Not Pregnant Enough?

Pregnancy and Homelessness

Suellen Murray, RMIT University
Jacqui Theobald, La Trobe University
Freda Haylett, RMIT University
Juliet Watson, RMIT University

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List of Abbreviations

ABS	Australian Bureau of Statistics
AOD	Alcohol and other drugs
AHURI	Australian Housing and Urban Research Institute
CALD	Culturally and linguistically Diverse
DHHS	Department of Health and Human Services
GP	General Practitioner
HPP	Homeless Prenatal Program
HSiH	Healthy Start in Housing (HSiH)
WADS	Royal Women's Hospital) Women's Alcohol and Drug Service

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Executive Summary and Recommendations

This research came out of concerns expressed by senior staff at Launch Housing and the Royal Women's Hospital that pregnant homeless women are not receiving the level of support warranted given their circumstances and that of their unborn child. Through research with 41 staff from health, housing and homelessness services, first-stage research sought answers to questions regarding the number of pregnant women in Victoria's homeless population, the ways that services work with this group and how improvements could be made (Murray, Theobald & Watson, 2018).

In this second stage of the research, the perspectives of 14 women who have had recent experiences of pregnancy and homelessness are documented. The research received approval from the Human Research Ethics Committees of RMIT University, La Trobe University and Launch Housing and was overseen by a reference group with specialist expertise in the area of pregnancy and homelessness. The research was undertaken using a qualitative approach and comprised a literature review and in-depth face-to-face interviews conducted over the period May to September 2019. Recruitment of participants occurred through the professional networks of reference group members and other service providers who had participated in the earlier stage of the research.

The research participants were aged between 20 and 36 years at the time of their most recent pregnancy, with an average age of 27 years. At the time of interview, four of the women had one child and another two were expecting their first; the other eight women had two or more children. The group included two Aboriginal women, three women of culturally and linguistically diverse (CALD) backgrounds and nine Australian-born women of English-speaking background. Half of the group of women disclosed a history of mental ill-health and two-thirds problematic alcohol and/or drug use. Most of the women had been exposed to gendered violence during their most recent pregnancy. All women were living in Melbourne at the time of interview but one woman had come to the city as she had been unable to access drug and alcohol support services in the regional centre where she lived.

The women had experienced the breadth of living arrangements including rough sleeping, sleeping in cars, motels, couch surfing, shared houses, rooming houses, crisis accommodation, emergency accommodation, youth refuges, specialist young women's refuges, specialist women's family violence refuges, residential drug detoxification and rehabilitation facilities, prison, community housing and public housing. Twelve of the women had experienced hazardous accommodation during pregnancy. While at the time of interview most women were living in relatively stable accommodation, only four had secured suitable long-term housing.

Pregnancy did not necessarily afford the women greater access to housing support or secure accommodation. The research found that, without these basic needs of shelter and stability met, it was very difficult for the pregnant homeless women to prepare for motherhood practically, physically and emotionally, with negative consequences for the mother and baby. While the participants described positive relationships with staff from homelessness, housing and health services and examples of interventions which provided timely support, there was also evidence that some parts of the housing and homelessness service systems did not prioritise the needs of this group of women and it is a neglected area of practice.

In relation to housing support, most participants could not access long-term safe and secure housing until very late in their pregnancy or until after the birth of their baby. Participants reported a number of problems in supported accommodation, including experiencing forms of harassment or assault, and being geographically isolated from networks of support. The masculine dominated nature of rooming houses restricted some participants' ability to safely and comfortably access communal facilities. Other women resorted to couch surfing, sleeping rough and living in cars, which increased their vulnerability and exposed them to sexual and other forms of violence and theft. Access to the nutritional needs of pregnancy was particularly difficult for the participants living in rooming houses and cars, couch surfing and sleeping rough.

Among the group of women there were those who experienced complex and co-occurring issues. For some, childhood trauma which had resulted in long-term homelessness compounded the difficulties they experienced during pregnancy. Most participants were exposed to gendered violence, with some reporting their pregnancy triggered an escalation in violence from partners and family members. Insecure residency status resulted in considerable difficulty leaving a violent relationship due to work ineligibility and no access to Centrelink income support. Homelessness could be further complicated by alcohol and drug use, impacting pregnant women's capacity to engage with antenatal care and other services.

Some participants reported positive experiences of support where complex and co-occurring issues were addressed; others reported siloing of responses where there was little attention paid to the relationship between their pregnancy and various other presenting issues. Participants reported that when they were able to receive support in a timely and coordinated manner, they managed to successfully reduce or stop their substance use. Central to the success of programs like the Women's Alcohol and Drug Service (WADS) at the Royal Women's Hospital was their capacity to offer a flexible wraparound model of care which also enabled women to develop a sense of optimism about their pregnancy.

Women reported experiences of reproductive ill-health and trauma. Several participants contemplated terminating their pregnancy because of their homeless circumstances. Reasons for ultimately not terminating included not having access to transport to get to appointments,

resistance from partners, and personal ambivalence about having a termination. Homelessness heightened the distress of miscarriage as there may not have been access to private spaces to bathe, grieve and manage the pain and associated bleeding.

Participants in safe and secure long-term accommodation were more able to prepare for the arrival of their baby. Pregnancy was an important time when participants reported a willingness to make significant changes and engage with support services, thus providing a critical window of opportunity for successful service provision. Participants reported positive experiences with caseload midwifery care, as well as forms of ongoing assistance and connection such as maternal and child health services, respite care, and playgroups. However, some women found group settings with other mothers and babies could be alienating and stigmatising due to their complex life circumstances.

Recommendations

The earlier research undertaken with service providers (Murray et al., 2018) led to 24 recommendations, all of which remain relevant after conducting this second stage of the research with women who have experienced pregnancy and homelessness. These later findings have informed the following recommendations.

Data collection

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

Research

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

Long-term housing

- Ensure long-term housing is the principal housing option offered to pregnant homeless women unless it is unsuitable for her specific circumstances
- Increase access to social housing for pregnant homeless women in a range of dwelling types and suitable locations which maximise women and children's stability, safety and wellbeing, including access to supportive networks and services
- Resource the A Place to Call Home program by restocking transitional housing dwellings when tenancies are transferred to permanent public housing

- Ensure private rental and other brokerage arrangements are available which suit the circumstances of pregnant and newly parenting women in terms of affordability and location
- Increase provision of social housing with wraparound support modelled on Housing First programs so pregnant women can access permanent housing and stabilise early in their pregnancy

Intensively supported transitional accommodation

- Drawing on good practice examples for young women and a new initiative for women aged 25 years and over, provide additional intensively supported transitional accommodation for pregnant homeless women
- Ensure transitional housing is available which suits the circumstances of pregnant and newly parenting women in terms of location

Crisis accommodation

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

Support – Improving practice

- Ensure pregnancy is taken into account as a critical factor for determining access to housing and support when pregnancy is first identified or disclosed
- Promote an approach to supporting pregnant homeless women which is based on early intervention and wraparound services
- Ensure information about support services is made readily available to pregnant homeless women through community health services, GP clinics and other specialist health and housing services
- Ensure information about reproductive health as it relates to termination is provided to pregnant homeless women through community health services, GP clinics and other specialist health services
- Ensure homelessness and health services are aware of the family violence Flexible Support Packages and the ways they can provide support to pregnant homeless women experiencing family violence

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

Support - Increasing resources

- Increase pregnant homeless women's access to a continuity-of-care model for their antenatal care
- Locate specialist housing support workers in hospital settings to assist pregnant homeless women to access housing support including after termination and miscarriage
- Increase specialised group parenting programs during early parenting to avoid stigma and enable social inclusion of women
- Increase pregnant homeless women's access to termination services through the provision of supported transportation
- Increase availability of drug and alcohol detoxification and rehabilitation facilities for pregnant women in metropolitan and regional locations

Training and education

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

Networks and integration

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

Chapter 1
Introduction

1.1 Background

When Sarah sought assistance to obtain housing when she was evicted from a shared house at very short notice, she discovered that, even though she was having a baby, she was 'not pregnant enough' to avoid homelessness (Perkins, 2019). At three months pregnant, Sarah and her partner—like all parents—wanted a place to live which was affordable, secure, safe and clean, and where they could begin to prepare for the birth of their first child. With no alternative housing available to them, they were referred to a private rooming house but soon moved to another in an effort to secure a less hazardous living environment. Very late in the pregnancy, with support from a housing service, they moved to crisis accommodation, but this, too, was insecure and unsafe—an environment unsuited to preparing for parenthood and inappropriate for a newborn baby. Three months after their daughter was born, they were offered secure long-term accommodation in public housing where they have been able to settle and establish the family home they had first sought nine months before. Homeless women who are pregnant can experience considerable difficulty accessing safe and secure long-term housing and, for many, there is not always the positive outcome Sarah finally achieved.

Sarah is one of 14 women who were interviewed for this research project exploring pregnancy and homelessness, building on prior research which investigated services providers' perspectives on this topic. This earlier research was based on interviews with 41 staff from 27 agencies and resulted in a report with 24 policy and practice recommendations (Murray et al., 2018). Both research projects aimed to build a body of evidence to inform service delivery and policy development to meet the needs of pregnant women experiencing homelessness.

First, the earlier research found there is no reliable information on how many pregnant women are homeless. In the absence of such data, service provision has occurred ad hoc in response to local need. Innovative programs and good practice exist in various organisations; however, the research confirmed there is no coordinated, system-wide response to pregnant homeless women. A lack of data on the incidence of pregnancy and homelessness in Australia is a significant gap in knowledge which could be used to inform social and health policy, as well as service delivery.

Second, service providers reported overwhelming demand for homelessness services and pregnant homeless women experience difficulty accessing housing support (Murray et al., 2018). They also revealed pregnant homeless women may not receive responses to their additional support needs when accessing housing support services. This stems from some practice in homelessness

services where pregnancy is not taken into account as a critical factor for determining access to support until late-term. In a housing crisis, women, like Sarah, may be referred to rooming houses, which are unsuitable once the baby is born and do not provide an environment conducive to preparing for parenthood. Aboriginal women and young women may access homelessness services which provide specialist support but fewer are available than is required. Many pregnant homeless women have experienced family violence but, due to an overburdened service system, they may not receive a family violence specialist response. A new initiative based on intensively supported transitional accommodation offers a dedicated resource for women aged 25 years and over who are least likely to receive a specialist response. However, access to long-term housing remains extremely limited. Serious shortages in safe, stable and affordable housing constrains the capacity of homelessness services to support pregnant homeless women.

Third, there is evidence in earlier research that the skills to work with pregnant homeless women were not possessed by some housing and homelessness service workers (Murray et al., 2018). Sensitively collecting information about pregnancy status and improving practice with this client group requires training and is needed to produce the best possible outcomes for the woman and her child.

Fourth, service providers reported the need for specialist and mainstream health support for homeless pregnant women to be well-informed of the needs and circumstances of this group of women. Highly regarded specialist health programs exist, including those which respond to women with complex needs. Wraparound provision of services, continuity of care and outreach constitute key elements of these programs. There is the potential to further initiatives for pregnant homeless women of all ages, including peer support, which was identified as particularly important for young women. Long-term support, while often needed, was limited. Finally, ongoing collaboration and further integration among and between specialist health and homelessness services were seen as means of improving responses to pregnant homeless women.

In conclusion, Murray et al. (2018) found these gaps in the service system—and in the collection of data—contribute to lost opportunities for intervention to provide the best possible outcomes for women and infants. In a further effort to understand the best ways to provide this support, the research underpinning this report then sought women's perspectives on their experiences of pregnancy and homelessness, as well as their access to services and potential improvements.

1.2 Policy context

Key policy areas relevant to this research include those concerned with housing, homelessness, family violence and support for vulnerable pregnant and parenting women and their children. Since the earlier stage of the research (Murray et al., 2018), there remains a shortage of social housing in Victoria, occasioned by decades of declining investment in affordable housing. The number of Australian households who live in social housing has dropped from 7 per cent of all households

in 1991 to 4.2 per cent in 2016 (Australian Housing and Urban Research Institute [AHURI], 2017). This has stemmed from the withdrawal of government investment in social housing (interrupted briefly between 2008 and 2012) and an overall long-term decline in the share of social rental housing, compared to population growth (Toohey, 2014; Milligan, Pawson, Williams & Yates, 2015).

The Victorian Labor Government's *Homes for Victorians* initiative has committed to increasing social housing to support vulnerable Victorians through a $1 billion Victorian Social Housing Growth Fund, and a further $201 million over four years to redevelop public housing estates (Victoria State Government, 2017a). Family violence is a key reason why women seek homelessness support and, in response to the Royal Commission into Family Violence, Victorian Government's *Ending Family Violence: Victoria's Plan to Change* contains a range of strategies including more funding for women's refuges, rapid housing assistance and the expansion of the family violence *Flexible Support Packages* initiative (Victoria State Government, 2016a).

For vulnerable pregnant and parenting women and their children, there have been some important policy developments in recent years. The launch of *Roadmap for Reform – Strong Families, Safe Children* grew from the Royal Commission into Family Violence and marked a commitment by the Victorian Government to shift the child and family system from crisis response to prevention and early intervention (Victoria State Government, 2016b). *Strong Families, Safe Children* identified a number of key priorities, including wraparound supports, better identification and support for victims of family violence, and building family capability and Aboriginal self-determination. The Victorian State Budget allocated $101.7 million for early intervention family services, with the broad aim of giving Victorian children the best possible start in life. Among these early intervention services are the *Healthy Mothers, Healthy Babies* program, which provides support to pregnant women who are not accessing antenatal care due to complex psycho-social issues (Victoria State Government, 2017b). The program delivers services to areas with high numbers of births, high rates of socioeconomic disadvantage and low service accessibility, and works with pregnant women throughout their pregnancies until they are effectively engaged with Maternal and Child Health Services (Australian Health Ministers' Advisory Council, 2016). Since July 2018, the Enhanced Maternal and Child Health program has also been flagged for expansion to cover 15 per cent of Victorians up to their third birthday, up from 10 per cent. This program is an extension of the universal maternal and child health service, designed to offer targeted supports to families needing additional help, with a particular focus on families affected by family violence. Homelessness is one of the risk factors for young children requiring early intervention. In addition to these, Cradle to Kinder, and Child FIRST, which work with families at risk of becoming involved in child protection and out-of-home care, continue to be funded. For Indigenous families, the Koori Maternity Service has been available in Victoria since 2000, providing inclusive and culturally-safe maternity care to Indigenous women and children (Victoria State Government, 2016b).

In the last decade, policy developments in maternal care have highlighted the need to develop evidence-based models of care for at-risk women. The National Maternity Services Plan provides a national framework to guide policy and program development in maternal care and made it a priority to expand implementation of caseload/team midwifery, and continuity-of-care models to more women, particularly in rural and remote areas (Australian Health Ministers' Advisory Council, 2016). This follows an evaluation at the Royal Women's Hospital in Melbourne which found caseload midwifery improved maternal and infant outcomes as well as reduced the rate of burnout for midwives (McLachlan et al., 2012).

1.3 Research design and summary of data collection

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

Using a qualitative methodology, this applied social research project collected accounts of women's experiences of pregnancy and homelessness through in-depth, semi-structured, face-to-face interviews. A comprehensive literature review of both academic and industry publications informed the research. The research was presented at a cross-sector forum as a means of both assisting in translating the findings and engaging the sector in taking the recommendations forward.

Recruitment of research participants was undertaken over four months from May to September 2019. Recruitment of participants occurred through the professional networks of reference group members and other service providers who had participated in the earlier stage of the research. Research participants were referred from six agencies: a specialist hospital-based women's support service, a specialist community-based health service, a generalist housing support service, two specialist young women's services, and a specialist women's domestic violence service. While there was engagement with other services, participants were not successfully recruited from these.

To ensure recency of the information collected, all of the women who were interviewed had been pregnant and homeless during the past two years. Five women had experienced an earlier pregnancy during which they had been homeless and this provided additional information regarding the challenges they had faced in securing long-term, safe and stable housing.

