A roof to start off with:

Young, homeless, pregnant and parenting in Adelaide

RESEARCH PAPER

Government of South Australia
Department for Families and Communities

A roof to start off with:

Young, homeless, pregnant and parenting in Adelaide

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1 Executive Summary

1.1 The study

Anecdotal information and available evidence suggests there are increasing numbers of homeless young women in metropolitan Adelaide. Logically, this also implies increasing numbers of children born into or experiencing homelessness in their early years. This study aimed to provide better understanding of issues related to antenatal, post-natal and early child-hood care for homeless young women and their children, and identify strategies to improve access to services, information and support.

The study was funded under the Department of Human Services' Research and Innovation Program. Ethics approval was obtained from the Department of Human Services Human Research Ethics Subcommittee and the Aboriginal Health Research Ethics Committee of South Australia.

The cultural definition of homelessness was used in this study, supplemented by the concept of iterative homelessness, in which homelessness is defined as repeated moves through inadequate forms of accommodation, including being tenuously housed for short periods of time, often at risk of eviction, harassment, exploitation and so on.

The major component of the study was repeat in-depth interviews with seventeen young women ranging in age from 16 to 24 years, exploring their experiences of homelessness, pregnancy and parenthood. This was supplemented by a survey of services, the collection of case-studies, and the collection of extra data relating to the health status of children in the ongoing SAAP client data collection.

A brief review of existing data and research indicates that:

- The actual number of young women who experience homelessness whilst pregnant or parenting is unknown, and impossible to quantify. However, approximately 1500 children accompanied 894 homeless young mothers in SAAP accommodation services in South Australia in 2003/4. The actual number of homeless, pregnant and parenting young people is likely to be much greater than this figure. Many would not have entered SAAP, and there is no way to calculate the number of young women who experience homelessness whilst pregnant.

- Young women who experience homelessness whilst pregnant are at heightened risk of poor birth outcomes

- Their children have a heightened risk of poor developmental, health and behavioural outcomes, and of abuse and neglect.

- There is currently very limited research on the particular issues for homeless young women around pregnancy and parenting.

Each section of the report concludes with a summary of observations, and key directions for the way ahead. The structure of this Executive Summary mirrors that of the report, and draws together the summary observations and key directions, with some commentary.

1.2 Experiences of homelessness

The seventeen study participants were aged between 16 and 24 years, with an average age of 20.4 years. Two identified as Aboriginal; the remainder were from English speaking backgrounds. Children ranged in age from 2 months to 4 years. Five young women were pregnant at the time of interview. Although all but one participant were currently housed, housing was still highly tenuous and unstable.

Summary observations

- Participants had all experienced years of tenuous housing and homelessness. They moved frequently between different living arrangements and forms of accommodation, and between different 'levels' of homelessness.

- Two sub-groups were identified. The *early homeless* (11 young women) first became homeless in their early to mid-teens as a result of family conflict and violence. The second group (*later homelessness:* 6 young women) first became homeless at a slightly older age as a consequence of domestic violence.

- Long-term homelessness had led to high levels of depression and stress, and feelings of isolation, loneliness, despair, guilt and low motivation.

- Difficulties in accessing private rental, the long wait for public housing, poverty, debt, and personal issues including violent relationships, relationship breakdown, mental health problems and the challenges in managing a house, had all contributed to housing failure.

1.3 Pregnancy

Almost all (13) of the participants had experienced homelessness whilst pregnant. In the words of these young women, '*moving around made my pregnancy a tense, stressful and unpredictable time'; 'it was a really lonely time for me'* and *'there were days when I had nothing to eat'.* Overall, it was *'the wrong time to be pregnant'.* Young women were asked questions about their housing status, confirmation of pregnancy, nutrition and health during pregnancy; antenatal care and preparation for the birth.

Summary observations

- Pregnancies were nearly always unplanned and confirmation of pregnancy aroused great anxiety and stress.

- Frequent moves between temporary arrangements continued throughout pregnancy, becoming increasingly more difficult as pregnancy advanced.

- Being pregnant increased feelings of vulnerability, fearfulness and stress, and the sense of desperation around housing. Consequently, young women often made decisions to stay where they would not otherwise have chosen to, including with unsuitable people, in difficult relationships and in unsafe places.

- Mobility, personal crisis, ambivalence about pregnancy, stigma and stress all contributed to poor levels of antenatal care. However, support, encouragement and help with transport (particularly achieved through involvement with SAAP services) made a big difference to antenatal attendance.

- Young women rarely disclosed their homelessness to health professionals and it was seldom identified during antenatal care.

- Self-reported rates of depression were extremely high. Stress and depression were the major health problems reported during pregnancy.

- There were high rates of smoking and poor nutritional intake during pregnancy. Access to food was a major issue.

- Young women lacked the resources (time, energy, money, information, storage space) to properly prepare for motherhood. Moving around made it difficult to accumulate and keep goods.

The way ahead:

- Better identification of homeless and insecurely housed young women in health services would facilitate links into care and support.

- Youth and homelessness specific health services have demonstrated success in engaging and supporting homeless young women in antenatal care.

- Positive, practical support and personal encouragement from services can overcome many obstacles to consistent health care.

- Food security strategies targeting homeless young people, especially during pregnancy, should be considered.

- Practical assistance in collecting and storing goods can make a big difference to a young woman's preparedness for motherhood.

1.4 Birth and post-birth

Adapting to a new baby is a difficult and challenging time for any woman. Most, however, face this challenge from a base of stable housing, support, and adequate financial and material resources. This was not the case for the young women in this study: layered on top of the normal adjustments and problems were many other complex issues and deprivations. Oongoing housing instability meant additional stress, depression and feelings of loneliness and isolation. Major issues of basic survival had to be confronted on a day to day basis, whilst simultaneously attempting to adapt to new motherhood.

Summary observations

- Young women's homelessness and insecure housing is usually not identified or disclosed during their hospital stay.

- Homeless women usually left hospital to stay temporarily with family, however these arrangements were tenuous and stressful. Those who went from hospital to SAAP had better stability and support.

- Housing stress, and associated issues of poverty, conflictual relationships, isolation and depression, are a heavy burden on top of the usual challenges in adapting to motherhood.

- Stable housing and support are critical influences on coping in the first weeks of motherhood. Homeless young women usually lack both these things.

- Moving frequently between temporary arrangements remains the norm post-birth.

- Participants all wanted to breastfeed, however sustaining feeding was the exception.

The way ahead

- Better identification by hospitals of homeless and insecurely housed young women would facilitate the provision of support and housing.

- Strong links and continued care pre and post birth between hospitals, SAAP services and Child and Youth Health would improve outcomes.

- Targeted support to vulnerable young women to continue breast-feeding would increase the liklihood of sustaining this commitment.

1.5 Parenting

Fifteen of those interviewed were currently parenting. Housing emerged as the most powerful factor impacting on parenting and quality of life for mother and child: *'my housing situation now has made a big difference to how I parent'.* However, housing was not the only issue, and problems were not 'solved' by housing alone. The young women's stories also demonstrated the fragility and tenuous nature of housing when attained, the complexity of factors with which they and their children had to contend; and the ongoing burden of depression, stress, isolation and powerlessness which they carried. Thus, young women in housing still said *'I feel really stuck'; 'it is so stressful'.*

Summary observations:

- Housing is the single most powerful factor influencing young woman's adjustment to and experience of parenting.

- The stresses associated with being homeless or tenuously housed directly impact on parenting capacity; they also result in compromises in parenting and children's exposure to environments which place at risk their health, safety and wellbeing.

- Stable housing and support are essential in coping with motherhood. Involvement with SAAP, when it brings both these elements, has a positive impact on parenting across a number of dimensions.

- Stresses for young women continue post-housing, and ongoing support is needed. Past and present experiences of violence and abuse; poverty and debt; limited personal networks; and the stresses of single parenthood with few resources or child-care, all impact. Long-term exposure to homelessness and associated factors also effect a psychological and emotional cost, and recovery is slow. Young women are likely to continue to feel isolated, depressed, 'stuck' and anxious even when housed.

The way ahead:

- Group programs can offer young women initial anonymity and provide an environment in which they develop confidence to ask questions or approach services individually.

- On site or mobile specialist services (such as Child & Youth Health clinics at SAAP services) help engage young women and create links.

- The attitude of workers is crucial in shaping how young mothers experience a service.

- Flexibility in service provision (eg. home visits, transport, or accompanying young women to appointments) is essential.

1.6 Health

Previous research has demonstrated that homelessness and associated conditions (such as exposure to violence) have a major negative impact on the health of both adults and children. Inadequate shelter; poor access to health care; poor nutrition and food scarcity; unhealthy lifestyles (including smoking, alcohol and substance abuse) and prolonged exposure to situations of stress and violence all result from homelessness. The women and children in this study were at risk of extremely poor health outcomes over both the immediate and longer term. However, the interviews also demonstrated that health outcomes and behaviour could be improved by innovative and flexible service delivery strategies.

Summary observations:

- Most health issues reported were stress related, with depression the most common issue.
- Support from services and innovative practices (outreach C&YH clinics in SAAP services, drop in services, youth-friendly services) are essential in supporting regular immunisations and child health checks.
- GPs are usually the first contact for health matters. Young women commonly attend GP clinics which bulk bill and are nearby. There is little continuity in health care.
- Limited access to food and poor nutrition are stand-out health issues for both mother and child, with potential all-of-life impacts.

The way ahead

- Innovative practices between health and homeless services in both maternal and child health would improve health outcomes for mothers and children.
- Depression and anxiety-related health problems call for holistic and partnership responses between services.
- Food security strategies to improve nutritional intake and access to food for homeless young women and their children should be considered as a matter of priority.

1.7 Plans

The structure of the study (with young woman interviewed up to three times over a number of weeks) allowed some opportunity to explore with participants both their plans for the immediate future, and the outcome of these plans. This provided a small snap-shot of the many barriers and obstacles which surround young women, and the continuing insecurity and instability of their lives. It was especially clear that *'you just can't plan your life when you don't know what is going to happen about your housing'.*

Summary observations:

- Plans and hopes for the immediate future were highly vulnerable, and likely to be derailed or overtaken by events or lack of access to the necessary resources.

- Stable, safe housing is the most important element in being able to successfully plan for the future.

- Access to child-care is a fundamental and essential element in strategies to improve education, employment and life opportunities for vulnerable young women.

- Post homelessness, housing remains tenuous and highly vulnerable. The little stability that is achieved, and associated with it, good intentions about parenting, are easily overwhelmed by circumstances, events and difficulties.

The way ahead:

- Ongoing, intensive support is essential for young mothers who are moving out of homelessness.

- This support should include practical assistance to plan and achieve against plans (such as child-care).

1.8 The surveys and case studies

Key services were surveyed about their experiences in working with young women who are homeless whilst pregnant or parenting. Services were asked to respond to specified questions and also invited to submit a case study. Responses confirmed the information generated through the interview process, and painted a picture of the many service delivery challenges in working with homeless young women, their intensive and extensive needs, and the barriers to successful outcomes.

Summary observations

- Services in Adelaide regularly have contact with a significant number of young women who are homeless whilst pregnant and parenting.

