforce.

‘Let Me Live My Life.’

Lily*

Introduction

This is the true story of an incredible woman. A story of much trauma and immense resilience, strength, and determination.

With the support of a trusted and compassionate support worker, Lily has been able to have a voice and share her experience.

This story was told at times through tears, with such bravery and generosity. There is so much to be heard and to be learned from this story.

Please read with reverence, care, and attention.

During an eight-year long relationship, Lily experienced every type of abuse that can be perpetrated. Terror, humiliation, isolation, bewilderment, manipulation, and violence. The police were called by neighbours, who had overheard the horrors. When the police attended, Lily and her three boys were referred to a family violence intake service but, at the time, there were no safe houses or motels available in her hometown. Lily was sent to another area, where a hotel room was available for her and her boys to seek refuge.

‘I arrived late at night, a motel in the city, two sleeping children’.

There was no one there to greet them on arrival and Lily found herself terrified, traumatised and alone in a huge city that she did not know.

For the duration of Lily and her children’s time in the city, she did not receive any face-to-face support. Lily received a phone call once a week from a family violence worker checking to see if she was safe.

Lily described these phone calls as cold, a voice without a face, just the same questions every time, like a script. During this time Lily had no one to communicate with regarding a plan for her future. Lilly felt totally isolated.

‘I felt like I was in prison, like I had been the one who had done wrong.’

‘So isolated, so lonely, nobody physically there to talk to, just a few phone calls.’

‘I thought, I’m done if my life is going to be like this.’

Due to the strain on the local hotel availability Lily and the boys had to move between bookings. One of these moves was due to the need for higher security and protection when David, the perpetrator, had tracked her through the location of her eldest child’s iPad.

At one point Lily had no option but to go and stay with her mother and stepfather. Within a few days, Lily spoke up about her mother's heavy drinking and was told to pack up and get out.

'I'd left one toxic environment to be in another.'

Lily felt that she had no choice but to return to her abusive relationship. After weeks of isolation that had felt like imprisonment, she decided that she had no choice but to 'return to hell'.

'I didn't want to be homeless.'

Lily had made the decision that she was going to leave David, but she couldn't see how. On her return, she experienced a violent sexual assault perpetrated by David and fell pregnant. Once he became aware of the pregnancy the physical violence escalated further. Physical abuse included being beaten to the head, kicked to the body and the use of weapons.

'Then one day he assaulted me when I was on the phone to my mum.'

Lily was forced to go back to her mother and stepfather's home even though she knew that this was not a safe environment. Lily reached out to the local homelessness entry point who assessed her situation but there were no emergency homes or support workers available.

Lily contacted the police again about the recent abuse that had been perpetrated by David and her fear that he knew where she was.

'There was nothing they could do, the next day David arrived at mum's screaming at me to give him money he needed to feed his ice addiction.'

That day David attempted to run Lily over. On the same day, a support vacancy became available through the Salvation Army Homelessness Services. The Homelessness Support worker reached out to Lily to make her first appointment and met with her to conduct an intake and assessment.

A broken, terrified woman sat before the worker and told her story. The traumas, the extreme violence and the current threat from David were all deeply appalling. The worker accompanied Lily to the police station to report the abuse that had occurred that day and sat beside her as she told her horrific story, her statement given through tears and fear.

'I was so scared that they would take my kids.'

The worker reassured Lily that this would not happen and referred her for specialist family violence assistance. The support worker went along to the appointment with Lily and advocated strongly, but again, there was no accommodation available.

Once again Lily had to return to a motel, traumatised, alone with three children. Lily felt hopeless and was even more convinced that her children would be taken. Lily was back to being cooped up in a small space with her children, with no cooking facilities. She felt like she was back in prison. This motel sat beside a highway on the outskirts of town, isolated but for the nightly horn of a truck as it passed.

'I was sure it was David.'

At last, a safe house became available through the specialist family violence service and was offered to Lily and her children.

'I was worried where we will be, my three boys and my new baby, and for how long?'

Lily spent a few months in this safe house. Despite having a house to keep her boys safe she experienced the same awful anxiety, disconnection, and lack of communication. Every day she carried a feeling of dread, always worrying about how long it would be before they were all homeless again. She worried for her sons and felt an overwhelming anxiety at how she would manage to provide the nurture and protection her new baby deserved.

At 37 weeks pregnant, Lily was becoming more and more afraid. Then a vacancy became available in a supported transitional unit through the Salvation Army. Finally, some good news for Lily and her children. Lily now had somewhere to go, somewhere to take her boys and stay for a while where she would receive some support to prepare for the arrival of her new baby.

Within a week of her due date the now heavily pregnant and utterly exhausted Lily gathered her precious boys and their few belongings and moved from the safe house into the Salvos accommodation.

The birth of her fourth son was extremely traumatic. There were complications. Lily's ordeal had taken a huge toll on her physical health as well as the health of her baby. He was rushed to the city. Medical professionals expressed to her that the violence and acute stress experienced during her pregnancy were to blame.

During her time in hospital Lily shared some of her journey with staff. Through those conversations a nurse and a midwife divulged to her that they too had experienced family violence.

'It was nice to know that smart people can still get caught in it.'

'That I wasn't just some gullible person that had fallen for it.'

Lily showed enormous resilience during her journey of homelessness and hopes that her story can lead to more understanding and maybe some changes to people's lives. Lily remains in safe and supported accommodation, engaging in a plan to stabilise her housing and keep her and her children safe.

'*I didn't know anything about family violence, it wasn't spoken about in school. If it had been, I would've known it wasn't me and would've left a long time ago.'*

'I am not that person anymore, I'm not that Lily that used to be with David.'

'Let me live my life.'

Thank-you Lily for your willingness to share your story.

* This article has been developed collaboratively between the client Lily, (not her real name), Ruth Griffith, Sonia Lefevre and Kellie Brown from The Salvation Army Homelessness Services.

‘I Didn’t Even Know Where I Was Going To Live…

Naima

People are going to tell you that pregnancy is one of the best experiences in the world, that you will have cute lovey-dovey dreams about your unborn baby and planning the nursery will become your job for the next nine months. But that wasn’t the case for me, I didn’t even know where I was going to live, let alone how to set up a nursery. Pregnancy broke me, I felt a hurt that I didn’t know I could ever feel. I had no one, my friends were awful, my family hated me, and I was about to have a baby with someone who also had no family support.

The first trimester was extremely hard for me. No one knew it was just me and my little baby. I had really bad morning sickness and I was exhausted. 10 hours of sleep and a 2 hour nap a day was never enough. A constant black cloud over my head at every waking moment. I’d ignore requests from friends and family because I didn’t want them to know something was up. How was I meant to tell anyone I was pregnant? Where was I even going to live?

Twelve weeks had passed, I still couldn’t believe it, and didn’t want to believe that there was a human growing inside of me. I had to tell someone, and I finally did. After staying awake all night I finally decided to go to the doctors with one of my workers later that morning. I knew what the doctor was going to say, but the thought still scared me because this time I knew I had to tell my family and my partner. After leaving the doctors I told my partner, and my workers told my parents.

My parents openly told everyone they no longer want anything to do with me. I lost my family, my friends and my home. I booked in to get a termination. I sat in the room to terminate my pregnancy. The doctor was talking to me. I just couldn’t do it.

I was 26 weeks pregnant the first time I felt my baby kick. I didn’t fall in love. I didn’t enjoy it. I felt like there was an alien inside of me. I felt like my baby wasn’t supposed to be there. I kept having horrible thoughts as I didn’t even know where my baby and I were going to live — something so basic — and I couldn’t provide that for my baby.

An organisation offered me somewhere to stay in a mother–baby unit. I wasn’t happy as it was somewhere isolated, but I went because I needed somewhere to stay. I went into a late labour four days after my due date. I started getting contractions that for five hours felt like 24 hours of pain! But when I held my baby for the first time, I cried. I cried because I was so happy. I’ve never felt love like this before. I didn’t know how to express my love to him. I didn’t understand how my parents didn’t want anything to do with us. I ended up staying with that organisation for a bit, then I contacted another organisation as I needed to move. It was a stressful period. My baby and I stayed with a friend of mine in her family home. He was in a portacot and I slept on the floor. They went overseas so I had to find somewhere else to live. One of the girls in my mothers’ group on social media helped me. She let me and my son stay with her. I told to her that the Department would take my child if I didn’t provide a safe place for him to stay. Eventually I got into a transitional property. Even motherhood got fun after that — I was finally able to set up my son’s bedroom and a play area, and we had a home! We went to sleep school so I could figure how I would grow with my son.

Those sleepless nights were all worth it. I hated them but they were worth it. The first two years were the biggest emotional roller coaster of my life. A lot changed, my friends changed, I was homeless, everyone was waiting for me to f**k up — but I didn’t!!!!

The Pregnancy and Homelessness Network: The Emergence of a Network to Transform Healthcare, Social and Housing Support for Pregnant Homeless Women and Their Infants

Dr Theresa Lynch, Convenor, Pregnancy and Homelessness Network and Coordinating Group

'The story of women's struggle for equality belongs to no single feminist nor to any one organisation but to the collective efforts of all who care about human rights.'
— Gloria Steinem

Beginnings, Aspirations and Achievements

Homeless pregnant women are among the most vulnerable members of our community and yet their voices are rarely heard. This is a story of a coalition of organisations and individuals who have formed a 'movement' to make their stories visible and improve their lives. Through our collective efforts we aim to disrupt the policies and practices that deny pregnant women access to health treatment, just and compassionate care and stable and safe housing.

Since the 1970s there has been a worldwide movement to promote and protect the human rights and fundamental freedoms of women. Networks and coalitions of women have worked for decades to ensure women enjoy cultural, economic, political and social development. Recent events globally tell us that women's rights remain a risk and there is still much more work to be done. There continue be a number of complex, critical and stigmatised areas of women's health where barriers and service gaps affect women's capacity to access responsive and comprehensive care. This is particularly true in areas where homeless pregnant women seek access to stable housing, maternity care and therapeutic support.

The lack of stable housing and stress of homelessness profoundly undermines women's ability to access health care, particularly pregnancy care. This in turn creates immediate and long-lasting harm to women and their child's health and wellbeing, their ability to bond with and care for their child and keep them safe. For many women, the inability to find suitable housing prior to birth will result in the removal of their baby from their care.

In response to unequal access for these vulnerable women to health care and housing support, an alliance of housing and drug and alcohol services in Victoria was first formed and supported by the Royal Women's Hospital in 2014.

The goal was to develop new and innovative solutions to improve vulnerable mothers' direct access to maternity care, outreach support and connections to housing services. The work of this alliance during a two-year period was critical in driving initiatives and building knowledge and relationships to improve healthcare for homeless pregnant women and their infants in Victoria. However, discrimination and social and economic disadvantages experienced by vulnerable pregnant women continued, and workers across the health and housing sectors continued to undertake actions to raise the public consciousness of the situation facing homeless pregnant women.

The actions of women leaders working together across several organisations ultimately led to a three-stage research project being undertaken in 2017 by Associate Professor Suellen Murray as the principal researcher. The project, supported by Launch Housing, La Trobe University, RMIT University and The Royal Women's Hospital[1] provided critical insight into the experiences of highly vulnerable pregnant women and newborns experiencing homelessness and how this impacts on their immediate and long-term health and well-being. The research addressed ways to improve service and policy responses and standards of care for vulnerable pregnant women and newborns. The study found being pregnant did not necessarily afford the women greater access to housing support or secure accommodation and highlighted serious gaps in the service system.

The Pregnancy and Homelessness Network was officially formed at the Pregnancy and Homelessness Cross-sector Forum hosted by RMIT University in November 2019. Inspired by the combined energies, aspirations and efforts of organisations and women with lived experience of homelessness this new movement emerged for homeless pregnant women and their infants.

The Network consists of a Coordinating Group representing over 25 health and housing services across Victoria and South Australia who are working together for change to transform healthcare, social and housing support that will lead to safe and healthy lives for pregnant homeless women and their infants.

The Network is an important vehicle for leveraging expertise and resources to improve access to services and support to vulnerable homeless pregnant women. It provides advocacy and strategic support for advancing further research and policy and practice changes to improve their health and social outcomes. An important focus is the creation of educational activities that build the capacity of staff across the sectors of health, housing and welfare to improve the standards of care for vulnerable pregnant women and their infants and to give them easy access to safe, stable and affordable housing.

Achievements of the Network have included a self-assessment tool, designed to understand how services were responding to pregnant women affected by homelessness. The tool was distributed across a range of health, housing, drug and alcohol and maternity services in Victoria in 2020, receiving a total of 172 responses. It provided robust evidence that services require knowledge and skills to enhance their expertise to assess, support, care and treat pregnant women and their children.

This has driven the Network's efforts to publish this edition of *Parity* and develop 'Short E-Learning Modules' with the support of the Council of Homeless Persons and prepare for a Women's Conference to be held in 2023–24.

The Network has also forwarded submissions to the Victorian Government's Homelessness Enquiry 2020 and *The 10-Year Social and Affordable Housing Strategy* in 2021.

The Network acknowledges and celebrates the remarkable achievement of the official launch of the Cornelia Program in April 2022. The Royal Women's Hospital, in partnership with HousingFirst Ltd and Launch Housing, led the vision and establishment of this important program, an Australian first, providing safety, support and a secure home for pregnant women and their babies. It has reinforced the importance of sustained advocacy in transforming the conditions in the lives of vulnerable women and children through the offerings of new services. It inspires further contributions to social change for pregnant women living at the margins of life.

The Network is expanding our advocacy and policy efforts to include the improvement of options of housing for women with multiple children. It is understood in the housing sector that large families do not have any long-term housing options and can end up waiting on the Victorian Housing register with no support. As a result, they often cycle through the system through multiple forms of temporary accommodation. Philanthropic support is being sought as a way of continuing our advocacy role for this activity and potentially other projects of the Network.

While our 'movement' is relatively new it is built on the successes and learnings of earlier feminist movements. Based on principles of idealism, optimism, determination and collective action there is a belief that in working together we can prevail in producing social changes and better social policy for the most marginalised and disadvantaged women and children. We know pregnancy is an important time where women report a willingness to make significant changes and engage with support services, thus providing a critical window of opportunity for early intervention to improve maternal and infant outcomes. We know that women can make positive changes, if given the opportunity to do so. It is our mission to provide all vulnerable homeless pregnant women the best possible opportunities to change their circumstances.

We look forward to our work together and welcome warmly new members.

Endnotes

1. Murray S, Theobald J, Haylett F and Watson J 2020, *Not Pregnant Enough: Pregnancy and Homelessness*, RMIT University, Melbourne. *https://cms.launchhousing.org.au/app/uploads/2020/05/Not-Pregnant-Enough-Pregnancy-and-Homelessness-2020.pdf*, and Murray S, Theobald J and Watson J 2018,*Pregnancy and Homelessness*, Launch Housing, Melbourne. *https://data.launchhousing.org.au/app/uploads/2019/08/Pregnancy-and-Homelessness-Report_FINAL_update-22.8.pdf*

The Extent, Nature and Impact of Homelessness on Pregnant Women and Their Babies

Dr. Freda Haylett, Professor Suellen Murray, Dr. Juliet Watson and Dr. Jacqui Theobald

Introduction

This article discusses the findings of two studies conducted by researchers at RMIT University and La Trobe University during 2017–18 and 2019–20, funded by Launch Housing and the Lord Mayor's Charitable Foundation respectively. In total, the research involved in-depth interviews with 14 women with recent experience of pregnancy and homelessness in Victoria and interviews and focus groups with 41 practitioners from 27 health, homelessness and related services. Most services were in Victoria, including those from regional and rural areas, with one from interstate that had been identified as an example of good practice.[1,2] Using these studies and an updated review of relevant literature, this article focuses on three critical components of pregnancy and homelessness: what is known about extent of the problem in Australia; the impacts of homelessness on pregnant women and their babies; and the gendered experiences of homelessness, including the harms of a 'gender-neutral' approach to supporting pregnant and parenting homeless women.

Counting Pregnant Homeless Women

There is not a lot known about the number of pregnant women who are homeless in Australia, and this represents a significant gap in knowledge that could be used to inform social and health policy and service delivery. In the United States (US) and the United Kingdom, some attempts have been made to identify the extent of pregnancy among the homeless population. In the US, for example, one study estimated one in five homeless women are pregnant at any given time, almost twice the rate of the general population.[3] Similarly, a London study found almost a quarter of young homeless women were pregnant.[4] Other research uncovered even higher rates of pregnancy among homeless women, finding that while 10 per cent of women in the US were pregnant in 2009, 50 to 60 per cent of homeless women were pregnant.[5]

However, our research found that pregnancy status was not routinely and consistently collected by homelessness agencies in Victoria, which would enable researchers to begin to estimate the extent of pregnancy among homeless women in this state.[6] Where data is being collected, it tends to be by specialist homelessness and health services who work specifically with women. In addition, sometimes these data are difficult to enumerate because they are embedded in case notes rather than in a formal system where they can be readily accessed. Figuring out a way to aggregate this data between and across health and homelessness sectors would significantly improve the accuracy of this information. To identify the number of pregnant women seeking housing support in Victoria, two snapshot surveys were undertaken in 2017 at Launch Housing and the Salvation Army Crisis Services Network. Reflecting international data, these surveys found that the percentage of pregnant women who were homeless was higher than that among the wider population of Australian women.[7]

Even so, such data only include those women who seek support from services or, if they do, disclose their pregnancy. There is, then, likely to be a population of pregnant women experiencing homelessness who remain invisible to services. Our research found that sometimes women do not disclose pregnancy because they fear this would make them less likely to be housed. They may be excluded from access to short-term crisis accommodation because they will need to move when their baby is born, which highlights a troubling disincentive in the system for women to disclose their pregnancy early on to support workers. Some women also fear that making services aware of their pregnancy could lead to their baby's removal by Child Protection, a finding also noted in other studies.[8,9]

The Impact of Homelessness on Women and Babies

Babies born to homeless women are at higher risk of birth complications, and longer-term medical complications are more prevalent among this group of children, including ongoing behavioural and emotional problems caused by the effects of maternal stress in utero.[10,11,12] A recent study in the US found a 73 per cent higher risk of low birth weight or preterm birth among infants born to mothers who experienced homelessness or threatened eviction, while infants had an increased risk of requiring a stay in a neonatal intensive care unit.[13] Our research also uncovered experiences of serious health complications during pregnancy such as gestational diabetes, preeclampsia and very low blood pressure. The women were required to manage these conditions in circumstances not conducive to rest and recuperation, and where access to necessities such as adequate nutrition was difficult to obtain.

An important aspect of having stable, secure housing is that women can prepare for the birth, both psychologically and practically.[14] Having a safe place means that a woman can consider what motherhood will entail and can acquire the material goods needed

to care for her baby, such as clothing and equipment. However, many of the women we interviewed did not have this opportunity to prepare for the birth due to the dangerous and precarious nature of their circumstances, such as living in a car, rough sleeping or couch surfing, where they were exposed to violence and other hazards to their health and that of the baby. When women are not stabilised in housing early in their pregnancy, it undermines the relationship between mother and baby during the critical early stages.

Gendered Experiences of Homelessness

Gender inequality impacts pregnant women in a multitude of ways that increase their risk of homelessness. One of the key hurdles pregnant homeless women face as they navigate support services is 'gender blindness', wherein their distinct needs as women are often overlooked and, while not necessarily intentional, a normative masculine (and white) model of service delivery is standardised. Consequently, policy and practice responses to homelessness have been criticised for being 'gender-neutral', relying on a 'one-size-fits-all' approach[15] despite there being *'gender-specific processes and practices involved in the navigation of poverty, violence, and social exclusion'*.[16]

Gender-based violence, in particular, is a significant factor in women's homelessness, and pregnancy is known to be a risk factor for the onset or an increase in family violence; it 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.[17,18] Our research also unearthed incidents of gender-based violence with most of the women interviewed having experienced family violence, sexual assault or child abuse in their past, and for many it had directly caused or contributed to a worsening of their homelessness circumstances.[19]

Conclusion

Our research found that pregnant homeless women are a largely unrecognised and highly vulnerable group. They have specific and complex needs that require greater attention and specialised responses from homelessness and housing services. The lack of reliable data on the numbers of pregnant homeless women makes it difficult to provide appropriate and targeted service responses meaning their unique needs, as distinct from men's, can be overlooked. This has implications not only for women but also for their babies as there are serious physical and psychological effects for both mother and baby in failing to provide safe, long-term housing.