The process of recruitment was carefully operationalised to ensure the women were aware they were under no obligation to participate, involvement was voluntary and whether they agreed to be interviewed or not would not affect their access to services. Additionally, due to the sensitive and potentially difficult circumstances they had experienced when pregnant and homeless, women were routinely offered referral to support services. Other means of ensuring the women were well-supported included informing them they could have a support person attend the interview with them, checking on their welfare over the course of the interview and offering breaks, and contacting them in the days immediately following the interview to confirm they were well and reiterating the availability of relevant support services.

There are two limitations to the research. First, even though the research was intended to have 'depth' (in-depth interviewing with a small number of research participants) rather than 'breadth' (research with a large number of participants gathering more superficial responses), it was expected there would be more than 14 (and up to 20) participants. While more women were referred to the researchers, more than a third of this total group did not proceed with the interviews or there were difficulties in engaging with them despite initial interest. The researchers were very flexible in accommodating their needs but, with an infant, and typically many other demands on their time, it is understandable some decided not to proceed.

Second, and finally, even though there exists diversity among the women in relation to age, family size, ethnicity and health status, only women living in Melbourne at the time of their interview participated in the research. Attempts were made to recruit women in non-metropolitan locations but these were unsuccessful. One of the women interviewed had come from a regional city to Melbourne seeking housing while homeless and pregnant as she had been unable to access drug and alcohol rehabilitation support there.

1.4 Glossary

Family: A woman (or couple) with accompanying children. In the homelessness service system, there is an important differentiation between a single, pregnant woman and a pregnant woman with accompanying children, as the latter will be considered a 'family' but the former is not, depending on the timeframe at which pregnancy is taken into account in providing housing support. The level of support a pregnant woman receives is thus impacted by whether she has other accompanying children and the way pregnancy is defined by a service.

Homelessness: A lack of suitable housing or being at risk of homelessness due to the inadequacy of the dwelling and a lack of tenure, control and access to space for social relations (Australian Bureau of Statistics [ABS], 2012a). 'Suitable housing' relates to both the pregnant woman and her unborn baby and, in time, her newborn baby.

Pregnancy: Among service providers there was no single timeframe which was used to determine pregnancy as a factor in the receipt of support. This could span any unverified time during pregnancy to a minimum of seven months verified by a medical certificate, to full-term (Murray et al., 2018). In contrast, women who participated in this research defined themselves as pregnant from the time this had been verified, and as early as two weeks.

Research participants: The women who participated in the research through being interviewed about their experiences of pregnancy and homelessness (in this research it is used interchangeably at times with 'women' and 'participants').

Single woman: A woman who has no children, or a woman who has children, but they are not accompanying her.

Social housing: Secure, affordable, long-term rental housing for people on low incomes and/or with special needs. Social housing includes public housing managed by the State and community housing managed by not-for-profit organisations.

Transitional housing: Supported short-term accommodation. A key element of transitional housing is that it is a temporary option, and tenants must actively be working with their support provider to apply for long-term housing such as public housing or a private rental.

1.5 Outline of the report

This chapter outlined the background and research design. Chapter 2 is a summary of the international academic and grey literature concerned with pregnancy and homelessness, with a particular focus on pregnancy as a turning point for homeless women; women's sense of bodily autonomy during pregnancy; health outcomes for women and babies; and best-practice models for pregnant, homeless women's care. Chapter 3 introduces the women who participated in the research through the presentation of brief biographies and summary characteristics. Chapter 4 considers the circumstances in which women lived prior to becoming pregnant and their experiences of finding out they were pregnant. Chapter 5 discusses in detail the women's pregnancy experiences during homelessness and Chapter 6 focuses on their access to support during this period. Chapter 7 considers their experiences of preparing for motherhood and the support they received after their baby was born. Chapter 8 presents the report's conclusions and recommendations.

Chapter 2
Literature review

2.1 Introduction

A significant number of women experience pregnancy while homeless and have difficulty accessing housing support due to the heavy demand for these services. A two-week snapshot survey taken in 2017 of the homeless clients of Launch Housing and the Salvation Army Crisis Services Network found 6.4 per cent of their female clients were pregnant. However, many pregnant homeless women do not access homelessness services and it is believed the actual number of homeless women who are pregnant at any one time is higher than this (Murray et al., 2018: 30). While the number of homeless women in Australia who are pregnant remains unknown, international research suggests the rate is higher than among housed women (Bloom et al., 2004; Cronley, Hohn & Nahr, 2018; Thompson, Begun & Bender, 2016).

Homelessness can be one of a number of intersecting disadvantages for pregnant women, which can also include family violence, alcohol and drug use, and mental ill-health (Cutts et al., 2015). The kind of housing support pregnant homeless women need also varies depending on their circumstances, with some experiencing an acute housing crisis, while others may be in a longer-term, chronic period of homelessness.

This literature review is primarily comprised of scholarly material from a number of countries, including Australia, the United States, the United Kingdom, and Canada, and focuses on four key areas:

- pregnancy as a turning point,
- pregnant homeless women's sense of bodily autonomy,
- health outcomes for pregnant homeless women and their babies, and
- models of care for pregnant homeless women.

2.2 Pregnancy as a turning point

Pregnancy is a transformative experience and can function as a catalyst for change. For homeless women, learning of their pregnancy can offer a conduit towards accessing health care and other services they may be lacking (Begun, 2015). Whether planned or subsequently welcomed, a number of studies on pregnant homeless women have found pregnancy can provoke a hopeful sense of attachment and connection to their unborn baby, in contrast to many of the experiences of abandonment and isolation the women may have experienced in their lives (Thompson, Bender, Lewis & Watkins, 2008; Tucker et al., 2012; Winetrobe et al., 2013; Crawford, Trotter, Hartshorn & Whitbeck, 2011).

In a study on young homeless people in California, pregnancy and early parenthood were found to be an instigator for 'personal transformation' and overcoming past traumas (Smid, Bourgois & Auerswald, 2010). For the women who already had children, their current pregnancy was seen as a chance to demonstrate positive parenting skills which had been difficult for them to put into practice in the past. Another study which looked at the reproductive health histories of 20 women in Texas found resilience was a key characteristic of these women and necessary to overcome adversity and preserve their families (Cronley et al., 2018). Pregnancy was often unexpected, suddenly transforming their lives, and 'frequently not in a positive way'. However, Cronley et al. (2018: 328) suggest that when service providers are properly trained in identifying the relationship between unexpected pregnancies, reproductive-health related traumas and housing insecurity, pregnant homeless women may use the event of a pregnancy to achieve 'a renewed sense of autonomy and purpose'.

In Watson's (2018) research on young homeless women, becoming a mother became the impetus for one participant to leave an abusive relationship and find a safe environment, and the impending arrival of a baby girl prompted another woman to begin a methadone program. This opportunity for a 'new start' occasioned by pregnancy was also the focus of an Australian study on the effects of motherhood upon homeless women. In interviews with 24 young women who had experienced homelessness, Keys (2007) found that, while pregnancy prompted the women to make positive changes, it was often difficult for these changes to be realised due to structural and individual barriers such as unstable accommodation, substance use, poor mental health, and volatile relationships. Moreover, pregnancy can be a starkly paradoxical experience, exacerbating existing problems for some women: 'In some cases it's the making of them, in other cases you'd have to say it's the breaking of them' noted one participant (Keys, 2007: 32). Overall, however, pregnancy and early parenthood can be employed by service providers as a crucial time when women can feel particularly empowered to take steps to improve their lives.

2.3 Pregnant homeless women's sense of bodily autonomy

Pregnant homeless women are vulnerable to coercion and abuse in reproductive settings, with trouble accessing the services they need and then, at times, facing paternalistic and dismissive attitudes towards their care when they engage with health systems. For example, the ability to first avoid pregnancy is compromised for homeless women. Research on young homeless people indicates contraceptive use is infrequent and inconsistent (Anderson, Freese & Pennbridge, 1994; Anderson et al., 1996; Gelberg at al., 2002). Reasons for this vary, but one study of 974 homeless women in Los Angeles found the main deterrents to contraceptive use are fear of potential health risks, having a partner who disliked contraceptives, and cost. Homeless women with a history of substance use were especially likely to report not knowing how to use contraceptives, confusion about the most appropriate method, and prohibitively high cost as being deterrents (Gelberg et al., 2002).

Decisions pregnant homeless women make around whether to carry their pregnancy to term or to seek abortion services are under-examined in the literature despite the high incidence of pregnancy among homeless women, particularly young women (Begun, Combs, Schwan, Torrie & Bender, 2018). Connolly (2000) notes pregnant homeless women can feel a societal pressure to consider termination because of inadequate financial means to parent, a stigma which burdens them with a feeling of being irresponsible. Connolly adds the feminist frame of individual choice can sometimes overlook the constrained social, political, and economic context in which homeless women make decisions about their reproductive health. A 2001 study of homeless adolescent women in a youth walk-in clinic in Seattle found women were resorting to self-induced abortions using drugs, herbal abortifacients or physical abuse due to concerns about high costs and feeling embarrassed about going to a clinic (Ensign, 2001). A more recent study looking at abortion attitudes and experiences among a group of young homeless women in Denver also highlighted troubling rates of self-inducement, with participants citing fears of stigma, judgement and violence from family members if they attempted to access abortion safely (Begun et al., 2018). Already experiencing hardship, pregnant homeless women's intimate relationships are particularly susceptible to discord regarding pregnancy, including situations where one partner may desire the pregnancy but the other does not, leading to disagreements regarding termination (Smid et al., 2010). However, Begun, Frey, Combs & Torrie (2019) note that, for pregnant homeless women engaged in survival sex or whose access to contraception is poor due to cost, location, or in the context of reproductive coercion by their partner, abortion forms part of a vital set of resources required for homeless women to achieve healthy, fully informed outcomes.

Pregnant homeless women can experience a loss of control over their pregnancy and birth and may have their birth preferences ignored by health practitioners. This makes them more susceptible to unwanted interventions in the birth of their baby, such as cesarean sections (Cronley et al., 2018). Without stable housing, recovering from major interventions like a cesarean section, which typically takes at least six weeks to fully heal, is significantly more difficult, increasing the chance of serious post-surgical infection. In addition to complex birth outcomes, a range of other reproductive-related traumas are common among homeless pregnant women, such as miscarriage, abortion, infection and involuntary sterilisation, bringing with them feelings of loss and, at times, violation (Cronley et al., 2018). This sense of violation in reproductive settings is particularly troubling given pregnant homeless women have frequently been exposed to sexual abuse in their earlier years and, therefore, dismissing their birth preferences forms part of a wider pattern of erasure and disregard for their personal boundaries—a phenomenon that has been referred to as 'cumulative victimisation' (Haley, Roy, Leclerc, Boudreau & Boivin, 2004; Kennedy, Bybee & Greeson, 2015).

The inability to properly look after their health during pregnancy or to prepare adequately for motherhood also denies pregnant homeless women control over their lives. Moore's (2014) study, which utilised a phenomenological approach with a homeless pregnant woman, Amy, found 'a

lack of control' was a key theme. From the unplanned nature of her pregnancy, to losing her job, and eventually falling into arrears, Amy's ability to control her circumstances was consistently undermined by external, structural factors. 'Everything is in their hands' Amy asserted, referring to the institutions she kept coming up against (Moore, 2014: 146). Nickasch and Marnocha's (2009) analysis of homeless people's experiences of the health system reported similar sentiments among participants, many of whom felt that 'fate' and 'luck' played a significant role in how they were treated by service providers, with one participant explaining she felt like a victim of her circumstances and lacked any free will.

Homelessness exposes women to increased risk of gendered violence (Murray, 2011; Watson, 2016). A longitudinal study of homeless adolescent women in the United States found two-thirds of the young women had experienced physical victimisation, with almost one half (46.6 per cent) experiencing sexual victimisation (Crawford et al., 2011). Substance use further increases pregnant homeless women's likelihood of victimisation. Sales and Murphy's (2000) qualitative study of 126 pregnant substance users, two-fifths of whom reported a period of homelessness in the six months prior to being interviewed, found 79 per cent had experienced violence during pregnancy. Without adequate housing, these women had no safe environment for themselves and their children and an unsteady foundation on which to devise a plan to leave their violent situation.

Homelessness sites, including the streets, rooming houses, private motels and other emergency accommodation, can be dangerous places, especially for women (Chamberlain, Johnson & Theobald, 2007; Robinson, 2010; Murray, 2011; Watson, 2018). The dangers associated with homelessness can lead women to rely on men for accommodation, material support and physical protection (Reeve, Casey & Goudie, 2006; Watson, 2016). Some homeless women manage this increased threat of violence by engaging in forms of survival available to them in the masculine-dominated homeless field (e.g., survival sex) by forming bodily alliances with men (Watson, 2018), which can result in pregnancy. Survival sex is often connected with commercial sexual activity; however, there are important distinctions which apply for homeless women, including that it does not always involve a clear fee-for-service transaction, the length of time spent together is unclear, it can occur within existing relationships, and the women do not identify as sex workers (Preston-Whyte, Varga, Oosthuizen, Roberts & Blose, 2000; Watson, 2018; Wojcicki, 2002).

2.4 Health outcomes for pregnant homeless women and their babies

A significant amount of literature on homeless pregnant women focuses on the health implications for the woman and her baby. Babies born to homeless women are at a high risk for low birth weight and preterm birth (Esen, 2017; Cutts et al., 2015; Moore, Arefadib, Deery, Keyes & West, 2017), with nearly a threefold increased risk for the latter (Little et al., 2005). A number of medical complications are more likely to manifest as babies of homeless women grow, such as asthma, respiratory problems, infectious diseases, trauma-related injuries, visual and neurological deficits,

and developmental problems (Cutts et al., 2015; Chapman, Tarter, Kirisci & Cornelius, 2007; Little et al., 2005; Moore et al., 2017; Stanwood & Levitt, 2004; Stein, Lu & Gelberg, 2000). Once they reach school age, the children of homeless women can experience problems with school adjustment as well as educational delays due to absenteeism and high dropout rates (Powers & Jaklitsch, 1993). Breastfeeding has considerable public health benefits but is less likely to be initiated or continued by homeless women due in part to a lack of access to lactation resources (Richards, Merrill & Baksh, 2011).

Physical complications for pregnant women can include anaemia, inadequate weight gain, bleeding problems and other acute and chronic health problems (Bloom et al., 2004; Thompson et al., 2016). The rates of maternal stress and anxiety are experienced at a higher rate in homeless women, and considerable discoveries in this field of study have been made (Banyard & Graham-Bermann, 1998). Stress is associated with hypertension and cortisol production, both of which are linked to low birth weight in infants (Ashdown-Lambert, 2005; Cutts et al., 2015). Exposure to stress in utero has also been linked with congenital malformations, cerebral palsy and behavioural and emotional disturbances in children (Hansen, Lou & Olsen., 2000; Li et al., 2009; O'Connor, Heron, Golding, Beveridge & Glover, 2002). For the women themselves, the toll of managing a pregnancy while homeless can trigger a mental health episode or exacerbate existing mental health problems. Research indicates pregnant and parenting homeless women experience disproportionately high rates of major depressive disorder compared with the housed population, but stigma remains a big problem in this area, causing many pregnant and parenting homeless women to feel a clinical diagnosis will lead to child welfare involvement and loss of their children (Bassuk & Beardslee, 2014).

Pregnant homeless women have difficulty accessing prenatal care and, therefore, may not be screened for common pregnancy complications such as gestational diabetes, preeclampsia, infection and stillbirth. Early and regular prenatal care is crucial, but ensuring it is accessible to homeless women has been a challenge. One study examining access to prenatal care among 183 pregnant homeless women in Florida found key barriers for the women included trouble getting transportation to appointments and difficulty arranging a babysitter for the children in their care (Bloom et al., 2004). When pregnant homeless women do access prenatal care, the unique set of needs which arise due to the intersection of homelessness and pregnancy are not always identified or dealt with in a 'pregnancy-friendly' manner (Murray et al., 2018).