- Surveys confirmed the complex, multiple issues which confront these young women; the difficulties of breaking out of homelessness and abusive life patterns; and the negative and compounding impact of homelessness on the wellbeing and safety of mother and child and on the mother-child relationship.

- Major concerns include the destructive impacts of homelessness on the emotional wellbeing of young women and children (including depression, stress and low self-esteem). Highlighted were patterns of unstable and violent personal relationships around the young women; ongoing issues of poverty; poor nutrition; poor health; drug and alcohol abuse; limited supports; and the impact on parenting of backgrounds of abuse and vulnerability. It was a common concern that young women are forced into or choose dangerous and inappropriate housing arrangements (such as a return to violent relationships) rather than risk renewed homelessness or coping on their own.

- Children are at a high risk of abuse, neglect and poor developmental outcomes; and the relationship between parent and child is significantly compromised.

- A range of service issues currently impede responses, including insufficient housing options; poor identification of high-risk young women and children in the health system; poor coordination and follow-up; service gaps and waiting lists; and service culture.

- Client-related issues also impact, including hostility, suspicion, mobility, shame, reluctance to engage and difficult behaviour.

- Antenatal and post-natal care become a low priority when a young woman is homeless; there is a natural focus on immediate needs and survival rather than health care and planning. Transience, lack of transport and lack of information are also barriers to attendance.

- The lack of coordinated care around these high-risk young women and children is highlighted.

The way ahead

- Strategies to improve the identification and follow-up of high-risk young women through the health system and provide coordinated and consistent service delivery, would improve outcomes.

- Increased home-visiting and outreach services, and services with a flexible modality of delivery and youth-friendly approach, are consistently identified as the most needed responses.

- The needs of homeless children should receive special consideration in homeless and child protection strategies and services, early childhood responses and primary care planning.

1.9 Final comments

Summary observations:

- The single most important intervention needed by homeless young women and children is stable housing, coupled with support.

- Homelessness has a destructive impact on every aspect of the lives of young women and children. These impacts are cumulative and compound over time.

- Parenting, quality of care, and children's basic needs are inevitably compromised by homelessness.

- The profound negative impacts of the factors which lead to young people becoming homeless (violence, abuse, family breakdown) are also exacerbated and compounded by homelessness.

- *Recovery* is an important component in moving out of long-term homelessness. People need opportunities to recover (emotionally, psychologically, physically and financially) from the trauma of homelessness.

- *Social inclusion* is another important element in successful rehousing: homeless young people have long and compounding experiences of exclusion and marginalisation; and need opportunities to participate and be included socially, and through education, work and activities.

- There are significant barriers to accessing health services for homeless young women and children. Some of these are related to the experience of homelessness; others to the nature of services and the service system.

- Existing services, especially SAAP, make a significant difference to the lives of homeless young women and children.

- With the 'right' approach, service modalities and culture, services can engage homeless youth.

- Support from services can mitigate some of the destructive impacts of homelessness and make a significant difference to service access and coping with pregnancy and parenthood.

- There are particular poverty traps associated with homelessness that make it harder to 'get out'.

- Homeless children experience extreme disadvantage, and their health and wellbeing is significantly compromised. The longer their exposure to homelessness, the more destructive, cumulative and compounding will be its impacts. Re-housing is a matter of urgency in the life of the child.

The way ahead:

- The considerable achievements of SAAP and other innovative services should be recognised, rewarded and built on.

- There is a need to strategically consider the provision of care and support, particularly in the areas of health and nutrition, for homeless young women who are pregnant and/or parenting.

- A health promotion approach to the population of young women who are homeless or insecurely housed should be considered.

- A key challenge for health services is to develop systems to identify homeless and insecurely housed young women in a way that is non-threatening and non-judgmental.

- Better links should be built between the health, homeless and other community services sectors to enable through-care, continuity of care, improved referral and case management processes, and better services.

- Consideration should be given to the development of a Homelessness Health Strategy. For this population group, such a strategy would incorporate better identification of homeless and insecurely housed young women in the health system; targeted health promotion and health education; nutrition and food security strategies; through-care and coordinated care initiatives; and a shift in service delivery modalities.

- A sense of urgency and priority should guide responses to homeless children.

2 Introduction

2.1 Background

Anecdotal information and available evidence suggests there are increasing numbers of homeless young women in South Australia. Logically, this also implies increasing numbers of children born into or experiencing homelessness in their early years.

In 2000/01, 825 homeless young women[1] with children were clients of Supported Accommodation Assistance Program (SAAP) services in South Australia. In 2003/04 this number increased to 894. Most of these young women were aged 20-24 years (71.6%), although 9% were aged 17 years or under. Indigenous young women were highly over-represented (24%). Domestic violence was the single most common precipitant for seeking assistance (in 34% of cases), followed by terminated accommodation (being asked to leave or evicted from where they were staying: 12%) and relationship or family breakdown (12%). Most young women (64%) had only one child, however over a third (36%) were accompanied by two or more children. Extrapolating these figures suggests that approximately 1500 children accompanied young mothers in SAAP services in South Australia during 2003/4.

Not all homeless young people access SAAP services: many are 'sleeping rough' and/or 'couch surfing', constantly moving between family and friends. Many probably are not identified as homeless in their contacts with health and early childhood services. Thus, the actual number of homeless young women with children is unknown, but will be substantially higher than the number indicated by SAAP data.

There is no data available as to the number of homeless young women (accessing services or not) who are pregnant.

2.2 The issues: a brief review of the literature

The association between homelessness and poor health has been well-documented. Homeless women face particular health issues with many suffering from depression, sexual health problems and asthma (Lindsay & Wessing, 2000: Huska and Fry, 2000). Poor nutrition, drug and alcohol abuse and high rates of smoking have also been identified (Howard 1995).

Research into pregnancy and early childhood development indicates inadequate antenatal care, poor nutrition, smoking and drug use during pregnancy are associated with poor birth outcomes. Evidence is also growing as to the fundamental importance of in-utero experiences and the first three years of life to learning, behaviour and health outcomes over the life course (Adelson et al., 1992; Chan et al., 2000; Cunnington., 2001; Hay, 1992; Wanger, 1993). There is also extensive evidence to suggest that young women, particularly those aged under 20, represent a high risk group with regard to pregnancy outcomes (American Academy of Pediatrics, 1999; Adelson et al., 1992, Chan et al., 1999). A study by Buchholz and Korn-Bursztyn (1993) identified factors such as the level of support, insecurity about the parenting role, depression and stress as impacting on the parenting skills of young mothers. The authors suggested that financial, social and emotional stresses faced by the mother, rather than age, are critical in determining the level of potential risk of child abuse.

Against this body of knowledge, it is clear that young women who are homeless and pregnant are at a higher risk of poor birth outcomes due to their own health status and associated risk factors. Their children are also particularly vulnerable to poor developmental outcomes, as well as at risk of abuse and neglect, with life long implications.

The issues of homeless, pregnant and/or parenting young women are not well covered in the literature. However, the existing literature and research highlights the complexities and

[1] Aged under 25 years

problems for this group. Research suggests that the pregnancies of homeless young women are likely to be unplanned (Howard 1995, Harrison & Dempsey 1997) and there are significant levels of increased risk during pregnancy. Homeless young women are likely to delay their first presentation for antenatal care, are less likely to access regular antenatal and post natal care or child health services, have a poor take up of services and have significantly reduced support networks and access to reliable information.

A study by MacDonald (1992) identified that issues include low levels of breast feeding, problems with asthma (for both mother and child), chronic respiratory and middle ear infections in children, lack of antenatal preparation, nutritional deficiencies, inadequate information about breastfeeding, post natal depression and pressure on young women to take drugs. Many young mothers in MacDonald's study had no concept of their own health needs, did not attend to health matters for themselves, and were less likely to do so for their children. Young women were reluctant to approach health services, particularly with regard to antenatal issues.

Poor nutrition will also affect mother and child. During pregnancy, women have an increased requirement for iron, calcium, folate and energy. Infants, toddlers and children need age-appropriate and specific nutritional intake early in life for adequate growth and development. Booth (unpublished PhD thesis) has investigated the experience of food insecurity amongst homeless youth in inner city Adelaide. Major aspects of food insecurity identified included: a sub-optimal food intake compared with both recommendations and an age-matched domiciled population, a heavy reliance on unorthodox food sources and practices (such as welfare services, begging and theft) and frequent hunger. Included in the study were some who were pregnant and parenting.

The adverse effects of homelessness on children has been recognised in overseas literature. For example, Wood et al. (1990) found that homeless children had more physical, emotional and behavioural problems when compared with children from poor families with accommodation. An Australian study by Efron et al. (1996) examined health and behaviour amongst children in homeless families. In comparison to the normative population, children in homeless families were found to have a greater prevalence of behaviour problems classified as 'deviant', intellectual disability, developmental delay, skin problems, vision problems, recurrent headaches, asthma and other breathing problems.

SUMMARY POINTS

The available data and research indicates that:

- **every year, a not insignificant, and it would seem, growing number of young women in South Australia experience homelessness whilst pregnant and/or parenting. Approximately 1500 children accompanied 894 homeless young mothers in SAAP accommodation services in metropolitan Adelaide in 2003/4.**
- **young women who are homeless whilst pregnant have a heightened risk of poor birth outcomes**
- **their children have a heightened risk of poor developmental, health and behavioural outcomes, and of abuse and neglect.**
- **there is very limited research on the particular issues for homeless young women around pregnancy and parenting.**

2.3 The study

Against this background, the current study was designed to provide a better understanding of issues related to antenatal, post-natal and early childhood care for homeless young women

and their children in Adelaide; and to identify strategies to improve access to services, information and support.

The objectives of the study were:

1. To gain a better picture of the numbers of homeless young women in metropolitan Adelaide who are pregnant and/or have children

2. To identify the extent to which these young women access antenatal and early childhood services, barriers to service access, and resulting issues

3. To gain a better understanding of the impact of a mother's homelessness on a developing child

4. To identify the current service response to these young women and children; and issues and dilemmas in providing services.

Specific hypotheses explored were:

1. With the growing number of homeless young women in metropolitan Adelaide there is an increased likelihood of children being conceived and born into the high risk situation of homelessness.

2. Homeless young women are unlikely to regularly access the services, information, support and resources, which are available to other women in the community for antenatal, post natal and early childhood supports. This increases the level of risk to the children.

3. There are considerable barriers for the target group in accessing existing supports, resources and information. These include the transience of the population, stigma, relevance, mistrust of services, physical access, poverty, cultural barriers and lifestyle issues, including the focus on daily survival needs.

4. Strategies can be developed to improve the access, relevance of services and supports to these young women to improve their access to resources and information which, it is believed will result in reduced risk to the children.

The study was funded under the Department of Human Services' Research and Innovation Program. Ethics approval was obtained from the Department of Human Services Human Research Ethics Subcommittee and the Aboriginal Health Research Ethics Committee of South Australia.

2.4 Target group and definitions

The research target group were young women:

- aged 25 years or under
- who were homeless and
- either pregnant and/or parenting young children 0 – 4 years of age.