Endnotes

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Pregnant and Homeless: The Perspective of a Pregnancy Outreach Worker

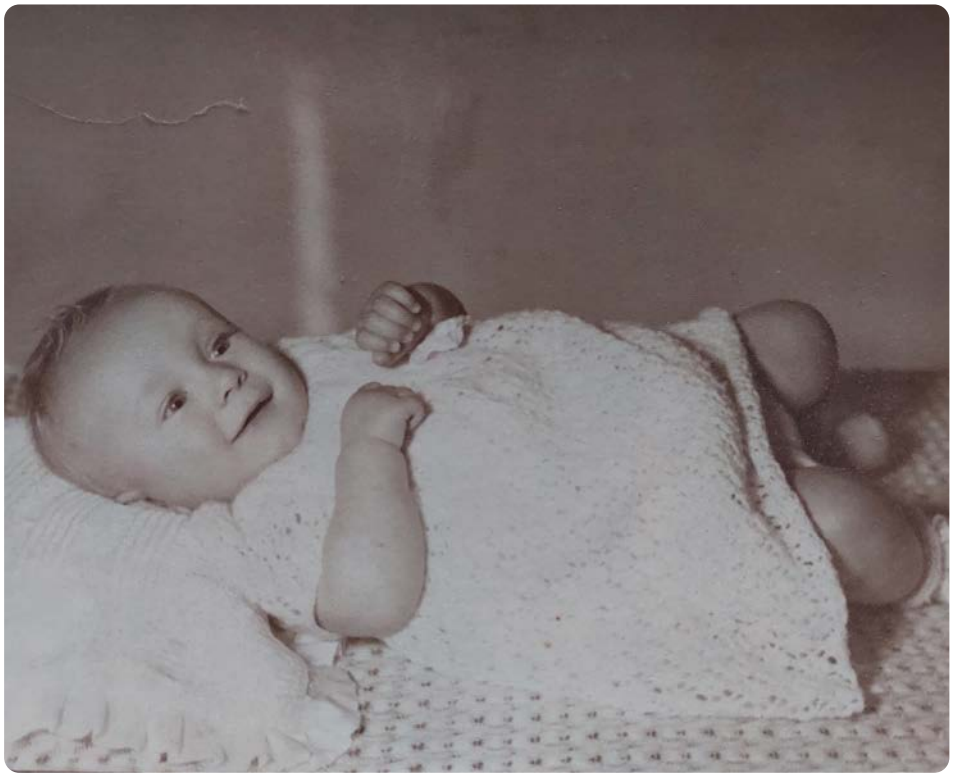
Amy Russell, Pregnancy Outreach Worker, Launch Housing

Pregnancy is a significant life event. With pregnancy comes new worries, responsibilities, excitement and anticipation. A stable environment in which to prepare is critical to the wellbeing of both mother and baby. But women who are both pregnant and homeless do not experience this critical stability. A woman who is pregnant and homeless may not have any antenatal care. She may be reliant on a partner who is perpetrating violence towards her. She might have a disability, or few or no financial or social resources. She likely has a trauma history and mental health struggles. She could be fleeing a dangerous home environment with children in tow. She is definitely vulnerable, worried about herself and her baby and terrified of what the future might hold. There likely will not be any baby showers and she may give birth without a support person present.

Women who are pregnant and homeless face insurmountable challenges, barriers and trauma. It is increasingly recognised that women who are pregnant and homeless are not receiving an appropriate level of support nor appropriate service responses considering the hugely vulnerable circumstances they, and their baby, are experiencing. It is clearly evidenced that trauma in-utero can have many detrimental impacts on the baby including issues with development and functioning, increased risk of miscarriage, early or traumatic birth, fetal distress, low birth weight and impairment of the baby's ability to form healthy attachments with others in the future. The individual cost to women and children, their families, and the wider community if they do not receive support is significant.

Launch Housing recognises the real and desperate need in the community for specialised supports for pregnant women who are experiencing or at risk of homelessness. I have the privilege of being part of one such program in my role as a Pregnancy Outreach Worker. My role is assertive and complicated, rewarding and devastating. I work within systems that may not necessarily recognise the increased inherent vulnerability of a pregnant woman or appreciate the impact of homelessness on the unborn child. My role is advocacy, coordination, champion, emotional support, transport provider and holder of hope.

I often meet clients at hotel emergency accommodation, unsafe boarding houses and refuges. Some of these women are rough sleeping in doorways or abandoned buildings. Often there are unexplained injuries, periods of disengagement, frantic desperate phone calls. All too often there is a partner who may act as a barrier to her seeking support or remain unknown. Many of the women I work with have had varying experiences with the



service system and have often lost trust and hope in its ability to deliver desired outcomes. Many have experience of being judged or fear judgement that can come with requesting support as a pregnant woman with multiple challenges and extreme support needs.

When I ask these women if they are ready to receive support for their mental health, or for their experience of domestic and family violence or to attend antenatal appointments, the common responses are:

> *'How can I when I don't know where I am going to sleep tonight?'*
>
> *'I can't focus on that while my baby and I don't have anywhere to live.'*
>
> *'The most important thing is finding somewhere safe to live for my baby.'*

A client may disclose that her partner has been seriously assaulting her or blocking her from attending antenatal appointments. I am struck by her strength and bravery in making these disclosures, I listen for what feels like hours as we make a safety plan together and I raise my concerns about the risks to her and her baby's safety. She is not ready to leave today, she does not have a home, she does not have any supports. She understands that I need to share this information, but she is not ready to leave today. She thinks it would be more dangerous to be alone and homeless and I think she could be right.

These women understand that there are organisations that are concerned about their ability to provide safety and security for their baby. Addressing substance misuse, complex mental health issues, or leaving an abusive relationship can be extremely challenging and complex, especially when the basic need of shelter is not being met. Thankfully there is an increased recognition across the sector that pregnant homeless women require swift appropriate housing-focused interventions. The Cornelia Program is a brilliant new initiative spearheaded by the Royal Woman's Hospital, Launch Housing and HousingFirst, that provides woman who are homeless or at risk of homelessness with safe accommodation. The program is seeing fantastic outcomes and is an excellent example of the power of philanthropy to instigate real change in the community.

There is no such thing as a typical day in my role. It could be that I spend many days simply trying to locate my client. I might spend a day at the fantastic Woman's Alcohol and Drug Service at the Royal Woman's Hospital supporting a client with their antenatal appointments. These are very long days at the hospital, and I can only support one client at a time in this space. Another day could begin with transporting a client to meet with Child Protection and advocating for them in this space, ensuring that it is recognised that they face many challenges and that they have shown immense strength in asking for help.

There are no shortcuts in this support role. Most women present with extremely complex needs and are at incredibly high risk. They require intensive, assertive responses that can be extremely time critical and time consuming. They often face challenges that have existed well before my intervention and require consistent and persistent support. My role is limited in resources and catchment, but I continually receive referrals and provide external consultations across Greater Melbourne. I have observed there is a huge need in the community for more programs such as this, that can work in the community directly with these women.

There are wonderful services that have a comprehensive understanding of how important early intervention is for these women and their babies. Collaboration with these services, in my experience, has been critical in achieving the best outcomes for women and their babies. However, there are some serious gaps in the system and supports available for women who are pregnant and homeless and often need intensive, assertive intervention. The women I work with are resilient and brave and I am so very lucky to have the opportunity to work with them. I share some incredibly sad moments, but I also see truly wonderful and exceptional demonstrations of strength. It is a real privilege to share moments such as the first time a baby's heartbeat is heard on the ultrasound, to support women to access stable housing for the first time in many years, or to simply listen to their story.

Stability and support are the key ingredients to supporting women who are pregnant and homeless. More holistic initiatives like the Cornelia Program and greater investment in intensive support staff are desperately needed to remove barriers for pregnant women to recover, rebuild and thrive in their pregnancy and motherhood.

Accessing Antenatal Care When You are Rough Sleeping: Barriers and Enablers

Professor Lisa Wood, The Institute of Health Research, The University of Notre Dame Australia and Natalie Bogoias, Homeless Healthcare

Background

'When we saw her on the streets recently, she was seven and a half months pregnant, and yet to have an antenatal appointment'

— Homeless Healthcare (HHC) Street Health nurse

'I could tell she was having contractions, but she was determined not to go to the hospital as she feared her baby would be taken away because she is homeless'

— Homelessness drop-in centre staff

'It is not uncommon to see women here who don't know if they are pregnant or not, or only discover they are late into their pregnancy'

— Homelessness service staff

Elsewhere in Perth, thousands of other women are meticulously planning their pregnancies or births, engaging in antenatal care with a provider of their choosing from early in their first trimester, and closely monitoring the trajectory of their baby's development via a plethora of 'what to expect when you are expecting'-type books, websites, apps, and social media blogs.

At a broader societal and health system level, there is now heightened scientific and policy attention to the critical importance of the first 1,000 days of life, from the point of view of both child development and future adult health and wellbeing.[1] As articulated in the recent Western Australian (WA) Sustainable Health Review:

> *'…the first 1,000 days of life, from conception until the end of the second year of life, are critical to developing the foundations of a person's future health, growth, and neurodevelopment. Both positive and negative experiences during these critical first 1,000 days of life have a significant influence on a child's future.'*[2]

Thus, pregnancy epitomises a 'tale of two cities'. Homelessness, and rough sleeping in particular, has a dual detrimental impact upon both pregnant women and their babies, and 'the first 1,000 days' for children born into such circumstances is far from a level playing field. As reflected in the literature, women experiencing homelessness are more likely than their housed counterparts to have unplanned pregnancies, less likely to receive timely antenatal and/or reproductive care, more likely to experience maternal, fetal and neonatal complications, and more likely to have low birth weight babies and experience postnatal depression, while their children are at greater risk of adverse child development outcomes.[3,4,5] At a more basic human needs level, pregnancy essentials such as quality sleep, good nutrition, stress mitigation and social support are largely unattainable for women who are trying to survive day-to-day on the street.

Homeless Healthcare street health outreach team

Figure 1: Barriers to Antenatal Care among Women Sleeping Rough. MH: mental health; AOD: alcohol and other drug.

Doing Something About This — A Western Australia Example

Over the past two years, Homeless Healthcare (HHC), through its Street Health outreach team, has identified and supported nine pregnant women living on Perth's streets. At the time of their first contact with HHC, these women were predominantly sleeping in tents, in parks or on footpaths, with these periods of street sleeping sometimes being interspersed with periods of couch surfing with family. For two of the women, it was their first pregnancy, but most had previously given birth. Sadly, the majority had had other children who had been taken into state care. Several of the families were Aboriginal, grimly reflecting the reality that intergenerational homelessness and trauma are more common amongst Aboriginal people in Australia.[6]

Barriers to Antenatal Care

Figure 1 summarises common barriers to antenatal care observed by HHC, not only among the nine women referred to above but also in the course of supporting dozens of other pregnant homeless women over the last decade. Some of the observed barriers reflect wider barriers to healthcare more generally amongst people experiencing homelessness,[7] while others are specific to the context of pregnancy and/or women's life circumstances and experiences of trauma either prior to, or concurrent with, homelessness.[8]

Trauma is intentionally the first barrier listed in Figure 1, as it casts a long, haunting shadow on the lives of women who are both pregnant and homeless. This reality was powerfully articulated in a recent article in the *British Journal of General Practice*, where the legacy of childhood trauma was identified as being both a pathway into homelessness and a barrier to antenatal and postnatal care.[9] The predominant types of trauma identified in the study (that is, childhood trauma and abuse, fractured families, family and domestic violence and untreated mental health or alcohol and other drug issues) are also seen among pregnant homeless women in Perth, but are compounded by the significant traumas experienced by Aboriginal and Torres Strait Islander people, who are over-represented amongst Australians living on the streets.

Collective, Coordinated, Trauma-informed Responses are Needed

Distrust of health and social services, and an aversion to telling one's story over and over again, are common attitudes amongst people experiencing homelessness that have been acutely observed among those who are both pregnant and rough sleeping. Consequently, collaboration, coordination and the building of shared trust have been essential hallmarks of efforts to support pregnant women on the streets of Perth over the last two years. In particular, a growing collaboration has beeen spawned between HHC, King Edward Memorial Hospital (KEMH) (Western Australia's primary maternity service), the Women and Newborn Drug and Alcohol Service (WANDAS) at KEMH and several other homelessness services. However, proactively seeking out healthcare, let alone antenatal care in particular, is simply not on the radar of people who are in daily street survival mode and contending with the barriers identified above. Therefore, recognising that critical engagement and relationship-building are vital precursors to any attempts to encourage women to attend antenatal or hospital appointments, gradual building of patient trust has been an essential first stepping stone for HHC's street outreach nurse. The following case study illustrates the trust, perseverance, and person-centred care coordination entailed in supporting just one of the women who have been pregnant on the streets of Perth in the last two years.

Background

Haley* is an Aboriginal woman in her late 30s who had been sleeping rough and couch surfing for four years prior to, and at the time of, her most recent (fifth) pregnancy. She grew up in foster care before reuniting with her mother in her late teens. She now has three children who are in foster care themselves. Haley has a history of PTSD, anxiety, depression, suicidal ideation, drug and alcohol dependence, frequent skin infections, and an STI that has been treated but required ongoing monitoring during her pregnancy. Haley has had many hospital admissions for illnesses that could have been effectively managed or prevented with adequate access to primary health care.

Haley has also been in a violent relationship for many years, and has often been hospitalised due to the serious physical trauma she has endured. She has been in and out of women's refuges, and has tried many times to leave her partner. At the time of her first contact with HHC during this pregnancy, she stated that she was determined to keep the baby when it is born.

Support Provided

Haley was referred to WANDAS for specialist antenatal care at 20 weeks gestation, by an HHC GP she saw at a drop-in centre clinic. However, she did not attend her appointments. Through purposeful and proactive engagement, the HHC Street Health team, along with Uniting WA case workers, developed a trusting, therapeutic relationship with Haley, and, in time, were able to support her to attend her appointments. Although she remained fearful of hospitals and of Child Protection potentially removing her baby, Haley, supported by the HHC outreach nurse, began to engage with her social/case workers, and thereby was able to receive vital, regular antenatal care, supporting her health and that of her baby.

On one occasion during her pregnancy, the team noticed Haley looking very unwell at a drop-in centre, and reporting abdominal pain and a large abscess on her leg. However, she refused an ambulance, so the team transported her to the KEMH Emergency Department. It transpired that Haley had sepsis, and she remained in hospital for a week to recover. During her stay, her other acute health needs were met, which would have been difficult to manage while on the streets.

Current Situation

Haley is now almost 38 weeks pregnant and has recently moved into her own apartment with the support of Uniting WA Accommodation Services. With the support of the team, she has continued to attend her antenatal appointments, and has engaged well with hospital midwives and her social worker. The Child Protection social workers will continue to support both her and her baby, as needed, when they return home.

The team provided critical links not only to antenatal care but also to other support services such as drug and alcohol counselling and 'Mother and Baby' supported accommodation services. Through effective inter-agency collaboration initiated by the team, Haley has felt supported enough to make her own positive choices and dramatically change the trajectories of both her and her baby's lives.

* not her real name

What Else is Needed?

HHC's outreach model and coordinated care approach to supporting pregnant women who are rough sleeping is vital but, to date, been entirely unfunded. There is also a paucity of tailored outreach antenatal care and accommodation options for pregnant women experiencing homelessness elsewhere in Australia. The Homeless Prenatal Program in San Francisco[10] is an example of an innovative community care model that potentially has merit to address this.

There is a dearth of accommodation and housing options for pregnant women and new mothers in WA. Further, more broadly, Australia seems to lag behind some other countries in terms of the availability of dedicated, supported accommodation of this kind. KEMH data shows that, for nearly half of the babies taken into state care in 2019–20, lack of stable housing was a significant contributing factor.

The fear of having one's baby taken into care remains a significant barrier to engagement with antenatal care for women experiencing homelessness. Policy and cultural shifts to rectify this are urgently needed.

The pregnancy period is just the beginning of the critical 'first 1,000 days' — even for women who get accommodation in time to be able to keep their babies, there remain barriers around access to postnatal care, child health services and support for parenting, all of which can impact upon child development and longer-term outcomes.

Homeless pregnancies need to be examined within the context of broader reproductive and sexual health for people experiencing homelessness. This is particularly important given the existence of homelessness clusters with relatively high rates of STIs and poor access to contraception.

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Young Women Navigating Homelessness and Pregnancy: Pathways Into and Barriers Out of Homelessness

Catherine Mann Research and Evaluation Coordinator, Rhianon Vichta-Ohlsen Research and Evaluation Manager, Lou Baker, Young Women and Young Families Manager

In 2020–21, Brisbane Youth Service (BYS) received 2,629 new enquiries for support from young people impacted by homelessness or related support needs. Specialist Homelessness Services (SHS) data indicates that approximately 1.1 per cent of young people who seek support nationally are young parents[1] and 17.2 per cent of new mothers are aged 24 years or younger, with younger mothers more likely to identify as Aboriginal and/or Torres Strait Islander.[2] At BYS, more than a quarter of the young people we support each year are young parents (26 per cent) and approximately 70 per cent of young parents coming to BYS identify as Aboriginal and/or Torres Strait Islander.

Women who are young, pregnant, and navigating homelessness have compounding and intersecting vulnerabilities, with both their own and their unborn child's welfare at risk.[3] Young women facing these challenges have increased risks associated with escalation of mental health concerns, family and relationship violence, physical health issues, poor nutrition, financial issues and a range of other stressors[4] including the broader elevated health issues that impact Aboriginal and/or Torres Strait Islander young people.[5] Babies impacted by parental homelessness are more likely to have pregnancy and birth issues including low birth weight, developmental challenges, thrive delays and other medical complications.[6]

For 45 years, BYS have supported young people experiencing homelessness including a dedicated service for young women and young families. The Young Women and Young Families (YWYF) team face ongoing frustrations around the barriers associated with finding and stabilising sustainable housing for young people who are pregnant, and in this article share their experiential learning. Pseudonyms have been used for staff member's privacy.

Pathways into Homelessness for Young Pregnant Women

Young parents and parents-to-be experience the same range of pathways into homelessness as any young person, including overcrowding, rental evictions, family conflict, mental health issues. Young parents-to-be are particularly at risk from the most common reasons for homelessness: family rejection and/or breakdown, family and relationship violence and financial hardship.[7] These life challenges are frequently complicated by other experiences of disadvantage, adversity and trauma in childhood and young adulthood.[8] Pregnancy can exacerbate pre-existing issues, lead to young people proactively seeking safe living environments, or lead to Child Safety interventions encouraging/requiring young people to find safer housing options.

Danielle, a YWYF worker explained:

> *Her parents didn't approve of her being pregnant, that was how she became homeless. We see a bit of that, but we also see that the young person or Child Safety may not deem their family safe enough, but there's actually not anything put in place as an alternative. This then ends up leading to children being removed.*

Relationship breakdowns during pregnancy are another key pathway into homelessness for young pregnant women coming to BYS for support. When a young woman's partner does not want to be involved in the baby's life, the young woman faces a difficult choice between leaving, being told to leave their home, or terminating their pregnancy.

> *Lucy (YWYF worker):* [The young woman] *left her partner because he had made it very clear he didn't want to be involved in the baby's life. She moved interstate, to Brisbane, and then had to sleep on the couch at her mum's place. There was, however, a lot of conflict in that household.*

> *Lottie (YWYF worker): Sometimes the young women get kicked out of the accommodation they're in by the boyfriend who got them pregnant, because they refuse to terminate.*

For some young women, an escalation of domestic violence once they become pregnant can be a key factor in leaving the relationship and home, even if that means sleeping rough or couch surfing.

> *Lottie: For a lot of young women navigating DV* [Domestic Violence]*, … an escalation in the DV when they become pregnant is often that tipping point where they might decide, 'enough is enough, I'm out of here'.*

Barriers to Ending Cycles of Homelessness for Young Pregnant Women

For young pregnant women experiencing homelessness, navigating Housing, Welfare, Health and Child Safety systems is complex and fraught with barriers to accessing the support needed. This is further compounded by the siloed nature of the service system. Safe, suitable and affordable housing is a key facilitator of ending cycles of homelessness for young people and providing a safe, stable and nurturing environment for their

safe space by Jess

Artwork courtesy of Taskforce

children.[9,10] While pregnant women may have once been prioritised for urgent housing, over the past three years, Queensland has seen the number of people on social housing waitlists increase by 65 per cent.[11] This has been coupled with a dramatic decrease in suitable private rental options, with rental vacancy rates at record lows and no affordable options for young people on youth allowance nor for single parents on parenting payments.[12]

SHS that provide accommodation in Queensland share vacancies on the Queensland Homelessness Information Platform (QHIP). BYS staff, however, have ongoing difficulty in supporting young pregnant women to access these vacancies.

> *Lottie: There is one* [Service provider] *that is pretty much the only one if [the young woman is] not prepared to go to refuge, but heaps of them aren't eligible for* [that service].

> *Erica (YWYF worker): It used to be that if somebody was pregnant or parenting it was easier to fast-track them through the housing process. But now there's just nothing: there's little to no vacancies in family accommodation on QHIP, Department of Housing can't house them any faster, [and] there's no community housing options available.*

> *Danielle: Pregnant young women are not eligible for places where they can have their baby with them, and the housing that they can access as a single woman, when there are vacancies, they won't continue to be eligible for that housing when they have the baby. They risk having the child removed or being homeless again. If they do get housing they can stay in with their child, and then Child Safety takes the child into care, they then lose their housing too. It's all a catch-22.*

Financial resources are critical in accessing suitable, affordable accommodation for young pregnant women. For young people eligible for Centrelink payments, the increased parenting payment is not accessible until their child is born, meaning, while pregnant, they cannot apply for housing that they would be able to afford once they receive the parenting payment. For young pregnant women who are not Australian citizens, government financial assistance and housing may not be available.