Exposure to domestic or family violence, for which homeless women are especially vulnerable, can also have devastating consequences for maternal and foetal outcomes, including

> complications resulting from abdominal trauma, such as abruptio placentae, fetal fractures, uterine rupture, and antepartum hemorrhage. Indirect causal pathways can be related to physical and psychological stress of the mother, imposed isolation

> leading to poor access to prenatal care, poor maternal nutrition related to financial restraints or food deprivation by the abusive partner, and behavioral risks such as smoking cigarettes as a reaction to the adversity of the violent, controlling relationship (Newberger et al., 1992, as cited in Espinosa & Osborne, 2002: 308).

As the existing research indicates, for pregnant homeless women there are many co-occurring disadvantages which can have negative health consequences for the woman and her baby, highlighting the importance of collaborative responses between health and housing sectors.

2.5 Models of care for pregnant homeless women

The models of care identified in the literature as most successful for addressing the needs of pregnant homeless women include group models of care (Fleming, Callaghan, Strauss, Brawer & Plumb, 2017), comprehensive prenatal care (Ovrebo, Ryan, Jackson & Hutchinson, 1994), housing-led initiatives (Feinberg, Trejo, Sullivan & Suarez, 2014) and caseload midwifery care (Rayment-Jones, Murrells & Sandall, 2015). A group model of care combines prenatal care with a group format in which pregnant women can receive integrated care, 'where education, peer support and psychosocial issues are included in the prenatal care delivery system' (Fleming et al., 2017). For pregnant homeless women who experience a multitude of barriers to adequate prenatal care, Fleming et al.'s research indicates that a group model can specifically overcome a number of issues frequently identified by these women, such as feeling a lack of control and a need for better support systems. Moreover, a randomised control study of women which compared group model care to regular prenatal care found a third reduction in preterm birth, as well as significantly better prenatal knowledge, increased preparedness for labour and delivery, and higher breastfeeding initiation (Ickovics et al., 2007). These findings have been replicated for high-risk groups like homeless women, in which both obstetric outcomes and psychosocial outcomes are improved under a group model of care (Byerley & Haas, 2017).

The *Homeless Prenatal Program* (HPP) has been running for 25 years in San Francisco and involves comprehensive, wraparound care. HPP embraces an ethos of 'giving back' by hiring former clients as case managers for the 4,000 families who access the program each year. HPP provides a range of services including 'housing, prenatal and parenting support, child development, family finances and stability, access to technology, domestic violence and substance abuse, family unification, and emergency support of basic needs' (Homeless Prenatal Program, 2019). A program evaluation conducted in HPP's early years noted the program's emphasis on a two-pronged approach to prenatal care which works on both personal empowerment and changing the structural and material conditions of the homeless women's lives to achieve better birth outcomes and promote the mother-child connection (Ovrebo et al., 1994).

Using housing as a strategy to improve birth outcomes was the core idea behind the Healthy Start in Housing (HSiH) program, which has been running in Boston since 2011. It is the first

program of its kind in the United States, forging a collaboration between the Boston Housing Authority and the Boston Public Health Commission and acknowledging the integral link between stable housing and healthy mothers and babies. A 2014 study on HSiH found it was successful in terms of achieving its objectives. This occurred in part because it was built on a 'housing first' approach, which focuses on problems of chronic homelessness, and integrated the former into a holistic model of care designed to resolve housing needs within a framework which recognised the specific needs of pregnant homeless women (Feinberg et al., 2014).

In Australia, caseload midwifery is being increasingly offered as a model of care in public hospitals due to its association with fewer childbirth interventions such as epidurals, caesarean sections and forceps deliveries, as well as increased maternal satisfaction and lower burnout rates for midwives (Dawson, Newton, Forster & McLachlan, 2015). This model places an emphasis on continuity of care and involves a pregnant woman seeing the same one or two midwives for the duration of her pregnancy who also attend the birth. Research points to benefits of caseload midwifery for women experiencing homelessness and other forms of social disadvantage, with one study conducted by Rayment-Jones et al. (2015) noting a third higher rate in spontaneous, vaginal childbirth than women receiving standard prenatal care. The women in this study were also much more likely to be referred to housing, psychiatric, domestic violence and parenting support services. In Australia, caseload midwifery care tends to be restricted to women deemed 'low risk' in their pregnancy, but there may be significant health benefits to offering this model to pregnant homeless women.

2.6 Conclusion

While certain areas of research investigating pregnant homeless women have been well-documented in the literature, namely maternal and infant health outcomes relating to the stress and substance use often associated with homelessness, there remains scarce knowledge about pregnant homeless women's experiences, including their attitudes towards abortion and related reproductive traumas. Much of the literature focuses on young women under the age of 25, and tends to be set within the unique political, economic and medical settings of the United States. Recent Australian studies suggest there is cause for further examining the potential benefits of caseload midwifery care for pregnant homeless women, with its potential to link women into appropriate supports and reduce the risk of interventions in childbirth.

Chapter 3
Introducing the research participants

3.1 Introduction

The aim of this research was to highlight women's perspectives of pregnancy and homelessness and to complement the research undertaken by Murray et al. (2018) which analysed the views of health and homelessness service providers. Consistent with an approach which values the individual subjectivity of each woman, in this chapter, brief biographies are presented first, followed by a summary of key demographic characteristics.

3.2 Brief biographies

Alishba is a 26-year-old partnered Australian-born woman of a CALD background with a 4-month-old child and two other children in kinship care. During her most recent pregnancy, Alishba spent time couch surfing but the environment was unclean and unsafe with little privacy, and much drug use was occurring around her. She suffered two needle-prick injuries during this time. Alishba received antenatal care through a specialist women's hospital-based support service which assisted with methadone stabilisation during her pregnancy. Alishba was referred to a specialist housing service and, as a result, had recently moved into transitional housing and has public housing available for her to move into when she is ready.

Alya is 31 years old and has two children—a girl aged four years and a boy aged 18 months. She was born in the Middle East and has lived in Australia for five years. During the period of pregnancy and homelessness she did not have permanent residency. Alya was sponsored to come to Australia by her husband who has lived in Australia for 20 years. Alya became homeless when she was pregnant with her son due to family violence, which involved her husband assaulting her in an attempt to force a miscarriage. After staying in a motel for one night, Alya contacted a specialist women's domestic violence service and she stayed alone in another motel for a month before she and her daughter were placed in a women's refuge for four months. Alya moved into transitional housing a month before giving birth to her son. The conditions at the refuge were difficult due to another resident's violent behaviour towards Alya and her daughter. The stress of being homeless badly affected Alya's health while she was pregnant.

Amanda is a 21-year-old partnered Australian-born woman of English-speaking background with three children in her care, including a 16-month-old. While pregnant with her first baby at 16, Amanda was forced to move out of home due to ongoing family violence which was posing a serious risk to both her and her baby. Amanda then spent some years in residential care, first living in a unit for young mothers and then in a more independent form of residential care. More

recently, Amanda has been living in transitional housing provided by a specialist young women's service and is waiting on a place in public housing.

Amelia is a 36-year-old single Australian-born woman of English-speaking background whose three-month-old child is in foster care. While she has regular contact with her child, Amelia is waiting to undertake drug rehabilitation before she will have the opportunity to have care of her full-time. During her pregnancy Amelia lived in a large shared community house, which posed considerable challenges in terms of accessing basic facilities for cooking and bathing. Prior to her pregnancy, Amelia had periods of rough sleeping brought on by the impact of episodic mental illness. Amelia's child has brought considerable joy into her life.

Bianca is a 22-year-old single Aboriginal woman who was seven months pregnant at the time of interview. Most of her pregnancy had been lived in her car until moving to transitional housing three months before giving birth having received assistance from a specialist young women's service. Prior to this pregnancy, Bianca suffered a miscarriage whilst living in her car, an experience she largely had to manage in public toilets and hotels. Since being kicked out of home in her mid-teens, Bianca has had episodes of mental ill-health but has benefited from receiving good support and stable housing.

Carolyn is a 25-year-old partnered Australian-born woman of English-speaking background who was eight months pregnant at the time of the interview. Carolyn has two other surviving children who are both in foster care. While now in public housing, Carolyn had periods of sleeping rough, couch surfing, and living in crisis accommodation and a motel earlier in her pregnancy. She initially sought drug detoxification in a large regional centre when her pregnancy was confirmed but was unable to get the support she needed so came to Melbourne. Despite these earlier thwarted attempts, Carolyn reported very positive experiences with services.

Donna is a 24-year-old single Australian-born woman of English-speaking background with a six-month-old child in her care and two other surviving children in foster care. Donna lost her second child to stillbirth. During her most recent pregnancy she lived for some time at a specialist young women's refuge as well as in other crisis accommodation where she felt unsafe. Previously, Donna had experienced periods of incarceration, sleeping in her car and sleeping rough, during which time she suffered sexual assaults. Donna developed a health issue during her pregnancy which made maintaining regular contact with services difficult. Donna moved into transitional housing before the birth of her youngest child where her ability to relax and prepare made a significant difference.

Jenna is a 32-year-old single Australian-born woman of English-speaking background who has an 18-month-old child. Jenna was homeless throughout her pregnancy, which included periods of sleeping rough and couch surfing. She has had long-term alcohol and drug use, with drug

rehabilitation undertaken prior to the birth. Jenna accepted little care until she was seven months pregnant and acknowledged she did not take up what she now considers to be very good support until this time. The birth of her child has been a major turning point and has provided the impetus to make major changes in her life.

Kate is a 26-year-old single Australian-born woman of English-speaking background parenting a seven-month-old child and with two older children in foster care. She has experienced family violence and periods of homelessness. Kate did not receive any antenatal care as she was unaware of her pregnancy until she gave birth, at which time she entered drug detoxification and rehabilitation programs. During her most recent pregnancy she had very positive experiences of midwifery support.

Layla is 27 years old and was seven months pregnant with her first child at the time of interview. Born in the Middle East, at the time of interview, Layla had been in Australia for 18 months on a spouse visa. She had recently received permanent residency but was not eligible for income support payments, depending instead on her husband's Newstart payments for financial support. After arriving in Australia, Layla lived with her husband in a shared house but when the other residents moved out, they became homeless as they could not afford the rent. They were placed in a hotel for a week by a welfare agency at which time Layla discovered she was four weeks pregnant. Over the next month, Layla and he husband spent four nights in a hotel paid for by a welfare organisation, then couch surfed at the home of an acquaintance and slept in their car. After this, Layla and her husband were accommodated in crisis accommodation before being moved into transitional housing.

Melanie is a 24-year-old single Australian-born woman of English-speaking background with a six-month-old child. Melanie became homeless early in her pregnancy due to family violence and ended up couch surfing and staying in motels. Melanie has a medical condition which increased her risk of miscarriage and preterm labour, requiring bedrest at a time when she did not have housing. Melanie made contact with housing services and spent just over two months in crisis accommodation before getting permanent community housing through another housing service when she was six months pregnant. With that permanence, Melanie was able to prepare for the arrival of her first baby and is now making plans for her future career.

Sally is a 29-year-old partnered Aboriginal woman with a newborn baby and an 18-month-old child. Sally experienced family violence from the father of her first child, and during this time was sleeping rough. She moved into transitional housing before the birth of her first child but was evicted after she became the victim of another violent attack from her ex-partner. Sally was sleeping rough for much of her most recent pregnancy, during which time she slept under bridges, had no access to clean clothes or showers, and was robbed and intimidated. Sally had positive experiences with her antenatal care, and this provided links to more supports. With

assistance from a generalist housing service, two months before giving birth, Sally again moved into transitional housing and now lives in public housing with her partner and children.

Sarah is a 35-year-old partnered Australian-born woman of English-speaking background with a 15-month-old child. She became homeless for the first time when evicted from a shared house due to the pregnancy. Sarah and her partner then lived in an unclean and unsafe private boarding house and later crisis accommodation which was also unsafe and did not suit her circumstances. Although their housing was inadequate, she was able to access helpful support for her pregnancy and other health needs, and eventually secured public housing.

Tania is a 26-year-old single Australian-born woman of English-speaking background with a 12-month-old and a five-year-old in her care. At the time she fell pregnant, Tania was living in overcrowded public housing and needed to leave. She spent some time in private rental but it was too expensive and she had to deal with complaints from a neighbour about her older child making noise. At eight months pregnant, Tania moved into transitional housing. She experienced health issues in both pregnancies and both children were born with low birth weight. Tania has experienced ongoing mental ill-health which has made advocating for herself and engagement with services more challenging; however, she is currently receiving supports which she feels positive about.

3.3 Summary of research participants' demographic characteristics

3.3.1 Age of research participants at most recent pregnancy

The women's age at the time of most recent pregnancy ranged from 20 to 36 years, with an average of 27 years. Most women were aged under 30 years, as indicated in Figure 1.

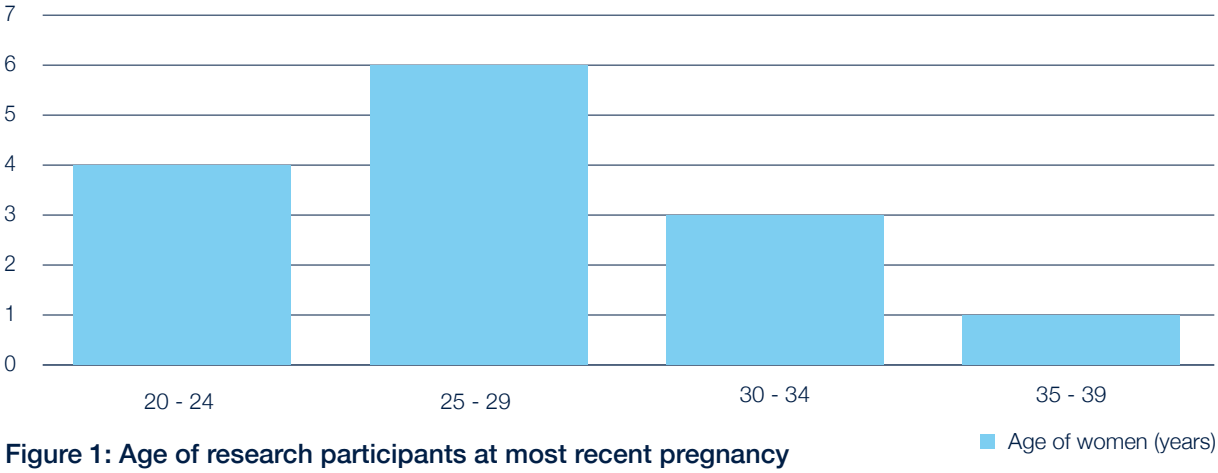

Figure 1: Age of research participants at most recent pregnancy

3.3.2 Diversity of research participants

The group of research participants included two Aboriginal women, three women of CALD backgrounds and nine Australian-born women of English-speaking background. Half of the group of women disclosed a history of mental ill-health and two-thirds problematic alcohol and/or drug use. Two other women reported sensory loss and ongoing physical ill-health.

3.3.3 Number of births and care of children

Among the women there had been 25 births, including two stillbirths, and three women were pregnant at the time of interview. Fifteen children, including one step-child, were in the care of their mother at the time of interview, and nine children were in foster or other forms of out-of-home care. Five of the women were aged 21 years or under at the time of their first pregnancy and all were homeless when this baby was born. Indeed, all of the women except one had experienced homelessness during all of their pregnancies.

Four women had one child and another two were expecting their first child; the other eight women had larger families, as indicated in Figure 2.