The Supported Accommodation Assistance Act (1994) defines homelessness as *inadequate access to safe and secure housing.* Within this broad context, the 'cultural' definition of homelessness proposed by Chamberlain and MacKenzie (1992) is now widely accepted across Australia. This definition considers the nature of accommodation/living arrangements, and proposes those which can be counted as homeless, as follows:

Cultural definition of homelessness:

Primary:	People without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.
Secondary:	People who move frequently for one form of temporary shelter to another and including people in SAAP accommodation
Tertiary:	People who live in boarding houses on a medium to long term basis

This definition was used for this study. However, consideration was also given to the concept of *'iterative homelessness'* proposed by Robinson (2003). This focuses on experience over time, and in particular the cyclical and repeat nature of homelessness, where people move back and forth between different 'levels' of homelessness and different forms of accommodation, become tenuously housed, and then homeless again, often in a trajectory of experience that lasts for years. Thus Robinson defines homelessness as *the repeated move through inadequate forms of accommodation, including being tenuously housed for short periods of time, often at risk of eviction, harassment, exploitation and so on*. This is an apt description of the experiences of participants in this study.

2.5 Components of the study

Interviews with homeless young women

The major component of the study was repeat in-depth interviews with seventeen young women exploring their experiences of homelessness, pregnancy and parenthood. It was intended to interview each young woman three times over a six week period. However, the interviewer lost contact with one young woman after the first interview, and another three after the second.

Participants were contacted through homelessness and other services. Young women were invited to participate if:

- They did not have a permanent address
- They had a permanent address but could not live there
- They had been living away from home with friends, in shelters, hostels, emergency of short term accommodation, squats or sleeping rough for one month or more.

Services advertised the research in common and waiting areas and/or identified potential participants amongst their clientele. Participants were recruited through SAAP funded agencies as well as the Playgroup Association of South Australia, the Parenting Network and Streetlink Youth Health Service.

Three flyers were developed, one for services telling them about the research, and two for potential participants. Young women could either contact the interviewer directly via telephone or e-mail, or provide consent for a worker to pass on their contact details. Most chose the direct contact option.

The semi-structured interviews covered demographic information, housing background, pregnancy issues, birth and post birth, breastfeeding, parenting, and the young woman's immediate plans.

The topics covered at each interview were determined by the young woman's pregnancy and parenting status and the concurrence with homelessness. For example, if the young woman's homelessness commenced when her child was 12 months old, the interview focused on parenting.

The interviews were conducted in a place nominated by the interviewee. Reimbursement of $20 was provided for each interview.

Survey of Services

In June 2002, 28 services working with homeless young women were invited to participate in a survey covering:

- an estimate of how many young women (meeting the research criteria) the service has worked with /had contact with in the last 6 months
- their major concerns and dilemmas in working with this group
- their observations as to the needs of children
- their assessment of the major impact of the mother's homelessness on accessing/attending antenatal care, post natal health checks and child development
- opinions on what could be done to increase the use of antenatal care and early childhood services for this group.

Survey participants were also invited to attach a case study.

SAAP client data collection

In an attempt to ascertain the health status of accompanying children, a survey of clients of SAAP agencies in metropolitan Adelaide was conducted between 11th November and 8th December 2002.

Young women (under 25 years) with children under four years of age were asked questions relating to:

- the health of their children, including disabilities and medical conditions
- current immunisation and child health check status
- the number of general practitioners seen and other health services used over the last 12 months.

Survey questions were attached as an addendum to the current SAAP client data collection form. Eighty young women (with one hundred and ten children) participated in the survey.

2.6 Issues and limitations of the research

Conducting qualitative research with homeless people poses many challenges, including establishing and maintaining contact with participants. The most at risk are often highly transient, sleeping rough, have limited contact with services, may be suspicious and difficult to engage, and are much harder to recruit. Consequently, research is often skewed towards the more 'settled', especially when participants are recruited through services.

This was the case in the current study. Apart from one young woman, all participants were housed (albeit in temporary arrangements) during the interview stage of the research and all were in contact with services. It was clear that their housing situations at the time of interview had led to decreased levels of vulnerability and risk. Thus, the interview sample was not representative of the homeless population as a whole, and certainly not those most at risk. A greater time period, and active, innovative field work, would be necessary to find and recruit homeless young women in squats, cars, sleeping rough etc.

Participants were informed of the interviewers' mandatory reporting obligations before and during the interview. 'Fear of welfare' was a very real issue for these women, and it is likely this was a barrier to disclosure.

Attaching health-related questions to the SAAP client data collection was an innovative attempt to draw in information from a greater number in the target group. However, difficulties were experienced in coordinating and collating this information and the quality of some of the data was questionable. Responses revealed generally better health status than anticipated. This is most likely because participants were not a representative sample of the target population: most had been in SAAP accommodation for some time and received support and assistance in health related matters (eg services arranged for immunizations to occur). It would be anticipated that a survey which only included young women at the point of entry into SAAP would produce quite different findings.

3 Experiences of homelessness

3.1 Participants

The ages of the seventeen interview participants ranged from 16 to 24 years with an average age of 20.4 years. Two participants identified as Aboriginal; the remaining were from English speaking backgrounds. Between them, participants had twenty-one children, ranging in age from 2 months to 4 years.

At the time of interview, two young women were pregnant with their first child and another with her third. In addition, two had pregnancies confirmed during the interviewing period, one with her second and one with her third child.

Eleven participants were parenting one child, including two who had another child being cared for by a family member following the involvement of child protection services. Four young women were parenting two children, including one who was parenting twins.

The SAAP Survey

- Eighty young women, with 110 accompanying children, participated in the SAAP survey.
- 40% of the young women were aged 18 years and under
- 9% were Aboriginal and/or Torres Strait Islander
- 15.5% of the children had lived in four or more homes in the past 12 months

3.2 Current housing

Table 1 summarises housing arrangements at the time of the first interview.

Table 1: Current Accommodation

Accommodation	Number
SAAP transitional housing	6[2]
Public housing	3
SAAP Accommodation	4
Private Rental	2
Squat	1
Caravan Park	1

Housing instability was clearly ongoing: over the six-week interview period, ten participants moved residence. Contact was lost with four of these; and only three were planned moves to longer term housing (with a 12 month lease).

[2] SAAP transitional housing refers to a SAAP service leasing a property from the South Australian Housing Trust. A SAAP client lives in the property, usually for a period of 12 months, and the client makes rental payments to the SAAP Service.

3.3 Length of Homelessness

> *'I have had housing difficulties all my life due to domestic violence. I moved around a lot with my mother when I was younger. I have been in shelters with my mother.'*

In the first interview, participants were asked to provide a brief description of their housing history and the types of accommodation they had lived in.

Young women usually identified a single reason for the beginning of homelessness, although from their stories it was clear that, over time, increasingly complex and multiple issues impacted on their ability to acquire and sustain housing. Thus they had all experienced long periods of uncertainty, numerous temporary arrangements, and housing failure.

All participants could be described as chronic or long term homeless (after Chamberlain and MacKenzie 1998). However two broad groups emerged, namely:

1. *Early homelessness*: *family violence and breakdown*. Most (11) had experienced housing difficulties and homelessness for at least two years (including four who had been homeless or insecurely housed for five or more years). Another two (one of whom was indigenous) described second-generation homeless (their first experience of homelessness was with their own parents). Commonly homelessness began between the ages of 14 and 16 due to family breakdown: they left home or were 'kicked out' because of child abuse, issues with stepparents or parental separation. Other factors identified included parental drug addiction and (parental) domestic violence.

2. *Later homelessness*: *domestic violence*. The second group (6 young women) were more recently homeless (between seven and eighteen months) and relationship breakdown and domestic violence were the common precipitants. Two said their partners had become abusive due to mental health issues and another two said confirmation of their pregnancy led to increased abuse.

3.4 Iterative homelessness

In accord with the 'usual' pattern of youth homelessness, all participants had, over their years of tenuous housing, moved frequently through many different options (living on the streets, staying with friends, periods of independent housing, SAAP services etc). Constant moving and searching for safe, decent and sustainable housing, and the unending struggle to get on top of things and get ahead were recurring features of their stories. The psychological and emotional cost was very high: depression, stress, anxiety, feelings of desperation, guilt, despair, failure and loss of motivation were commonly described.

> *Sue is 16. When she left home she and her partner sayed for a while with a friend's family. They then moved to a boarding house; then on to other friends; then to a youth shelter. Sue next returned to her mother's house but was soon 'kicked out' again. Since that time she has been living with friends and in squats.*

> *Claire is 17, and left home when she was 15. "This has been the first place of my own. Since I left home I have been staying with friends, extended family. I have been moving around from place to place every couple of months, I have only been able to stay at people's places a few weeks. I tried to get private rental in Murray Bridge and Mt Barker. It was impossible because of my age and that I had no one to go guarantor.""*

All had experienced housing failure. Relationship breakdown (usually including violence) debt, poverty, and the struggle to manage were common causes. Mental health and substance abuse problems were identified as contributing factors.

Private rental was particularly difficult. Cost was often prohibitive, and properties that were affordable were frequently described as 'dumps', unsafe, unsanitary, or located in rough, dangerous areas. Most identified discrimination by landlords against young single mothers.

Five young women had debts they were repaying, mostly incurred from unpaid rent. However, debts were also associated with household utility bills, gambling and substance addictions. Some still had debts sustained when properties were damaged in the context of domestic violence.

> *'Trying to get housing is so expensive and there is nowhere good to get housing that I could afford. You can get cheaper housing easily in areas like……. and I did consider…….. but I think it's too rough around there. Landlords won't rent to a single mother with children. They think you are going to have parties and trash the place'.*
>
> *'I lost my flat for financial reasons as I was struggling to meet the rent and bills. Going from supported accommodation to private rental was also hard and a shock. In supported accommodation you just pay rent, in private rental you have to be responsible for a whole lot of other bills and that makes budgeting hard.'*
>
> *'When I became pregnant we were sharing a house. There were a few DV issues. I had enough and kicked him out. I had to get out as we had a physical struggle. He came back later and smashed my house up. He destroyed everything, the property, a lot of my possessions; he also put graffiti all over the house. That left me with a $3000 debt with the Housing Trust for what he'd done.'*

Debt compounded the struggle to access and maintain housing. One participant had been forced to declare bankruptcy, which now worked against her in the private rental market.

SUMMARY OBSERVATIONS

- **Participants had all experienced years of tenuous housing and homelessness. They moved frequently between different living arrangements and forms of accommodation, and between different 'levels' of homelessness.**
- **Two sub-groups were identified. The *early homeless* first became homeless in their early to mid-teens as a result of family conflict and violence and were the majority of the participants. The second group (*later homelessness*) first became homeless at a slightly older age as a consequence of domestic violence.**
- **Long-term homelessness had led to high levels of depression and stress, and feelings of isolation, loneliness, despair, guilt and low motivation.**
- **Difficulties in accessing private rental, the long wait for public housing, poverty, debt, and personal issues including violent relationships, relationship breakdown, mental health problems and the challenges in managing a house had all contributed to housing failure.**

4 Pregnancy

Thirteen participants were homeless whilst pregnant. These young women were asked questions about their housing status; confirmation of pregnancy; nutrition and health during pregnancy; antenatal care and preparation for the birth.