Employment is not necessarily a protective factor for young women once they are pregnant. Many are unable, because of safety, health issues or employer discrimination, to sustain their employment through the pregnancy. However, having employment or savings becomes a barrier to accessing financial benefits that they need to prepare for parenting.

> *Lottie:* [Young pregnant women] *don't qualify for parenting payments so they can't afford a private rental generally.*

> *Danielle:* [Young pregnant women] *can't access the parenting payment because* [they] *haven't had the baby yet but also* [they] *might not be able to work because* [they're] *pregnant.*

For young pregnant women who are under 18 years old, accessing Centrelink supports can be complicated by difficult relationships with their parents.

> *Erica: When they're under the age of 18, trying to get payments through Centrelink can be really tricky because of their age and conflict with their parents. I've had young people whose parents will refuse to sign a form saying there's any conflict at home, to confirm that [the young woman] can't stay there.*

BYS staff also noted financial barriers for the organisation in terms of brokering young pregnant women to stay in motel/hotel accommodation.

> *Erica: We were recently working with a heavily pregnant woman who was sleeping rough and couch surfing, she was 30+ weeks and just getting more and more stressed and desperate with nowhere to go. Access to emergency accommodation was challenging and is not suitable generally anyway yet she was about to give birth and she knew the consequences of not having housing.*

> *Lottie: We are getting a lot of referrals for pregnant women who are sleeping rough, and they've had the baby, there may be more of a chance that we can find temporary accommodation for them — but when they're pregnant we just have to safety plan around rough sleeping or couch surfing, even though we know that that's a key developmental stage and stress is really going to impact the baby.*

While being pregnant is associated with barriers to accessing housing, homelessness complicates pregnancy care through the hospital system.

Erica: When a young person is homeless, she is often unable to access antenatal support from a hospital because you need to be living in the catchment of a particular hospital to receive their support. When you are transient or homeless you don't have an address in any catchment. We had one young woman where the hospital was trying to get her to pay several hundred dollars for antenatal classes. She couldn't afford that; she was living out of a car.

Homelessness is often a key trigger for pre-birth notifications to Child Safety and children being taken into care at birth.

How Can We Break Down These Barriers?

It is clear, from the professional evidence of BYS staff, that the most critical issue is the interaction between Housing, Welfare, Health and Child Safety systems. A systemic failure to coordinate responses to young pregnant women who are homeless, or at risk of homelessness, has created a support vacuum in which young women are unable to access the supports that they need to care for a new-born prior to the birth. As such, beyond the need for stable antenatal health and wellbeing during the pregnancy, they are unavoidably placed in a situation of being unable to prepare to provide safe stable living environment for a baby. The siloed systems create a loop in which a pregnant woman is treated as a single person until the birth, and she cannot access parenting support until after it is required to be in place. An integrated coordinated inter-departmental welfare response that views a pregnant woman as transitioning into parenting is a critical and urgent requirement to address these complex systemic barriers to safe and sustainable housing for young pregnant women.

Enhanced integration of welfare responses would ideally include advance access to parenting payments and rent assistance during the third trimester, where there is evidence that housing is unstable and potentially impacting the wellbeing of the mother and baby. In addition, the waiving of age as a barrier to accessing Centrelink payments would see young women who are pregnant automatically qualify for independent payments, removing family 'permission' as a barrier to the financial means to access safe housing. More broadly, young pregnant women are just one group, albeit a highly vulnerable group, who need enhanced housing policy responses that will strengthen affordable housing for young people.

Acknowledgement

Many thanks to the YWYF team for sharing their practice wisdom and reflections on the challenges faced by young pregnant women they have supported.

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Women, Homelessness and Gendered Stigma

Rachael Willet, Overdose Prevention Clinician, Taskforce

Homelessness occurs as a result of a multitude of complex interacting factors from both an individual level and a societal level. Individual complexities range from traumatic childhood experiences such as poverty, abuse, neglect, removal from parents and being placed in foster care, mental illness, substance abuse and social isolation.[1] The societal factors can range from unemployment, inequality, lack of affordable housing and barriers to service access. The 2016 Census night revealed that 116,427 people were estimated to be homeless,[2] while the 2020 Launch Housing homelessness monitor[3] stated this number had increased to around 290,000 by 2019. The Australian Institute of Health and Welfare (AIHW) (4) reported that 60 per cent of the 278,300 clients assisted by Specialist Homelessness Services across Australia in 2020 were women.

Research has often demonstrated a strong correlation between homelessness and substance use. While Thomas and Menih[5] advise a high percentage of the population attribute substance use as the cause of homelessness, not all people who experience homelessness use substances, nor is it necessarily the cause for those who do.

Women experiencing homelessness face gendered stigma and unique challenges such as access to menstruation supplies, fear of sexual assault, experiences of sexual assault and vulnerability to sexually transmitted diseases and blood-borne viruses, often due to resorting to sex work to gain income to support substance use.[6]

Homelessness is just one of the intersecting factors affecting pregnant women which is often intertwined with family violence, alcohol and drug use, and mental ill-health.[7] The number of homeless pregnant women is largely unknown as they often do not access services due to fear of being judged and reported to Child Protection. However, Murray et al[8] suggest higher rates of pregnancy internationally among homeless than housed women. Additionally, access to prenatal care for pregnant women experiencing homelessness is concerning for both mother and baby. The difficulty these women face limits the ability to screen for crucial pregnancy complications such as gestational diabetes, preeclampsia, infection and stillbirth.[9]

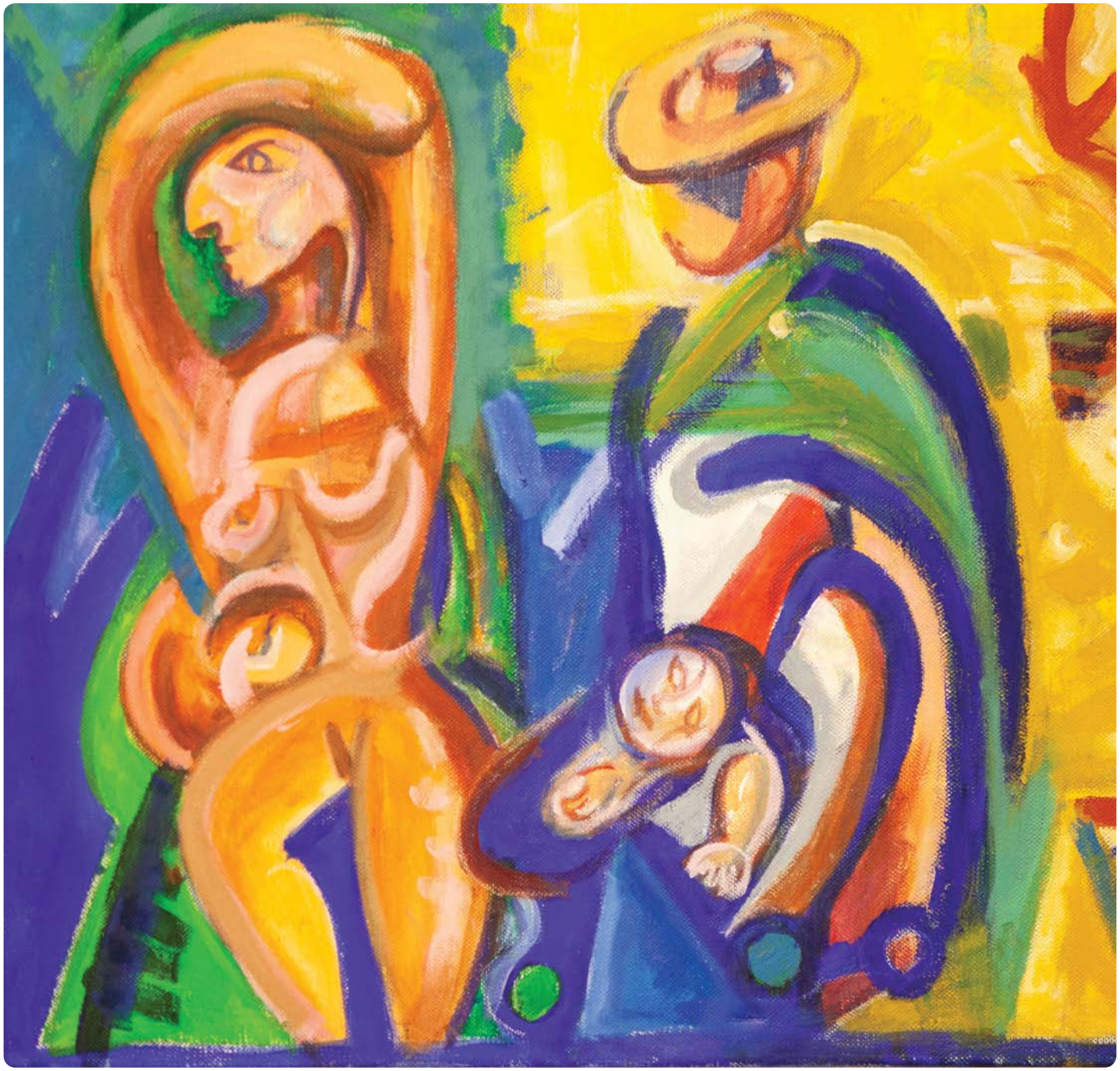
As distressing as these complications can be for a new mother, homeless pregnant women who use substances face additional stigmatisation and often dire consequences including incarceration and removal of children following birth. The impact of these additional stressors exacerbates pre-existing mental health issues and perpetuates the cycle of substance use.

Pregnancy among this disadvantaged cohort is viewed as a 'window of opportunity' as women access antenatal care, they can be supported with additional services such as drug and alcohol treatment, mental health treatment, family violence intervention and housing support to name a few.[10] As shared by Murray et al,[11] pregnancy — whether unwanted or planned — can be a constructive opportunity for repairing past traumas associated with abandonment, childhood abuse, and emotional detachment experienced in their own lives. This can be a potential catalyst for healthy attachment to their unborn child and renewed sense of focus on purpose and change.

A multi-disciplinary approach to care of homeless pregnant women is imperative to addressing the barriers to both prenatal care and post-natal care. This approach should include midwifery case management, education, peer support and psychosocial support, particularly in the areas of trauma recovery, self-efficacy and safe appropriate housing. Equally important is advocacy for these women in navigating service barriers such as lack of appropriate housing options which force vulnerable women into unsafe rooming houses while pregnant. Research confirms early access to care and support is vital for improved psychosocial and obstetric outcomes.

Moreover, Miles and Francis[13] provide valuable insight into the challenging nature of health professional engagement with pregnant women who use illicit substances. They reviewed literature which identified negative attitudes and prejudiced views of women who use drugs that increased when the woman was pregnant. This flawed perception leads to further stigma and shame and increases the lack of trust in services. It was further identified in the literature that mental health nurses, drug and alcohol nurses and social workers had a more positive attitude and greater knowledge to support these complex pregnant women.

This research provides an opportunity to develop specialised service hubs for homeless pregnant women who use illicit substances to access safe, non-judgemental early intervention and care pathways.



The focus on enhancing positive future outcomes and empowering women to take control of their lives can be life-changing for future mothers and children.

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Culture and Care for Pregnant Unhoused Aboriginal Women

Jo Doherty, Family Violence Practice Lead and Ella McNicol, Project Officer,
Elizabeth Morgan House Aboriginal Women's Services

Aboriginal* women** are becoming mothers younger than their non-Aboriginal counterparts[1] and experience homelessness at significantly higher rates. For many Aboriginal mothers, pregnancy is a time of celebration and joy at the thought of growing their family. For some, particularly those that are experiencing housing instability, it can be time of immense anxiety and fear. This is particularly when the systems designed to support them during this critical period of neonatal development are instead policing them. Sadly, their concerns are often well-founded. In 2018–19, a fifth of all Aboriginal children placed in out-of-home care were under a year old and Aboriginal children were removed at nine times the rate of non-Aboriginal infants.[2]

An increase in the use of prebirth child protection notifications is creating further barriers to pregnant Aboriginal women accessing regular and appropriate antenatal care, due to fears of notifications being made. Aboriginal women are also less likely to engage with neonatal services and experience higher rates of stillbirths and children who pass from Sudden Infant Death Syndrome (SIDS). Maternal mortality rates for Aboriginal women are nearly three times higher than for non-Aboriginal women, and perinatal mortality rates of Aboriginal infants are 50 per cent higher.[3] As well as founded fears of racism and discrimination by Child Protection, hesitancy in engaging with mainstream neonatal services is often amplified by a lack of cultural awareness and competency within such services.

For over 65,000 years, Aboriginal communities had their own diverse ways of safely supporting pregnant women to have healthy pregnancies and births. Birthing was Women's Business and pregnant women were highly honoured as the centre of a community's focus. Colonisation and attempted genocide aimed to decimate these sacred support systems and forcibly replace them with western ways.

Pregnant Aboriginal women need culturally appropriate neonatal support systems. Yet, the fears associated with being homeless and the social misconception that homelessness means a mother is incapable of providing stability for their unborn child have resulted in lower engagement with key services. Many go as far as to say a woman's failure to engage in western ante and neonatal supports is tantamount to child neglect. However, when a pregnant Aboriginal woman is not engaged with such 'care', it is often as a protective measure, to shield against pre-birth notifications being made to child protection services.

Child protection risk assessment guidelines are based in western perceptions of what constitutes 'family' and are thus biased against Aboriginal ways of knowing and raising children. In addition, many of Child Protection's identified 'risk factors' target families that are experiencing socio-economic disadvantage, including those who are unhoused. Evident in this assessment is the assumption that homelessness is the fault of the individual experiencing it, rather than the fault of the systems which cause it. Aboriginal people continue to experience systemic discrimination within the child protection system, and Aboriginal women experiencing homelessness are at an even greater risk of having their children removed at birth or shortly after due to these compounding injustices.

Aboriginal women are first becoming mothers on average six years younger than non-Aboriginal women and are almost 11 times more likely to be under 18 at the time of giving birth.[4]

Many of these mothers have themselves been accommodated in residential or 'resi' units under Children's Court Orders. Due to this intergenerational factor, many lacked the opportunity to witness positive role modelling, as the system fails to provide a loving and stable environment in which to be raised. Upon exiting residential care, available extended family support networks have been disrupted or decimated, and these young mothers often do not have adequate social resources to support them as a new mother. They often face additional discrimination in society as young mothers and the system fails to support them as matriarchal figures would have, had they remained within their communities. It is an all-too-common story that often culminates in the system removing their newborns. Aboriginal mothers are then required to independently secure accommodation to be reunified with their babies, yet no affordable accommodation is available. The cycle of removing Aboriginal children from a loving mother and their cultural foundations continues and the impacts are devastating.

Homelessness is just one of the many long-standing issues faced by Aboriginal people since invasion, colonisation, and the subsequent loss of land. There is a housing crisis in Victoria, and this is compounded for many Aboriginal people who face discrimination in the rental market. Pregnant women with no other children in their care often

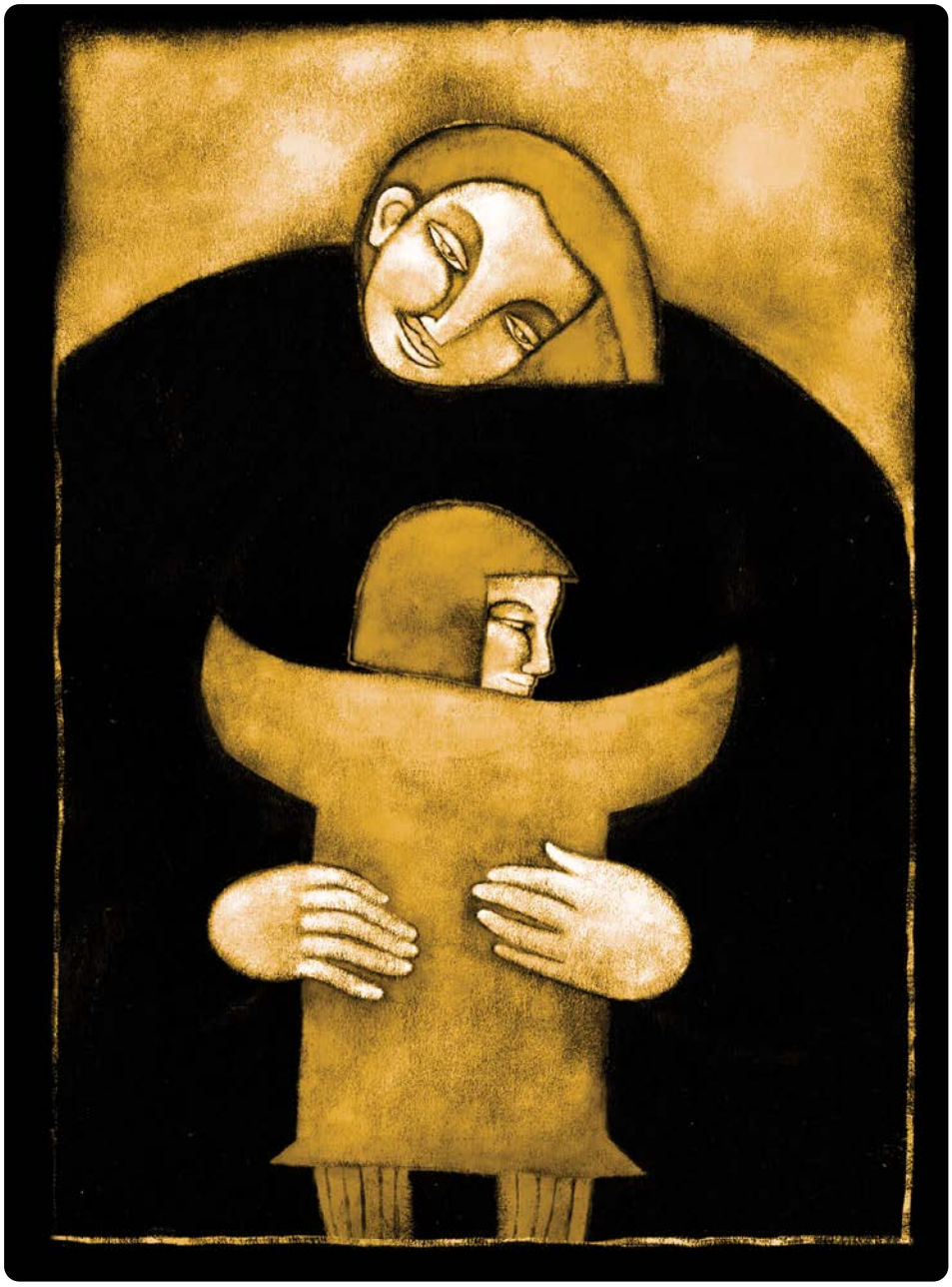
fall through the system's cracks as they are identified as ineligible for social housing programs and accommodations that are specifically designed to support either single women or women with children.

Pregnant women often do not 'fit' into either category. Pregnant Aboriginal women who are living in overcrowded homes to avoid unsafe temporary accommodation are not prioritised by the housing sector, yet Children's Courts will not return infants to families where child protection services see the mother's accommodation as overcrowded and 'unsuitable' to live in. Such contradictions between these systems place Aboriginal women in impossible situations.

Family violence is the primary cause for women's homelessness in Australia[5] and Aboriginal women are 32 times more likely to be hospitalised from family violence than non-Aboriginal women.[6] Family violence can first present or significantly worsen during pregnancy and the presence of violence during pregnancy or with a newborn is identified as a high risk evidenced based factor for assessing the risk of lethality or severe injury.[7]

Pregnant Aboriginal women experiencing family violence often face the impossible decision of staying housed with the person using violence or fleeing their home to enter a state of being unhoused and transient or reliant on the temporary nature of the refuge system and, either way, are at risk of child protection intervention. Pregnant Aboriginal women experiencing family violence and/or homelessness exist at a dangerous intersection and are too often let down by services which are incapable or ill-equipped to support them during such a crucial time.

There must be a coordinated effort to ensure systems can act efficiently and appropriately to support pregnant Aboriginal women in a culturally competent way. Aboriginal women should not fear attending prenatal appointments. Unhoused Aboriginal women should be able to access culturally safe healthcare for themselves and their children without fear that their child will be removed from their care at birth.



When homeless Aboriginal women present to health services, they should be assisted and supported in accessing stable housing. Homelessness cannot and should not be used as justification for yet another Stolen Generation. Aboriginal knowledge must be upheld and recognised as indispensable in ensuring safe and competent healthcare for First Nation's people, families, and communities.