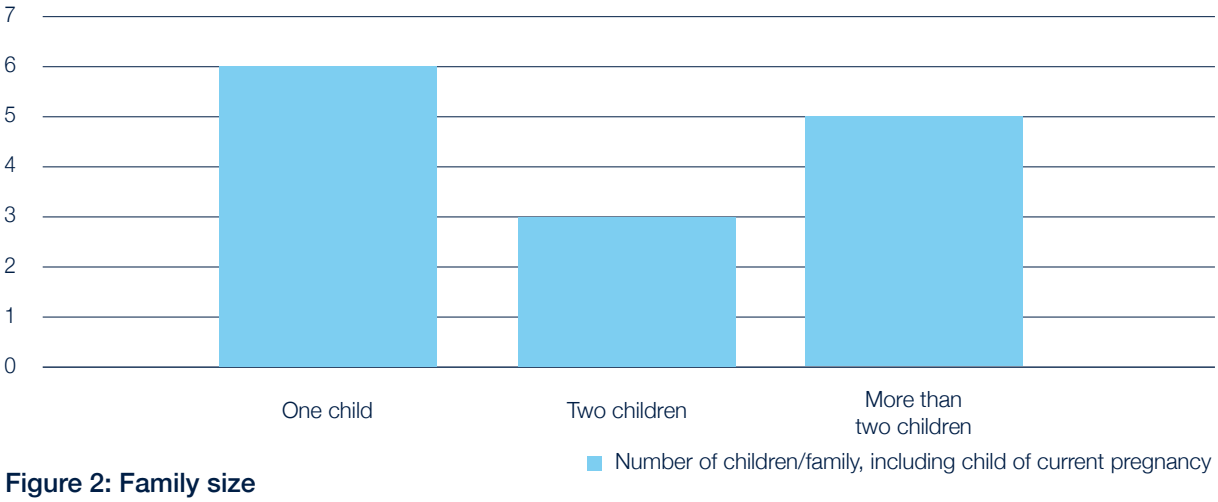

Figure 2: Family size

3.3.4 Living arrangements

During pregnancy and homelessness, the women experienced the breadth of living arrangements including rough sleeping, couch surfing, sleeping in cars, hotels, motels, shared houses, private rooming houses, crisis accommodation, emergency accommodation, youth refuges, specialist young women's refuges, specialist women's family violence refuges, residential drug detoxification and rehabilitation facilities, prison, community housing and public housing.

At the time of interview, only five women had secured long-term secure housing, as indicated in Figure 3. However, one woman's community housing was of poor quality, unsuited to a child, and she could not stay there if she gained the care of her baby. Most women were living in relatively stable accommodation but with uncertainty regarding their long-term housing.

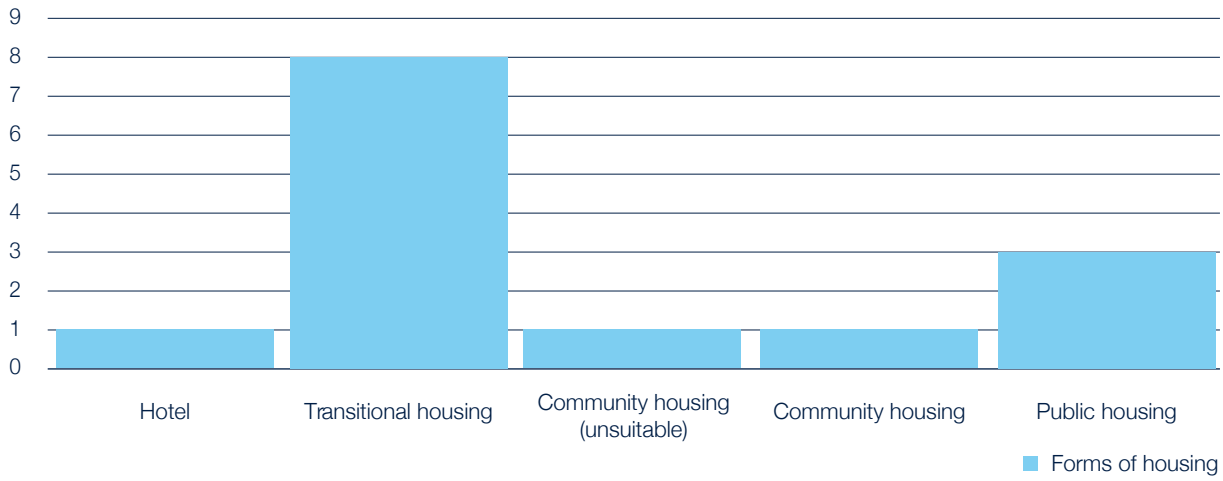

Figure 3: Housing at the time of interview

Chapter 4
Before pregnancy and finding out

In my experience, I would say family violence, mental illness, drug addiction, homelessness, the whole lot comes hand-in-hand.

Kate

4.1 Introduction

This chapter recounts the women's early experiences of being pregnant and homeless and, as Kate suggests, there are co-occurring issues which can compound the difficulties of pregnancy. First, this chapter considers the women's circumstances leading up to becoming pregnant and homeless. A majority of the women reported traumatic experiences in their earlier lives which contributed to them becoming homeless, and subsequently being homeless when they became pregnant. For some, these earlier experiences cascaded into longer-term issues including family violence, problematic alcohol or drug use and mental ill-health and, in turn, added to them not having safe and secure housing while pregnant. For others, there had not been such earlier experiences and becoming pregnant had, in itself, precipitated homelessness. Second, this chapter reflects on the women's experiences of finding out they were pregnant. For a range of reasons, the women did not always know they were pregnant, and this awareness of their changed status is explored from their perspectives.

4.2 Living with trauma

Of the 14 women, nine discussed a range of traumatic experiences they had endured in their lives prior to or upon finding out they were pregnant, including family violence, child sexual abuse and adult sexual assault. For these nine women, their experiences of violence triggered their homeless circumstances because it simply became too dangerous to remain living with their abuser/s. Five women did not disclose experiencing violence prior to falling pregnant, and in their accounts instead noted insecure residency, drug use, incarceration and mental ill-health among the factors which contributed to their homelessness.

For the women who spoke about their traumatic pasts, some reflected on how it had shaped their trajectories in life. Bianca, for example, was kicked out of home at 15 years old after defending herself against her mother's abusive boyfriend and then lived 'in a park under a slide for about two weeks'. She moved around a lot after leaving home, including a period of time living with her aunt where she was exposed to a violent assault, as she explained:

> [I was] living with my aunty for about nine months and she was raped by four men while I was in my room … so I went to a homeless shelter … asked for support, told them that I was suicidal, so they called the ambulance, the CAT team, the police.

Bianca described feeling like she did not have any family support until after having her son and getting her own place, both of which precipitated reconnecting with her family. As she explained: 'I've been through depression due to sexual assault and rape in my past but, yeah, I couldn't bring myself to tell any of my family what happened to me because I had no support there'.

Jenna and Amanda experienced other forms of violence in their family of origin. Jenna described how her experience of childhood sexual assault had been exacerbated by her mother continuing to have a close relationship with her abuser, including visiting him in gaol despite having knowledge of the nature of the abuse. Amanda recalled having to put herself in harm's way to protect her younger siblings:

> So, growing up as a child I went through family violence [and] I was the eldest out of five … instead of having Dad hit my younger siblings, I'd take it all which probably didn't help my upbringing because after that I went out and became a little party animal and just got drunk every night, went out and smoked weed … like I didn't really care.

Five women recounted their homelessness began or worsened after suffering abuse at the hands of their partner. Studies on gender-based violence and homelessness note the paradoxical role men play in the lives of homeless women. Although homeless women will sometimes form intimate relationships with men to access a sense of safety and protection in an environment which is hostile to them, these relationships can also be unsafe for women and make their housing circumstances more insecure (Watson, 2016). Sally's ex-partner was violent towards her, and the situation was so volatile she ended up losing her transitional housing accommodation. Sally explained that 'nobody helped me really to get a house again, they just chucked me in hotels and that because of how fearful they were of him coming back'. She eventually fell pregnant while sleeping rough and did not move into more secure housing until two months before her baby was born.

Melanie's partner had been 'extremely abusive' and, when she fled for her safety, it triggered 'a few rocky years'; however, she was beginning to get back on her feet after securing long-term community housing. Donna also had to flee an abusive relationship. Before falling pregnant with her now six-month-old daughter, Donna and her two older children were removed from their home due to her ex-partner's violent behaviour, leading to a long period of homelessness which included sleeping in her car and couch surfing. Years earlier, Donna left a residential unit for teenagers to move in with her partner and described how not having other family to turn to left her dependent on her partner to keep a roof over her head. Once she fell pregnant with their first child, the violence and financial manipulation escalated, continually sabotaging Donna's opportunities to house herself and her children. For another participant, Jenna, a violent kidnapping and assault which occurred because of a debt owed by her partner pushed her into homelessness: 'I was homeless after that … [until] about six months before pregnancy'.

Before falling pregnant, Kate had been moving between her parents and her partner's parents' households. Family violence was occurring in both homes, and Kate's partner also posed a significant threat: 'I could have died realistically because of how violent he was'. Kate reflected on how difficult it was to unlearn the abuse she experienced as a child: 'Most people actually don't realise because it's taught to us from a kid so that's what we're used to'. She added:

> Like, I remember when they [service providers] first told me healthy relationships, you can have an argument without yelling and it boiling up. I literally turned around to the worker last year and said, 'you've got to be joking'. Like, 'where do you come from, lovely?' Like, not in my world. I'd never heard such a thing.

The circumstances in which women were living were to then impact on when and how they found out they were pregnant.

4.3 Finding out

The women's experiences of finding out they were pregnant were influenced by a range of factors related to their mental and physical wellbeing and whether they were living in stable housing. Troublingly, four participants spoke about the patterns of abuse in their relationships becoming more severe in response to their pregnancy, reflecting research which has shown pregnancy to be an aggravating factor in domestic and family violence (Johnson et al., 2003). Some women experienced this onset or escalation in violence after finding out they were pregnant. Jenna's partner reacted violently: 'When I told him I was pregnant, he put me in hospital'. The father of Melanie's baby responded by threatening to induce a miscarriage. She reported he told her 'if you don't terminate, I'm going to come and terminate it for you'. Donna's ex-partner went so far as to attempt 'to do his own caesarean'. Alya and her daughter became homeless after escaping from her husband who attacked her when he found out she was pregnant with their second child. After escaping and disclosing the assaults to the police, Alya was put in a cell at the police station and effectively criminalised. With the added complexity of requiring an interpreter, Alya faced many challenges navigating the legal system and housing services.

The severity of housing stress impacted the experience of finding out about the pregnancy. Bianca learned she was pregnant while living in her car, a situation she described as 'the worst'. This was preceded by rough sleeping and periods of time sleeping at different relatives' overcrowded houses for short stints. Carolyn's housing situation was similarly precarious; she had been staying in a motel when she realised she was pregnant, but soon had to start sleeping in her car as a way of escaping heavy drug use in her previous accommodation.

For participants in more stable housing at the time they learned of their pregnancy, the possibility of successfully withdrawing from drugs and alcohol seemed more hopeful. Amanda was living in transitional housing and had been drinking heavily and using marijuana when she fell pregnant

but disclosed that '[I] found out I was pregnant with my daughter and from there I have pretty much gone cold turkey from everything'. For Tania as well, being older and, as she stated, 'more settled' in transitional housing where she was linked in with services, made her recent pregnancy significantly easier than her first. Tania was supported by the specialist Women's Alcohol and Drug Service (WADS) at the Royal Women's Hospital through her pregnancy and felt better able to advocate for herself: 'I was a lot stronger the second time around because I know now—I knew what to say and what rights I had'.

For some, finding out about the pregnancy was the catalyst for greater uncertainty. Sarah had been living in a share house for six months with her partner and a long-time friend, but upon disclosing her pregnancy to her friend, she was abruptly told to leave. Following this, Sarah spent most of the remainder of her pregnancy in unsafe temporary accommodation, trying to find somewhere stable to where she could bring her baby home. Similarly, when Jenna disclosed her pregnancy news, the friend she had been relying on for a place to stay reacted strongly: 'I found out I was pregnant and then she kicked me out and then I was homeless for probably – from three months pregnant to about six months pregnant'. Layla's circumstances were already tentative when she received the news from her doctor she was pregnant: 'Three days after staying in [a] hotel, I got a baby check and I realised that I [was pregnant]'. After having one more week of accommodation provided by a welfare agency, Layla and her husband began sleeping in their car. Being recently-arrived migrants, they did not have a large network of family and friends to help them navigate such a big life transition: 'We didn't have anyone, it was just both of us'.

A common theme among the participants is that their pregnancies, while often welcomed, were overshadowed by their acute experiences of homelessness, problematic drug and alcohol use, family violence, and mental ill-health. Managing these complex and co-occurring issues took up much of their time and attention, undermining their ability to focus on their unfolding identity as a mother and on preparing materially and emotionally for a new baby. This meant finding out about the pregnancy sometimes came at a late stage, and for one of the participants, Kate, it was not until she delivered her daughter alone in a bath that she realised she had been carrying a baby for the past nine months. Amelia was also unaware she was pregnant until halfway through. Four months before giving birth, Amelia began antenatal care at a community health clinic.

4.4 Conclusion

In this chapter it is evident violence during childhood and in their intimate relationships impacted on the women's ability to secure long-term stable and safe housing before and during pregnancy. For others, their pregnancy precipitated homelessness. For some, not finding out about their pregnancy until late left little time to obtain support for housing, problematic alcohol and drug use, mental ill-health and family violence. In the next chapter, we further consider women's experiences, particularly in relation to the forms of accommodation and the impact these had on their pregnancy.

Chapter 5
Enduring homelessness and pregnancy

They can't guarantee that they're going to move you somewhere that's safe until your baby is actually born, which is the most stressful idea.

Sarah

5.1 Introduction

First, this chapter presents a detailed picture of women's lives during homelessness and pregnancy, paying close attention to the various forms of unsuitable accommodation available and the impact they have on women's health and their ability to stay safe and prepare for motherhood. Second, as Sarah highlights, the chapter notes difficulties in accessing long-term secure housing and, for some women, the complexities of managing the need to access support for alcohol and drug use, family violence and mental ill-health.

5.2 Homelessness during pregnancy

5.2.1 Unsuitable forms of accommodation

The research participants described living in a range of unsuitable and unsafe forms of unsupported accommodation while homeless during their pregnancies which included private rooming houses, hotels, motels, cars and couch surfing, as well as sleeping rough. Participants' accounts (as detailed below) reveal their safety was undermined in masculine-dominated homelessness spaces, where their exposure to environmental violence was common (Watson, 2018; Murray, 2011; Robinson, 2010). They also revealed a range of immediate health and wellbeing implications which stemmed directly from living in inappropriate and insecure environments.

Rooming houses and sleeping rough were described by participants as violent and lacking in security, which undermined their safety and wellbeing. Sally described how she slept rough under an inner-city bridge while heavily pregnant and sought to stay near light in order to be safe. During that time, Sally experienced victimisation including theft, where people would 'just take your money and stuff like that and stand over you'. Following an eviction from a share house, Sarah and her partner were referred to a private rooming house by a specialist homelessness service while she was in the early stages of her pregnancy. Sarah experienced anxiety from the violent behaviour to which she was exposed and was unable to obtain support to find more suitable accommodation. As Sarah explained:

> I'd wake up in the morning and I'd be cleaning up blood off the floor, like there'd be really bad fights all the time … you could hear everything happening in the house and fighting in the middle of the night … I didn't even think the lock on our door was

> going to help; I was so afraid that somebody was just going to come through the door and start going off at us … so we went back to [our service provider] about it and they said there wasn't really anything they could do.

Sarah also described how she was forced to 'go out in the car … [and] driv[e] around all night' because she didn't 'want to stay home'. This was particularly difficult given she was 'really tired' from her pregnancy.

The masculine-dominated nature of rooming houses also restricted some participants' ability to safely and comfortably access communal facilities. Amelia explained how she was required to share a bathroom in a community rooming house with many men until late in her pregnancy, which limited her capacity for privacy and comfort:

> It got really hard at the end because it was the middle of summer and the last couple of weeks I got really wide … and I didn't have a lot of clothes to wear and I was in and out of the shower and … it wasn't nice. It would have been so lovely just to have my own bathroom just to … sit in privacy.

Obtaining nutritional and fresh food to support their pregnancies was also particularly difficult in rooming houses, as well as for those living in cars. For example, Amelia was not comfortable accessing the communal kitchen in the community rooming house she resided in because it was dominated by another resident, which undermined her ability to purchase and prepare healthy and well-balanced meals and increased her reliance on takeaway food. Sarah too explained how her diet was restricted due to being forced to 'live on noodles' as a consequence of exorbitant rent charged by her private rooming house provider.