4.1 Confirmation of pregnancy

Most young women were in a steady relationship at the time they conceived their first child, although the relationship had sometimes ended before the birth. Almost all pregnancies were unplanned: exceptions were one participant who planned her pregnancies with her steady partner and another who wanted a baby and decided to become a sole parent.

> *'The Doctor confirmed the pregnancy but didn't tell me what to do next. I had to go on what my family told me to do. I was late starting (antenatal appointments*).'

Generally, pregnancy was confirmed around six weeks by a GP, and the young women were then referred to antenatal services (although this did not always happen). However, two did not return to the GP for another appointment, in one case due to moving around and the other because of ambivalence about the pregnancy.

Confirmation of pregnancy was, for most, a shock, that aroused stress and anxiety, although three also reported positive feelings of excitement. Worries were centred around their housing situation, their responsibility towards their baby, and how they were going to manage, including with the physical vulnerability or pregnancy.

> *'When I found out I was pregnant I had just turned 16. I was scared and I didn't know how to tell the father I was pregnant. I was heaps worried about what I was going to do. I had no housing and I was really worried.'*
>
> *'When the home test was positive I was shocked and crying hysterically. It was the wrong time to be pregnant.'*
>
> *'It was stressful. I was worried about being on the streets. I was worried about physical assaults and getting beaten up, not getting an income and having to get food from Fred's Van…. It was a scary time wondering what was going to happen'.*

4.2 Accommodation during pregnancy

> *'I spent my pregnancy moving between my mother's, my boyfriend's and my step dad's place. I would carry my clothes and possessions around in a backpack. The bigger I got the more difficult it was to handle moving around and I got really big towards the end of my pregnancy. Moving around made my pregnancy a tense, stressful and unpredictable time.'*

Whilst pregnant, the young women continued to move frequently between temporary arrangements. Most identified at least four moves and some said they moved so often they couldn't remember them all. All were driven by the need to find settled accommodation before the baby was born: their housing insecurity became an even greater concern to them.

Most commonly, accommodation during pregnancy was with friends, family, extended family, boyfriends and boyfriends' families. Temporary arrangements with family were difficult times, marked by conflict. Staying with friends was also a mixed experience: sometimes it was supportive and friends helped out in practical ways (food, transport); at other times women had property, household goods or money stolen, experienced dangerous situations, or were in conflict with others in the household. Some felt their pregnancy made it even harder to get private rental. Two women lived on the streets for periods of time whilst pregnant. Overall, it was clear that the lack of options and poverty, combined with their pregnancy, forced young women to stay where they would otherwise not have chosen to, including with unsuitable people, in difficult relationships and in unsafe places.

'We don't get along, we clash, I was reluctant to move there, but she didn't charge us rent.'

'I applied for about 20 rental places and was not successful. I was pregnant at the time, so I think this was the reason I didn't get anywhere. I had no idea what was going to happen about where I was going to live, finding a place and what was going to happen to me'.

Most (9) used SAAP services at some time during pregnancy. However one said she was not willing to be separated from her partner and *'there's no youth service that takes couples'.* As a result she had spent almost all her pregnancy moving around, staying with friends and living in squats. Another was too afraid to go to SAAP because she thought shelters were unsafe.

4.3 Antenatal care

Irregular antenatal care has been associated with a range of poor birth outcomes for both mother and child (Cunnington, 2001).

For study participants, mobility was the biggest barrier to regular antenatal care. Those who moved frequently had many missed appointments and used different doctors (usually a bulk-billing GP near to whereever they were living at the time). Young women also said they missed appointments due to transport problems, relationship issues, ambivalence about pregnancy, the stresses of homelessness, and stigma associated with their situation.

'I have had three health checks through different doctors. Depending on where I am living, I just find a doctor that is nearby and go there. I just decide when I need a check. I know it sounds terrible about my checks. I'm going through a stage of denial where I try not to think about having a baby because I know everything will be different.'

'The hospital appointments shook me around more, as I was alone. When I went to the hospital I always cried as I saw other women there with their partners and boyfriends. It was just shit for me, a really lonely time for me. This contributed to me not going to the appointments. I also had transport difficulties.'

Support, encouragement and help with transport, however, made a difference to health care. Thus, the regularity of antenatal care increased when living in SAAP. For example, two young women had little antenatal care during the first two trimesters then moved into SAAP: staff provided support, helped make appointments and assisted with transport. Another very mobile young woman was able to maintain a very regular pattern of attendance due to support from friends and then SAAP workers.

All participants said they were given basic health messages regarding smoking, drug and alcohol use and nutrition. Some said they were given a lot of information (usually pamphlets.) Some were motivated to access information themselves (usually by taking pamphlets from common/waiting areas) and also used books, but most relied on information from mothers, friends or acquaintances.

Young women were generally reluctant to ask questions of professionals in mainstream services, mainly due to lack of confidence and feelings of vulnerability. Dismissive responses sometimes discouraged further attempts.

'If I talked to them when I was anxious I wasn't taken seriously, midwives would then say 'I felt the same as you when I was pregnant.' It was not helpful, I didn't want to hear about how someone felt 20 years ago'.

It was rare for young women to tell health professionals of their homelessness. Fear of welfare authorities, judgmental responses and stigma impeded disclosure.

Streetlink Health Service, a specialist service targeting at risk youth in the inner city, was highly regarded by those who used it for antenatal care. Medical staff were described as supportive, understanding and thorough and the drop-in approach was valued.

'(Streetlink) were heaps good, they were heaps nice. They had a good attitude towards me. I felt comfortable and there were heaps of young women there my age with kids going there. I was anxious during my pregnancy, I had doubts about how the baby was going, was it growing okay, was everything all right. If I talked about these doubts at Streetlink, they didn't even question it but would say things like – 'we can listen to the baby's heart if you are worried, would you like to listen to the baby's heart?'

'Streetlink feels comfortable, it's small, you walk in and you know straight away where to go. There is someone sitting at a desk. I could always go and see a Nurse, as you didn't have to make an appointment, you could just drop in.'

4.4 Health and nutrition during pregnancy

In discussing their pregnancy, most used words such as stressful, anxiety, worry, loneliness and depression. Worries were about their future, where they were going to live and how they were going to manage. Trying to find accommodation, to be settled prior to the baby's birth, was a major preoccupation.

'I have found the time very stressful, all the time trying to find accommodation. When I have the baby I've got to have a roof to start off with. Worry about accommodation has been a source of great anxiety.'

Self-reported rates of depression were extremely high: five of the thirteen said they suffered from depression during their pregnancy, and three took anti-depressants.

'I had severe depression. I had to go to the Doctors and was on anti-depressants. I was also on Valium so I could sleep. I was crying all day and night. I felt suicidal at the time.'

All smoked cigarettes pre-pregnancy. When pregnancy was confirmed, two gave up smoking. The others continued to smoke although some reduced the amount. All were aware of the health warnings about smoking whilst pregnant, but said it was a way of coping with stress and depression.

Most reported limited or no use of other substances whilst pregnant. One young woman said she used speed for the first four months of her first pregnancy and smoked dope and drank alcohol through her first and second pregnancy. Another two said they 'smoked a few cones' to manage stress and morning sickness.

Good eating is a fundamental support to a healthy pregnancy. During pregnancy, women have an increased requirement for iron, calcium, folate and energy. However, about a third of the young women said they did not always have enough food whilst pregnant, sometimes experiencing hunger or not eating for days at a time. A high intake of 'junk food' was widely reported. Living in a shelter, or in one case, incarceration, improved food intake.

Going hungry

'There were days when I had nothing to eat. I used to have pains in my stomach from hunger. I would put the bite on people to try and get money to get something to eat. I would go to a drop in centre, they sometimes had food.'

'There have been times when I haven't had money to buy food. This has been around times when the bills come in. I have had to go and get food vouchers a couple of times. There is an orange tree in the back yard of this place and there were a couple of days where I ate nothing but the oranges from that tree because I didn't have any money to buy food.'

'When I was in private rental housing while I was pregnant the rent was high, so there was not much money left for food. Overall I didn't eat well during my pregnancy between having no money and being so sick.'

'I didn't eat very well while pregnant. I was struggling to get baby stuff. I didn't have much money and what I had went on buying things for the baby. I couldn't afford to eat. There were days when I went without something to eat. I drank only water as couldn't afford anything else.'

Financial difficulty was the primary reason for inadequate food intake, often associated with high rents and having to buy things for the baby. Food storage, preparation and access to food when sleeping rough were particularly problematic, and usually resulted in a reliance on unorthodox food acquisition strategies, predominantly charity food services. Genna, currently living in a squat, described a daily routine focused on food acquisition:

'I get up at 7.45 to get to Hutt Street (Day Centre) for breakfast. I do washing and have a shower (at Hutt St) which is usually done by lunch time. I have lunch at Hutt Street, this costs $1.50 and is usually a home-cooked meal, some kind of casserole with meat and veg and a dessert, like jelly. If I can't afford to pay for the lunch I'll hang around till 2.30 for the free afternoon tea: cakes, tea and coffee. Usually I am able to pay for lunch as Hutt Street will allow credit. Then I walk around until it gets dark, then go to Fred's Van for dinner, usually sausages or soup, sometimes fruit or a cake. On Saturdays, Hutt Street is closed so I go to Teen Challenge for breakfast and the Magdalene Centre for dinner, which is usually soup and dessert. On Sundays I go to the church near Truscott Hi Fi and get a meal of cold meat and salad.

There have been times when I haven't been able to get food; my partner will steal chocolate bars for me to eat. That's happened about five or six times during this pregnancy. I return to the squat at night and go to sleep…..I went without food more often when I wasn't pregnant and there were days when I didn't eat anything. Now I am trying to do the right thing for my baby. At times I don't feel like eating anything but I will make myself eat for the baby.'

4.5 Preparing for motherhood

Getting settled before the birth of their child was a consuming issue during pregnancy. Trying to find a place to live, along with the necessary household and baby goods, was emotionally and financially demanding.

'I didn't think much about what it would be like to be a mother as I was thinking more about finding a place to live and just day to day things I had to do.'

Many said they were so concerned with meeting the basic need for shelter that there was little time to think about future motherhood. All struggled to accumulate the goods they needed and it was common for larger items to be obtained late in pregnancy or after discharge from hospital.

Two young women attended a baby care/parenting course through a homeless service and felt they benefited from the information and advice. Three said they had read a lot during pregnancy about caring for a baby and new motherhood.

Friends, family and workers/services provided information about what was needed. For example, one young woman, who had limited personal support networks, said she had been given a book on what to buy from the Women's and Children's Hospital which had been 'very helpful'.

Most used secondhand stores to purchase baby items, and many were given goods by friends, services or workers. The personal kindness of workers was frequently highlighted: many had passed on goods and items no longer needed by their own families. One young woman said her partner's mates shop-lifted to get the necessary baby-goods.

> *I didn't know what to get for the baby but the staff at (the Detention Centre) were really helpful. They told me because they had kids. They gave me a lot of clothes from their children that they didn't need or use anymore.'*

> *'I didn't have much until I moved into the (SAAP Service) and they helped me get a lot of things. Before I went there I only had a bassinet on lay-by, which I paid off. I had bought bits and pieces along the way as I could afford them. Money was always an issue. I got given a cot, mattress, a pram and heaps of baby clothes through (the service).'*

The families of three young women provided some material support at this time, despite normally very strained and difficult relationships. For example, one young woman spent her pregnancy living on the streets and in shelters and *'didn't get anything for the baby really. I didn't know what to get, had no idea'.* After the birth of her child she was allowed to return to live with her mother who had set up a nursery (although this arrangement soon broke down).