* Aboriginal is inclusive of both Aboriginal and Torres Strait Islander

** EMH acknowledges that not all people who become pregnant or give birth are women.

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Confessions, Conflict and Credibility: A Perth Emergency Key Worker's Experience Supporting Pregnant Women Sleeping Rough

Cate Pattison, Ruah Community Services

It's just gone six in the evening and the night is drawing in fast. Winter snaps abruptly in Perth and dusk is on the doorstep early as the city streets quickly empty of people on this wet June evening.

Key Worker Emma arrives at the Safe Night Space for women experiencing homelessness in East Perth, a service delivered by Ruah Community Services on behalf of the City of Perth, established in 2021 in response to concern for the safety of women sleeping rough in Perth. Available between 7pm and 7am, the community centre from which it operates is basic but offers a shower, sofa or bean bag and, if the donations have come through, a hot meal to heat in the microwave.

Approaching the building, Emma notices women waiting together in a car and doesn't need to check the CCTV monitors to know that a group will already be taking shelter from the rain in the alcove at the front of the building. She lets in Ruah colleagues arriving for the first of two shifts and has a chat to the security workers from Rooforce, an Aboriginal-owned agency who provide valued trauma-informed security for visitors and staff.

Emma is a young mother herself. She hopes that a pregnant woman who had come to the centre twice a few weeks ago will show up again tonight. Danielle was first brought to the Safe Night Space by police as an emergency placement shortly after 2am one morning, after the Noongar Patrol found her at the city train station. Staff soon ascertained she was 32 weeks pregnant, a diagnosed diabetic and under maternity care at King Edward Memorial Hospital.

Danielle also shared her personal challenges around alcohol, cannabis and methamphetamine use. Concerned for her immediate health, staff contacted Crisis Care (Department of Communities). It was discovered Danielle already had a case manager and a birthing plan — as well as a potential warrant for the child's apprehension upon birth, to be actioned if she didn't comply with conditions set by the Department. On her second visit to Safe Night Space the following night, Danielle confessed she was still drinking heavily and felt severely depressed and anxious. She has not returned to the Safe Night Space again since.

Danielle's case is a familiar scenario encountered by Emma and her Team Lead, Josh. As professionals, they are trained to address these situations and follow clear guidelines around privacy and confidentiality in line with a client-centered approach. Gaining permission to advocate on the client's behalf is essential. Once this has been granted, help to connect to the right services can begin. It's this principle, however, that can prevent access to the best advice and care, for both mother and baby. The prospect of connecting to medical and social services will often be the barrier for a woman to continue to engage with the Safe Night Space. Anecdotally, workers know that some pregnant women sleeping rough will avoid any services at all for this reason, shutting down opportunities for harm minimisation, emotional support or access to brokerage. There was also now a real risk that Danielle would be too fearful to present to hospital when she went into labour and that could result in her giving birth without any midwife assistance and, potentially, alone on the street.

Situations like this bring sharply into focus the difficulties that the people who work in this sector must constantly address: whose interests and wishes should take priority: those of their client desperately in need of support to cope with the devastating trauma they would inevitably soon face, or those of her unborn child? While excellent prenatal care is made freely available for women like Danielle, Emma and Josh observe that this tends to drop away once their babies are taken into care. They witness the intense distress, trauma and irrevocable damage from this experience for women who were already experiencing homelessness and a raft of other pre-existing challenges.

As the clock strikes 7pm, women are welcomed into the centre. They register at the front desk but aren't required to show ID — as a low-threshold service, all women seeking safety and shelter are welcome, as long as they follow guidelines around respect and behaviour. Gary from Rooforce helps some with suitcases and visitors quickly find their favourite spot for the night. Some come with a pile of luggage and their own bedding, others with little more than a handbag. Mobile phones get plugged in, towels handed out, new clothes given to Tam who has arrived soaked to the skin and a water bowl is found for Diedre's dog. There is no sign of Danielle.

There are 17 women in the Safe Night Space this particular evening and Emma knows that one of the recent regulars, Jill, will be keeping the team busy tonight. When Jill first came to the centre last month it took a while to understand her situation. In and out of homelessness for

many years, Jill had given birth three months earlier and her baby son was now living with his father. Jill openly shares her ongoing challenges around drugs and alcohol, as well as her mental health difficulties, the medical diagnoses of a brain tumor and contact details for her appointed Guardian. Her complex needs, combined with the recent trauma of having her child removed from her, have resulted in Jill now experiencing psychosis and cognitive impairment, and displaying unsafe behaviour on the street (attempting to conceive another child as she grieves the heartbreaking removal of her son). Her untreated addictions have resulted in a new habit of ingesting hand sanitiser. Emma and Josh have worked with Jill to try and navigate a support pathway, sharing in the frustration she faces in the service network system, within which she simply does not fit.

Although now actively seeking help for AOD recovery, necessary for any hope of being reunited with her children, providers of relevant services are unwilling to accept Jill due to her serious medical condition. Conversely, she has struggled to remain in the hospital system or sustain medical treatment due to her ongoing addictions, subsequent behaviour and self-discharging. As Emma and Josh seek referrals for Jill, they too become disheartened at the lack of options available, while observing her vulnerability escalating. Liaising with Jill's Guardian, they suspect an Involuntary Treatment Order will be the only option to progress any effective treatment for her. However, without an official diagnoses of mental illness this will be complex, or even impossible to achieve.

It's now 10pm and Emma lowers the lights in the Safe Night Space. She knows that Jill, who is particularly distressed tonight, probably won't sleep and will keep everyone awake. 'Good luck!' she says to the team who arrives for the second shift. As they hand over, an Aboriginal woman and her 19-year-old daughter present at the door, referred by a nearby women's refuge that's been at capacity for months. Making them comfortable, she notices that the daughter is pregnant. Seeing the closeness between these two, she gets a strong feeling that this baby will be okay. As she packs her things up to head home, Emma reflects on both her concern about what might have happened to Danielle, and that she still hasn't worked out how to process the internal conflict she encounters in so many aspects of her work. Parking those thoughts, she instead focuses on the sense of pride she feels, knowing that at least Ruah's service is there, a final safety net, to catch any woman in Perth facing a cold, unsafe night on the streets.

This account is based on real experiences however all names have been changed.

Responding to the Housing Needs of Pregnant Women and Infants During the First 1,000 Days

Dr Jennifer Weber, Chief Executive Officer, Caroline Chisholm Society*

The Caroline Chisholm Society has long advocated for a Housing First approach in support of pregnant women and infants. As a specialist service in the First 1,000 Days, the Society has spent the past 50 years working with pregnant women and their children, providing much needed supports and interventions in response to family violence, exploitation, early parenting, financial insecurity and growing concerns in housing instability and homelessness.

Since commencing services in the late 1960s, the Society quickly transitioned from a volunteer network providing emergency housing and material aid supports to being an accredited and registered community services provider, operating across the western suburbs of Melbourne and Goulburn Valley with a reach to over 30,000 families over the course of its work to date.

The most prevalent issues faced by the women and families receiving services through the Society are increasing financial and economic insecurities, housing instability and homelessness, mental health concerns, social isolation and family violence. For some women, presenting in the later stages of their pregnancies often reveals situations of high risks including financial and housing instability.

A point of difference for the work of the Society has been its well accessed material aid program, with a common visit to outreach or in house services providing baby essential packs, prams, nappies and formula. These visits often reveal the crisis in need for women giving birth and leaving hospital to then arrive in need with little to no supports in place for the care and wellbeing of a new-born baby.

Women may be less inclined to connect with service providers for fear of a report to or involvement with Child Protection. Either real or perceived, this remains a significant barrier to why pregnant women are inclined to avoid service connection and involvement for fear of putting at risk their aspirations and hopes in being a mother.

Young pregnant women may have experienced family violence, are often excluded from the family home and may present with mental health issues, little confidence and a limited knowledge of parenting. They are less likely to be able to secure accommodation for themselves and their children, maintain positive routines and, due to their changing circumstances, are often unable to set appropriate boundaries in relationships.

Pressures upon them may make it difficult for them to manage their own emotional and mental health and respond to their children's emotional health and social wellbeing. Their wellbeing and that of their children may be further impacted upon by issues in relation to intergenerational trauma, separation, loss and grief.

Housing supports and pathways through to employment, education and training are crucial in enabling young people to move out of the cycle of unstable and insecure housing and into a more positive trajectory of adult capability.

In more recent times, and further evidenced through the past two years of the COVID pandemic, the growing number of cases of pregnant women presenting with experiences of sexual exploitation, violence, mental health and housing issues. This has been of particular concern across the western suburbs of Melbourne with the pandemic as it has exacerbated housing instability and housing options for pregnant women.

Unborn Reports

In 2019 the Department of Families, Fairness and Housing (DFFH) identified a cohort of women impacted by unborn reports as a priority focus. The concerns for the conditions in housing for pregnant women and unborn reports in the western suburbs of Melbourne identified that there were potentially over 2,000 women at risk of such reports. With little data readily available to determine what the situation is when it comes to those experiencing housing insecurity or homelessness, and with under-reporting, the unborn report data doesn't necessarily reflect accurate numbers of pregnant women in need of prevention and early intervention specialist services including housing supports. And yet we know from our work that pregnant women involved in an unborn report tend to present

with housing instability and financial insecurity as an immediate need.

According to the Victorian Child Youth and Families Act (CYFA), Child Protection services can receive an unborn report; share information about a mother of the unborn child with a service provider for the purposes of assessing risk or seeking advice on the most appropriate service to provide assistance; provide advice to the person who made the report; or provide advice and assistance to the mother of the unborn child.

This is an opportunity that is often missed in connecting a pregnant woman into support services as in cases of self-referral the immediate needs are overlooked as the case for intervention is less likely to be initiated prior to baby being born.

Promising Practices: Maternal Wrap Around and Housing First is Key

For the work of the Society as a specialist agency in the first 1,000 days of a child's life and early years, pregnant women seeking supports may typically present in need of essential material aid, financial supports or may be experiencing a crisis including exploitation as a result of unstable housing arrangements.

We know from the research into the first 1,000 days how a baby's brain development develops more quickly than at other time of life, with early experiences critically important in affecting baby's cognitive, social and behavioural development. Specialist services during this important time include the implementation of evidence-based programs providing for the health and safety for mother and child, promoting the mother child relationship focussing on attachment, and community connection in support of family functioning.

The Society has also invested in collaboration in developing a maternal wrap around approach, engaging 10 principles — family voice, natural supports, collaboration, community based, culturally component, individualised, relational team focussed, persistent, outcome based — and drawing on research to integrate trauma-informed practice.

Over the past two and half years, the Society has worked with over 100 women and their families experiencing inadequate or inappropriate housing arrangements and supporting 25 experiencing homelessness. Of these, several pregnant women presented in response to referrals from government agencies, food banks, and hospital social workers, and self-referral.

They were often presenting due to precarious living arrangements through limited financial resources, a lack of understanding of how the prenatal health system operates, lack of agency in advocating for their needs through various service systems in health and community services. Fearful of being reported at the time of birth, cases are often managed to stabilise a housing situation with the concern that a baby, born to a mother in a hospital emergency ward, may not be released into the care of the mother post-birth due to uncertainty around housing.

Sliding Door Moments

The prenatal stage also provides for time in working with mum to address their social and immediate health and physical care needs. This is a critical stage of development and wellbeing, including the impact of mental health issues, alcohol and other drug issues and prenatal pregnancy checks to ensure the soon-to-be mum is able to meet both the physical and emotional needs of her baby.

One such pregnant woman — Lea* — contacted the Society as her financial supports were impacted as a result of COVID lockdowns, and her cash in hand job had come to an end due to the physical nature of the work and the risks to her health in continuing. In working with Lea (34 weeks pregnant), it was soon revealed that due to her visa status, she had limited access to medical and health supports and, in trying to save for the birth, was now sleeping on a mattress in a shared one-bedroom flat with a couple who made the offer to her when they had heard through friends of her situation.

Often, pregnant women like Lea are trying to navigate the system with misinformation of what health and community services they may qualify for or are able to access, and where appropriate supports may be available.

And then there are women like Simone*, in the late stages of pregnancy, with lived experience of out-of-home care placements. Young pregnant women are familiar with the system, highly suspicious

of services, and wanting to avoid at all costs any involvement in the system and services, will go to great lengths to avoid being in contact with services and supports for concerns — perceived or real — that they risk being involved with Child Protection following the birth of their child.

At 37 weeks pregnant, Simone attended Centrelink due to a mix-up in her income support, Centrelink staff were able to ascertain that Simone's situation was more than a mix-up on payments. While couch surfing, having had to leave her family of origin due to violence, Simone had never sought out or received antenatal check-ups.

We often refer to these cases as a sliding door moment. The reputation of the Society's specialisation in the first 1,000 days is well known and held in high regard as a service available regardless of referral pathways and in the efforts we make to find the right, timely and responsive supports necessary for mother and her baby.

It's this same reputation that works when a social worker who knows of our work contacts a practitioner to connect with and to figure out a plan going forward. It's the contact that means a doula package, a practitioner, clothing packs and baby essential items along with family reunification work are mobilised to ensure the safe delivery of a baby; along with the efforts in supporting mum in her transition into parenting, and building her capacity for meeting the social and emotional wellbeing and developmental needs of her infant. It is the work of practitioners to gather the right supports on walking into situations revealing the precarious living arrangements that place both mother and baby at risk of further exploitation and harm; and we know that, if we can reach a pregnant woman sooner in her pregnancy, that housing supports and wrap around approach can deliver better outcomes for both mother and baby.

Upholding the Dignity of Motherhood

The case for early intervention at such a critical stage during pregnancy cannot be overstated as the science and social research confirms the importance of the first 1,000 days and the need to intervene sooner to maximise the time in meeting the developmental needs of soon to be born baby.

Ensuring a pregnant woman is provided with greater coordination in the service system — across health and community — is designed to be responsive to the overall social, emotional and economic wellbeing for mothers and their babies.

There remains a desperate need for a response in the western suburbs of Melbourne for pregnant women and their new-born babies. They are relying on our advocacy to mobilise community, business and government partnerships to deliver a much-needed prevention and early intervention approach designed to meet the ever-growing need for support of the social, wellbeing, developmental and economic outcomes of women and children.

* Lea and Simone – not their real names

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Sixteen Years Old and Pregnant, No Secure Family and Facing Homelessness

Curated by Susanne Wells, State Manager, Youth Services East
from input provided by the teams at the St John of God Social Outreach
Young Mother and Baby Program in Victoria and Western Australia*

Introduction

The title of this article, although confronting, is something that we are hearing more often in our services. Young women who are pregnant encounter many barriers when faced with homelessness. Many come from households where there was overcrowding, violence or substance use. The opportunity to develop key life skills such as budgeting, cooking and even cleaning may not have been role modelled to them. Their peer relationships are still evolving, and pregnancy puts them on a very different path to many of their supports.

They have very little agency in creating a safe and secure home. This is further complicated by the difficulties in accessing access the housing market; young people are often unable to secure rental properties due to their age and lack of rental history.

Young mums should be excited about bringing a new baby into the world however, when faced with homelessness and limited resources and opportunities, that experience can become fraught with anxiety and fear.

The Young Mother and Baby Program

The Young Mother Baby Program (YMBP) at St John of God Social Outreach's Horizon House provides stable accommodation and individualised support to young mothers aged 16 to 22 who are experiencing, or at risk of, homelessness.

Young women are able to access support during their pregnancy and into their motherhood journey, with professional workers delivering support and case management to enable the young mother's move towards independent living. There is a focus on individual goals in the areas of:

- independent living skills
- parent education and skills development
- social, emotional and physical health
- access to education, training, employment
- social connectedness, relationships and community links.

The YMBP operates under the Horizon House model of residential support, which allows young people to move between support tiers according to their individual needs. Young mothers can stay for 12 months in each tier, with the goal of moving through the tiers to ultimately live independently.

Tier 1: Accommodation and intensive support with residential staff.

Tier 2: Transitional accommodation (non-staffed) and case management support.

Tier 3: Outreach support for young women living independently within their communities.

The YMBP is a self-directed program committed to hearing the voices of the young women who participate. There is a focus on building young women's capacity to make decisions and they actively contribute to all areas of case planning and the identification of areas for their own growth and development. Young mothers meet weekly at a house meeting to plan meals, housework, decide on engagement activities, discuss any issues regarding the house and are invited to give feedback on the program.

The YMBP provides safe and secure accommodation for young mothers and uses an innovative and integrated trauma-informed model of care. This model was developed specifically to guide work within the Horizon House programs, drawing on an understanding of trauma-informed care while providing parenting education and advocacy to empower young mothers to actively engage in a range of relevant services and activities in their community.

Nationally, the YMBP has the capacity to support 30 young

mothers and their babies across the three tiers at any given time in Victoria and Western Australia. The program does not receive government funding in either state and is supported by St John of God Health Care.

YMBP works closely with services who provide specialist mental health support from pregnancy into early parenthood, as well as the Centre for Non-Violence in Bendigo. These partnerships have seen many benefits for young mothers, with a strong focus on building parenting capacity, understanding family violence, and promoting safe relationships, along with addressing any mental health challenges the young mothers may be managing.

The Realities of Homelessness

Case Study 1: Katie — Western Australia

Katie is a 16-year-old from a culturally and linguistically diverse background who lived in extremely overcrowded accommodation due to the current housing climate. After discovering she was pregnant, she was forced out of the family home due to her family's view on teen pregnancy. Subsequent periods of homelessness and a succession of unstable living environments contributed to increased stress during Katie's pregnancy, resulting in reduced engagement at school and with social supports.

When she entered the Young Mother and Baby Program at St John of God Horizon House, Katie required help with all aspects of motherhood, but with increased stability, reduced stress and effective modelling by staff, developed a healthy connection with her baby and greater parenting capacity. Her baby now continues to thrive, hitting developmental milestones, while Katie has grown more confident in her ability to parent and live independently.

Despite the support of the program, Katie still faces the issue of housing affordability and accessibility, meaning there is a real risk that she and her baby will be unable to secure long-term housing beyond the current program, or any other programs she can be referred to. This barrier could lead to Katie having to return to overcrowded or unstable housing

conditions. Social and public housing waitlists are very long (as are those specifically for young mums) and current private rentals are often not affordable for young mothers with limited capacity to earn income.

Case Study 2: Sarah — regional Victoria

Sarah is 20-year-old Aboriginal woman who has been couch surfing due to limited family supports and the risk of family violence, and her partner was incarcerated during her pregnancy, leading to further isolation. Homelessness, her partner's absence and unstable living environments all contributed to increased stress during her pregnancy, leading to panic attacks and health anxiety.

As the state's Child Protection Service requires all children to have safe and stable accommodation to be part of pre-birth planning, they became involved due to Sarah's homeless status. Sarah took to motherhood quite naturally and navigated the involvement of Child Protection with confidence. However, she would not have had the opportunity without the provision of stable accommodation through the Horizon House Young Mother and Baby Program.

Despite this, Sarah's most pressing ongoing issue relates to housing accessibility and an inability to secure long-term accommodation beyond the current program. There is also a lack of programs that provide accommodation for the family unit, meaning she may return to unstable housing conditions when her partner is released from prison.

Young Women's Reflections

Refection 1

My time at the Young Mother and Baby Program and how it has changed my life forever.

Before I was lucky enough to be accepted into the YMBP I was homeless, five months pregnant and going from bed to bed, often unsure of where I was going to sleep. I was at my wits' end; my body was completely exhausted and at times I was sleeping on the train just to get some rest. My whole life fit into a suitcase, and I was carting it around from town to town. I was trying my hardest to be strong, when the baby program called to tell me I had been accepted into the YMBP. I remember crying for an hour because I finally had a home. I had somewhere I could feel secure.

The YMBP house has taught me so many things; my cooking skills weren't very good before I moved in and since then my cooking and baking is nothing less than amazing. I always knew I would be a good mother but thanks to the YMBP I am an exceptional mother. The YMBP took me to all my maternity appointments and gave me so much support, all of the classes I've taken at YMBP have helped me to understand my daughter and understand myself as a mother. Thanks to them I am a patient, caring and loving mother.

After I had my daughter, I had quite a few complications and because I was too tired, I ignored them. If it wasn't for Linda (Horizon House Case Manager) pushing me to see a doctor and trying her very best to support me to do so, I would have got a lot sicker than I did.

Every single night for months a caregiver would sit with me while I breastfed my daughter because I often got so tired that I fell asleep with my daughter in my arms. Every single time I doubted myself, YMBP was there to lift me back up. They supported me every step of the way. I don't know where I would be without them. I have learnt not only living skills, but I have learnt life skills that I will use to continue to move on in life. A couple of weeks after I had my daughter, my post-natal depression and anxiety got really bad. It made me feel like a bad Mum. But YMBP were always there, supporting me in counselling appointments — they were there every morning to make sure I took my tablets — they were always there.

Now I am living independently, I have reached my goal. I have had times that I struggle, but I know I am not alone, and I still have YMBP supporting me. I have no family here in Bendigo and the caregivers at YMBP are the closest thing I have to a family. The YMBP has made me strong. They have made me kind and patient and more understanding. They have made me a great mother, a good friend, and most of all, a strong independent woman. There will never be enough words to explain just how grateful I am for all YMBP has done and continues to do for me.