The safety and wellbeing of participants was also compromised when couch surfing. These situations enhanced their vulnerability to sexual violence and theft, alongside persistent exposure to drug and alcohol use. While pregnant with her son, Alishba was forced to couch surf, and experienced ongoing invasions of her privacy, theft of food and money, as well as needle-stick injuries resulting from residents not disposing of used syringes. This caused considerable anguish during her pregnancy, which continued following the birth of her son.

Donna experienced extensive sexual violence while couch surfing, which compounded her drug use, including while pregnant. She reflected on how experiences of sexual assault were a key catalyst for her to continue using drugs 'until [she] was 16 weeks pregnant'. Her extreme vulnerability to sexual violence was enmeshed with drug addiction, which served as a strategy to manage the trauma of her experiences by 'knock[ing] [her] out'. It was also a means of managing her safety by 'rely[ing] on drugs to keep me awake'. Constant exposure to drug and alcohol use while couch surfing was particularly challenging for women like Donna who were using substances

heavily. Participants faced significant constraints on their ability to minimise or stop using under these conditions, which prohibited their ability to progress a safe and healthy pregnancy and envisage a future as a mother. Carolyn explained how she too was unable to stop using drugs while couch surfing because 'the ice was there, the marijuana was there, the alcohol … and I was trying to quit for the baby and I couldn't'. This led to the frightening prospect that her baby was 'going to die' unless she was able to move away from this location (and the general area) and access support.

Four participants spent time living in their cars while pregnant, which they considered a safer option than couch surfing because it provided an improved sense of security. Donna explained how living in her car provided protection from sexual assault: 'I used to live in my car. I actually kind of prefer that because that was my security with a lot of sexual assaults from couch to couch'. However, despite an improved sense of security, participants described various practical challenges which accompanied living in cars, including the difficulty of managing hygiene (e.g., oral health), dealing with extreme weather conditions, and fitting belongings into the small space of a car. In total, Bianca and her partner lived for ten months in their car. During this time, she discovered she was pregnant. She was forced to sleep uncomfortably in the front seat, as she described: 'My boot was full, my back seat was full, so literally all I had was my front seat to sleep in and it was the worst. But I dealt with it'. Bianca also explained that, despite moments of respite afforded through showering, as her pregnancy progressed, it became increasingly arduous during the harsh winter conditions:

> I always felt like I stunk even though I was showering every day because I was going to a swimming pool every day just to have a shower. But it was just getting harder and harder because you'd walk into the shower, you'd want to stay in there for hours on end but can't, because the water goes cold.

Bianca was five months pregnant before finally moving to a transitional housing property.

While ostensibly a better option than sleeping rough or living in cars, residing in hotels and motels also presented difficulties for women, particularly when they were left without adequate support. Often women and children are placed in motels while awaiting refuge and do not receive adequate emotional and practical support (Murray, Bullen, Watson & Theobald, 2017). Alya, for example, was placed in a hotel for a month while pregnant after leaving an abusive relationship. The uncertainty this produced left her feeling so 'distressed' that her 'blood pressure dropped' to the point where her 'doctor said she [will] have a stroke if you don't take her to the hospital'. Alya was then admitted to hospital for two weeks.

5.2.2 Survival sex

Survival sex is the exchange of sex for material provisions such as accommodation, food, and alcohol and other drugs (Watson, 2018). It may also be used by women as a way to provide for

non-material needs such as physical protection and improved status through bodily alliances with men in environments which are highly hazardous for women (Watson, 2016). For Jenna, survival sex was an alternative to sleeping rough:

> Yeah, I was sleeping outside at times … I'd go home with men I didn't even know and hang out with them all night. Sometimes I would sleep with them—I don't even really remember half the time. Because I was pregnant, I thought I'm not going to get pregnant again, so I was just such a mess. It was terrible.

As noted in the previous chapter, Jenna described an experience six months before she was pregnant when she was kidnapped, held hostage and bashed. Experiences such as this provide a context for why women perceive survival sex as a viable resource for managing their safety:

> I was actually kidnapped and I was held hostage at a place and I was brutally bashed and I nearly died. They broke my jaw, I had to get an operation … because the man owed money, the guy I was seeing. He couldn't pay, so they took me—he let them take me.

Donna relied on a man she referred to as a 'sugar daddy' to provide accommodation when the car she was living in broke down:

> No car, no roof, no nothing and, luckily, I had one of my friends—it's kind of complicated, more like a sugar daddy we'll just say. Basically, he obviously put me in accommodation, hotel, but obviously that—being a sugar daddy—obviously you have to pay both ways, so as long as I took care of him, he would pay for the hotel.

Donna described some of the complications which can arise from survival-sex arrangements. The man with whom she was involved was also her drug dealer; during this time, she was often substance-affected and he was with her '24/7'. This made it difficult for Donna to engage with housing services while she was with him. However, when he ended the relationship due to a visit from her former partner, so did her accommodation because, 'once he stopped paying, obviously I was screwed, beyond screwed'. As Donna's situation indicates, survival-sex relationships are inherently precarious because the material and the more abstract support they offer are withdrawn as soon as the relationship ends (Watson, 2016).

5.2.3 Complex and co-occurring issues

It is evident from participants' accounts many experienced a range of complex and co-occurring issues prior to and during their experience of pregnancy, including family violence, drug and alcohol use and mental ill-health. This section elaborates further on the intersecting nature of participants' experiences, including the centrality of gendered violence.

Thirteen participants reported experiences of, and exposure to, gendered violence during pregnancy and homelessness. This included the perpetration of family violence by partners, alongside other forms of violent victimisation including sexual assault. These often formed part of a continuum of violence experienced throughout their lives. Family violence was described in relation to physical abuse, alongside other behaviours including stalking and threats to harm women and their unborn babies. For example, Kate described being thrown from a car by her partner while pregnant, and Ayla recounted being beaten by her husband, an assault intended to bring on a miscarriage.

Gendered violence and homelessness were often accompanied by drug and alcohol use and mental ill-health, signifying participants' management of traumatic life experiences. The relationship between family violence and mental ill-health (Oram, Khalifeh & Howard, 2016), alongside other poor health outcomes for women, is well-established (Webster, 2016)—the women in this study were no exception. Indeed, mental ill-health was an ongoing challenge for many participants, who reported experiences of depression and anxiety throughout their lives. Kate's comment below reflects the interdependent nature of these experiences, alongside the underpinning influence of family violence as a key catalyst for other issues:

> If I get back into family violence, it [will] most likely kick off my mental illness … and it's more likely to kick off my drug use whereas, I've been clean for seven months.

After leaving her husband due to family violence, Alya experienced being homeless and pregnant without permanent residency. Women without permanent residency lack options in relation to both social housing and income support, and they are ineligible to work. Alya's trauma was exacerbated by the actions of police, who incarcerated her in response to an intervention order taken out against her by her husband on false pretences. Alya's experience reveals the compounding oppression and vulnerabilities facing migrant women who are without permanent residency and who are trying to escape family violence:

> I was pregnant and the police, they put me in a box where they put the criminals and, really, I felt as I was choking … I was so worried that when the police released me where would I go? Especially that I did not have permanent residence. So, that's why I was putting up with him and life here is difficult.

Participants also described how the complex issues they faced generated particular challenges in relation to their pregnancy. For example, the combination of housing instability, gendered violence and drug and alcohol use impeded Jenna's ability to connect with her baby and plan for the future. In part, this meant with only 'five weeks left before [she] gave birth'. Jenna explained:

> I didn't have anything for the baby, I had nowhere to live … I didn't know where I was going to give birth to my son, I didn't even plan any hospital, I had no idea. I was

> carrying this baby wondersuit in my bag everywhere I went, in a plastic bag I bought for him—it was $4 from Target … I carried that with me through the whole time.

As canvassed previously, the process of finding out about pregnancy could generate additional stress, which in part stemmed from concerns about the impact on pregnancy from drug and alcohol use. For example, being homeless and heavily using drugs meant Carolyn could only envisage a future where her baby would be removed by child protection services or would not survive. This combination of factors also meant Carolyn felt suicidal while homeless and pregnant, and recalled it was out of concern for her partner and children which prevented her from going ahead: 'I did think about committing suicide … [but] I can't hurt him like that, I can't hurt the kids like that. So, yeah, I just kept fighting and kept fighting'.

Some participants, including Carolyn, reported that when they were able to receive support, they managed to successfully reduce or stop their substance use. However, some carried unrelenting guilt and shame concerning potential harm to their baby, further demonstrating the ongoing and enmeshed relationship between drug use and mental ill-health. For example, Bianca felt distressed about having consumed alcohol while pregnant, explaining it had made her want to 'hurt myself and hurt myself because I wish I knew earlier so I didn't drink'. In relation to her drug use while pregnant, Jenna explained she 'felt terrible about what I've done and I still do'. Asking for help meant Jenna accessed appropriate support, albeit late in her pregnancy.

5.3 Housing support

5.3.1 Seeking long-term secure housing

Finding out about pregnancy often provided an impetus for participants to engage with support (e.g., specialist homelessness services) in an endeavor to stabilise their housing and create conditions where they could envisage a future as a mother and safely care for their baby. However, Australia's lack of affordable long-term housing, combined with the underfunding of specialist homelessness services (Muir et al., 2018; Powell et al., 2019) constitutes a key barrier to resolving pregnant women's homelessness. Indeed, at the time of interview, most participants were still not permanently housed. Highlighting the significant inequality in relation to secure and safe housing in Australia, Bianca reflected:

> Government need to make buildings for just homeless people and just have a roof over their head and support the homeless people. Because there's people out there that have housing and have it all and there's people that live on the streets.

Participants' accounts also revealed how particular policies of service providers generated barriers for women trying to stabilise their housing while early in their pregnancy. As Murray et al. (2018) found, Victorian homelessness services adopt a policy of prioritising access to family or other forms of supported accommodation for single women late in their pregnancy or immediately

after birth, and this has significant implications. As Tania reflected: 'How are you supposed to get stable … if you have to be a certain amount pregnant before you can get access?' Participants overwhelmingly reported feeling stressed and fearful in response to the uncertainty produced from not knowing how and when their housing would stabilise. As Sarah's comments below indicate:

> You shouldn't have to worry about it until the very day you come home with your child; you shouldn't have to have a baby in your arms to have somewhere safe over your head even if it is a hotel room, you know what I mean? … You need to be six months pregnant or more. Like, what is that a magic number for? … I don't understand.

More generally, worry about housing was a shared experience of participants. Donna revealed how, despite reassurance from her service provider she would eventually be securely housed, her anxiety remained: 'Obviously I'm going to be sitting there worried and stressed like, what am I going to do? Obviously because the baby [is] coming'. Carolyn reported feeling constantly anxious about her housing and revealed how it undermined her ability to prepare for the arrival of her baby. She recalled telling her housing worker in crisis accommodation: 'I'm worried about this housing situation because I know I've only got a limited time here and … I'm struggling—baby hasn't got anything prepared'. The uncertainty surrounding their housing meant much time and energy was directed to trying to resolve it. As Bianca said, 'I worked my arse off until I got somewhere'. And this often meant there was little time for other things like connecting with the experience of being pregnant. As Donna revealed:

> I was not prepared, I did not get myself attached to the pregnancy at all or anything like that until I was at least 30 weeks, 32 weeks. That's when I started to organise the baby things.

5.3.2 Supported accommodation

Participants described staying in various forms of supported specialist homelessness accommodation including youth and family violence refuges, as well as other forms of crisis and medium-term transitional accommodation throughout their pregnancy. These findings reveal there are particular challenges for pregnant women residing in supported accommodation which require recognition and attention.

Participants raised concerns relating to the location, structure and safety of supported accommodation. At times, these conditions produced circumstances not conducive to women's welfare both during and immediately after pregnancy. For example, several participants recounted concerns about residing in communal forms of supported accommodation (e.g., women's refuges) which related to the behaviour of other residents. Sally described her experience in refuge as 'overwhelming' and 'intimidating', noting her exposure to the drug use of other residents. Ayla

recounted how both she and her daughter experienced racism and were exposed to violence while in refuge, which unsurprisingly impacted her mental health and undermined her safety:

> They put me in the refuge and I stayed … for three months, but … one woman, like she was crazy, she tried to kill me…. I was pregnant, she said, 'you're Muslim, I don't like you' and she tried to strangle me … It was very difficult for my daughter, it wasn't safe. They all had mental health problems … it affected me very badly psychologically. They were all on drugs, the people there … we didn't even dare to sit in the common lounge … They were even hitting my daughter at the refuge.

Their experiences led Sally and Alya to argue the need for emergency accommodation for pregnant women with independent living spaces so they could be in control of their environment. Challenges relating to the communal nature and built environment of women's refuges have been documented (Murray et al., 2017). In Victoria, core and cluster models are gradually being deployed to enable improved experiences of and access to support (Nyhuis, 2018). Some negative experiences of Muslim women in Australian refuges have also been documented (Ghafournia & Easteal, 2019) and Victorian refuges have not been well-resourced to meet the needs of diverse groups (Murray et al., 2017).

Similarly, and as revealed by Kate's comment below, her lack of access to secure housing undermined her ability to maintain control of her surroundings. The provision of safe and stable housing is needed because it provides women with autonomy, and promotes their human rights to equality, safety and wellbeing. This is of particular salience to women like Kate, whose enduring experience of family violence had undermined that right her entire life:

> I wish I could just create the environment that I want and I was in control of who was coming in and who was going out, and what behaviours were allowed in my house. Oh, 150%, but I could never do that.

Some participants highlighted how the location of their transitional accommodation could be far away from their networks of support services. For Alya, being without permanent residence meant she was forced to spend most of her meagre special benefit on taxis because there was no suitable public transport: 'It's far from public transport, there is no train, no bus near me and I don't drive … and I'm on special benefit so … lot of the money goes toward the taxis'. For Donna, the location of her transitional housing property in an outer suburb away from services meant that, in the days and weeks immediately after giving birth, she was required to travel daily to the city to attend appointments, which had implications for spending time with her baby:

> From day one of having bubs … she was not even three days old … [I was] … every day travelling to the city and back so I barely get to spend any time with her and

> enjoy the newborn things because obviously appointments … I spent the majority of that time travelling. I couldn't really complain because I had a roof over my head, I guess. You just had to do whatever you had to do.

Notably, Donna's comments also reveal she felt no entitlement to more suitably located accommodation or that she could raise concerns about the impacts on her. A sense of being undeserving permeated other participants' accounts too, which highlights the influence of neoliberal discourses such as individualism and responsibilisation which influence the housing and homelessness policy context in Australia (Stonehouse, Threkheld & Farmer, 2015).

Challenges in relation to some models of supported accommodation were also reported. For example, Sarah recounted how, in the weeks leading up to giving birth, she moved into a form of core and cluster supported accommodation which was in part designed to meet the needs of pregnant and parenting women. However, there were features of the property unsuitable for pregnancy, including steep flights of stairs and a lack of cooling options in the height of summer. Furthermore, Sarah recounted feeling unsafe in the environment due to the violent behaviour of other residents:

> It was really unsafe … There was an office worker that was there occasionally, it was just hit and miss if you got in touch with them … the people there, it was the same issues … drug issues, alcohol issues and … just a lot of violence which, like, I have a really hard time with.

While participants reported difficulties in supported accommodation, they also reported the provision of the more stable forms of housing meant they could begin the process of preparing and planning for the arrival of their baby as well as participate in everyday activities. Sally recounted how stable housing generated 'a good feeling obviously because you knew that you were settled' and it meant she could 'start buying stuff for the baby'. Similarly, Donna reflected that stable housing enabled her to get prepared for the arrival of her baby and participate in 'normal' daily activities:

> I started preparing myself … getting stuff that I needed, actually making some time to treat myself to doing normal things … like even going to the movies … going to the zoo, having that stability meant I could live normal.

Alya described it in the following way: 'Well I feel free, I can cook … I clean my house, I see the house clean. Got my own bathroom, toilet'. For Bianca, being in stable housing helped manage her anxiety and the isolation which stemmed from living in her car: 'Now that I've had somewhere stable … like I can go out, I can meet people, I can do what I couldn't do when I was in the car'. It also facilitated improvements in family relationships and receipt of support: 'Now that I have

my own place, my mum, my sisters, my brother, everyone is so supportive'. Secure housing had enabled a shared sense of excitement and anticipation at the impending arrival of her baby.