Many had to wait for the Centrelink parenting bonus to obtain larger items such as prams and cots.

> *'It was hard trying to get things for the baby because I didn't have much money. I was only getting $300 per fortnight. I had to live and I was going to school at the time so it didn't leave much to buy baby things.'*

> *'It was very hard buying things because I also needed to keep buying clothes for myself because I was getting bigger all the time and still had bills to pay.'*

Moving around and staying in temporary accommodation made it difficult to acquire goods, particularly larger items. Lack of access to storage facilities and having to continually move possessions were major issues. Sometimes items were lost or stolen between moves, and often accommodation services did not have storage space. These were all barriers to forward planning and positive anticipation of impending motherhood.

SUMMARY OBSERVATIONS

- **Pregnancies were nearly always unplanned and confirmation of pregnancy aroused great anxiety and stress.**
- **Frequent moves between temporary arrangements continued throughout pregnancy, becoming increasingly more difficult as pregnancy advanced.**
- **Being pregnant increased feelings of vulnerability, fearfulness and stress, and the sense of desperation around housing. Consequently, young women often made decisions to stay where they would not otherwise have chosen to, including with unsuitable people, in difficult relationships and in unsafe places.**
- **Mobility, personal crisis, ambivalence about pregnancy, stigma and stress all contributed to poor levels of antenatal care. However, support, encouragement and help with transport (particularly achieved through involvement with SAAP services) made a big difference to attendance.**
- **Young women rarely disclosed their homelessness to health professionals and it was seldom identified during antenatal care.**
- **Reported rates of depression were extremely high. Stress and depression were the major health problems reported during pregnancy.**
- **There were high rates of smoking, and poor nutritional intake during pregnancy. Access to food was a major issue.**
- **Young women lacked the resources (time, energy, money, information, storage space) to properly prepare for motherhood. Moving around made it difficult to accumulate and keep goods.**

THE WAY AHEAD:

- **Better identification of homeless and insecurely housed young women in health services would facilitate links into care and support.**
- **Youth and homelessness-specific health services have demonstrated success in engaging and supporting homeless young women in antenatal care.**
- **Positive, practical support and personal encouragement from services can overcome many obstacles to consistent health care.**
- **Food security strategies targeting homeless young people, especially during pregnancy, should be considered.**
- **Practical assistance in collecting and storing goods can make a big difference to a young woman's preparedness for motherhood.**

5 Birth and post birth

Adapting to a new baby is a difficult and challenging time for any woman. Most, however, face this challenge from a base of stable housing, support, and adequate financial and material resources. This was not the case for the young women in this study: layered on top of the normal adjustments and problems were many other complex issues and deprivations. For all of them, ongoing housing instability meant additional stress, depression and feelings of loneliness and isolation. Major issues of basic survival had to be confronted on a day to day basis, whilst they simultaneously attempted to adapt to new motherhood.

5.1 Hospital

All participants were homeless or insecurely housed when they gave birth. All but one either chose not to inform hospital personnel of their housing status or were not asked. One deliberately misled staff into believing she was going to live with her mother on discharge as she did not want them to know she would be living independently. The one girl who did tell staff about her homelessness was assisted by hospital social workers to apply for public housing.

Participants generally described their stay in hospital favourably and felt they had been supported. However, some felt they were given little information about parenting, what to expect as a new mother and community supports.

Most were in hospital for the usual amount of days. One left a day early because she had 'had enough'. Another said hospital staff wanted her to remain for a psychiatric assessment but she discharged herself 'at her own risk' after six days.

> *'Although I was having difficulties with housing I didn't tell anyone at the hospital about my situation. I had an address down. I didn't feel the need to tell them about it. I didn't want them to know too much.'*

> *'Soon as I got out of hospital, two days later FAYS came over with a notification of neglect. It was reported that (baby) would be in danger with me. I think the report came from the hospital. They offered me heaps of help while I was there but they didn't say to me they thought I wasn't coping, they gave me no indication I wasn't coping. I would have rather them say that to me than report me.'*

5.2 Housing

All had somewhere to go to when they left the hospital, although this was usually SAAP or staying temporarily with family. However, only one young woman's accommodation remained stable after the birth: she maintained her tenancy in SAAP transitional housing for 12 months and then moved to community housing.

Several were offered accommodation with their own or their partner's mother: in all cases the arrangement soon broke down and they had to move again. For example, Paula was homeless again when her child was four weeks old after being 'kicked out' of her mother's home. Her mother had offered accommodation when the baby was born but then said she had '*had long enough to find a house'*. Paula was only able to take a few baby clothes and bottles and had nowhere to stay. Thus commenced a period of several months where she moved from friend to friend, culminating with the involvement of child welfare authorities and the removal of her child.

Living with family and friends with a new baby was very stressful. There was always a history of conflict and poor relationships with family; managing a new baby when 'under sufferance' in a house was very difficult; and there was ongoing pressure to find something of their own and move on. Margaret, for instance, spent her time confined with her baby in a bedroom to minimise conflict and protect her baby from the unsanitary conditions in the rest of the house. She was also expected to take responsibility for all household chores.

Moving frequently between casual arrangements remained the norm. Helen lived between two places while her twins were very young. Every four weeks she would leave the children's father's public housing to spend a short period of time with extended family. This was done to avoid his rent being increased: they would not be able to manage financially if they declared de-facto status. This cycle of moving continued until she secured her own housing some months later.

Another moved into SAAP housing post-birth. Whilst she acknowledged the support provided, she found congregate living difficult. She also felt staff had high expectations of parenting and were scrutinising her: this added to her anxiety.

5.3 Support

Aside from housing, support was the critical factor in determining how young women coped with the first weeks of motherhood. Those who found the transition relatively smooth had supports available to them (emotional and practical) from friends, family, workers, or partner. However, this was not the experience of most participants, who had few or inadequate supports, both professional and personal.

Only four young women had home visiting post-natal follow up, organised by the hospital before discharge.

One young woman, despite having little support, said she coped well because of her reading and participation in a parenting and baby care course during pregnancy.

> *'I was really stressed out with a new born because of not getting much sleep. I got a lot of help off (my friend). She helped me with bathing and changing nappies. She helped me with practical baby care, showing me how to do things.'*

> *'After I had the baby I went back to my house. I freaked out, I was crying and I didn't know what to do. I had no support, no family. I then went back into the hospital for one night due to depression. The social worker then contacted (the SAAP service).'*

5.4 Breastfeeding

Existing research (Macdonald 1992) and anecdotal evidence indicates that homeless young women are less likely to breastfeed. Against this, it is clear that there will be particular issues in reliance on formula for feeding when homeless (cost; problems with hygiene; portability; access to the necessary facilities).

The overall impression from the interviews was that the young women wanted and attempted to breastfeed, but found it very difficult, especially in the first weeks, and usually discontinued soon after birth. Considerable support, encouragement and information was needed if breastfeeding was to be sustained. Young women generally said they thought they weren't given enough support and information about breastfeeding, especially in hospital.

'I really wanted to breastfeed and had heaps of milk but I had trouble. I tried to feed (baby) the whole time I was in hospital. My baby wouldn't attach and he'd cry. I don't feel they gave me much help. They didn't offer me the breastfeeding unit, which I was really pissed off about. I didn't know about it while I was in hospital but later found out about it from a friend, when it was too late. If they had told me about it I would have gone while I was still there.'

'By the time I fed her, settled her, then expressed milk for the next feed, cleaned up, she'd be awake. I didn't get the chance to rest and it was so exhausting.'

Two were breastfeeding at the time of the first interview and intended to continue for at least a year. Both had initial difficulties, but persevered until feeding was established. Another two decided to put their babies onto formula whilst in hospital, and felt they had not been given the assistance they needed to overcome initial difficulties. The others gave up breastfeeding soon after discharge, generally because they found it too hard, demanding or exhausting. The frequency of demand-feeds led some to believe they did not have enough breast milk and they felt reassured by the formula. Only one young woman consulted a community child health nurse about feeding problems.

Usually, formula and nappies where the first two items purchased at each 'pay' period. It was also common to hear that young mothers would forgo other items, particularly food for themselves, to meet this cost.

SUMMARY OBSERVATIONS

- **Young women's homelessness and insecure housing was usually not identified or disclosed during their hospital stay.**
- **Homeless women usually left hospital to stay temporarily with family, however these arrangements were tenuous and stressful. Those who went from hospital to SAAP had better stability and support.**
- **Housing stress, and associated issues of poverty, conflictual relationships, isolation and depression, are a heavy burden on top of the usual challenges in adapting to motherhood.**
- **Stable housing and support, are critical influences on coping in the first weeks of motherhood. Homeless young women usually lack both these things.**
- **Moving frequently between temporary arrangements remains the norm post-birth.**
- **Participants all wanted to breastfeed, however sustaining feeding was the exception.**

THE WAY AHEAD

- **Better identification by hospitals of homeless and insecurely housed young women would facilitate the provision of support and housing.**
- **Strong links and continued care pre and post birth between hospitals, SAAP services and Child and Youth Health would improve outcomes.**
- **Targeted support to vulnerable young women to continue breast-feeding would increase the liklihood of sustaining this commitment.**

6 Parenting

6.1 Homeless and parenting

Fifteen of those interviewed were currently parenting.

Stable housing, or *'having my own place'* was clearly the factor that made the biggest difference to parenting experiences.

Some interviewees were feeling more positive about their parenting role. Common factors in these cases were:

- access to supported accommodation either during pregnancy or upon discharge from hospital
- changes of residence were planned (e.g. from emergency to transitional housing)
- supports were available through services and included a combination of housing, health and parenting support.

'My housing situation has made a huge difference as I didn't have a routine when (baby) was first born and living in my boyfriend's mother's house. Having my own place is much better. I think there is a big difference for (baby). She is more settled, sleeping better and crying less. With my current house I have got it all sussed now, I feel pretty comfortable and settled.'

'It's much better being in my own place. In your own house you are more relaxed and I can let (baby) have a whinge. I think I am a better parent and more relaxed about parenting now I am in my own place. I'm less stressed out, more comfortable and relaxed.

For a second group, ongoing homelessness forced them to make compromises in parenting, and they acknowledged that as a consequence their children were exposed to less than ideal circumstances.

Living in a car

Jenny and her two year old lived in her car on and off for six months. She vividly described her stress and desperation in trying to get out of the situation, plus her consuming feelings of guilt at what she was putting her child through. Living in the car posed issues around safety, access to laundry, bathroom and kitchen facilities and food storage. Her life in the car was very much a day to day existence: parking in shopping centre car parks or parks to sleep at night, driving around to find toilets, living on take away food and trying to keep her toddler occupied, particularly as her child only had two toys that could be played with while sitting in the back of the car. Jenny was also in the middle of toilet training her child, and he contracted a bad respiratory illness. They are now housed and Jenny says she is much more relaxed, able to have friends come over to visit and happier that her child has a bedroom, space to play and toys.