Refection 2

What was your life like before you came to YMBP?

I was living at my parent's house when I found out that I was pregnant. I later realised it was too overcrowded and that I had family that wouldn't approve of me being pregnant at a young age. So, I had to leave.

What's it like not having a safe place to live when you are pregnant?

It's difficult not having a safe space to live. It made me have anxiety attacks and I couldn't really reveal that I was pregnant to my family or anyone, because I didn't know how they would react.

Why did you want to come to YMBP?

I was referred to YMBP from a refuge. I heard they offered a lot of support, so I had to come try it out. I'm glad I did because it makes me feel a lot safer.

What was it like for you when you first had your baby?

It was scary, because I didn't know what I was gonna do — having a baby at a young age and especially if I had to live with family — I was worried and scared of not being stable.

What is it like for you to be a Mum now?

I love being a mum because it makes you feel complete and loved. I never really had this bond that I have with my baby, with my own mum. But it's still scary first time.

What has been good and what has been bad about YMBP?

What has been good about this program is that I get a lot of support and the staff here have my back and this place feels like home. The bad is there has been some staff that have left and that is sad.

Is there anything else you'd like to add?

More young Mums need to come here.

* This article was a joint effort from the teams at the St John of God Social Outreach Young Mother and Baby Program in Victoria and Western Australia. For further information please contact Susanne Wells, State Manager Youth Services East

Shifting the Narrative to Prevention: Supporting Mothers who are Pregnant, Homeless and with Intersecting Needs

Lisa Abbott, Executive Manager, Social Impact and Growth, TaskForce

Since 1973 TaskForce has been providing specialist support for people in serious need in Victoria. The people who access our services have experienced significant disadvantage or a crisis in their lives and as a result are prevented from reaching their potential. Our core services focus on addressing social issues of alcohol and other drug dependence, unemployment, youth disengagement, and high risk-taking behaviours, supporting our clients to transition back into 'mainstream' services and supports. In addition to our core services, we work in partnership to develop collaborative and innovative projects to meet the needs of those who have intersecting needs and fall through the gaps of existing services.

In 2019, Jessie* found herself pregnant, homeless and parenting a toddler. Despite a life of complex challenges, including the impact of intergenerational poverty and homelessness, Jessie was making every effort to provide the best life for her daughter and unborn child. After a violent incident involving family, Jessie lost her accommodation, finding herself homeless. Due to not being able to provide a safe environment for her toddler, her child was removed from her care until she could source suitable accommodation.

Without a rental history, no familial support and no access to Centrelink due to her citizenship status, Jessie accessed local housing services who located a rooming house where she was able to share a room with her daughter, an environment neither suitable or safe for a young mother and child. Housed in a suburb away from her connections and with no specialist service support, Jessie found herself isolated, overwhelmed and struggling. By fortune alone, Jessie was connected to a passionate health professional through her antenatal care who went above and beyond to reconnect Jessie with specialist supports, place her toddler into childcare and advocate for suitable housing.

Despite the best efforts of the health professional the process was both fraught and delayed. Not being located in 'the right catchment' and not understanding the housing system delayed processes. However, after several months, Jessie finally secured stable housing and moved in with her toddler. Four weeks later she gave birth in the home. Three years on, Jessie remains in stable accommodation and is a proud mother to two thriving children. She remains engaged with specialist supports and feels connected to her local community.

I think back to Jessie and wonder how different the lives of her two children would be if she had not been connected with that one professional who went beyond the expectations of her role. I wonder where her two children would be and fear for what could have been their life trajectories if their mum was not able to secure stable housing. Our system should not depend on 'luck' as to who women get referred to and their capacity to advocate and 'work around' the system. Women and their children deserve the best of care, particularly if we are going to disrupt trajectories of intergenerational poverty and homelessness.

Barriers to accessing safe and stable housing for women is commonly cited as the most significant frustration for professionals from across sectors. In my experience as a worker, with many years caring for young and criminalised women, the system is broken. Our efforts are focused on manipulating system flaws to achieve sustainable outcomes. For our most vulnerable women and their babies, investing in and creating a safe and stable environment is essential to give the child the best start to life.

There is an increasing body of research pertaining to the importance of the first 1,000 days from conception. The *Strong Foundations: Getting it Right in the First 1,000 Days* research highlights the impact that a pregnant mother's physical and mental state can have on shaping their child's brain. It provides evidence that a mother who is homeless while pregnant would experience greater levels of stress and disadvantage and overall adversity, directly influencing their unborn child's development even before they were brought into the world.[1]

The influence of a mother's experiences on neurological development in children in utero is a relatively new field of research, however we only need to refer back to psychologist Abraham Maslow[2] who highlighted shelter and warmth as two of the most basic physiological needs for human survival. The failure to provide housing to pregnant women places them and their babies at greater risk of further lifelong health and social disadvantages.

While housing is the key element, women who present with intersecting needs often face additional barriers to accessing safe and secure accommodation. Alcohol and drug use, mental health and family violence all contribute to greater challenges for women who are pregnant and homeless. Despite the widely known research pertaining to the impact of these presenting

complexities on the future of the mother and their unborn child, there is a paucity of community support for women with intersecting needs in the earliest stages of pregnancy.

The gravity and urgency of the issue seems overwhelming. However, solutions can be found in innovation and collaboration already being driven in Victoria. It is not necessary to reinvent the wheel: models of care exist and are proven across the globe. While the Victorian Government drives the development of an early intervention framework and supports additional early learning, investment must be prioritised, in community settings, for pregnant women with multiple needs. Safe and stable housing is one element of care for consideration. However, wrap-around models of service support are essential to ensure that the baby and their mother have the best chance at a positive future and reduce the need for statutory and future service intervention in the child's life.

The University of Washington's Parent Child Assistance Program (P-CAP)[3] is a drug and alcohol abuse intervention for new and expectant mothers. Its primary aim is to help women obtain substance abuse treatment, stay in recovery, and address such complex problems as lack of housing, domestic violence, child custody, and other legal issues. In addition, the P-CAP intervention is designed to assure a safe home environment and regular health care for participants' children. While housing is still the missing piece, there are opportunities to enhance current housing models within Victoria and create opportunities for communities within these settings.

Working across systems is harder than it seems. Our system, from top down, is often siloed. Complex social problems require concerted effort and intervention, cross-sectoral collaboration at policy and practice level, adequate funding for collaborative models of care, and a few brave organisations to drive this work.

At TaskForce, we have seen the positive impacts when pregnant women are supported to address their intersecting needs and access antenatal supports. We have seen the benefits to women when support is provided at the earliest possible time, sustained throughout the pregnancy and co-ordinated with mother and baby at the centre.

While we need approaches across the continuum, providing community-based support at the earliest possible time to pregnant mothers with intersecting needs is an essential, yet rare, service. Children born into a stable environment, with a mother enriched by supports and capable of providing present and loving care, results in children who experience healthier lives, stronger relationships and better outcomes.

Endnotes

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Young Mothers Breaking Barriers at Ginda Barri

Freya Tola, Communications and Digital Specialist, Community Housing Limited

Pregnancy can have a transformative impact on life. Understandably so, with the introduction of a myriad of new things to consider: factors such as lifestyle and behavioural changes, additional costs and potential stress. For young adolescent women who become pregnant, there may also be an increased risk of poor health and wellbeing, reduced education and employment opportunities, social and gender discrimination, and stigma.

The latest New South Wales (NSW) Government District Data Profile report identified a significantly larger number of adolescent mothers giving birth in the Mid-North-Coast compared to the rest of the state.[1]

According to the report, in the Mid-North-Coast 4.4 per cent of all births were mothers aged 19 and under. That is more than double the NSW state average of 1.9 per cent.[2] Out of the six Local Government Areas (LGAs) in the Mid-North-Coast region, two — Nambucca and Kempsey — were identified as locations where mothers faced much greater hardships compared to other LGAs like Port Macquarie.[3] In Kempsey, this percentage was the highest with 11.5 per cent.[4] The report highlights the need for additional programs dedicated to providing support and aid to young mothers in the Mid-North-Coast, especially in the towns of Nambucca and Kempsey.

In 2015, South Kempsey-based school, Macleay Vocational College, established 'Naanggu Dhalayikurr Ginda Barri'. The program's name translates into English as 'Mother, Child, Happy Place' and is designed to assist young vulnerable mothers who are at risk of or experiencing homelessness to pursue and complete their education.

Ginda Barri, as it is more widely known, initially began as a two-day-a-week program where young mothers studied Community and Family studies. However, the positive response from the young mothers attending led to an expansion of the program.

The college now partners with several local organisations providing young mothers with increased access to resources such as food and transport. One of these partnerships is with Community Housing Limited (CHL), Australia's largest community housing provider, which delivers affordable, safe and secure housing to low to moderate income households. The work relationship formed in 2018 as part of another initiative but would eventually grow and strengthen into what it is today.

Together, they provide young mothers at Ginda Barri with increased access to affordable housing. The college oversees the education and support services while CHL provides affordable housing and oversees tenancy and property management.

Macleay Vocational College Principal Ryan said, *'Ginda Barri provides such a unique and vital service to the young mums of Kempsey. In essence, it removes the stigma of being a young mum and allows them to stay engaged in education and access the services they need to ensure*

their child thrives. Our young mums can still set aspirational goals for themselves and with the support of the College, go after them knowing their child is being well cared for. Now with the support of CHL, we can offer safe and secure accommodation close to school and remove a number of barriers that may have made school "a bridge too far".'

Ginda Barri Developer and Facilitator Sue Seager said, *'It's not just about the girls getting their HSC. It is a holistic program in identifying the barriers to finishing their education, gaining employment, securing housing. Housing is a huge one. You cannot commit to study, getting a job, trying to mind a child while you are homeless.'*

In July 2021, a $5.5 million NSW Government investment in social housing provided the young mothers at Ginda Barri with the opportunity to pursue and complete their education without the stress of trying to find housing in an extremely tight market with low vacancy rates.

CHL has built and is managing a new 22-unit housing development located across the road from the school. At a minimum, six of these units have been designated to the young mothers in the Ginda Barri program with the option to offer more if required. Each unit is an open plan two-bedroom, two-bathroom home with a courtyard. The homes are around the corner from the Kempsey Primary School and close to amenities with the Kempsey CBD only a 10-minute drive away.

CHL NSW State Manager Megan Davidson said the partnership combined essential housing and support services that allowed young mothers to get back on their feet and work towards a brighter future for their families.

'CHL is very proud to be part of this unique and successful program that delivers the essential ingredients needed to get ahead in life. The young mothers have a range of support services to assist with the education and parenting aspects of life and CHL provides the stable and affordable housing. We know that without the safety and security of a home it is impossible to focus on other aspects of life like education and employment.'

The provision of both housing and onsite support services for the young mothers at Ginda Barri is what makes it successful according to Sue Seager.

'Our program is unique in that we help enable and encourage the girls. We do this one stop shop approach. We bring everything here,' said Sue.

Ginda Barri staff pick up and drop off students, provide healthy foods, and bring Registered Training Organisations on-site to allow the young mothers to concentrate on their studies. This removes the barriers of traveling to a TAFE college and organising childcare.

For Sue, a key principle for anyone working in the community sector is: *'Don't mould your clients to fit the needs of the funding or what your organisation is about; you must make the service fit the needs of your client base'*.

Endnotes

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A Conversation on the Margin: The Living Free Project

Megan Conway, Team Leader, Living Free Project

'My name's Bethany, I'm 28 and live with my two-year-old son Jaxon*.*

Before getting the amazing support from Taskforce and SalvoCare Frankston my situation was very different. I struggled with homelessness for a few years, living in my car and couch surfing at times, didn't have much support around me at all and also was in a negative relationship, I can thankfully say I have my beautiful son Jaxon though, through it all.

About a year or so after applying for housing I had the support from my worker from SalvoCare who after a long wait found me and Jaxon transitional housing. We have been living in our unit in Frankston for nine months now.

Whilst previously living in my car I had no licence at one stage and got pulled over by the police several times, resulting in having to go to court. Thankfully I had my Living Free Outreach worker and the team at TaskForce to support me with my court issues to start with and now to provide ongoing support for myself and Jaxon, from counselling, parenting tips, food and products to live for me and my son and also full time work! All thanks to my Living Free worker, if it wasn't for her help I wouldn't be able to stand proudly today, she's helped me get back on my two feet and helped me find myself mentally! They are a great network for support and I would recommend them to anyone who is struggling hard.'

* Names have been changed for client privacy

The Living Free Project, with TaskForce Community Agency, is funded by Victorian Legal Services Board Grants Program, Ian Potter Foundation and Gandel Philanthropy.
The Living Free Project is a targeted integrated response to vulnerable young females aged 10 to 17 years who have been reported missing and women 18 to 30 years in contact with the justice system.

Through a multi-component model, the project provides service delivery via assertive outreach and supported care co-ordination that is strengthened by project co-ordination that focuses on referral pathways, capacity building and systemic advocacy. With the overall objective to address the dynamic risk factors presenting for vulnerable girls and women, the project works to break the trajectory that often sees them entrenched in the justice system as adults.

When we first receive a referral of our women 'on paper' and see their pending legal issues, they can sometimes look the same. Driving or drug charges. Services involved. Child Protection. Complex co-occurring issues? Mental health issues. Substance dependency. Family violence. Trauma history. It's a familiar profile. As a clinician working in youth work and drug and alcohol counselling for the past 16 years, it can become normalised when we hear similar stories. However, every single woman I have then met, and had the privilege to hear their own story and walk alongside them in their journey to make and sustain change in what can sometimes be a very uphill battle, has reflected a broken system and how origins beyond their control set a trajectory, sometimes almost too narrow to alter. Each familiar story should then echo and reflect our need as a society to bring change to systems.

One young woman I have had the privilege of supporting is 28-year-old Beth, who has articulated her experience through the justice system, brought about by charges from living in her car while homeless and pregnant.

One clear point that resonated with me during our reflective conversation on this topic was Beth's seemingly simple solution: if those vulnerable were listened to instead of punished maybe we would have our solution. Are people listening? Seemingly not the ones that should be. Beth's point was the two-year period of time that she was homeless and actively seeking help she felt like she was unheard. If we let people like Beth lead the conversation, perhaps we have a better chance of finding answers.

Each system seemed to compound the challenges Beth faced. The starting point was that, due to family of origin disadvantage, school was hard and growing up felt like it was 'us versus them', those in a position of vulnerability versus those in privilege. Experiencing or witnessing violence at a young age became a normalised environment leading to value systems that continued to leave her in similar relationships in young adulthood. *'Whatever stopped you from seeking help or support?' 'I didn't know it was out there'*, or hesitancy to ask for reasons of shame, embarrassment or fear of consequences. *'I was scared Child Protection would think I was not a fit mother, and potentially take my child away.'*

Beth fell pregnant while living in her car with her partner. Beth said it was a constant stress of finding money to buy petrol and places to park at beaches or camping spots, while seeking help and avoiding being that noticeable. When she gave birth in hospital, and states that she did

explain she was being discharged to homelessness, there was no support on offer. Beth, recovering from a caesarian section, and her newborn baby couch-surfed briefly, as her partner had then been sentenced for outstanding charges and was now in prison.

With mental health issues unaddressed, Beth asks, *'but who do you tell?'* when there is an entrenched family history of mental ill-health and of learning how to cope with symptoms by substance use. Drug and alcohol use *'was what I saw'*. Substance use becomes the adaptation to the cage within which many people live. Becoming sober won't guarantee security, safety and an escape from the realities of this life. Instead, it is connection. It is connection to oneself, to family, and to community.

Homeless and pregnant, living in her car, Beth was unlicensed during periods of time and unlucky enough to be pulled over. Cue charges on driving and possession of substances. Alcohol and other drugs (AOD), mental health and homelessness have been the factors that led her to the justice system: these are not exactly the criminogenic factors of individuals who should be taking up the resources and time of the justice system. Thankfully with her tenacity to seek help and support and demand for her voice to be heard this is where we met. Beth describes needing someone who would listen, someone who she could trust and would trust in her. A support she could be open and vulnerable with, who maybe could share her potential, viewpoint and life view ahead of her.

Working together we made a (treatment) plan with a focus on relapse prevention and AOD psychotherapeutic counselling, and support and advocacy in meeting conditions and requirements for her pending court matters and 'reducing the risk of reoffending'. Beth's risk of reoffending became irrelevant once she had secured safe and stable housing.

Living Free is lucky to be flexible enough to offer and provide that wrap-around model of care, to ensure that all avenues of health and wellbeing could be addressed

if needed. Beth was linked with a GP and funded for the out-of-pocket expenses for a psychiatric assessment for medication review and management. With housing and mental health stable and supported, Beth no longer needed AOD to cope and worked to reduce her use to non-use eventually.

Living Free supported Beth to update her resume and attend interviews through TaskForce Education Hub to return to the workforce. Following a successful interview, we could fund a trade uniform which she needed. Beth then proudly began her new job with a static and digital display manufacturer.

The best call was on a Friday afternoon when Beth called to say she had resolved all pending charges and had received a fine and would have no conviction recorded. Beth said *'now that I have been given half a chance, they* [justice system] *will never see or hear from me again.'*

Sometimes the barriers are as simple as provision of material aid, phone credit and travel cards, while others will be more complex. What's needed is advocacy with services and systems, guiding and walking alongside women. Other identified areas of support for Beth were being a consistent person, always listening and being guided by where she wanted to go in her life, not the value systems of others telling her how her life should look like.

Homelessness in Pregnancy: The Fetal Experience

Anna C Tottman FRACP, PhD, Specialist Neonatologist, Royal Women's Hospital and Women's Alcohol and Drug Service

Pregnant women who are homeless experience food insecurity, inadequate nutrition, poor dentition, violence, alcohol and illicit substance use, mental illness and difficulty accessing health care at higher rates than the housed population. Her fetus is not merely a passive observer to these adverse maternal experiences — rather, the fetus also experiences the maternal environment via the placenta and maternal hormonal signaling. These experiences allow for adaptation of the developmental trajectory of the fetus such that it can prepare itself to best fit the environment into which it anticipates being born. From the moment of conception to the child's second birthday, the first 1,000 days of human development represents the most rapid period of growth and maturation within the human life course, and a period exquisitely sensitive to external influences. As described in the hypothesis of developmental origins of health and disease, fetal and childhood experiences during these first 1,000 days may shape wellbeing into adulthood and beyond; egg development within the fetal ovary means that a pregnant mother also impacts the development of her grandchildren.

Babies born to women who are homeless are more likely to be born preterm (less than 37 weeks of a normal 40-week pregnancy) and more likely to be low birth weight (under 2.5 kg) than babies of housed mothers.[1] Being born preterm is an independent risk factor for a number of life-long developmental challenges, such as lower intelligence, movement difficulties, problems with hearing and sight, and at worst death or severe disability creating significant detriment to a child's quality of life. These risks increase with shortening duration of pregnancy.[2] Low birth weight confers further risk to the developing child, as fetuses whose growth has been restricted adapt to an inadequate placental nutrient supply, adaptations which after birth may put them at increased risk of adult-onset metabolic conditions such as obesity and type two diabetes.[3] Inheritance of obesity is not only mediated by the maternal nutritional environment; maternal stress, depression and socioeconomic disadvantage may also contribute via alterations in maternal stress hormone concentrations which change the development of fat deposits and insulin resistance in the exposed fetus.

The late impacts of increased maternal stress are demonstrated in both animal models and a small human study, which revealed that young adults born to mothers suffering a major stressful life event during pregnancy had higher body fat percentages, altered lipid profiles and worsened glucose tolerance compared to young adults born at similar weights and gestations whose mothers had not suffered significant stress in pregnancy.[4]

After birth, mothers continue to influence the developmental trajectory of their children via lactation and the act of breastfeeding. Breastmilk provides not only a source of personalised nutrition, but exposes the baby to hormones, immune complexes and beneficial bacteria. In high-risk infants, breastfeeding has been shown to induce alterations in gene expression (epigenetic changes) which may buffer babies from the adverse developmental impacts of high stress fetal environments.[5] Breastfeeding also protects babies from sudden death in infancy.[6] Unfortunately, babies of homeless mothers are less likely to be breast fed or to receive maternal breastmilk for many reasons, including lack of support to establish milk supply, separation of mother and baby for medical or protective reasons, and the risks of neurotoxin transmission via breastmilk contaminated with illicit substances such as methamphetamines.

Thus, the adverse experiences of homeless mothers shape the fetus to prepare them for entry into a

hostile, stressful world. Although these preparations may improve short-term survival, in the long-term they are associated with an increase in the risks of metabolic disease, obesity, addiction, poor cognitive function and mental illness.[7] But the first 1,000 days of the human life course marks an opportunity to intervene and mitigate the intergenerational effects of maternal trauma and disadvantage.