5.4 Impact on health

Pregnant women experiencing homelessness are more likely to experience physical and mental health risks which will impact both mother and baby compared with the wider population (Esen, 2017; Shaw & Willard, 2016). Several participants experienced pregnancy complications. For example, Layla developed gestational diabetes, Melanie displayed early signs of preeclampsia and needed to be induced at 38 weeks, and Alya had very low blood pressure. These serious conditions needed to be managed in circumstances which are not conducive to rest and recuperation, and it was common for the women to be convinced it was the stress associated with homelessness which was contributing to, or exacerbating, their health problems.

Lack of access to a safe and clean environment is a major challenge for women who miscarry while homeless. Bianca and her partner were living in her car when she became pregnant. They spent one night in a hotel room following a family celebration, where she subsequently experienced a miscarriage. As she explains:

> Well, the night of the miscarriage we got a hotel room … just have a relaxing night, try and get a good night's sleep and then finding out that I was bleeding. Like, we got back to the hotel room at three in the morning, we had to be out by ten—like, there was no time to rest.

Bianca was left to handle the physical side effects of the miscarriage, including blood clots, while returning to living in the car. This meant tending to her bodily needs in public toilets and hotels and showering at public swimming pools.

Homelessness can impact a pregnant woman's capacity to attend antenatal care and they are less likely than other women to engage with pregnancy services (Bloom et al., 2004). Jenna found out she was pregnant at 19 weeks yet did not commence antenatal care until much later. She was living with a friend but was forced to leave due to the pregnancy, after which time she couch surfed, slept rough and did two prison sentences for theft of food and alcohol. This period included alcohol and other drug use and incidents of intimate partner violence to the point where, as Jenna stated, 'I was never sober and never not in a violent situation to actually go "I'm pregnant, can you help me?"' This affected Jenna's capacity to engage with pregnancy services because, although 'I was getting big, I could feel the baby, but I was that numb that I didn't feel myself'. In addition, Jenna described feeling 'in my heart I just wasn't ready to face I'm pregnant' and this caused her to be unable to give up abusing alcohol until late in her pregnancy. Jenna experienced seizures during her pregnancy and was hospitalised three times due to the impact of her alcohol use. However, being homeless meant she had nowhere safe to stay on discharge, making it difficult for her to maintain sobriety:

> That's when I would sleep, and I'd get healthy again and then I wouldn't drink and then I'd leave the hospital, but I didn't have a safe place to stay. If I had somewhere safe after I left hospital, there's probably a 50/50 chance maybe I wouldn't have kept drinking if I had the support, but I didn't have any support.

Kate did not seek any antenatal care because she did not realise she was pregnant until she delivered her baby. Throughout her pregnancy, Kate had been 'living a life of chaos' which involved 'going between places' couch surfing, and drug use. Like Jenna, being homeless, and the associated turmoil, dislocated Kate's connection with her body. For Kate, this meant that, although she had given birth on two previous occasions, she did not recognise the signs of labour. Kate attributed not realising she was pregnant to using the contraceptive pill, which allowed her to skip her periods, and not experiencing weight gain or 'any kicks':

> I ended up in the bathtub with these really, really sore cramps in my stomach and it's at that point that I actually thought, 'when was the last time I actually allowed my body to have a period?' because I was skipping constantly with the pill … It was at least a year and three months and I thought 'holy shit', now my body is obviously saying, 'yeah, Kate, you're going to cop it now'. So, I passed blood clots … I passed out in the bathtub and I gave birth to [my daughter] but didn't know any of this at all.

Some participants described feeling a sense of shame about the potential health problems their babies might undergo due to complications which occurred during pregnancy. Although Jenna 'did everything properly for the last six weeks … it still is not good enough in my heart'. She was fearful her son would develop foetal alcohol syndrome and had him tested every couple of months. Amelia expressed anger about the psychiatric clinic making her stay on antipsychotic mediation which could have harmed her foetus because they did not want to risk her having a psychotic episode. And Carolyn, who had previously experienced a stillbirth, spoke of feeling responsible her baby would die in utero because she could not stop her drug use while homeless. Furthermore, she was fearful the mental health problems she was experiencing due to her homeless circumstances would be passed on to her baby, which would lead to a life of hardship:

> I'm going to stress myself out too much and bub's going to die … or this baby's going to survive but she's going to be filled with all these negative chemicals, these brain chemicals of anxiety, depression, stress, all this stuff; she's not going to get the positive chemicals … I kept saying to them I don't want my child to be like me.

Similarly, Donna reported how being pregnant while homeless was synonymous with stress, which in her view 'could lead to cause a lot of complications'.

5.5 Conclusion

Unable to secure safe, stable accommodation, many of the pregnant, homeless women who were interviewed for this research endured shocking living conditions which were highly unsuited to them and their newborn child. Their accounts provide compelling evidence of the ways in which the service system did not meet their basic needs of shelter and security. While most could not access long-term housing until late in their pregnancy, supported temporary accommodation was limited and, for some, dangerous, unclean and isolated. Most of the women lived for some time during their pregnancy in unsupported accommodation such as sleeping rough and couch surfing, as well as sleeping in cars, private rooming houses or in hotels in highly hazardous situations. In these circumstances, there was little opportunity to prepare for motherhood. Compounding these experiences were the impacts of complex and co-occurring issues such as drug and alcohol use, mental ill-health and family violence. In the next chapter, we consider the women's accounts of the assistance they accessed.

Chapter 6
Accessing support during pregnancy

[The housing support workers] were welcoming … they know exactly where a person's coming from—they don't judge; they're just great people.

Alishba

6.1 Introduction

Having considered how the research participants experienced pregnancy and homelessness in Chapter 5, in this chapter, we examine the support they received. Housing, health and pregnancy support services were discussed in the interviews, as well as support for abortion, and child protection. While challenges were raised, there was strong evidence of positive experiences and clear direction on what they considered to be good practice to support pregnant homeless women.

6.2 Support during pregnancy

6.2.1 Positive support experiences

Like Alishba quoted above, other research participants described experiences of engaging with housing and pregnancy support workers as very constructive. Several reported experiencing housing workers as welcoming, accessible, supportive and non-judgmental and being assisted to access various forms of supported accommodation while pregnant. For example, Carolyn and Sally noted staying in crisis accommodation with access to support workers 24 hours a day was particularly helpful when trying to manage the stress and uncertainty of their circumstances. As Carolyn recalled:

> When I'd be getting ready to go to bed and I'd walk down and I'd be 'oh can I talk to one of the workers? I'm just having emotional night … and I'm having a craving right now' … they just sat there and they listened. Like, most of the time, that's just what we ask for, someone to sit there and just take in and not judge us, really.

Similarly, Bianca's reflections demonstrate the significance of care and support for pregnant women alongside the provision of appropriate housing, having moved from her car:

> I've got to call this home, so it was amazing like from going to a car seat, to a bed, it's just heaven. It was amazing. The support I've had from [my workers] is just great, like if we're struggling with something they're there. If we need to be taken somewhere or picked up from somewhere, they're there … So, the support's amazing … [my workers are] just like another mum … it's amazing, like they show us love and support … something that I haven't had in a while.

Being in supported accommodation facilitated access to a wide range of supports for women in addition to those directly related to their housing and pregnancy. Participants reported accessing counselling services to deal with experiences of violence, oral health care, legal assistance and support to obtain permanent residency status. There was also evidence of effective and active collaboration between service providers, and participants reported extremely positive experiences of receiving support from such programs. For example, it was common practice for specialist health programs providing pregnancy support to refer pregnant women to homelessness support workers and vice versa. For example, Sarah's engagement with WADS quickly led to her accessing other key support services: 'They did tell me about St Kilda Mums and introducing me to [the Bolton Clarke nurse] … she's just so good … like, I'm pretty grateful for all of that'.

In relation to the WADS program, in particular, several participants said it provided a flexible wraparound model of care where workers demonstrated a commitment to incorporating their 'client's view of the problem' and to 'go above and beyond' to meet their support needs. They also described their practice framework as incorporating values of 'sincerity', 'care' and 'respect'. Sarah reported how engaging with WADS enabled her to develop a sense of optimism about her pregnancy:

> I was feeling really down on myself about having to increase my methadone and I was like this is really bad, like I feel really terrible and guilty and whatever. Those are the people that would say 'hang on a minute, like what are you talking about? You don't have anything to feel guilty about … you're doing this for your baby' … and … educate you about things that you would otherwise not know … It made me feel really positive about everything happening at the time like these people were building … a positive relationship with me which I've never had people do in the past, especially not consistently.

Participants also reported positive experiences of pregnancy support through caseload midwifery programs which provide continuity of care and enable women to be cared for by the same midwife. Kate revealed how this was important because the midwife took the time to 'explain everything fully and make sure that I understood from start to finish what was going on'.

6.2.2 Importance of a timely and coordinated response

Obtaining support in a timely manner was reported by participants as important to create the conditions required to stabilise their lives, experience a safe pregnancy and envisage a future for themselves as mothers. Some participants were fortunate enough to receive support at the time they sought it. For example, while making the decision to obtain support was difficult, when Jenna did reach out during her pregnancy, a coordinated and timely response was forthcoming from her support worker:

> She said 'look, we'll get you a taxi from where you are now, and we'll get you a taxi to the hospital and we'll start rehab' … I went to … detox for three weeks and then I was on a waiting list for rehab … they called me and said, 'we can accept you' and I was just so happy.

Pregnancy was an important time when participants reported a willingness to make significant changes and engage with support services, thus providing a critical window of opportunity for timely service delivery. As revealed by Sarah when she discovered she was pregnant: 'I was in that state of mind it was the best time to get myself linked into those services because it meant that I would actually follow through … and pick up the phone when people call, go and make my appointments'. Kate's comments also indicate early intervention can be critical in both the short- and long-term, including in relation to enabling women to have children remain in their care:

> If you have certain issues in your life from when you're pregnant, if you can admit to that and then you can get people to walk along and help you through, then I think that'd be the best way to tackle it. Because then they wouldn't have the children being removed … they may be able to work a plan and a way through from when they're pregnant, from the start. Rather than starting from when the child's born or when things load right up.

Unfortunately, not all participants were able to access support services in a coordinated and timely way. As indicated below, Carolyn was unable to obtain the specialist drug and alcohol support services she needed in the regional area where she had been living. She was frustrated she needed to move to obtain support because, by this time, she was well into her second trimester:

> It's either Child Protection's going to take my baby or my baby's going to die, so either way, I'm not going to be bringing my baby home from the hospital. I need a house, I need drug and alcohol support, I need like it right now and they wouldn't assist me … By then I was halfway through the second trimester, so roughly between 15 to 20 weeks and like I remember saying to [my worker], 'like this really fucks me off like [that town] is only right there' and they're telling me … 'there's no supports pretty much for people that are pregnant and homeless and addicted to the drugs' and all this shit. I was like 'but what, I come an hour away and you guys are here?'

Carolyn's view on what was needed was quite clear: 'Stop wasting money on bullshit, put the money into the services that need it … there needs to be more detox facilities that accept pregnant people'.

The siloed nature of the service system was another issue raised by participants who felt a holistic response was needed which recognised and engaged with the interconnection between various presenting problems, as described by Kate:

> They've got like AOD's [alcohol and other drugs] in one section and family violence is in another section and they've got mental illness in another section and then they've got homelessness in another section. They've got your general wellbeing in another wheel. They sort of don't put it all together … they sort of don't show how each circle bounces off each other.

6.2.3 Knowing where to seek help

To obtain support services, women need to know how to locate them. However, some participants in this study said information was not often readily available. For example, Kate explained her general practitioner (GP) was unable to provide her with information about support services for pregnant homeless women with drug and alcohol issues: 'Where do you start to get the help … I went to my GP and the GP didn't even know where to direct me. No-one knew where to direct me'. Similarly, Tania explained how hard it was to find information about relevant support services without knowing someone with expertise in the area: 'You don't know those things unless you know someone who's experienced those things and that's the scary part about it. I kind of just wish that I knew what was out there'.

Participants also revealed it could be very difficult to ask for help in the first instance. For example, Bianca revealed that, for a long time, she didn't tell anyone about being homeless, including her friends, family or even her long-term GP:

> The only health support I had was my GP and I'd only go there if there was something wrong or if I felt sick. But they didn't know that I was homeless either … I don't think Centrelink know either because I just didn't know how to tell or where to go for help.

Bianca explained her reluctance to disclose being homeless stemmed in part from her concern that she 'didn't want people to worry'. It is also probable Bianca avoided telling people she was homeless because of the associated stigma and shame (Johnson, Hellene & Coutts, 2008; Watson 2018). The shame associated with being homeless and pregnant was also evident in Kate's revelation that she needed to become intoxicated to ask for help: 'I had to drink a bottle of vodka to ring [my support worker]; I had to get the courage up. I said "look, I'm so ashamed"'.

Some participants reported making information in relation to services more accessible was needed so women could be better informed about the options available to them. Many women may not be aware support services exist or be able to identify their needs in relation to support. For example, Tania felt there should be 'a bit more out there … just something letting you know that they were out there to help … pamphlets saying … support for single and homeless'. Furthermore, because of issues in relation to shame and stigma as noted above, pregnant homeless women may not feel able or willing to ask for help directly. Sarah suggested it would be helpful for services to be more proactive in providing a range of information about support services to women without them

needing to request it by 'just giving it upfront so that everybody knows what is available to them without having to ask. I think that's the best you can do'.

6.3 Accessing abortion and contraception

Upon finding out, six participants contemplated terminating their pregnancies. This was in direct response to their homeless circumstances which undermined their ability to envisage the possibility of motherhood. Only one woman decided to go through with the procedure, which she explained was because she already had two young children, one of whom was just six months old at the time. Some of the participants disclosed conflicted feelings about having an abortion, qualifying their statements by saying they were personally opposed to it. 'I'm against abortions, so I found it hard', stated Donna. Another struggled with continuing with the pregnancy but then came to believe the pregnancy was fateful which provided a reason not to have an abortion. 'Should I be terminating? … she could be my one chance to have a baby', noted Melanie, adding:

> Straight up I was like, I can't have this baby and then after a couple of days I was like I can't not have this baby … I found out I was pregnant on Mother's Day too, which was sort of like a sign.

Confusion about when it was 'too late' to have an abortion influenced the choice of one participant, Layla, who had initially agreed with her husband's support on a termination. They felt their circumstances at the time, which included managing her husband's disability and living predominantly out of their car, would make having a baby difficult. However, after Layla's first visit to a GP when she learned she was four weeks pregnant, she then developed the belief she was too far along in her pregnancy to have an abortion:

> I thought that the baby is too big for [abortion] to happen and my husband spoke to me and we decided to keep it, but I didn't have any information of any place to go for abortion, just the GP who mentioned that I'm pregnant.

Also finding out she was pregnant while living in her car, Bianca had to wrestle with whether her circumstances were too uncertain for her to continue with the pregnancy. On the one hand, Bianca thought she was 'so against abortions' while, on the other, she felt 'abortions should happen if they need to happen'. Bianca's lived experience of the structural constraints to having a baby imposed by poverty and homelessness meant she had insight into the circumstances whereby women may need and want to seek a termination.

After losing a baby to stillbirth, Carolyn was afraid it would happen again:

> I knew that if I stayed sleeping in the back of my car addicted to the drugs … that sometime during the pregnancy the baby was just going to die anyway and I thought I can't go through that again.

Carolyn wrestled numerous times with the idea of termination, which produced considerable anguish, but was unable to go through with it because she fundamentally wanted to keep her baby:

> Six times I tried to push myself to have an abortion due to my circumstances and knowing that there was no way in the world an environment a child should be brought into which yeah, it really killed me. I couldn't do it, so I gave up trying.

Concern a termination might upset her partner also made Carolyn rethink things: 'Something in my head made me realise it wasn't only me that had lost a baby, it was [my partner] as well and I couldn't push myself to hurt him by choosing to take his baby's life pretty much'.