'We have a life now, we can get out into the community. We have the luxury of being able to lie down when we go to sleep.'

Looking for permanent housing, with the every-day pressure of house-hunting, was emotionally and physically exhausing, and drove the daily routine for some mothers.

> *I spend all my time trying to find a place to live. Nearly everyday I'm out looking for places. I think I have looked at hundreds, that's what it feels like. I am so tired of having to get dressed up and put make up on every day to go out looking….. The times I am at home, I'm pretty tired… We don't really have a routine at the moment because of trying to find a place to live'.*

Several participants had recently entered SAAP from a period of crisis. They said SAAP support had improved their parenting, and it was now possible for them to focus on their child/ren and develop parenting skills and enhance their mothering. However, they still felt unsettled and in limbo. Waiting to secure a place of their own led to uncertainty, frustration and concerns that breaking the cycle of moving around may never actually happen.

> *'My housing situation now has made a difference to how I parent. I'm doing it all myself. It gives me the experience of doing it all on my own, while also giving me support by having a worker available. It could have been worse, I could have been all on my own.'*

Living in a caravan park

Anne described the problems in caravan park living, namely safety and space issues, lack of privacy and limited amenities. The caravan was crowded with little room for play. She kept the children close when outside, not trusting their safety amongst the resident population. She and the children shared a bed. It was hard to toilet the children at night, and she had to be mindful of the level of noise they made as other residents were not tolerant. Her children often witnessed verbal and physical disputes between residents. Anne would like to have her own house but the cost of rent, furnishing and buying household goods made it financially unviable.

'Even if you do get a house you then have to get things like a fridge, it makes it hard and very expensive just to try and set yourself up so you can live. You have to have so much for a house. It's just impossible for me. I can't handle living in fear of eviction. I need and like security. I just moved in here with our clothes. They supply things like knives and forks and kettles. You don't have to go without here. Things that are supplied and break down get replaced. It's an on-site van with a fridge.'

6.2 Stresses after housing

Participants who were currently housed still identified stressors affecting their parenting and housing stability.

Two young women were experiencing conflict with current or former partners. One felt unable to leave a violent situation because she feared renewed homelessness with a very young infant; the other was involved in a stressful family court dispute.

Georgia, now in private rental, was highly stressed about both money and health issues. She had chosen private rental because she '*did not want to be moving from shelter to shelter while waiting years for public housing*'. She felt in a 'Catch 22' situation with her housing, which impacted on her health, adding to feelings of hopelessness and depression.

> *'I'm now classed as independent because I am in private rental. So I can't get SAHT housing. I can't use the services I need because their funding is for homeless people, people in public housing, or disadvantaged people. Because I am in private rental I am seen as doing all right, which is just not the reality. I feel really stuck.'*

Amanda had accepted public housing although she had reservations about the location of the home. Initially she was able to settle and establish a routine for herself and her children but had been disturbed by prowlers in the middle of the night and was currently involved in a dispute with a neighbour. This had disrupted the family's routine and children's sleeping patterns. She had applied for a transfer but thought her application unlikely to succeed.

Feeling of loneliness and isolation were common. Moving around meant the loss of contact with friends, and the focus on day to day survival and the need to find accommodation left neither energy nor opportunity to maintain what were already limited social supports and networks. Some young women were reluctant to become involved in programs or services that could provide social contacts due to their uncertain circumstances: there was little point if they had to soon move somewhere else. Isolation, depression and uncertainty led to loss of motivation and energy. One lonely young woman said she would like to be involved in a partnered relationship, however she knew her eagerness could mean she made a poor choice which might jeopardise her child's safety. She had seen others form relationships out of loneliness, where men had subsequently abused them and/or their children.

Young women who had experienced domestic violence or substance abuse were often in positions where social ties or relationships needed to be severed for reasons of safety and rehabilitation. Those who had no other supports often said that staying with an abusive partner was preferable to being a sole parent.

> *'It was really hard living with him and parenting the children but in some ways now it is harder on my own. It is so stressful. I miss help, at least he did do some things to help me. I want to provide a safe, happy environment for them. Safe I am now providing and can provide. I don't know if it's any happier though.'*

For those in housing, lack of transport, childcare problems, relationship issues and poverty continued to be major barriers to getting ahead, changing things and feeling better about life.

There was considerable stress associated with parenting '*all on my own'* with no support and limited or no opportunities to have '*a break*'. Some had consented to child care arrangements they were not entirely comfortable with because they desperately needed time out. Others said single parenting made it difficult to be consistent with limit setting and discipline with their children: they often '*gave in to have some peace'*.

6.3 Advice and Information

Those currently parenting infants were more likely to seek information and advice from services, particularly Child and Youth Health. Those parenting toddlers and preschoolers tended to rely more on informal sources, or compared their child to others the same age. They were also less likely to address any concerns they had.

For most, initial contact with Child and Youth Health was through another service, predominately on-site visiting at SAAP services. This facilitated contact with local Child and Youth Health Services when housing circumstances changed.

Most felt the advice they received was helpful and easy to put into practice, particularly around issues such as feeding, settling and infant development. Those parenting older children were less positive about services' advice, particularly around behavioural issues. Participants often felt expectations of parents were too high and there was little understanding of day to day pressures and problems.

> *'(Playgroup workers) have been the motivators for me. I wouldn't have accessed services or got information, I wouldn't have used services without them. I have also used the parenting sheets they have with the kids. They helped me enroll her in Kindy and provided transport to get it organised. They will also do follow up for me about things or information. They bring things from home like clothes for me and the kids. They have found and given out jumpers to those kids here that haven't got warm clothes. They have been a strong support for me and I have been happy to take their advice.'*

Young women were very aware of community views and stereotyping. Many made comments about not wanting to be the *'povo single mother, the stereotype single mother living on welfare, the type of mother where the children run all over her'.* Anne, living in a caravan park, said there were many young families and women with children moving into the park and the stigma associated with being seen as '*trailer trash'* was well known. This perception made them wary when accessing services: they wanted to be respected for doing their best in difficult circumstances.

SUMMARY OBSERVATIONS:

- **Housing is the single most powerful factor influencing young woman's adjustment to and experience of parenting.**

- **The stresses associated with being homeless or tenuously housed directly impact on parenting capacity; they also result in compromises in parenting and children's exposure to environments which place at risk their health, safety and wellbeing.**

- **Stable housing and support are essential in coping with motherhood. Involvement with SAAP, when it brings both these elements, has a positive impact on parenting across a number of dimensions.**

- **Stresses for young women continue post-housing, and ongoing support is needed. Past and present experiences of violence and abuse; poverty and debt; limited personal networks; and the stresses of single parenthood with few resources or child-care, all impact. Long-term exposure to homelessness and associated factors also effect a psychological and emotional cost, and recovery is slow. Young women are likely to continue to feel isolated, depressed, 'stuck' and anxious even when housed.**

THE WAY AHEAD:

- **Group programs can offer young women initial anonymity and provide an environment in which they develop confidence to ask questions or approach services individually.**

- **On site or mobile specialist services (such as Child & Youth Health clinics at SAAP services) help engage young women and create links.**

- **The attitude of workers is crucial in shaping how young mothers experience a service.**

- **Flexibility in service provision (eg. home visits, transport, or accompanying young women to appointments) is essential.**

7 Health

7.1 Mother's health

Young women were asked how they would rate their overall health. All said they had experienced periods of extreme stress and tiredness, most commonly when housing was uncertain or temporary. However just over half (8) rated their current health as good.

> *'I have no energy and can't be f… I need the B12 tablets but they are so expensive. I am now sleeping in as late as I can. I get up when (my child) wakes. I feed her, wash her bottles, clean up. Basically I spend most of the day sitting around with her as I have no energy.*

The others reported ongoing issues including anemia, anxiety and panic attacks, agoraphobia, chronic lethargy, headaches, backache and skin conditions. Depression was the most common issue (raised by about a third).

7.2 Children's health

All participants said their child/ren's immunisations were currently up to date. Some had been late, however all were now back on schedule often due to assistance or intervention from SAAP or FAYS.

> *'I was good with getting (child's) immunisations done up until I lost it with the drugs then I think I missed a couple. I can't really remember. FAYS organised to have them up to date when (she) went into foster care.'*

Most said their child's health checks were also up to date but they generally were not as diligent with these as with immunisations. Child and Youth Health Centres, including Second Story, were most commonly used for health checks.

Factors that influenced the regularity of immunisation and health checks included:

- having visiting child health nurses on site (for example at SAAP services or visiting health clinics at caravan parks)
- easy access to clinics, or clinics that were easy to get to by public transport.
- drop in services.

All said they used a General Practitioner when their children were unwell. However only three had a regular doctor. Most used a bulk-billing GP within walking distance or public transport of wherever they were living. Some also expressed dissatisfaction with GP services.

> *'They seem not to give advice on what to do. They have an 'I'll-give-you-a-script-and-you- can-go' attitude. Sometimes I can't afford to have the scripts filled so I have to wait.'*

Child development

The most common concern raised by those parenting 'older' children was speech development. Anne was aware that her child 'didn't talk that well' but had been ambivalent about seeking help mainly because she did not know how to go about it.

Anne and her children were living in a caravan park and began participating in a weekly on site playgroup, part of a pilot program run by the Playgroup Association. As she developed a relationship with the workers, they supported her assessment that assistance was needed, arranged a speech pathologist to visit, and supported her in contact with the health professional. This was crucial in ensuring the child had an assessment and follow up.

'Playgroup workers raised his speech with me and organised a speech pathologist to come and assess him the next week. She has given me a lot of information about this, how to talk and interact with him. I need to be talking with him a lot more. They have just been fantastic and the playgroup has been really good for the kids. They have been great and so supportive'.

The SAAP Survey

In the survey conducted through SAAP services, young women with accompanying children were asked about General Practitioner usage. 29% (23 of 80) reported seeing three or more GPs over the past twelve months with two having visited ten or more.

Young women were also asked identify the two health services they used most often in the past 12 months (aside from GPs). Results are summarized below

Table 2: Health Services most often used (aside from GPs)

Other Health Services used	N	%
ACIS	2	2.5
Clinic 275	1	1.3
CAMHS	2	2.5
Community Health Centre/ Service	8	10.0
Child and Youth Health	36	45.0
Hospital	32	40.0
Noarlunga Health Village	5	6.3
Shine Clinics	2	2.5
Streetlink	6	7.5
Shopfront	1	1.3
Second Story	16	20.0
Women's Health Statewide	1	1.3
Other	6	7.5
Not stated	34	42.5
Total	**80**	**100.0**

Child and Youth Health was the service most often used (45%), followed by hospitals (40%) and Second Story (20%).

Most children were reported not to have any medical condition at the time of the survey. Conditions most frequently described were asthma, ear nose and throat infections, and skin conditions.

Only two children were reported as having a disability – one intellectual and one behavioural.

7.3 Nutrition and food

'I don't budget for food, as I barely have enough to get by. After everything comes out of my money, rent, bills, I have $100 left. Then all of (child's) stuff comes out of that. I get a phone card every pay, as it is a necessity and I have to have it. I usually end up with $20 left which usually pays for my food, loo paper etc. So it can be very hard. I try to eat a meal at night. I'm also trying to pay off clothes for my child. I try and pay off $5 per week'.