For high-risk women, timely access to antenatal care lengthens duration of pregnancy and is protective against preterm birth. Safety from violence reduces the direct risk of trauma to the fetus and the indirect risk of high maternal stress levels. A balanced maternal diet with a secure supply of both micro-and macro-nutrients supports adequate placental nutrition and normal fetal growth and development. And after birth, the act of mothering and the formation of strong, loving attachments between mother and child may be protective for both in terms of long term physical and mental health.[8]

Policies that support the mother–baby dyad can have important effects on children's neurodevelopmental outcome, as shown in a large, randomised control trial performed in low-income families, where a poverty reduction intervention starting at birth was associated with protective changes in children's brain activity at 1 year of age.[9] The first 1,000 days represents a real opportunity for positive change in the lives of homeless mothers and their children.

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An Inevitable Collaboration? Working Together to Support Pregnant Women Experiencing Homelessness and Alcohol and Other Drug Related Harm

Rose McCrohan, Manager Curran Place Mother and Baby Residential Withdrawal Service, Uniting Vic.Tas, Kerri Felemonow, Manager, Women's Alcohol and Drug Service, The Royal Women's Hospital, Sally Coutts, Manager Cornelia Program, The Royal Women's Hospital

'There's no stability. I hadn't really had [any] *stability my whole life. I had nothing. No structure, no security, no nothing'*

— patient from The Women's Alcohol and Drug Service

Pregnant women at the intersection of homelessness and alcohol and other drug-related dependency and harm are among some of the most disadvantaged in our community. They face stigma, discrimination and significant barriers to accessing appropriate pregnancy and postnatal health care for themselves and their infant.

Homelessness is often only one issue affecting pregnant women experiencing alcohol and other drug (AOD) harm. Many have past and/or current experiences of family violence, trauma and co-occurring mental health issues. The complex ways in which these issues intersect, amplify and influence the trajectory of a woman's path to safe and secure housing and her journey towards recovery from AOD use is not straightforward.

It is for these reasons that the Women's Alcohol and Drug Service (WADS) at the Royal Women's Hospital came together with Uniting Alcohol and Other Drug Services (Uniting) and the Cornelia Program to find better ways of working. WADS and Uniting have for many years held the view that better collaboration and integration can improve access to treatment options and outcomes for pregnant women using substances and their babies. This article discusses how services from separate organisations can work cooperatively to support at risk women, recognising that there are distinct gendered drivers of both AOD use and homelessness.

The Women's Alcohol and Drug Service

WADS was established in the late 1980s due to a growing demand for specialist services for AOD dependent maternity patients. The WADS program is the only state-wide AOD service providing specialist clinical services and professional support for pregnant women with complex substance dependence and psychosocial issues. WADS comprises a multidisciplinary team situated within the Social Model of Health Division at the Royal Women's Hospital, recognising the cycle of disadvantage that many women experience and the range of health and wellbeing issues that need to be addressed. As part of routine obstetric care women also access addiction medicine, social work, psychiatry, pharmaceutical, dietetics, physiotherapy, paediatric, lactation and legal assistance, an education coordinator and outreach social worker.

Lack of affordable housing and homelessness are significant social issues that impact the women we work with, impeding their recovery. Many patients live in poverty and have cycled in and out of homelessness, experiencing unstable family relationships and exposure to violence both before and after becoming pregnant. Women are acutely aware these issues impact on their AOD recovery, and sometimes perpetuate continued AOD use whilst a woman is pregnant.

WADS patients, like many women affected by AOD, report that their AOD use directly relates to managing stressful life experiences and past traumas such as sexual assault and abuse, family violence and being placed in out-of-home care as a child.

The fact that so many of these patients have experienced gendered violence and structural barriers requires models of care that are trauma-informed and women-centred to build on the existing strength and resilience of these women. Historically though, there have been very few services in Victoria that offer this type of specialist support. Our partnership with Uniting Vic.Tas's Curran Place Adult and Mother Baby Withdrawal Service is one such partnership that fills a service system gap.

Uniting's Curran Place Adult and Mother Baby Residential Withdrawal Service (Curran Place)

In October 2016, Uniting Vic. Tas, funded by the Victorian Department of Human Services, added a four-bed purpose-built wing to its existing 12 bed AOD withdrawal facility. Designed by architects in collaboration with AOD clinicians, it is the first of its kind in Victoria, specifically designed to cater to the needs of mothers and their newborn babies.

Parenthood, and birth of a new child, can be a prime motivator for ceasing or reducing AOD use. For many, withdrawal can be an important early step in an AOD treatment plan and a starting point for longer term behaviour change.

Curran Place allows a mother to complete a withdrawal from AOD and remain together with her infant (up to 12 months of age or walking stage). Many women access the service during pregnancy or in early days post-delivery and many are referred to us from WADS and the Cornelia Program as part of a longer-term plan to address a woman's substance use and find safe and stable housing.

Some of the women we work with have multiple admissions throughout their pregnancy and into the early months after birth. The majority have complex substance use, mental health and housing issues. Many also have contact with the criminal justice system, previous children in out-of-home care, current family violence and other factors that bring them to the attention of child protection services, as well as partners currently on remand or in custody. These women require long-term, wrap-around support that can address the multiplicity of health and social needs.

On arrival at Curran Place, childcare workers, a family worker, nurses and AOD staff facilitate more independent parenting as the mother commences full time care of her infant for the first time since birth. A mother will also use this time to bond and form a strong attachment with her baby while addressing her AOD use.

When we opened the service in 2016, we did not anticipate the number of women who would be facing imminent homelessness at the point they were seeking AOD treatment from us. Family violence often means they have been brought to the attention of Child Protection and the ongoing violence in the home places them at risk of losing care of their newborn child. Finding appropriate pathways into stable and safe accommodation has been one of the major challenges for our service over the past five years.

It is through the relationships with specialist services like WADS and Cornelia that admission to Curran Place becomes a stage in the journey of recovery, reducing substance use and supporting long term goals of mother and infant remaining together.

The Cornelia Program (Cornelia)

The Cornelia Program is a collaboration between The Women's, HousingFirst and Launch Housing with each organisation working together to provide housing and wrap-around support to pregnant women and new mothers who are homeless. The program opened in August 2021 with the first intake of women and babies. Since then, over 40 women and their babies have participated in the program. Referrals come through the Women's Hospital from WADS and the Social work team and a range of community services.

Pregnancy and birth are often moments when women are actively motivated to make positive changes to break the cycle of homelessness. Cornelia provides these women with stable housing with wrap-around support for a period up to 12 months to improve the health and wellbeing of these women and babies and change the trajectory of their lives. Its role is to engage with a woman and help her address the circumstances that may have contributed to her homelessness.

Substance use is one aspect of a woman's care that she will continue to be supported with in the community. Staff regularly review with a woman where she is on her path to recovery and will provide care coordination throughout the duration of her tenancy. This includes liaising with a range of specialist AOD supports within the community and the hospital as part of her antenatal care. The midwife is also able to provide support to the women throughout their pregnancies and then six weeks postnatally, facilitating birth education sessions, breast feeding support and postnatal in the home care. The ability to seamlessly refer a woman to Curran Place either before, or after the birth of her baby has enabled a positive outcome for several women and their babies by keeping them together and improving the health and wellbeing of both mum and baby.

Importantly, accessing Curran Place whilst participating in the Cornelia Program does not jeopardise a woman's tenancy. The positive relationship with our housing partners enables a woman to negotiate having her rent reduced whilst she pursues AOD treatment and support. This allows her to return to a stable and supportive base to continue addressing her substance use and develop proactive strategies for recovery.

There have been a number of women who have transitioned to permanent housing — or been reunited with children where this had not been previously possible. Cornelia staff stay engaged until women have moved to their new housing and are linked with the relevant community supports. There has also been a small number of women where the child has not been able to stay in their care. In these cases, the program provides continued care which includes ongoing support and referral to address any substance dependence. Women can stay in the program for the duration of their 12-month tenancy and continue engaging with program support staff to improve their chances of reunifying with their child and breaking the cycle of homelessness.

It is in the coming together that we can provide a better service to women and their infants. And in doing this we can hope to support women to break the cycle of homelessness, harmful substance use, and family violence that affects so many of the families we work alongside.

Pregnancy and Postnatal Services Key to Reaching Women at Risk of Violence and Homelessness: The Eastern Community Legal Centre's Family Violence Programs

Marika Manioudakis, Director, Family Violence Initiatives, Eastern Community Legal Centre,
Megan Ross, Principal Lawyer, Family Violence Initiatives, Eastern Community Legal Centre,
Daniel Scoullar, Director, Social Change Projects

During an ordinary visit with a maternal child health nurse, Maria* was asked about how things were going at home since the birth of her six-month-old daughter.

Over the course of the conversation, Maria revealed how her husband's aggressive behaviour had worsened to the point where she was often frightened for her daughter and herself. His outbursts of anger were more frequent and often triggered by issues relating to housekeeping and normal infant behaviour such as crying or waking in the night.

This behaviour included monitoring and controlling her behaviour and interactions with friends, family members and others. As a result, Maria was unable to seek advice from family violence or community legal services without putting herself in danger.

Fortunately, this maternal child health (MCH) service was part of an innovative partnership with Eastern Community Legal Centre, Boorndawan Willam Aboriginal Healing Service and three local councils to help identify and support women and children experiencing violence.

At Maria's next MCH appointment, time was put aside for her to speak to a community lawyer and a family violence advocate to better understand her situation. They gave Maria the information and tools she needed to decide what was best for her and her daughter.

This was all done at the same time and in the same location as her regular MCH appointment, where her baby's measurements, health and development progress were checked.

Over time, Maria disclosed the full extent of the violence at home. Working with the community lawyer and the family violence advocate, she developed a safety plan and considered various legal options such as reporting the violence to the police and obtaining a Family Violence Intervention Order, which she later chose to do.

Without this integrated service working through a universal health service, Maria and her baby would have endured more violence. It is unlikely she would have been able to access support without increasing the risk of harm to herself and her daughter.

This program, knowns as Mabels, is one of Eastern Community Legal Centre's innovative partnerships with mainstream health and community services.

Family Violence: The Leading Cause of Homelessness for Women and Children

Family violence remains the leading reason why women and children become homeless in Australia. In 2017–18, 42 per cent of all people presenting at Specialist Homelessness Services reported they were escaping violence. One in six of these people were aged nine and under.[1]

Many groups at the highest risk of homelessness also experience high rates of family violence. This includes:

- Aboriginal and Torres Strait Islander women
- young women
- pregnant women
- women with disability
- women experiencing mental health issues
- women leaving a relationship
- women experiencing financial hardship.

It is a common experience for homelessness services to see people presenting with an urgent need for housing as well as an experience of family violence.

Coercive control is also a common feature of family violence, which can include controlling money and shared property. Women in this situation may not have an independent rental history, access to financial resources or the ability to bring possessions with them. Some have debt, fines or legal issues caused by their former partners.

Women are also at significant risk of homelessness in circumstances where they have been misidentified by police as the perpetrator of family violence. It is not uncommon in such situations for police to apply for a Family Safety Notice against the woman, including the children as protected persons and excluding her from the home.

Women with insecure migration status experience additional challenges accessing housing and financial support due to eligibility requirements for social housing and income support payments.

The impact of family violence on children is significant. Children experiencing homelessness have increased adverse effects on their health, wellbeing, education, relationships and community connectedness. According to Australia's National Research Organisation for Women's Safety

(ANROWS), more than two-thirds (68 per cent) of mothers had children in their care when they experienced violence from their partner.

Alarmingly, pregnancy and the early stages of parenting are one of the most dangerous times for a woman experiencing family violence, with the statistics showing that:

- one in 12 women hospitalised for partner violence are pregnant[2]
- family violence is associated with increased rates of miscarriage, low birth weight, premature birth, fetal injury and fetal death[3]
- more than one in four mothers experience family violence in the first four years after having their first child[4]
- 50 per cent of women with children in their care experiencing violence report that their children have seen or heard violent incidents[5]
- children of mothers experiencing family violence in the first year postpartum are more likely to have emotional and behavioural difficulties by the age of four.[6]

Homelessness or insecure housing can lead to women losing primary care of their children, including to the perpetrator of family violence. Women can be deemed to be failing to provide a safe or suitable environment for their children in those circumstances, despite fleeing the home due to safety risks created by the other parent's use of violence.

Legal and psychosocial assistance at an early stage is crucial to ensuring women facing these circumstances are aware of their rights and the options available to them, including by ensuring courts are appropriately appraised of the family violence and consequent impacts experienced.

Although pregnancy and the early stages of parenting are one of the most dangerous times, it is also a time that women and children are engaged with health services, and when health practitioners are being required to routinely screen for family violence. It is through effective partnerships

with health services at this critical time that Eastern Community Legal Centre has been able to provide an early intervention legal response to women and children experiencing family violence.

WELS: Supporting Women Through Pregnancy

Eastern Health and Eastern Community Legal Centre have collaborated to develop WELS (Women Engaging and Living Safely). WELS is an innovative partnership that responds to the needs of women attending maternity services in the eastern suburbs of Melbourne.

As part of antenatal services, health practitioners routinely screen for family violence, enabling them to identify women and children who may be at risk. WELS integrates community lawyers within the health service to ensure that health care professionals are supported and provided the resources to better respond to disclosures of family violence.

It provides pregnant women with the option to engage in safe, easily accessible family violence legal support alongside their antenatal healthcare appointments.

The WELS model shares important features with Eastern Community Legal Centre's other integrated family violence programs, providing access to a community lawyer, family violence advocate and, where appropriate, a financial counsellor. WELS also screens for women at risk of homelessness and works through housing partnerships as needed.

WELS provides the following legal and psychosocial assistance:

- risk assessment, safety planning and options to seek safety from violence
- Family Violence Intervention Orders
- Child Protection intervention
- impacts of separation on parenting and property
- information and advice concerning birth registration
- pathways for ongoing legal assistance, including family law advice, representation and other legal matters
- referrals for financial counselling where appropriate.

By providing an integrated specialised family violence legal response at a critical time in a woman's experience, WELS offers an early intervention to limit or prevent further harm to both women and their unborn children.

The strong outcomes delivered by WELS during its two-year pilot indicated it would be a highly successful program if expanded and rolled out across other maternity services in Victoria and nationally. Eastern Community Legal Centre and Eastern Health are currently seeking additional funding to enable the program to continue.

'We have referred quite a number of women to WELS for support. This valuable service has provided them free legal advice in a safe and supportive environment that they are comfortable in. Many of these clients have never ever had the opportunity to speak to lawyer.'

— Midwife

Mabels: supporting women after the birth of their child

Mabels is a Health Justice Partnership between Eastern Community Legal Centre, Boorndawan Willam Aboriginal Healing Service and three Victorian local government councils.

Mabels gives women attending universal maternal child health services the chance to receive integrated family violence and related legal advice, safety planning, information and referrals, from a family violence lawyer and family violence advocate.

Aboriginal women also have the option of service from an Aboriginal community-controlled organisation.

Mabels provides the following legal and psychosocial assistance:

- risk assessment, safety planning and options to seek safety from violence
- Family Violence Intervention Orders
- Child Protection intervention
- impacts of separation on parenting and property
- information and advice concerning birth registration
- pathways for ongoing legal assistance, including family law advice and representation
- referrals for financial counselling where appropriate
- cultural support and connection for Aboriginal and Torres Strait Islander women.

By providing an integrated specialised family violence legal response for women after the birth of their child, Mabels is able to identify risk factors for violence and work with women already experiencing violence to inform and equip them with the options they need to make the right decisions for their family.

The strong outcomes delivered by Mabels in its first few years indicate it would be a highly successful program if expanded and rolled out across other maternal and child health services.

Since its establishment in 2015, over 950 women have been referred to the program. Of the women that have provided feedback, 85 per cent reported feeling like they had options they didn't previously know about, 91 per cent reported they had the information they needed to take the next steps and 100 per cent reported feeling safer.[7]

'You're vulnerable after you've had a child. You're tired, not sure of yourself. It was great to have [the lawyer and family violence advocate] *linked in together. It gives you confidence that you're doing the right thing and reassurance that you're not going crazy.'*

— Mabels client

'Mabels has changed our practice. It has changed everything, in such an incredibly positive way. And it makes me really emotional when I think of all the women we have seen that we couldn't do anything much for, and now we can.'

— Enhanced Maternal and Child Health Team Leader

SAGE: A model for integrated family violence services for women before and after pregnancy

One of the programs that underpins the work of Eastern Community Legal Centre is the SAGE program. It is designed to be a trauma-informed and strengths-based approach to supporting women to engage with legal system and their legal options in seeking safety for themselves and their children. The SAGE program offers an intensive integrated service delivery approach, including:

- intensive legal casework support, advice and representation, primarily in family violence, family law and child protection matters
- specialist family violence advocacy and support
- risk assessment and safety planning
- financial counselling
- trauma-informed and strengths-based approach
- strong referral pathways, including to housing and homelessness services
- wrap-around support that draws on service partnerships.

SAGE prioritises women at increased risk of family violence and homelessness and who face additional barriers to accessing the legal system. The program is not time limited, so women may remain engaged with the program for as long as it takes to resolve their legal matters, in some cases several years.

* Name changed for privacy and safety reasons

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Passages: Pregnancy, Homelessness and Navigating the Pathway Home

Niamh Kiely, Manager Homelessness Services, St Vincent de Paul Western Australia*

Passages Youth Engagement Hubs (Passages) in Perth and Peel in Western Australia operate under a unique model of service delivery, which is rooted in the Low Threshold and Change approach. This model of service delivery aims to reduce barriers and makes working with young people experiencing homelessness about the individual and their unique circumstances as opposed to their presenting problems. It is client-led, time unlimited, trauma-informed, non-judgemental and focuses on the establishment of a trusting relationship between service provider and service user.

Passages have supported a significant number of young women who are experiencing homelessness and are pregnant, on their journey to parenthood.

Youth homelessness in itself presents a unique set of barriers and vulnerabilities that require specialist responses from services. Pregnancy compounds many of these difficulties and often exacerbates the complex circumstances experienced by the young woman.

Young women who are pregnant and are experiencing, or at risk of, homelessness may also have a range of co-occurring issues such as problematic alcohol and drug use, domestic and family violence, mental ill-health, experience of trauma and abuse and socioeconomic disadvantage. It is common that the pregnancy is overshadowed by these complex issues and can undermine the young woman's ability to prepare mentally, physically, emotionally and materially for the introduction of a child.

Finding out about a pregnancy sometimes acts as a stimulus for change for many young women. For example, they may be more motivated to engage with support services in an effort to source stable housing and improve their overall situation, thus providing a critical window of opportunity for timely service delivery. In contrast, sometimes the process of finding out about their pregnancy can generate additional stress, trauma and instability, which in part can stem from concerns about homelessness, drug and alcohol use, relationship status or previous experiences of pregnancy which have been negative. There can also be a sense of shame attached to the pregnancy which may or may not be associated with the individual's experience of homelessness. These factors can sometimes lead women to conceal their pregnancies, particularly in the first and second trimester — therefore limiting early interventions. It is vital that homelessness, housing, child protection and health services continually review current approaches and practices in responding to young women who are pregnant and experiencing homelessness to ensure they feel safe, supported and free from judgement.

The system presents many barriers which hinder a young woman who is experiencing homelessness to achieve positive change during pregnancy and/or after birth. This includes, but is not limited to, a lack of suitable, sustainable and affordable housing and an underfunded and under-resourced service sector. Service providers also generate barriers such as accessibility requirements, complex referral processes and prioritisation policies.

Due to these systemic and service-specific barriers, many young pregnant women experiencing homelessness remain in a range of unsuitable and unsafe situations.

Accommodation options present as one of the biggest issues and often there is no other immediate option than to reside in unsupported accommodation which includes private rooms, hotels, cars and couch surfing or rough sleeping, all of which have negative impacts on safety and wellbeing.

While accommodation and support options for young pregnant women do exist, the demand exceeds the supply. Furthermore, the accessibility requirements remain out of reach for many, particularly those with co-occurring issues. Service eligibility criteria include limits around age, gestational periods, substance use, number of children as well as intensive engagement expectations, and often an inability for the woman's partner to also be accommodated. To expect a pregnant woman with particularly complex needs to meet these requirements is often unrealistic and inconsistent with Housing First principles.

Overall the absence of stable accommodation impacts the ability and capacity of a young pregnant woman or mother to address obligations such as antenatal care and other health-related appointments, and often leaves them vulnerable to ongoing problematic substance use and poor mental health. Additionally, an absence of stable accommodation creates issues with practicalities

such as storage, access to fresh and healthy food, adequate hygiene and rest. It also leads to increased displacement and transience which in turn leads to inconsistent engagement with support networks.

Involvement with Child Protection is a common occurrence for many young women experiencing homelessness and can be an additional source of fear, stress and trauma as they begin to navigate obligations in the absence of adequate support provisions such as assistance accessing services. It is understood that a fight or flight response is often enacted when young women are not provided with adequate trauma informed support. Sometimes young women struggle to envisage a future as a mother without the involvement of Child Protection, particularly those who have historic involvement either as a child or with a previous pregnancy. While it is recognised that the involvement of Child Protection is absolutely necessary in some cases, it is important that the mother's unique life circumstances are considered and a person-centred response to case planning is enacted to ensure expectations are reasonable.