The logistical difficulties of getting to and from an appointment to terminate a pregnancy were also raised and became a reason for one woman not have an abortion. Donna made multiple bookings for the procedure, but did not receive the support she needed at the time, as she explained:

> The second time and third time I did book the appointment, unfortunately I had to have someone to drive me away from a hospital after it and no-one would do that for me, so potentially I kind of got stuck with [the baby].

When no one would agree to do it, she felt despair: 'I was 16 weeks pregnant, it was too late to have an abortion and I was basically stuck with her, so I did try to overdose and do both of us a favour'. Donna's experience illustrates the desperate lengths women will go when reproductive care is not readily accessible. In reflecting on her reasons for wanting a termination, Donna explicitly cited homelessness:

> I didn't have a roof over my head, just the homelessness did play a big part in that, so going against my beliefs of the abortion. If I originally had a roof over my head, it wouldn't worry me that much … even though I'm not too fond of who the father was, it wouldn't have been that problem if I was not homeless.

After she was unable to get an abortion, Donna adopted a mentality of self-reliance to get her through the pregnancy. Without a stronger social safety net on which to rely, Donna had to navigate fragmented, ad-hoc supports where a lot of the work in relation to negotiating access to resources fell to her:

> I think after that I realised that [the baby] was staying. There was nothing I could do and I had this responsibility but I had to do whatever I could to make sure that I had a roof over her head. So, that's when I went every single day for almost two, three weeks to different housing organisations, getting transferred to there, back, forward,

> back, forward, go to a hotel and the next day back there, then the hotel again—like, they wouldn't book it for two, three nights, they would only book it for one night and then I'd have to go back and sit there all day at the housing office waiting for them to send me instruction.

Services would frequently tell Donna last minute there was nowhere to put her for the night: 'It's like, well, I'm pregnant, like what am I going to do? Sit there and sleep in that car that was really unsafe. It was freezing cold'.

None of the women reported use of the abortion pill, available for women who are up to ten weeks pregnant, and after this the only option is a surgical procedure. The abortion pill is a cheaper and less invasive option than surgery, but homeless women may be less likely to use this option because they do not learn of their pregnancy until too late, or do not have access to the most current information. It may also be the case they may be precluded from its use due to increased health concerns. In effect, pregnant homeless women are further disadvantaged in their attempts to manage their reproductive health.

Some participants talked about not using any contraception when they fell pregnant, which in Amelia's case delayed her access to prenatal care. Amelia did not think it was likely she could conceive and, therefore, did not see a doctor until halfway through the pregnancy. Her psychiatric medication caused extreme fatigue and affected her memory so that she repeatedly forgot to take the contraceptive pill: 'So I went off it [the pill] and we didn't think it mattered because my partner apparently shot blanks'. Amelia went on to explain, 'then my belly just got bigger and bigger and I was like, well, I can't sort of deny this anymore'. Another participant, Tania, deliberately decided not to use contraception: 'At that point we just wanted a baby and wanted to start a family', adding, 'we didn't have a house, we didn't have anything but at that point we didn't think that mattered. We had each other, do you know what I mean?'

Contraception as a form of reproductive coercion was reported by one participant. Alya's husband was abusive and had been giving her the contraceptive pill to take every day, insisting he did not want children with her. 'He was giving me contraception pills', she said, 'but I was putting it under my tongue and then throwing it away'. She fell pregnant, an outcome she had wanted, but that also led to her becoming homeless due to her husband's abuse escalating: 'He wanted me to have abortion but I didn't want that and escaped and called the police'.

6.4 Child Protection

Involvement with Child Protection was a common occurrence for many of the women interviewed. Despite this, only one participant, Amelia, did not have custody of her baby, although five participants had older children born prior to the research period who were not in their care. Reasons for interventions from Child Protection were typically due to a lack of appropriate housing

combined with other factors such as family violence, mental ill-health and alcohol and drug use. For Amelia, Child Protection became involved when the medical service she was attending while pregnant made an unborn child report. In Victoria, unborn child reports are intended:

> To prevent future harm and reduce the likelihood of Child Protection intervention after the child's birth by working earlier and in partnership with the mother and appropriate services to address the need or risk factors. The guiding practice principle is one of supportive intervention, rather than interference with the rights of the pregnant woman (Department of Health and Human Services [DHHS], 2018).

At the time, Amelia was living in community housing which would not allow children to live there. She was also living with a mental-health condition and using drugs. Amelia expected to access public housing a month before she delivered her baby but this did not eventuate. Furthermore, she tested positive to a mandatory drug test a week after childbirth, which led to her baby being taken into care by a family member. Amelia spoke of Child Protection no longer being interested in providing assistance once her baby was taken into care:

> I need to be clean off ice and I need suitable housing but even though it's a court order that I need suitable housing, neither establishment [Child Protection and Office of Housing] will give an inch … Since giving birth there's just zilch, like no-one cares anymore.

Intervention by Child Protection, although envisioned as supportive, was not always experienced as such. The issues which contribute to Child Protection's involvement for pregnant women can generate fear of punitive, rather than compassionate, responses. Kate had two children in care who were on reunification orders and a seven-month old baby in her care. As she stated:

> It's like a catch-22, though, because if they admit that they've got an issue with drugs, then obviously Child Protection could be told and they may not want that, so I think that the system needs to be improved in that way more so that if Child Protection are told they support rather than punish … At the end of the day, they got certain things … to tick off and that's all they care about. Like, they're not supportive whatsoever. Like, I've told them, 'you guys are worse than the cops. You think criminals hate the police; I'm telling you, you are way worse to deal with'.

Kate was particularly critical of Child Protection expecting women to fulfil obligations without providing adequate provisions such as assistance towards engaging with services. For Kate, this created the circumstances in which children would be taken into care:

> So, like Child Protection, instead of trying to help you in crisis situations, if it's easier to remove the kid or easier to take you to court and put an order on you, that's what

> they'd do. They wouldn't explain to you, for example, where to go to seek the help they want you to seek … They were very good at saying what they wanted, 'go get a family violence counsellor' was another one they wanted you to go do, but where do you go get a family violence counsellor? Where do you find one of them?

Carolyn was in the situation where, for her first pregnancy, she was already a client of Child Protection having 'spent most of my life in foster care'. Aged 16, Carolyn became pregnant while living with her partner but moved to couch surfing with various family and friends due to his violence:

> He turned violent so I got shipped around pretty much by Child Protection because I was still a Child Protection kid myself … I refused to go back into foster care, being 16 years old and pregnant—I was like I'm having my own baby, I don't need someone to look after me.

Following a three-week stint in secure welfare, Child Protection arranged for Carolyn to stay in a student hostel, followed by permanent accommodation where she stayed for three years. Carolyn had extended contact with Child Protection with both her children due to homelessness, family violence and drug use, and they were not in her care at the time of the interview. At eight months pregnant, Carolyn's circumstances had stabilised and Child Protection had closed its file on this baby. For Carolyn, Child Protection had almost always been a part of her life, and she expressed mixed feelings about the support offered. On the one hand, Carolyn spoke of the fear 'that Child Protection's going to take my baby', while on the other she discussed positive interactions with workers:

> When you're working with the support workers, you can see after a couple of times of meeting them … who's there because they have compassion for that role and who's there just because it's an awesome pay cheque.

Although encounters with Child Protection could be a fraught experience, for some women the involvement was positive. While staying at a refuge with her baby after giving birth, Jenna became intoxicated. She fled with the baby when she was informed by the refuge Child Protection would be called; however, she then made contact herself. Although this led to Jenna losing custody of her baby for some time, she regained custody after securing transitional housing and stopping her alcohol consumption. Jenna continued to have contact with Child Protection as they arranged for her to have respite from her baby, a service she valued, stating: 'Once a fortnight for the night he still goes to the carers … They're a good part of my life, they're fantastic'.

Kate, in particular, suggested Child Protection intervention could be improved through earlier and better engagement and follow-up with other support services to ensure women have the best opportunity to prepare for parenthood:

> If you're going to admit that you've got X, Y, Z issues in your household or in your life, that they actually stand by you and with the services to support you rather than punish you for having these certain things go on. Yeah, that'd be one of my major, major, major, major things … And if they could start off from pregnancy so if you have certain issues in your life from when you're pregnant, if you can admit to that and then you can get people to walk along and help you through, then I think that'd be the best way to tackle it. Because then they wouldn't have the children being removed and that sort of thing, they may be able to work a plan and a way through from when they're pregnant, from the start. Rather than starting from when the child's born or when things load right up.

6.5 Conclusion

The women recounted timely and caring interventions which made considerable difference to their experiences of pregnancy, such as being offered transitional housing, supporting them to reduce or cease their drug use and assisting them to engage with antenatal and other support services. Flexible, wraparound models of care were greatly appreciated by the women and were indicative of services working together across the range of issues the women were facing. In particular, continuity of care fostered a sense of trust and familiarity. At the same time, there were concerns about the role of Child Protection, which some women found punitive, reflecting a lack of appreciation of the difficulties of their life circumstances. In the next chapter, we consider what it meant to the women to become mothers, and how they went about it.

Chapter 7
Becoming a mother

[My baby], she really is the best thing that's ever happened to me.

Amelia

7.1 Introduction

While it could be understood a woman becomes a mother at childbirth, it is also the case that mothering can start long before. For many women, protection and care of the unborn child, and preparing for the birth, are integral to this process of becoming a mother. However, as we have seen, pregnant and homeless women often do not have the circumstances in which these mothering activities can take place, or only when very late-term. For some women, there were crucial turning points at which they committed to become the best mothers they could possibly be, which laid the ground for the process of preparing for the birth. These two aspects of becoming a mother are considered first in this chapter, followed by the women's experiences of accessing mothering support.

7.2 Turning points

Pregnancy was an important time during which many participants, including Amelia (quoted above), reported making significant changes in preparation for the arrival of their baby. This included engaging with housing support services for the first time or following through with prior supports, managing or reducing substance use, addressing mental health issues, and preparing emotionally and practically for the arrival of their baby. This was the case for a number of participants who were motivated to reach out. The birth of Amelia's daughter reinforced her determination to get clean, because now she could do it for her baby:

> I haven't been happy for a good few years now and [my daughter] makes me really happy … my life is going nowhere, I've got no career, I can't work because the schizophrenia aside, I do have anxiety and stuff and that's led to the [demise] of my working life … But if it wasn't for [my daughter], like I don't know if I'd ever really have any reason to not do drugs or to quit drugs or anything like that so she really is, I mean – and everyone says, 'oh, well, you should be doing it for you' and it's like, well, I am doing it for me but [my daughter] makes it worth it, like, there's actually a reason.

Bianca's pregnancy was the impetus for accessing services. With the close memory of having lived in her car, and the new stability of transitional housing, Bianca chose to follow up with supports, stating that 'I worked my arse off until I got somewhere,' echoing a sentiment of personal responsibility expressed by some of the participants towards their circumstances.

Despite her social anxiety, Bianca was motivated by her fast-approaching due date, and went about confronting daunting tasks, such as attending appointments to meet with people who could help her get into a more stable place to live.

Alishba's most recent pregnancy also served as a catalyst for linking in with housing support, thanks to assistance from a WADS social worker. Prior to this, she had been sleeping on a couch in a rooming house where a lot of drug use was taking place. She explained, 'I started going to the hospital for my check-ups and spoke to one of the social workers there' who helped her and referred her to specialist housing support. Through that referral, transitional housing was quickly offered to Alishba, with a public housing property soon to follow.

Jenna also revealed a significant turning point which occurred late in her pregnancy. After learning her baby's sex at a mid-pregnancy ultrasound, the magnitude of the task ahead struck suddenly, and she mentally disengaged from the process, including stopping antenatal care until the end of her pregnancy. But after years of struggling with alcoholism, knowing she was soon to become a mother and needing to make big changes right before she was due to give birth, Jenna chose to enter drug rehabilitation:

> I put my foot down and I demanded help from WADS, I demanded it. I was very serious about it, I want to go into rehab. I'm not leaving this detox until I get into rehab. I really put my foot down and … I was doing it myself.

Fortunately, Jenna received a transitional housing property and did not have to return home from rehabilitation to a place unfit for her newborn son.

Despite pregnancy being a known risk factor for episodes of mental ill-health, participants talked about how becoming a mother had improved their sense of wellbeing. In addition to a new baby bringing a sense of confidence, hope, and optimism, pregnancy and motherhood can be a pivotal time when women receive wraparound support they may not have received in the past, which enabled opportunities to engage with their community in new ways which enhance wellbeing. Melanie reflected on her experience:

> It's improved my mental health dramatically which – I was very concerned about postnatal depression. I've got a history of depression, PTSD and anxiety and whilst I still fret sometimes it's all about her, like is this normal? Is this okay? But my anxiety and depression have decreased dramatically since having [my baby]. She has dramatically improved my life, I am so just blessed to have her.

Melanie talked about how witnessing her daughter thrive has made her a more confident person. 'I sort of feel like I have a purpose all of a sudden', adding:

> I lacked a lot of self-confidence and raising such a clever baby has given me a lot of self-confidence. Because she is so switched-on and doing so well, both developmentally and health-wise, it's very reassuring that I'm at least doing something right. Yeah, I don't know, it's very much a turning point for my mental health.

7.3 Preparing for motherhood

Preparing for motherhood hinged considerably on the participants' housing arrangements. Those in more stable housing had a place to set up a space for their new baby, and the relative freedom to prepare mentally. However, those in less secure circumstances, including sleeping rough and staying in crisis accommodation, did not have the same ability to reorient their lives around their baby's impending arrival. Melanie has been in long-term community housing since halfway through her pregnancy, which had given her the stability needed to make plans: 'It was a few months before [her daughter] came about which was good, I had time to settle in and Launch helped me get linked in with St Kilda Mums who helped with a cot and stuff like that'. A housing support worker helped Melanie attend prenatal classes and organised referrals to trusted doctors. Melanie's permanent place in community housing gave her more security relative to some of the other women: 'I had time before my baby was due to settle and prepare and nest'. Having a stable place to call home allowed Melanie to 'mentally prepare' for motherhood, an experience denied to other participants in more acute housing stress. This meant that, in the lead up to the birth, Melanie could ponder questions such as 'who are they going to be?' and 'how can I be the best parent?'

After some time spent living in her car, Bianca moved into transitional housing and the stability helped her get to appointments with services and prepare for becoming a mother. This had a big impact on her life, as she explained: 'Now that I've had somewhere stable and I can go out, I can meet people, I can do what I couldn't do when I was in the car'. In different circumstances to Melanie and Bianca, Amelia said she felt like she was living in a kind of limbo, waiting for applications for drug rehabilitation and public housing to be approved, which she hoped would give her the stability necessary to regain custody of her three-month-old daughter. Her daughter's birth had given Amelia the motivation to get clean. However, demonstrative of the bind women are sometimes put in, Amelia's housing application for a family room had been denied because she did not have custody of her daughter, but to have custody she first needed to prove she had suitable housing.

Carolyn's experience of multiple forms of homelessness while pregnant, coupled with drug use, meant she also was unable to prepare, disclosing that 'I've only got limited time' to sort out housing and get ready for her new baby. Sarah had needed to move around during her pregnancy because she had not felt safe in any accommodation, which had put planning on hold:

> I was getting towards the end of my pregnancy and we had nothing, like nothing. We had a couple of things for [her daughter] but I didn't have anything beyond a pram

> and not even a car seat and a capsule. We had nothing to sleep her in or anything because we didn't have anywhere to really put it either.

Other participants spoke about how having trouble accessing income support payments prevented them from being able to prepare for the arrival of their baby: 'Centrelink didn't want to pay me and I didn't know what to do, where to go' recalled Alya, who ended up surviving on charity vouchers until Centrelink approved her Parenting Payment. Due to her residency status, Layla could not receive Centrelink benefits and had to depend on Newstart paid to her husband. Under Australian law, permanent residents are subjected to a four-year waiting period before they are eligible to receive Newstart and many other types of income support (Department of Human Services, 2019). This significantly impeded Layla's ability to access adequate housing and she noted that 'we weren't really able to rent a separate house for ourself with the high bills of electricity and gas and everything', forcing them to live at times in their car during her pregnancy. Sarah, too, attempted to manage her income support payments, but there was simply not enough there to support the dietary requirements of pregnancy; 'we were living so close to how much we earnt'.