Infants, toddlers and children need age-appropriate and specific nutritional intake early in life to ensure adequate growth and development. The interviews with young women clearly demonstrated, however, that food insecurity, for both mother and child, resulted from homelessness. It was also evident that access to food and nutrional intake improved with housing, but food security and quality was still issues.

'When I was younger and on the streets I would eat when there was food available. I wasn't eating the healthiest but at least it was something

All the young mothers interviewed wanted to feed their children properly. Young women consistently identified, however, two major factors impacting of their access to food: poverty, and the availability of facilities for cooking and food storage.

At times of housing crisis young women spoke of limited access to food, going hungry when they had no food, and sporadic access to poor quality food. This was vividly captured by Jenny, in her description of living for six months in a car with her toddler:

Living in a car

'We had no place to store food and I had to buy drinks and milk as it was needed because it was summer and you couldn't have milk and things in the car. I couldn't keep drinks cool, so I had to buy them all the time, mostly water. There was no point in using food services because I couldn't put the food anywhere. We lived on fast food and take-away. I would try and buy (my son) rolls and sandwiches. I'd buy take-away chicken. We ate a lot of hot chips because it was cheaper. He also ate a lot of lollies. I bought him lollies because it helped to keep him occupied, give him seomthing to do, look forward to.

Housing made an enormous difference to food intake for Jenny and her son: *'The luxury of being able to cook and have home-cooked meals, meat and veg. Having somewhere to store food'.* However, Jenny still reported using charity food services '*a lot'*, especially '*when the bills come in'*. She felt shame and embarrassment in asking for such help.

'Some food services are okay and others ask a lot of questions about why you need their help. The real churchy ones want to know everything, how you've spent your money. If you have to be there in the first place you feel pretty low. It's hard having to go.'

Periods of being housed or in SAAP accommodation brought access to kitchens, and was accompanied by an increase in food consumption. However, poverty, the extent of support, stress, appetite and cooking skills still influenced the quality and types of food prepared and eaten. Trying to meet the child's need for food was the first priority and if necessary the mother limited her own intake. About half the participants had used a food service (in a homelessness service).

> *'When I have to make tea I usually have something that I heat up and eat, or make things like eggs.'*
>
> *'Since I have been on my own I'm slacker with food at dinner times because I have less time to prepare food. So overall we would eat more frozen food or frozen pizza. It's hard to keep the kids occupied so I can make tea. I didn't realise how much the other person does at tea time, so you are free to cook.'*

Thus, a food-recall for the previous day provided by fourteen young women indicated that:

- Six (42%) had **missed meals.**
- Five (36%) reported a **current loss of appetite**.[3]
- Another two said they were **dieting.**[4]
- Food intake for nine of the fourteen (64%) the previous day included instant or fast food (for mother and often children). Two-minute noodles, frozen foods and take-away foods were prominent. This was despite many of them stating that they had a healthy diet, '*ate better than they used to'* or made *'decent, home-cooked meals'*. For example, one pregnant young woman with an infant (who said she liked cooking) listed the food she had eaten the previous day:

> *'(I ate) nothing until 2pm. Then had a packet of Chicos (lollies) and a small packet of chips. I cooked wedges at 4.30, later had 2 slices of apricot pie with cream. During the day I drank a bottle of coke. I eat when I can….. I like to cook but it is all new to me. What I eat is pretty much based on finances '*
>
> *'I have appetite loss at the moment. I'm not eating properly because I just don't feel like eating. I have been forcing myself to eat'.*

Breakfast:	*Bowl of 'Special K' cereal and milk*
Mid-morning:	*A packet of potato chips*
Lunch:	*A meat pie*
Dinner:	*A meat pie and potato wedges, a Vanilla Coke*

Participants also demonstrated variable knowledge of the nutritional needs of infants and young children. Some also reported putting their infants on solids very early (eg. one month old).

[3] Booth (unpublished PhD thesis) also identified this in her study of food insecurity amongst homeless young people in Adelaide. Possible causes include stress and adaptation to reduced food intake.

[4] Also noted by Booth and possibly related to issues of body control.

Almost all participants said they could cook. Three, who had experienced long-term cyclic homelessness, left their parental home in their mid teenage years with no cooking skills. One subsequently learnt to cook in shelters, and another attended cooking classes at the SAAP service.

Poverty was a major influence on food intake, both before and after housing. Twelve young women (currently housed) said they had a weekly food budget. Table 3 summarises the self-reported expenditure on food and grocery items of these participants. The data suggests very tight budgeting, which will consequently affect the type, quality and amount of food in the house.

Table 3: Family type by household expenditure per week

Couple with one child	Single with one child	Single with two children	Expenditure per week ($)
✓			150 *
		✓	125 **
		✓	120
✓			100 *
		✓	100 **
	✓		100 *
	✓		60 *
	✓		60 *
	✓		80
	✓		40 *
		✓	40 *
	✓		30
2	6	4	
Average expenditure per week			
125	62	96	

* denotes the inclusion of toiletries and cleaning products in weekly expenditure.

** denotes the inclusion of nappies, toiletries and/or cleaning products in weekly expenditure.

> *'I learnt to cook through my mum and grandmother and taught myself some things. With my ex- boyfriend I had to learn to be a better cook quickly because if meals weren't what he wanted or cooked the way he wanted it cooked, he'd throw it at me.'*

> *'I like cooking because I've lived in so many refuges, you had to cook while you were there. So I learnt to cook. Every night was a set dinner and the person whose turn it was had to cook what was on the menu. So if you didn't know how to cook it you had to find out, or else it was too bad.'*

SUMMARY OBSERVATIONS:

- **Most health issues reported were stress related, with depression the most common issue.**
- **Support from services and innovative practices (outreach clinics in SAAP services, drop in services, youth-friendly services) are essential in supporting regular immunisations and child health checks.**
- **GPs are usually the first contact for health matters. Young women commonly attend GP clinics which bulk bill and are nearby. There is little continuity in health care.**
- **Limited access to food and poor nutrition are stand-out health issues for both mother and child, with potential all-of-life impact.**

THE WAY AHEAD

- **Innovative practices between health and homeless services in both maternal and child health would improve health outcomes for mothers and children.**
- **Depression and anxiety-related health problems call for holistic and partnership responses between services.**
- **Food security strategies to improve nutritional intake and access to food for homeless young women and their children should be considered as a matter of priority.**

8 Plans

'You just can't plan your life when you don't know what is going to happen about your housing. I just can't get ahead, I'm in a no win situation.'

'Getting a house is the only thing I can think about.'

In the second interview participants were asked to discuss their plans for the next month.

Most spoke of things which would improve their quality of life, which they felt would in turn improve opportunities for their children. Obtaining employment, returning to education and attending courses were commonly proposed. Access to affordable, appropriate childcare was, however, the biggest barrier to carrying out these plans. As most did not have family supports they were pessimistic about achieving their goals.

For those without stable housing, plans were also dependent on becoming 'settled'. It was near impossible to plan whilst housing was uncertain. Feelings of tiredness, pessimism and frustration at being '*stuck in a waiting game'* were common.

Other hopes focused on day to day practicalities such as accessing child care, health or other services, purchasing furniture, household items or things for their children. One young woman intended to apply for course at University.

By the time of the third interview a month later, few participants had managed to carry out their plans. Personal crises, depression and stress, poverty, relationship issues (including violence or harrassment from previous partners) lack of support, lack of knowledge and continued uncertainty about housing all impacted.

'I felt something click in my head the other day. It was really unhealthy. I felt like killing myself… It's just the tired thing, I think. I'm just exhausted from having to do everything….It's hard doing it all on my own…. I just think "why can't someone take her for 5 minutes?"'

'I have been feeling really stressed and haven't been sleeping well. I just lie there thinking about the things I need to do, moving, and the money I need. People say that money isn't everything but when you don't have it, it is.

Three had successfully obtained long term tenancies and two had already moved. Although this was positive, there were also stresses along the way. One woman had property stolen in the move, including most of the baby items she had recently purchased. Another was under considerable financial stress as her direct lease had come through quicker than anticipated and she had little leeway for moving costs.

The tenuous nature of housing was clear: even in the month between interviews, half of those in housing (6) had experienced crises which threatened their new housing, for example:

- Greta had to move from transitional to emergency housing due to threats from a neighbour. The move had unsettled and angered her child, who had to leave the kindergarten she had just started in and begin again in a new area. She was also unsure if she would be able to maintain her attendance at a young mums' group and the social contacts she had established via the group. She no longer had access to a refrigerator and couldn't afford to buy one. This left her *'back in a day to day existence, I can't do shopping because of it.'*

- Clare was experiencing escalating conflict with her partner and was very depressed. Ending the relationship would mean moving again.

- Georgia had been prescribed medication for depression and was unsure whether she would or could remain in her house.

Poverty continued to be a major issue affecting personal well-being and the ability to '*get ahead'*. Almost all participants raised issues about money in the follow-up interview, and expressed feelings of anxiety, stress and frustration about money. Young women felt trapped and caught: poverty restricted their ability to get on and make something of their lives. Thus, hopes for study or work depended on the ability to get affordable child-care; and they lived with the stress of having to watch every cent and constantly save for basic items (such as a fridge, furniture for their house, or to mend appliances.) Two still had debts they were repaying with. There was no margins in their bugetting: something going wrong or an unexpected bill could throw them back into crisis and homelessness.

> *That's my main problem, financial. I would never have taken out my Centrelink loan if I knew I was going to be moving into my place so soon. I took out the loan but spent most of it on myself, to buy some clothes. I can't remember the time before that when I bought myself some clothes. I regret it now but then I felt really good about myself. It was nice to feel like a woman.*
>
> *'I got the car fixed but something else is wrong with it now. They told be it could be the head gasket. If it is there is no way I could afford to have that fixed, but the car is my life-line. I wish there was a government subsidised garage for people on pensions. I wish there was a Medicare system for cars for people on concessions.*

Young women also continued to struggle and feel pressure about issues related to their children and parenting. Tiredness and stress took its toll on their capacity to cope, especially for those without a partner. Two young women who did have partners, however, noted the impact (especially seen in behavioural problems) of arguments and, in one case, domestic violence, on their children. A child-protection notification had been made about the child of one participant; another was considering travelling inter-state to see if she could regain custody of her eldest child.

> *'My stress level is still high with the kids. There has been a lot of naughty behaviour and fighting between the two. (My son) just doesn't listen to me…. I am still taking him to the psychologist… He had his first transition session at Primary School last week: it didn't go well, he ended up punching some kids. The kids have seen (my partner) physically abuse me and spit on me and (my son) has spat on me.'*

Thus, although most participants were in housing and receiving support, their housing remained highly vulnerable. Loneliness, depression, stress, ongoing grinding poverty, difficult relationships, few opportunities and little joy was still the reality for most. The little stability that had been achieved, and their good intentions about parenting, could easily be overwhelmed. The challenges in this situation, and the strength, personal and practical resources and support needed to actually re-establish and successfully parent after long-term homelessness, deprivation and abuse, cannot be overestimated.