The introduction of the new pilot Therapeutic Court (Danjoo-Bidi-Ak) in WA is an important step forward in supporting young women and mums to have agency over their journey; acknowledging the trauma of current and past engagements with Child Protection while establishing accountability of all stakeholders to ensure safety of the mother and child is at the core of all communications.

Passages Youth Engagement Hubs provide intensive advocacy, intervention and support to expectant mothers. The flexibility of our service model allows us to respond to the growing need and offer a continuity of care to young people when they are at their most vulnerable. Passages support young mums to source accommodation, access maternity care, link in with various health and mental health supports, or alcohol and other drugs specialist services. We help young women navigate the child protection and justice systems. These systems can be demoralising and daunting for anyone. A young person experiencing homelessness and pregnancy who is facing the risk of their child being removed into care requires particularly intensive and sensitive support. This support, provided on a continual journey from birth through to motherhood, is an integral part of our service delivery and has been fundamental to achieving positive outcomes for mother and child.

The work of supporting young women to manage various presenting problems including pregnancy and early motherhood while transient and without housing is significant. A flexible, holistic and person-centred model of care is essential to positive outcomes. This approach will ensure systems are set up to support young women who are pregnant and experiencing homelessness, to break the cycle of trauma and disadvantage.

It is important to recognise and acknowledge the relationship between pregnancy and complex co-occurring issues to enable a trauma-informed approach while providing wrap-around services and continuity of care. Enhancing a young woman's self-worth along the journey is indispensable. This approach would also increase the likelihood of positive outcomes with navigating reunification processes and a reduction of children in care.

* Passages Youth Engagement Hub provides individualised support in a day service setting to young people aged 12 to 25 in Perth and the Peel region of Western Australia and is joint venture between joint venture between Vinnies WA and the Rotary Club of Perth and Mandurah.

Opinion 1

Cicely Alderson-Hughes and Joseph French

South Melbourne Families Team, Launch Housing

Home is Where Healing Can Begin

Home: the place where we find safety and shelter from the outside world, where we rest and recover, where we keep our things, where we lay our head each night and where we raise a family.

Home is such a vital part of a person's life, identity, sense of belonging and overall health and wellbeing, which is why it is staggering to know there are so many people without a home in our 'lucky country'.

We know that family and domestic violence is the largest growing driver of homelessness for women,[1] including expectant and new mothers who are at an even greater risk.[2]

And this situation is only worsening. Last year, Victoria Police's recorded crime trends[3] showed the number of family violence incidents was higher in every month during 2020 than during 2019, in part due to the impacts of the COVID-19 pandemic.

Many women and their children escaping family and domestic violence will access crisis accommodation. Much of this accommodation is already at capacity, pushing women and children into staying in small, often run-down motels, sleeping in their cars, on the streets, or returning to unsafe households.

It is unacceptable that we don't have enough suitable options for women and children to find safety and stability at such a critical time of need.

Even if a woman is able to access crisis accommodation, the clock starts ticking the moment she and her children enter this short-term option and there are currently very limited ways forward into permanent housing after this time runs out.

In theory, crisis accommodation provides a short-term stopgap until medium-term transitional housing, or long-term permanent accommodation becomes available. However, with the realities of social and affordable housing shortages across the country and rental supply and affordability at an all-time low, long-term stability is out of reach for so many families.

This is resulting in an overreliance on emergency accommodation and short-term options which can prolong the period of crisis for women and children, perpetuating trauma and instability, which has negative impacts on children and their development, including extended episodes of disengagement from school and social activities.

During pregnancy, extended periods in crisis accommodation can cause prolonged stress at an already stressful time and can lead to in-utero trauma and high-risk pregnancies.

How can we expect women who are dealing with the trauma of violence and homelessness to manage a housing crisis and rebuild their lives?

We need to turn our attention to more holistic ways of supporting women and children in crisis and, where possible, find ways to bypass or move quickly from crisis accommodation to help families rebuild and find stability as quickly as they can.

A Housing First approach[4] to rapidly re-house women, and women in pregnancy or motherhood, who are escaping family violence into permanent supportive housing will give them the best chance to rebuild their lives. Permanent housing combined with support services under the one roof is a proven approach that gives women and children a fresh start.

This type of model has been successfully tried and tested in New York through a pilot project called Keeping Families Together[5] undertaken from 2007 to 2010. The pilot provided permanent

Cornelia Program mother and baby

supportive housing to 29 highly vulnerable families who had been homeless for at least one year and had issues with child abuse or neglect. The families received services to assist with parenting, mental health and addiction support, vocational training, violence prevention, and support for any other needs specific to each family.

An evaluation of the pilot showed promising results for supportive housing as a holistic solution enabling families to achieve housing stability while resolving their child welfare cases and keeping children safe.

Children were supported to engage with school, address learning gaps and build positive peer relationships. Wrap-around support services in the building addressed any physical, developmental or behavioural concerns and helped children to heal from the trauma of homelessness and family violence.

Through this pilot, 90 per cent of the families remained housed, 61 per cent closed their child welfare cases in an average 10 months after moving in, and 63 per cent had no further involvement in the child welfare system.

Launch Housing has partnered with Uniting to build on New York's model to address a specific gap in affordable permanent housing options for women and children experiencing family violence, child protection issues, and homelessness in Victoria.

Known as Viv's Place, the project is the first-of-its-kind in Australia and will begin opening its doors to over 60 women and 130 children from July.

In addition to 60 apartments, the building has 24-hour security and a range of wrap-around support services located in the building including health, legal, education and living skills specialists. Children will have access to counselling services, trauma-informed playgroups, art groups and after school clubs.

This model not only makes it possible for women and children to leave family and domestic violence, it provides permanent stability to families and puts them at the centre of care, bringing support services to their door so they can recover in the safety and security of their home.

Our hope is that Viv's Place, and other supportive housing projects, will provide evidence to support the need for more holistic solutions to give women and children the best opportunity to recover and rebuild their lives.

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Meg Ady

On Pregnancy and Homelessness

I have a vivid memory of running through a field filled with tulips, with my two toddlers, all of us covered in mud, sunshine brightening the red, yellow, purple and orange flowers surrounding us. The world seemed so bright and filled with life and goodness. I was internally struggling to integrate this happy, privileged world of mine with an experience the previous evening.

S was a regular at the homeless youth drop-in centre where I volunteered. She is a kind, funny, quirky woman, with a cool partially shaved hairdo, a deep resonant voice, and a hearty, cheeky laugh. She had called me the night before, saying she was in labour, asking me to meet her at the hospital. Being in that particular labour ward was challenging for me, as it was where I had lost 2.5 litres of blood giving birth to my first child, and where my second child had been whisked off to neonatal intensive care, minutes after birth.

S told me she was really scared about birthing her baby. She hadn't attended any prenatal classes and had been homeless for the whole of her pregnancy. She had slept the previous night under a bridge. In her typical manner, she joked about this, saying that of all the bridges in the city, this one was her favourite, so she considered herself lucky. She didn't know what to expect from the process of giving birth and didn't know where she and the baby would go when they left the hospital. She felt inadequate and very frightened. Our conversation was concrete and practical. I am a midwife, so was able to gently explain what was happening to S's body, and what might happen next.

There is a sense in which our bodies are not our own, as we give birth. So many things can go wrong. I told S she was not in control of what happened, but she was in control of her responses. S was very skilled in this sort of thing. She hadn't been in control of her housing situation, but she had chosen under which bridge to sleep, the previous night, 39 weeks pregnant, her hips uncomfortable against the cold, rocky ground.

The softness and quietness of the moment S's baby was lifted into her arms was very emotional for me. Moments before, S had been loudly vocalising as she pushed, the young obstetrician applying pressure to forceps on either side of baby's head due to fetal distress, and the room had been filled with machine and human sound.

Now there was only the sound of S whispering *'you're here!'*, the sound of her baby's first cry, the wobble of my own tears, as we bore witness to the wonder of new life. Grounded the next day in the mud of tulips and toddlers and big blue skies and my own privilege, I found myself crying again. S didn't know where she and her baby were going to go when they left the hospital. S didn't have clothing or nappies or a room for her baby, or even a room of her own. I thought of the cot I had painted for my babies, the warmth of my house, the piles of clothes and toys and books our children had been given at various baby showers, and of sleepless nights soothing my colicky babies. I wanted the world to welcome S's baby the way it had welcomed mine. I wanted to be able to somehow provide for all the babies and parents who were impoverished.

I have been thinking about pregnancy and homelessness a lot, since the recent outlawing of abortion in some of the states in America. I am curious as to how much money has been budgeted for all these babies who are going to be born, their families, for health care, nappies, housing, food, childcare, preschool education, poverty reduction and mental health care for post-partum depression and post-traumatic stress disorder and other diagnoses.

S told me while she was in early labour, she was frightened her baby would get cold if they had to sleep under her favourite bridge together, because her blanket had not been enough to stop the chill from creeping into her body from the cold hard ground. I wanted so much to make the world a place where every baby being born has a warm home awaiting them. S and I conversed in the days following her baby's birth, and S told me about an aunt who lived in the country who said she was happy to create a home for S and her baby. As a result, S moved there, but missed the city and was parenting her little one in a warm, safe place. They are doing really well now.

Nurturing babies and their mothers and fathers and non-binary parents, is one of the most important tasks of any society. I am deeply saddened at the low value placed upon this nurture in Western capitalism. Aside from exploiting families with babies by trying to sell them things they don't actually need (given that research consistently indicates early brain development is most significantly helped by a baby interacting with their primary care giver) little value is placed on the importance of providing a safe, warm, nourishing home for each baby born into the world, and the resources and supports needed for parents to provide for their children.

S longed to provide for her child in a way that felt materially impossible for her, before her aunt stepped in to help. As she held her newborn in her arms, she said *'I didn't know it was possible for me to feel this much love. I am so scared I'll pass on my own shitty life to my baby.'* There are homeless transgender fathers, homeless non-binary parents and homeless mothers giving birth most days, all longing to give their babies the safety and warmth and physical comfort they themselves have been denied.

I cannot imagine anything more important than this for governments around the world when making their budgets. In that beautiful, muddy tulip field, I wept to think of S being homeless, holding her baby, not knowing how she was going to be able to provide care and nurture. I think it will be a sign of significant social healing if and when, one day, all over world, adequate funding is provided for impoverished families, and no one has to endure the experience of being pregnant and homeless or face the prospect of being homeless with a newborn.

Opinion 3

Kristie Looney

General Manager, Housing and Property, Uniting Vic.Tas

When I was invited to write an opinion piece for submission to *Parity*, I spent some time reflecting on my work in the housing and homelessness sector over the last two decades. I am very proud to have witnessed, and been involved with, many wonderful examples of program and service innovation to meet the needs of women experiencing homelessness, including pregnant women. But I have come to realise that the heart of the issue is our failure to provide safe, stable, long-term housing to women during pregnancy and motherhood. The intergenerational and substantive underinvestment in social housing leaves women trapped in cycles of homelessness, poverty, and family violence.

Uniting is the largest community service provider in Victoria, reaching Albury-Wodonga in the north, Mallacoota in East Gippsland, and the Wimmera region in the west. In 2020–21, we provided 67,000 community meals for those in need, answered 72,500 Lifeline crisis calls in Melbourne and Ballarat, and worked with 3,500 people experiencing homelessness to find safe accommodation.

We operate 13 dedicated homelessness programs across Victoria in both rural and metropolitan areas. We are the intake and assessment point for government-funded homelessness services in eastern Melbourne, Sale, Horsham, and Ballarat. Together with Uniting Housing Victoria, a registered community housing provider, we currently manage a portfolio of over 900 tenancies across Victoria.

We also deliver the Victorian Government's From Homelessness to a Home and Homes for Families programs across different regions, and the Street 2 Home Program in Central Highlands. But it is not in our dedicated housing and homelessness services that we usually see the needs of pregnant women and new mothers, in fact pregnant women experiencing homelessness are all too often hidden from view.

Pregnant women experiencing homelessness are largely invisible. What I often experienced when working in women's housing services — before my time at Uniting — was women making impossible choices and putting themselves and their pregnancy at risk to have a warm place to sleep. The worst part was knowing some women returned to violent relationships just to have a roof over their head.

How are these women to prepare for motherhood, especially first-time mums? How are they to do all the things that an expectant mum with a home can do? We talk about the 'nesting' period and preparing for baby's arrival — how can these women do that?

With the right support, pregnancy, and especially new motherhood, can afford significant opportunities for change. The research tells us this, our service experience does too. This is where innovative, wrap-around services like those showcased elsewhere in this edition can make a difference. With the right support and housing security, women can use this chance to break intergenerational cycles, rebuild lives, and start to think about their future — rather than just surviving. Central to this though is safe and secure housing. A house first provides a person safety and shelter, but with time it becomes a home and a place to heal.

A place to heal from trauma and abuse, to address other issues. It provides a sense of security, helps to build new habits, and connect with community, which in turn builds confidence and a sense of self-worth. Eventually, it leads to new friendships and a sense of belonging. We know for example that family violence often escalates during pregnancy, and in many instances all that is needed to leave the situation is a safe home. If we can provide women with safe and secure housing, we have the foundation for a new beginning; for healing, and for a healthier future for them and their child.

We must match this positive opportunity with practical, integrated measures across community services and government. It starts with recognising that we have a long way to go. There remains no single broadly accepted and practical definition of homelessness in Australia, nor any significant understanding of the issues confronting pregnant women experiencing homelessness. The March 2021 Victorian parliamentary inquiry

into homelessness, for example, notwithstanding its merit-worthy investigation, findings, and recommendations, failed to address it, with no mention of the words 'pregnancy', 'mothers' or 'motherhood' in its final report. Similarly, the July 2021 Commonwealth parliamentary inquiry report mentions pregnant women just once, in the context of the discrimination they too often experience.

We also lack realistic data on the extent of 'the problem'. We do not know how many pregnant women are experiencing homelessness in Victoria. We can reliably estimate, however, that the numbers are likely to be in the thousands per annum. That on any given night possibly hundreds of pregnant women across the state are without secure and stable housing. We also know that the problem is largely driven by a lack of social housing, poverty, family violence and a host of related trauma, AOD issues, and mental ill-health.

The inter-agency and integrated care space has significantly developed in recent years in Victoria, as Rose McCrohan, Kerri Felemonow and Sally Coutts show elsewhere in this edition. From 2021, the collaborative Cornelia Program between the Royal Women's Hospital

(RWH), HousingFirst and Launch Housing has clearly demonstrated the value of specialist wraparound services to pregnant women and new mothers facing homelessness. Fine-tuning services to target AOD, such as the joint efforts of Uniting AOD, the Women's Alcohol and Drug Service (WADS), and the RWH to stand up the Curran Place Adult and Mother Baby Withdrawal Service, again demonstrate the value of specialised care, treatment and support for pregnant women and new mothers experiencing homelessness.

These initiatives are changing many lives for the better, yet they cannot provide enduring solutions in the absence of pathways to long-term, stable and secure housing for these women. The cycles of disadvantage, homelessness, and the re-introduction of trauma continue to threaten these families. Secure housing offers the best chance for these women and families, and for us to support family-wide and intergenerational change.

In Vancouver, the Housing First approach is a catalyst for women and mothers with babies through the Union Gospel Mission's Sanctuary Stabilisation Program. The program stabilises these families for the first six to 12 months, and then provides them with transitional housing for up to five years. This allows sufficient time for the many other issues facing a family to be adequately addressed and supports provided in order to improve health and wellbeing, increase community connection, social inclusion, and reduce the likelihood of these families being further impacted by issues including AOD-related harm.

Drawing on evidence from our own work and from that of others, Uniting increasingly centres our response on the need for a Housing First approach. Secure long-term housing provides the foundation upon which all our interventions and pathways can be effectively and robustly built. Not all pregnant women need the wrap-around service interventions and integrated support we provide, but all need housing security as a precondition to stability and growth.

At present, to highlight just one example, only one per cent of rental listings in the Victorian private real estate market are affordable to single parents on income support. While many of us welcomed the Federal Government's recent commitment to build 30,000 social houses over five years, it falls well short.

The Leptos Review of the National Housing Finance and Investment Corporation in 2021 estimated that there is a need for $290 billion of investment across Australia in the next 20 years to close the shortfall in social and affordable housing.

The present commitment fails to adequately address the chronic and decades-long underinvestment in social housing in Victoria.

Many organisations, like Uniting, are playing a role by engaging and mobilising philanthropists, freeing up land, undertaking capital investments, and designing and delivering wrap-around services in partnership. I am heartened by the partnership we have with Launch Housing, donors, and the Victorian Government to open an Australian-first apartment building for at-risk women and children. Based in Dandenong, Viv's Place will provide permanent housing with wrap-around support services in a new building to provide a fresh start for more than 60 women and 140 children escaping family violence and homelessness.

But we need this to be the beginning of sustained investment in infrastructure coupled with wrap-around services. The Victorian Housing Peaks group estimates an additional 60,000 social homes will be required in the next 10 years. Uniting has joined the sector in calling on the Victorian Government to establish a pipeline of social housing development by funding construction of at least 3,500 new houses per year. This investment needs to focus on areas experiencing acute housing affordability stress. It must include diverse stock to meet a range of family and accessibility needs. Additionally, we have asked the Government to explore legislating recurrent funding for social housing development.

State planning reform and policies that increase social and affordable housing supply in new developments should form part of this investment. Government has a role in incentivising new developments to include a percentage of affordable housing through rebates and other market mechanisms. We know this works, as demonstrated through increased affordable housing stock in South Australia, New South Wales, and many places overseas. We were hugely disappointed that the Social and Affordable Housing Contribution was pulled, and we need to further investigate and advocate for the role of inclusionary zoning policies in Victoria.

We have an obligation to the women and children with whom we work to provide adequate housing and to articulate the value of this investment to government. New Social Return on Investment (SROI) approaches can provide the evidence we need for integrated interventions and social housing investment. An SROI evaluation by the Women's Property Initiative (WPI), for example, revealed that for every dollar invested in WPI, $11.07 of social value is created, with most of the value arising from improved emotional wellbeing, improved personal safety and increased independence. I look forward to the outcomes from the investment in Viv's Place.

What I know, both from a professional and lived experience, is that the Housing First model works. We can continue to invest in the wrap-around intensive interventions like those discussed in this edition, and that Uniting is delivering in partnership with the RWH; and we need these services. They are vital. But if we do not have pathways into long term stable and secure housing then it's all for none. These women will revert into homelessness, into insecure and unsafe situations, and we are going to see these women again and again. Without long-term housing pathways we are failing to provide these families a safe and secure start. We must commit to a Housing First model, and to do that we require a commitment from government to address the years of underinvestment and provide ongoing adequate investment in social housing. I am passionate about the potential to do things differently and see huge opportunity to realise genuine and enduring change!

Opinion 4

Lisa Lynch

Chief Operating Officer, the Royal Women's Hospital

Clare Manning

Director Social Model of Health, the Royal Women's Hospital

Sally Coutts

Program Manager, Cornelia, the Royal Women's Hospital

The Women's: Creating Healthier Futures for Women and Babies

For more than 165 years, the Royal Women's Hospital (the Women's) has led the advocacy and advancement of women's health and wellbeing; advocating for women and babies, campaigning for change, and championing the cause of health equity.

Developed over a decade ago, the Women's Declaration reflects that legacy and captures the essence of who we are and what we stand for. This culture has endured through more than a century of transformations in health and health care, as well as major changes in the social, economic, and legal status of women.

Our advocacy is informed by the views of our patients and consumers, with a focus on complex social issues such as family and sexual violence, promoting gender equality within a health context, and de-stigmatising women's health issues.

We continue to advocate, informed by voices of women, for acknowledgement of the social determinants of health to redress the disadvantage and discrimination that affects women's health and their ability to access high quality care and services.

At the Women's, we apply a social model of health approach to help address some of the inherent inequities in our health system. Our Social Model of Health Division brings together the Women's services and programs that specialise in providing care to women facing complex challenges that may adversely affect their health. It has responsibility for ensuring the hospital's clinical and social support services are coordinated, aligned and leveraged to provide wrap-around care for the women who need it most. In particular, the division has a focus on ensuring a woman's social, economic, cultural, environmental, geographic, and other factors are considered in her care plan, with the overall aim of reducing health inequalities and addressing systemic inadequacies that affect health access and outcomes. Informed by a strong evidence base, our commitment to the social model of health ensures we can offer a continuum of care approach, depending on the complexity of each woman's clinical presentation and social circumstance.

Pregnancy and Homelessness: Cornelia, an Australian First Through Partnerships and Advocacy

Pregnant women who are experiencing homelessness represent one of the most vulnerable population groups in our community. Unfortunately, the number of homeless women who are pregnant

Cornelia Program mother and baby

is unknown due to a lack of available data. International evidence, however, indicates that the rate of pregnancy among women who are homeless is likely higher compared to women who have access to safe and secure accommodation.