Being able to access prenatal vitamins and adequate food to sustain them during pregnancy was noted by eight of the women as being an important factor in preparing for motherhood. Even when they did not learn of their pregnancies until late in gestation or had other issues clouding their ability to focus on what was coming, prenatal vitamins and a good diet were one of the ways the participants attempted to take control over what was happening. For example, Jenna spoke about 'doing everything properly' for the last six weeks of her pregnancy by engaging with health services and beginning prenatal vitamins. Stacey appreciated having help from a community health service, where she was able to access food and prenatal vitamins at no cost to her. However, Alishba noted the difficulties she had faced in maintaining control over a healthy diet while couch surfing: 'I'd bring my food, I'd put it in the fridge, name it, put labels in it with my name on it and [later] my husband and I can't find it, it's gone'.

7.4 Mothering support

7.4.1 Support from services

The participants spoke about receiving a range of mothering supports since giving birth, including from maternal and child health nurses, mothers' groups and playgroups, WADS and respite carers. Many spoke about how services had stepped in to provide practical advice and assistance on how to care for their new baby, something many of them had not been able to plan and prepare for during pregnancy due to their necessity to prioritise more acute needs.

The expenses involved in preparing for a baby were out of the reach of most of the participants, and intergenerational poverty and family violence within some families of origin meant it was not always safe and feasible to rely on family to help arrange supplies for their new babies. St Kilda Mums was frequently mentioned by the participants as a crucial service which filled this gap,

effectively doing the work of organising material resources at a high-stress time when many of the participants were unsure about where they would be living by their due date. Half of the women reported relying on St Kilda Mums, and spoke positively of their experience. As Melanie explained:

> My support worker at the time, came to me and she's like what do you need or what don't you have? I told her what I didn't have which was basically everything and so she put down – and the only thing they couldn't help me with was a breast pump and they were apologetic with that and I'm like, you've given me everything like – very, very grateful for all the help.

Jenna had only five weeks left in her pregnancy and had not yet organised anything for her baby. 'St Kilda Mums came in and donated everything', she said, and they had set up a bassinet and provided nappies, baby wipes and more.

Since having her third baby, Alishba has been attending a mothers' and babies' group at the Royal Women's Hospital. The group was helping her recognise the developmentally normal changes her baby was going through and 'how you [can] read your baby when he's crying'. The group, run by her social worker, has also been providing crucial breastfeeding support. In addition, hospital staff were checking whether her son had contracted hepatitis C from needle stick injuries she suffered when she was pregnant and couch surfing.

A number of participants discussed the important role maternal and child health nurses had played in their postpartum care. Donna had received support from a specialist maternal and child health nurse who was helping her navigate early motherhood. This additional support is an extension of Victoria's universal maternal and child health services and is provided to vulnerable families who may be experiencing early parenting difficulties and other factors such as maternal mental ill-health and family violence (Victoria State Government, 2018). Jenna received support from an Aboriginal maternal and child health nurse, a recently developed Victorian state initiative designed to provide more culturally-responsive services for Koori communities (Victoria State Government, 2018). Jenna and her baby have also been able to attend an Indigenous playgroup. For new mothers who are dealing with health issues which have arisen from pregnancy, childbirth, and the postpartum period, maternal and child health nurses can be an important part of the care she receives. This was the case for Melanie, who has a medical condition which increased her risk of pregnancy complications and postpartum haemorrhage:

> I had in-home visits for my first few maternal child health appointments which was helpful. Yeah, the hospital helped set that up and – everyone was very, very helpful along the way, I'm very grateful for it all.

Participants spoke positively about other services which had stepped in to provide care for their babies, giving them a much-needed break. Amanda reported that

> [DHHS] just thought, due to the fact of being a young mum, having the upbringing that I did, that it'd be good just for me like my mental health, not that I did have mental health problems at the time, just my mental health—it'd be good to have that one or two-night break which it was, it was brilliant.

Jenna, too, was receiving respite care. Her respite carer had set up a room in their house for her son to accommodate weekly visits. She said, 'she's a beautiful lady'.

Cradle to Kinder was noted as a service providing practical support in the early weeks of new motherhood. Getting to and from playgroup can be a challenge for young mothers who do not have a driver's license or live far away from public transport. Amanda spoke about how helpful it was to have a worker from Cradle to Kinder to assist her to get to playgroup with her new baby and noted how they also provided for her materially with new baby supplies.

The experiences with mothering supports were not always positive, with the stigma of homelessness and problematic drug use leading to social exclusion within group parenting settings, and trouble relating to and connecting with other new mothers. After she was born, Sarah's daughter had to stay in a newborn special care nursery for 12 weeks due to methadone withdrawal. For Sarah, this made her feel like she could not properly open up with others in the parents' group:

> With our new parents' group about your babies and whatever and you say, 'oh, the child is still at the hospital' and then they ask 'why?'. We always have to say like, 'oh, she was a bit underweight' or whatever, like I don't want to say that she was in there because she was withdrawing because her mother's on methadone, like that's another one of those things so – and I just feel like I can't be honest with anyone.

Sarah added she and her partner have become 'hermits' through the process of dealing with homelessness and pregnancy and maintaining old friendships and starting new ones has been difficult. Like Sarah, Tania's children had prolonged stays in hospital after birth due to methadone withdrawal and low birth weight, which meant she missed out on the customary appointments mothers frequently have with maternal and child health nurses in the early weeks after giving birth. As a result, 'I haven't really built a rapport with them yet', Tania stated.

Kate explained her radically different life circumstances alienated her from the other mothers. 'When I went to this mothers' group', she said, 'I didn't connect with none of these mothers because my life was completely the opposite to what their lives were'. Moreover, 'they were all getting engaged and married and all sorts of shit and I had chaos going on from start to finish'. Sarah shared similar sentiments, noting the embarrassment she felt with the pronounced differences in circumstances between her and the mothers she has met since giving birth: 'They're like rich [Melbourne] mums and that's fine … but it's also like a point of shame. Like, I don't want anyone to know that I live in public housing, they won't let their kid play with my kid'.

This alienating experience in the mothers' group made Kate reflect on the need for pregnant homeless women to have the opportunity to connect with others facing similar predicaments:

> Making those new connections so they've got sort of the same sorts of people that they can relate to and they can speak to and they're making a new connection so they're not alone being pregnant probably for a start, they're not the only ones trying to get off the drugs or deal with mental health issues or whatever and they feel like they can go through the path with other people, not by themselves.

The themes of isolation, disconnection, and shame characterised participants narratives in reference to mothers' groups and playgroups and illustrate the problem of assuming all women unify around the common experience of having a baby, without other complex life circumstances affecting their ability to engage fully in their communities. 'When you're dealing with that much chaos in your life, the last thing you want to do is rock up into a [mothers' group] where you think, "oh my god, I'm going to be judged again"', added Kate.

7.4.2 Family support

The extent to which the participants' families were involved in offering support after the birth also significantly shaped their experiences as a new mother. Most of the participants interviewed were single, but for those who were partnered, there were some positive examples of fathering. Tania praised her partner's commitment to being a father: 'I was always grateful that I had such a good co-parenting relationship with the first [father] and I was like, imagine if I had another child and it didn't end up like this?' Carolyn credited her partner with pulling her out of a severe mental health episode in response to having to manage multiple forms of homelessness, including rough sleeping and couch surfing, while pregnant. 'He's the only reason I'm alive', she said. Amanda discussed how having her family's support, particularly with child care, had reduced her reliance on services. Bianca's family did not reach out during her pregnancy when she was in a critical situation living in her car, but since her son's birth and she has obtained more stable accommodation, it has enabled her family to become supportive.

Other participants spoke about more difficult experiences of family support after they had given birth, mainly due to a history of violence in their family of origin. Jenna explained how severing ties with her family has been necessary to keep her and her son safe:

> I don't have any family support. I'm not close to my family, they're [interstate] and they're very violent and on drugs too – I still talk to my mum occasionally but I haven't seen them in seven years and I do not plan on my son and I going to see them. I've had to cut ties with them because I don't want him to be brought up the way I was and the way I was brought up was just disgusting, to be honest with you.

Tania was relieved to have a flat of her own with her two young children as part of a transitional housing tenancy, as she had felt guilt around needing to rely on family members while pregnant.

7.5 Conclusion

Pregnancy was an important time when participants reported a willingness to make significant changes and engage with support services, thus providing a critical window of opportunity for early intervention. However, homelessness significantly impacted the women's ability to prepare mentally and materially for the birth of their baby, as well as impacted their access to routine antenatal care. The women reported that, after the birth of their baby, maternal and child health services, respite care, and playgroups were important means of support but, for some, group settings with other mothers and babies could be alienating and stigmatising due to their complex life circumstances.

Chapter 8
Conclusion and recommendations

8.1 Conclusion

The perspectives of the 14 women whose accounts are detailed in this report add to those of the 41 staff from health, homelessness and housing support services in alerting us to the dire circumstances women who are pregnant and homeless experience (Murray et al., 2018). The women were aged from 20 to 36 years at their most recent pregnancy, with the majority of women aged under 30 years. Three of the women were pregnant at the time of interview and there had been 25 births in total across the lives of the 14 women. All but one of the women's experiences of these 28 pregnancies had occurred while they were homeless. Among the 14 women, 13 had been exposed to gendered violence during their most recent pregnancy and 12 had experienced hazardous accommodation including sleeping rough and in cars, couch surfing and living in private rooming houses. The impact of co-occurring issues including insecure residency status, family violence, alcohol and drug use and/or mental ill-health compounded the difficulties associated with pregnancy and homelessness.

Pregnancy did not necessarily afford the women greater access to housing support or secure accommodation. Indeed, in many cases, the women were 'not pregnant enough'. The research found that, without these basic needs of shelter and stability met, it was very difficult for the pregnant homeless women to prepare for motherhood practically, physically and emotionally, with negative consequences for the mother and baby. While the participants described positive relationships with staff from homelessness, housing and health services, as well as examples of interventions which provided timely support, there was also evidence that some parts of the housing and homelessness service systems did not prioritise the needs of this group of women and that it is a neglected area of practice.

In relation to housing support, most participants could not access long-term safe and secure housing until very late in their pregnancy or until after the birth of their baby. Participants reported a number of problems in supported accommodation, including experiencing forms of harassment or assault, and being geographically isolated from networks of support. The masculine dominated nature of rooming houses restricted some participants' ability to safely and comfortably access communal facilities. Other women resorted to couch surfing, sleeping rough and living in cars, which increased their vulnerability and exposed them to sexual and other forms of violence and theft. Access to the nutritional needs associated with pregnancy was particularly difficult for the participants living in rooming houses and cars, and for those couch surfing and sleeping rough.

Among the group of women there were those who experienced complex and co-occurring issues. For some, childhood trauma which had resulted in long-term homelessness compounded the difficulties they experienced during pregnancy. Most participants were exposed to gendered violence, with some reporting their pregnancy triggered an escalation in violence from partners and family members. Insecure residency status resulted in considerable difficulty leaving a violent relationship due to work ineligibility and no access to Centrelink income support. Homelessness can be further complicated by alcohol and drug use, impacting pregnant women's capacity to engage with antenatal care and other services.

Some participants reported positive experiences of support where complex and co-occurring issues were addressed; others reported siloing of responses where there was little attention paid to the relationship between their pregnancy and various other presenting issues. Participants reported that, when they were able to receive support in a timely and coordinated manner, they managed to successfully reduce or stop their substance use. Central to the success of programs such as WADS was their capacity to offer a flexible wraparound model of care which also enabled women to develop a sense of optimism regarding their pregnancy.

Women reported experiences of reproductive ill-health and trauma. Several participants contemplated terminating their pregnancy because of their homeless circumstances. Reasons for ultimately not terminating included not having access to transport to get to appointments, resistance from partners, and personal ambivalence about having a termination. Homelessness heightened the distress of miscarriage as there may not be any access to private spaces to bathe, grieve and manage the pain and associated bleeding.

Homelessness significantly impacted participants' ability to prepare mentally and materially for the birth of their baby, as well as impacted their access to routine antenatal care. Participants in long-term secure accommodation were more able to prepare for the arrival of their baby. Pregnancy was an important time when participants reported a willingness to make significant changes and engage with support services, thus providing a critical window of opportunity for successful service provision. Participants reported positive experiences with caseload midwifery care, as it fostered a sense of trust and familiarity, and also linked them to other relevant supports. Forms of ongoing assistance and connection such as maternal and child health services, respite care, and playgroups were important to participants and provided valuable support. However, some women found group settings with other mothers and babies could be alienating and stigmatising due to their complex life circumstances.

8.2 Recommendations

The earlier research undertaken with service providers (Murray et al., 2018) led to 24 recommendations, all of which remain relevant after conducting this second stage of the research with women who have experienced pregnancy and homelessness. These later findings have informed the following recommendations.

Data collection

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

Research

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

Long-term housing

- Ensure long-term housing is the principal housing option offered to pregnant homeless women unless it is unsuitable for her specific circumstances
- Increase access to social housing for pregnant homeless women in a range of dwelling types and suitable locations which maximise women and children's stability, safety and wellbeing, including access to supportive networks and services
- Resource the A Place to Call Home program by restocking transitional housing dwellings when tenancies are transferred to permanent public housing
- Ensure private rental and other brokerage arrangements are available which suit the circumstances of pregnant and newly parenting women in terms of affordability and location
- Increase provision of social housing with wraparound support modelled on Housing First programs so pregnant women can access permanent housing and stabilise early in their pregnancy

Intensively supported transitional accommodation

- Drawing on good practice examples for young women and a new initiative for women aged 25 years and over, provide additional intensively supported transitional accommodation for pregnant homeless women
- Ensure transitional housing is available which suits the circumstances of pregnant and newly parenting women in terms of location

Crisis accommodation

- In situations where long-term, stable and sustainable housing or supported transitional accommodation are not immediately available, increase and improve access to suitable crisis accommodation for pregnant homeless women
- Prioritise access to crisis accommodation for homeless women following the disclosure of pregnancy

- Prioritise crisis accommodation for homeless women immediately following a termination or miscarriage
- Provide flexibility in the length of time crisis accommodation is available to avoid pregnant homeless women exiting with nowhere to live
- Review access to family violence crisis support to ensure pregnant homeless women with complex needs are not disadvantaged

Support – Improving practice

- Ensure pregnancy is taken into account as a critical factor for determining access to housing and support when pregnancy is first identified or disclosed
- Promote an approach to supporting pregnant homeless women which is based on early intervention and wraparound services
- Ensure information about support services is made readily available to pregnant homeless women through community health services, GP clinics and other specialist health and housing services
- Ensure information about reproductive health as it relates to termination is provided to pregnant homeless women through community health services, GP clinics and other specialist health services
- Ensure homelessness and health services are aware of the family violence Flexible Support Packages and the ways they can provide support to pregnant homeless women experiencing family violence
- Promote assertive provision of information and referrals relevant to pregnant homeless women by service providers
- Promote homelessness, health and other services working together to provide long-term support to women during pregnancy and early parenting
- Enable services to provide relevant good practice elements of continuity of care, outreach, wraparound provision of services and peer support
- Raise awareness with service providers of the housing and health needs of women who seek a termination rather than continue with a pregnancy
- Underpin service provision by trauma-informed care

Support - Increasing resources

- Increase pregnant homeless women's access to a continuity-of-care model for their antenatal care
- Locate specialist housing support workers in hospital settings to assist pregnant homeless women to access housing support, including after termination and miscarriage
- Increase specialised group parenting programs during early parenting to avoid stigma and enable social inclusion of women
- Increase pregnant homeless women's access to termination services through the provision of supported transportation

- Increase availability of drug and alcohol detoxification and rehabilitation facilities for pregnant women in metropolitan and regional locations

Training and education

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

Networks and integration

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

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