Compounding the challenges and level of disadvantage experienced by these women is the lack of an integrated service response that is tailored to the specific needs of pregnant women experiencing homelessness. There is also evidence that a significant proportion of frontline workers do not possess the skills and knowledge to work with pregnant homeless women in a sensitive and effective way.

The Cornelia Program, a joint initiative of the Women's, HousingFirst and Launch Housing, aims to break the cycle of insecure housing for vulnerable women and their babies. It is the first such collaboration in Australia between a hospital, a housing provider and a homelessness service that focuses on this cohort of at-risk women. A key objective of the program is to apply a social model of care that combines housing, maternity care and a range of other social supports and services to enhance the health and wellbeing outcomes of homeless pregnant women and their babies and shift their life trajectory.

Independent academic researchers have been engaged to rigorously evaluate the program's impact on enhancing health and wellbeing outcomes. Examples of key measures include clients' engagement with the program and other specialist services, quality of service provision, housing outcomes, clients' quality of life, community engagement and integration, level of independence and reliance on government support.

The lived experiences of up to 10 participants will be at the centre of the evaluation with multiple in-depth interviews that will capture each woman's experience and how their circumstance changes over time. This qualitative data will be supplemented with quantitative data collection and analysis of the Women's routine clinical perinatal data as well as a participant survey that will measure client outcomes across a range of maternal and infant health and wellbeing indicators. The researchers will also undertake interview programs with the project staff, partner organisations and external stakeholders.

The Cornelia Program is fully funded for five years through philanthropy and the Victorian Government's Department of Health and Department of Families Fairness and Housing.

Opinion 5

Becky Oakley

Launch Housing

The Cornelia Program: A Place Where Mothers Can be Mothers

'About 14 months ago I was homeless, living on a mattress on the floor. I didn't have any supports around me.'

Fleeing overnight from a severely violent relationship, Jaime felt she had no choice but to leave her home and take her chances. She took with her whatever personal belongings would fit into her car and a small amount of savings. Jaime was also pregnant.

With her only options being sleeping in her car, or on a mattress on the floor of peripheral friends, Jaime reluctantly chose the latter. But sadly, this option did not come with the safety she needed and once again, she experienced violence in barely adequate accommodation.

Her story reflects those of many women who are pregnant, but who have no stable or safe home to prepare for motherhood.

RMIT's study *Not Pregnant Enough? Pregnancy and Homelessness 2020*[1] reported that despite pregnant women's vulnerability and increased health needs, the women they surveyed experienced significant barriers to accessing housing support and secure accommodation.

The research recommended intensive supported accommodation and the inclusion of pregnancy as a critical factor in determining access to housing and support. These recommendations were heard.

In 2021, through the collaborative efforts of the Royal Women's Hospital, Launch Housing and HousingFirst, the Cornelia Program was created. The program was made possible through funding from generous donors and the Victorian Government, who supported the opportunity to transform the lives of women and children.

The Cornelia Program is an Australia-first initiative that aims to break the cycle of homelessness for

Cornelia Program mother Jaime and son with Haleh, Minister Wynne and Minister Foley

pregnant women and new mothers. It provides a supportive pathway to safe accommodation, social services and compassionate health care.

Jaime was one of the first women to be accommodated and assisted by the program in its pilot year.

'Coming here…my whole life has turned around. I had to pinch myself when I saw the place because I couldn't believe something like this was available to someone like me,' she said.

Named after Roman hero Cornelia Africana, celebrated for her dedication to her children, the program provides expectant and new mothers with access to accommodation for up to 12 months, alongside tailored wrap-around health care and social support.

Women in the program receive specialist maternity health services, along with support to access other health and psychosocial programs. They are also provided with support to access long-term and stable housing.

Launch Housing Families Team Manager Nadine Howard said that whilst the program is fairly new, they have already seen some incredible outcomes within a matter of months.

'Many of the women have already moved on to long-term housing and are doing really well,' Nadine said.

Women accessing the program are among the most marginalised and stigmatised in our society. Many of the women have experienced long term homelessness and family violence which has impacted many aspects of their life, in some cases including their ability to care for their children.

The program aims to alleviate these disadvantages, putting women and their babies at the centre of care and giving them the stability and support to focus on motherhood.

'Many women talk about the relief they have when they move in, knowing that they can use 12 months to nest while they focus on the health and safety of themselves and their babies,' said Launch Housing Senior Support Worker Karen Janssen.

Cornelia Program mother and baby

Karen says that sadly, due to the situations they've been in, some of the women the program supports have had children removed by Child Protection in the past. She says these women may hold fears that their new babies could be taken from them, but the program helps to prevent these devastating separations.

'That is probably the best outcome of all. That the babies remain in the women's care. Mothers get to keep caring for their babies and to keep bonding. And the environment that we provide allows them to demonstrate that they're more than capable.

I want to help them realise how resourceful they've been, how resilient they are, how strong they are to push through all the barriers they've faced,' Karen said.

The program provides proof that the right support, paired with stable housing, can make an enormous difference to outcomes for families.

Since the program started in August 2021, 43 women have been supported and 13 have already moved on into their own permanent housing.

'It's a combination of having an apartment of my own and a place to call home as well as the staff's assistance. I feel very lucky,' said Jaime.

'I've remembered I am a good Mum, and I can be a good mum. It has turned my life around.'

Endnote

1. Murray S, Theobald J, Haylett F and Watson J 2020, *Not Pregnant Enough? Pregnancy and Homelessness*, Lord Mayors Charitable Foundation. *http://rmit.edu.au/notpregnantenough*

Giovanna Savini

Chief Resident Services Officer, HousingFirst Ltd

Make the Extraordinary Ordinary: Why Every City Should Have a Cornelia Program

A St Kilda apartment block beats out a rhythm each day. Morning sees bleary-eyed mums drink coffee in ones and twos as babies sleep in their cots, finally. Prams and buggies jostle into the surrounding streets and onto laps of the nearby park and then some supermarket shopping. Nurses and support staff arrive to weigh babies and check in on expectant ladies and mums. Yoga and wellbeing sessions are taken. Feeds given. Cuddles. Babies laid down for the afternoon nap.

New, anxious residents arrive. Happy, excited but still a little anxious mums and their babies are farewelled, off to long-term housing, facilitated by the small tight-knit team in the corner office.

Night-time routines are performed: soothing baths, tactile books, pats and lullabies and sleep, for a few hours, maybe even through the night. Mums retreat to the couch, savour an hour or two of me-time streaming Netflix or calling mates before exhaustion overcomes them.

An ordinary day. An extraordinary day.

This is the Cornelia Program, the housing-first program in St Kilda, Melbourne. One that is putting vulnerable pregnant women and new mums at its centre, delivering health and care services right to their door. And with up to 36 women living in the same building, each in their own studio apartment but on a similar motherhood journey — with moments of joy and moments of exasperation — it is a program that is forging friendships and a community spirit among the mothers.

We Don't Want to be Unique

At the moment, the Cornelia Program is unique, an Australia first. It's fully funded for five years due to the generosity of the Victorian government and private donors and the commitment of the Program's partners: the Royal Women's Hospital, Launch Housing and HousingFirst. The Cornelia Program deserves to be a permanent fixture and the partners have established an independent evaluation framework that will hopefully vindicate that belief and secure recurrent funding to sustain the program long-term.

Whilst the Cornelia Program will improve the lives of dozens of mothers a year and perhaps 250 mums over the next five years, true success would be the replication and scaling up of the initiative.

Ideally, every city would have a vulnerable mother and babies' program. What would it take to achieve that?

Acknowledge the Need

No one is quite sure how many homeless pregnant women are out there in Australia. There is no definitive data. We know that many homeless people are female and young. On Census night in 2016, there were 49,000 homeless women and most of them were under 35. International evidence indicates that the rate of pregnancy among homeless women is likely higher compared to all women, so realistically, there are likely to be thousands of homeless pregnant women in Australia at any one time.

Moreover, these women tend to have many challenges. More than 80 per cent of the 180 pregnant women supported by the Women's Alcohol and Drug Service (WADS) each year lack access to secure and stable housing. Ninety seven per cent experience at least one obstetric complication, 90 per cent have experienced violence in the past, 72 per cent are experiencing violence in their current relationship, 84 per cent have Child Protection Services involved in their pregnancy, and 46 per cent have had contact with Child Protection as a child.

Housing First, Not Treatment First, Makes Sense

Clearly homeless pregnant women face numerous challenges, and they often require multi-service assistance. Unfortunately, too often the appropriate response is rarely on offer and, even when it is, it is patchy, inconsistent and uncoordinated. And when left unaddressed, homelessness can become entrenched, for the mother and, even more tragically, for future generations, ratcheting up the costs to society.

Readers will be familiar with the housing first philosophy. Provide the homeless secure housing

from which to help tackle their other problems. The Chief Executive Officers of HousingFirst, Launch Housing and The Royal Women's Hospital believed that this approach should work for pregnant homeless women.

Harness the Power of Government, Agencies and Donors

Nevertheless, to bring the Cornelia Program to fruition hasn't been easy. The Chief Executive Officers assembled a 'dream team' of specialised and complementary skills. Working in a genuine collegiate fashion, the team took the concept and designed a robust model. A costed business case was crafted, underpinned by governance principles of transparency and accountability and independent evaluation.

The plan was pitched to stakeholders of each partner organisation, to the philanthropic community, to external support agencies and to the Victorian government. The case was won. Support was built for addressing the challenge and the proposed approach. Around $3 million in philanthropic funding was secured and matched by the Victorian Government.

If it can be done in Melbourne, it can be done elsewhere. And with a newly-elected Federal Government, one more willing to fund social housing than its predecessor, now is the opportunity to make the case in Canberra across multiple ministries — women, housing, health, finance — that integrated housing solutions address far more than just homelessness.

Already a Success

Since the doors opened in August 2021, 43 pregnant mums have resided in the Program with 13 moving on into stable, long-term housing, and 22 babies have been born. And counting.

Awareness and appreciation of the Program is also building momentum for scaling up. The partners have received approaches from other housing and support services wanting to understand the blueprint.

But the success is more fundamental than these numbers and the prospect of expansion to other jurisdictions.

Success is *'yes, we can help you'*. It's support. It's a home. For a mother. For her child.

Kate Mecham

Policy Manager, Safe and Equal

Family violence, homelessness and pregnancy: Keeping the perpetrator in view

A note on language: Safe and Equal recognises that family violence impacts people across a diversity of gender identities, social and cultural contexts, and within various intimate, family and family-like relationships. Consequently, we predominately use the gender-inclusive terms 'victim survivor' and 'perpetrator' to acknowledge the complex ways family violence manifests across the community. Importantly, the term 'victim survivor' refers to both adults and children who experience family violence, recognising that children and young people who experience family violence are victim survivors in their own right. However, where references are being made specifically to the experiences of women, we use gendered language to accurately reflect this. As this article refers to people who are pregnant — who are predominantly women, I have chosen to use gendered language in this article.

As the peak body for family violence services in Victoria, Safe and Equal is very pleased to sponsor this edition of *Parity* and draw attention to the interconnections between pregnancy, homelessness and family violence.

We know that pregnancy and immediately post-birth are times of increased risk of family violence. In the case of intimate partner violence, as relationship dynamics begin to change with the impending birth of a baby, family violence may start for the first time or it may escalate if already present, putting both mother and baby at risk. For young people who are pregnant, family violence risk may be present in the form of intimate partner violence and/or from their family of origin who may not be supportive of the pregnancy, further complicating the level of risk experienced and the types of supports needed to support young mothers and their children.

It is common for women and young people to find a new impetus to leave family violence when they become mothers, or when it becomes clear that their children are also being affected by the violence. Violence against themselves may be tolerated, but violence against their children is not. Thus, pregnancy creates both an opportunity and risk — an opportunity to engage with victim survivors of family violence to talk about safety, and a risk as pregnancy is already a time of increased risk that increases again at times of separation or when planning to leave.

We know that family violence is the leading cause of homelessness among women and children. Many mothers are faced with the dreadful choice of remaining in a violent relationship or taking their children and leaving only to be faced with the very real prospect of becoming homeless. Family violence is also the leading cause of youth homelessness, as many young people who experience family violence leave home to escape. For young women experiencing homelessness, the risk of family violence, sexual assault and pregnancy increases.

This nexus of pregnancy, family violence and homelessness is why this edition of *Parity* is so important. Research on the experiences of women who are pregnant and homeless has demonstrated that a vast majority of these women have experienced family violence. In the mix of pregnancy, medical needs, homelessness, possible drug or alcohol addiction and/or mental illness, where is the perpetrator?

When working with women who are pregnant and homeless, these critical questions must be asked. Is this woman a victim survivor of family violence? Is attempting to leave family violence the reason they are homeless? Are we recognising and supporting both the woman and her children's acts of resistance and efforts to stay safe in the face of violence? Where is the perpetrator? Is the system keeping them in view? Do services know where they are, what they are doing, and how their actions may have impacted and still be impacting the mother and child? Are we viewing mental illness or substance abuse through a trauma-informed lens, which may reveal that these issues are a response to family violence-related trauma? Are we recognising that, for some of these women and children, family violence may still be occurring?

That this trauma is not an event they have left behind, even if they are being linked in with other services? If the abuse, violence, coercive control and resulting fear are ongoing, recovery from family violence is not possible. Are we able to acknowledge what a mammoth task it may be for the mother to effect certain changes in her life at this time? Are we able to adjust service expectations accordingly, with a view to keeping both mother and child safe and — ideally — together?

In such scenarios, it is critical that we shift our focus to the perpetrator of family violence and assess to what extent their actions are the root cause of many other issues someone who is pregnant and homeless may be experiencing. If the family violence risk from the perpetrator was removed, how might the health, wellbeing and safety of each woman and her baby be improved?

Fortunately, Victoria is starting to make this shift. The introduction of the family violence Multi Agency Risk Assessment and Management (MARAM) framework is supporting non-specialist family violence services who work with victim survivors of family violence to better assess the safety needs of both adult, child and adolescent victim –survivors. The Family Violence Information Sharing Scheme (FVISS), Child Information Sharing Scheme (CISS) and rollout of the Central Information Point (CIP) all are enhancing services' abilities to share risk-relevant information about perpetrators and victim survivors to better inform risk assessments, safety planning and holistic service delivery.

These reforms are still in the early days of implementation, and their full effect on outcomes for victim survivors, including women who are pregnant and homeless who have experienced family violence, is still yet to be felt. But they are also not enough on their own. Even when fully implemented, much will rely on the expertise and experience of individual practitioners to be able to utilise these tools effectively. It is, therefore, necessary that sectors are resourced to support their staff to use these tools and work collaboratively

with other sectors to answer these critical questions through multiple practice lenses to get the best picture of what a client needs.

We also need housing.

Homelessness cannot be solved without housing. No woman should be forced to make the choice between putting herself and her children at risk of homelessness or continuing to experience family violence. We cannot reasonably expect anyone to address mental illness or substance abuse issues when they are homeless, managing a pregnancy and faced with the prospect of bringing a baby into the world without a safe place to live. We also need more crisis accommodation for young people who are independently fleeing family violence, either from an intimate partner or family of origin, to stop the intergenerational impact of family violence.

The Victorian Royal Commission into Family Violence very clearly found that children experience the effects of family violence prior to birth. Yet the service infrastructure and amount of safe, affordable, long-term housing to support women who are pregnant and experiencing family violence and homelessness remains insufficient to address their needs. We are immensely pleased that attention is being drawn to this group of women and children and look forward to the ensuing conversation about what is needed and how to best support them.

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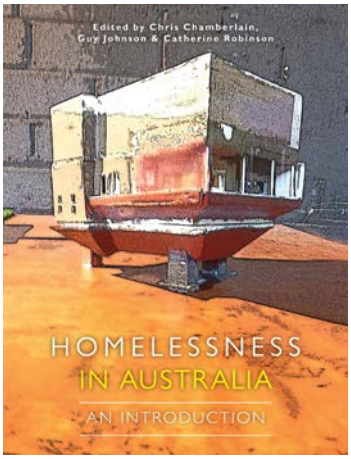
Homelessness in Australia: An Introduction



Homelessness in Australia: An Introduction provides thought-provoking, up-to-date information about the characteristics of the homeless population and contemporary policy debates.

Leading researchers and advocates from across Australia have come together to contribute their expertise and experience to produce a foundational resource that will set the benchmark for the future analysis of homelessness. Editors, Chris Chamberlain, Guy Johnson and Catherine Robinson are all recognised experts in the field.

Homelessness in Australia: An Introduction is published by New South Press in association with the Victorian Council to Homeless Persons, one of Australia's leading peak homelessness advocacy bodies.

Homelessness in Australia: An Introduction contains 14 chapters.

Part 1 includes: an essay on homelessness policy from the start of the nineteenth century to recent times; a chapter measuring mobility in and out of the homeless population and a piece on the causes of homelessness.

Part 2 is about contemporary policy issues and discussions. It has chapters on: the debate about definition and counting; gender and homelessness; young people; older people; Indigenous homelessness; domestic and family violence; people with complex needs and the justice system; trauma as both a cause and consequence of homelessness; and people who are long-term or 'chronically' homeless.

Part 3 includes a piece on the 'failure of the housing system' and a chapter on 'reforming the service system'.

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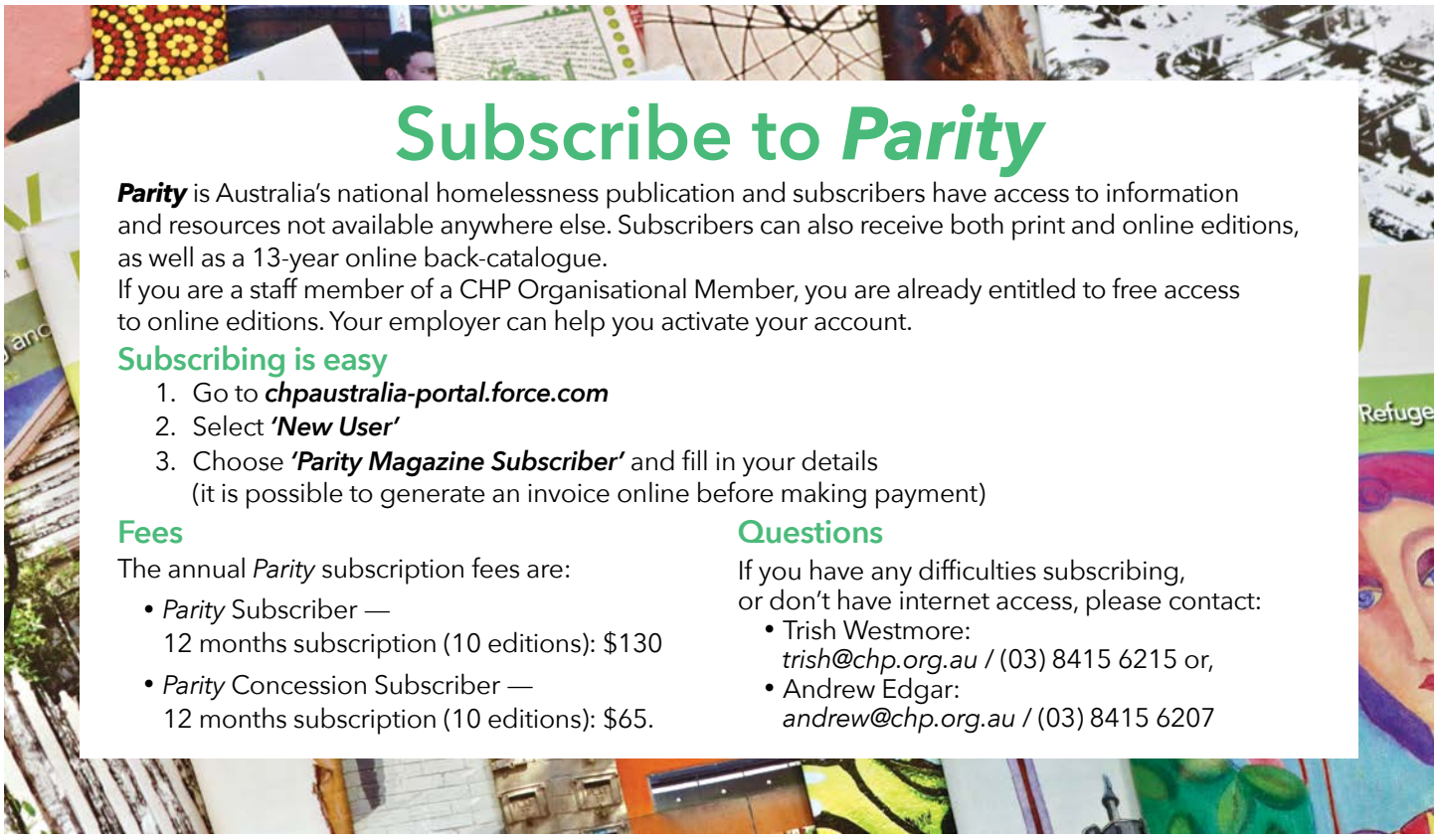

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