SUMMARY OBSERVATIONS:

- **Plans and hopes for the immediate future were highly vulnerable, and likely to be derailed or overtaken by events or lack of access to the necessary resources.**

- **Stable, safe housing is the most important element in being able to successfully plan for the future.**

- **Access to child-care is a fundamental and essential element in strategies to improve education, employment and life opportunities for vulnerable young women.**

- **Post homelessness, housing remains tenuous and highly vulnerable. The little stability that is achieved, and associated with it, good intentions about parenting, are easily overwhelmed by circumstances, events and difficulties.**

THE WAY AHEAD:

- **Ongoing, intensive support is essential for young mothers who are moving out of homelessness.**

- **This support should include practical assistance to plan and achieve against plans (such as childcare).**

9 The Surveys and Case Studies

As part of the project, key services were surveyed about their experiences in working with young women who are homeless whilst pregnant or parenting. As well as responding to specified questions, participants were invited to attach a case study.

9.1 Participating Services

Twenty one services (including one Aboriginal-specific agency) responded to the survey and eleven case studies were submitted.

Survey participants were asked to estimate how many young women (meeting the research criteria) the service had worked with /had contact with in the last 6 months (Table 4).

Table 4: Estimated numbers of homeless young women with children in contact with participating services within last 6 months

Service	Number	Participating agencies
SAAP Accommodation Service	223	5
Health Service	154	8
Community based service/program	22	3
Family support/welfare service	34	2
Unknown	71	3
TOTAL	**504**	**21**

These figures cannot be used as an indication of the population in the target group (young women may present to more than one service; some may not present to a service at all or be identified as homeless in their contact). However, it does suggest that services have contact with significant numbers of young women who are homeless whilst pregnant or parenting; and that SAAP agencies are the most likely point of contact.

9.2 Practice concerns and dilemmas

Services were asked to identify their major concerns and dilemmas in working with this target group. Key themes are outlined below.

- **The emotional and personal impacts of homelessness** on women and their child/ren were identified to include isolation, loneliness, marginalisation, lack of social supports and networks, and disconnection from family and community. Homelessness impacts on mental health: young women were reported to suffer from low self-esteem, worry, anxiety, stress and depression and sometimes misuse drugs and alcohol as a response to homelessness.

- Patterns of **unstable and violent personal relationships**, in particular partner relationships, which increases the risk of child abuse amd children's exposure to violence.

- **Poverty** - lacking the financial means to access goods and services and unable to get ahead or break the cycle. Debt, insufficient income, and lack of budgeting skills were identified as contributing factors.

- Poor **nutrition** and **inadequate food intake**.

- **Poor health and problematic access to health services** – specifically, little or no antenatal care, and little continuity of care, were widely reported.

- **High levels of unplanned pregnancy** due to factors including limited knowledge of safe sex, contraception and conception, and high risk behaviours and life-styles.

- **Limited knowledge** amongst homeless young women of information and services in relation to pregnancy, parenting and child development.

- An **absence of positive role models** and little experience of good parenting in their own lives.

- **Increasing incidence of mental health issues and drug and alcohol problems** amongst the population, including substance abuse during pregnancy.

Cindy

Cindy (aged 17) was pregnant when she first entered the SAAP service with her 18 year old partner. Cindy's background includes involvement with child protection authorities because of her experiences of child abuse, a severe eating disorder and depressive incidents. Her relationship with her partner was extremely volitile, and marked by violence, and both have a history of drug use (including, in Cindy's case, drug-induced psychosis). Whilst pregnant, Cindy did not attend ante-natal appointments or classes. Her baby was born very premature, and was in hospital for several weeks Soon after the birth, Cindy's partner broke off the relationship. Cindy brought the baby home alone, to transitional housing supported by the SAAP service. She refused offers of assistance, and is resistent to intervention of any kind. She had no family supports. Soon after bringing the baby home she began to be harrassed by a neighbour, who had mental health and alcohol problems, and so she had to move to a different property. Her baby developed severe health problems, and Cindy's own mental health issues re-emerged. After a notification to FAYS, the baby was found to be suffering from serious non-accidental injuries, and was also very sick. The baby is now in foster care.

9.3 Barriers to housing

The difficulties and sheer hard work it took to obtain housing for young clients was a key issue identified across services.

> *'The opportunity to find private rental is virtually nil, once the landlord knows they are young, single parents.'*
>
> *'Trying to get, locate accommodation for clients. Services are always full or near capacity and there is a lack of accommodation options. Making referrals and chasing accommodation can be very frustrating for workers.'*
>
> *'If you do manage to get accommodation for someone it feels like you have struck gold.''*
>
> *'Providing health education and services is very difficult when the young woman's immediate needs are not being met (i.e. shelter). It's hard to talk about nutrition when the young woman and her children haven't got anywhere to sleep.'*

Services identified two major barriers, namely:

- The lack of housing options. This was central to concerns and a source of major dilemmas for service providers.

- Prejuidice against single mothers and homeless people in the private rental market.

The consensus was that many young women will return to dangerous or inappropriate housing situations (including domestic violence) rather than risk a return to homelessness. This was consistent with the statements from the young women.

Jasmine

Jasmine is in her early 20s and has three children. Her current partner (Richard) is about 20 years older, and was recently released from prison. Jasmine's childhood was marked by homelessness, intinerancy and abuse. Her mother is currently homeless. Jasmine has extensive debts with the Housing Trust and believes she is on a 'private rental black list.' The family were living in a tent in a caravan park when they became known to an outreach program in the caravan park (sponsored by the Playgrouop Association).

Following intervention by FAYS and in fear of the children's removal, the family rented a caravan. At one stage, Richard reported the poor state of the caravan to the local government. Upon inspection, the van was deemed unfit to live in and they were given one week to move out. The family felt their only option was a tent, but feared the response from FAYS. The Playgroup Association negotiated with FAYS to accept the tent-option until more suitable accommodation could be found.

Jasmine and her partner were committed to their children and wanted to be good parents; however they had poor parenting skills and limited knowledge about child development, children's needs and parenting. The oldest chld's behaviour was becoming very difficult for them to manage and they did not know how to respond to tantrums, defiance etc. Support to the family including building parenting skills and insight; teaching them to play with their children; and helping them understand the impact of their living situation on their children. The family had little ability to advocate for themselves or access services, and the Playgroup Association worker negotiated extensively across the service system to advocate for the family, access housing, and obtain household goods. They also negotiated debt repayment, linked them in with community supports (such as a playgroup) in their new area, and linked them to HAPPI (the Homeless and Parenting Program).

9.4 The service system

Service system issues featured heavily in the survey responses and case studies. The following key concerns/issues were identified:

Resource issues

Overwhelmingly respondents reported a lack of services and resources across housing, health, welfare and education, to assist and support young women who are homeless whilst pregnant or parenting. Access to free counseling services was particularly identified as an issue.

'Not having the time and resources to adequately respond, dealing with the issues can be very time consuming, frustration at not being able to provide what is needed.'

Responding to homeless young women was demanding for agencies. The kind of support required (intensive, varied, across multiple life domains) was difficult to provide. Time constraints and the inability to respond to immediate needs (including waiting times for services) were central concerns.

The case studies demonstrated that a major focus of services' work is repeatedly advocating and negotiating on behalf of the young women, frequently with limited success.

The relationship between services and the young women

Tensions in the relationship between homeless young women and services emerged as an issue. Young women, with their troubled personal histories, complex current circumstances and sometimes limited competence (due to disability or mental health issues) are often 'difficult' clients and not easy to engage. They frequently have long, and sometimes negative, histories of relationships with services and society. Agencies identified that this sometimes led young women to percieve services as hostile, unhelpful and dismissive. Examples were also provided where young women experienced judgmental responses. Both impacted on the nature of the relationship with staff and the potential for successful intervention.

Case study

'Because of (her) immaturity, she had difficulty taking in the information given to her and she found herself frightened and lost during labour. As she does not trust adults, she found it difficult to respond to the midwives in the labour ward. The midwives and delivering doctor were judgmental and were not clear in their instructions to her. Consequently when the worker arrived to support her she had not been told how to push, and was only breathing her way through stage 2 contractions, with the doctor happy to perform a forceps delivery. Worker taught her how to push, the midwives caught on and assisted her to push and the baby was delivered naturally.'

Fear, shame and stigma all impacted on willingness to access services, disclose homelessness amd discuss parenting or other issues with services. Workers thus reported it was often difficult to engage, establish a relationship of trust and find out what was 'going on'. There was also a tension in supporting mothers whilst obligated to ensure the child's safety.

Inconsistencies and fragmentation

The service system was repeatedly described as fragmented, particularly early intervention services for young parents, post-natal services and specialist health services. This was a particular burden for SAAP services.

Those providing shared antenatal care and referrals to specialist health services experienced problems with information sharing about significant health issues and felt there was a paucity of feedback from some agencies.

'We often spend lots of time trying to organise visiting parenting services, pediatric developmental assessments, mental health review for young parents and the like but this is not available in a co-ordinated fashion.'

Inconsistent approaches and interventions within the same agency were illustrated in the case studies. The lack of prompt and consistent follow up was often viewed as contributing to crisis situations that may have been avoided with earlier review and assessment.

Case study: Wendy

Wendy is 23 and homeless. Her history includes extreme violence from a previous partner; 3 children all in foster care; incarcaration for drug-related crime; and opiate addiction with multiple efforts at detoxification. She is HepC positive. She presented to the health service at approximately 17/40 weeks pregnant, with no previous ante-natal care. Initial antenatal review, bloods and ultrasound were organised and a referral made to the high risk perinatal unit. Wendy remained reluctant to attend hospital appointments throughout her pregnancy. She felt staff were rude to her, were judging her and would not support her desire to parent her pending child. She was very frightened that her history would mean that her newborn baby would be taken away from her. During pregnancy her drug use reducted markedly and ultimately ceased. Her accommodation remained problematic. She moved between shelters and staying with friends. Her current partner was incarcerated, and she was threatened with violence by a previous partner and had to use some subterfuge about her whereabouts.

Contact and care-management between the health service and the hospital was problematic. The health service provided detailed referral information and requested that they be informed of any management plan. Despite the high risk status and their on-going role, they had no contact from the hospital during the pregnancy, nor did they receive any feedback on treatment for the newborn. The discharge summary from the hospital contained no recommendations for ongoing care of the infant or a follow-up appointment. Arranging post-natal care was left up to Wendy.

SAAP service criteria

Criteria in some areas of the SAAP sector were a source of frustration. Thus, it was reported that SAAP family services do not take a referral unless the baby has been born, which presents difficulties when attempting to secure accommodation close to the young woman's expected delivery date. In the youth sector, a young women is eligible for a service if aged under 25, however an older partner cannot be accommodated, therefore the couple must separate or go elsewhere. Given the partner is usually the only support for the young woman, it was reported that some refuse a service when it means separation.

Affordable community supports

Finding affordable community supports, services, education and training was also a dilemma. Particularly noted were affordable parenting courses; supports and groups for those suffering from mental health issues; counselling; and affordable childcare.

9.5 Antenatal and postnatal care

It was widely agreed that antenatal and post-natal care become a low priority when a young woman is homeless. There is a natural focus on immediate needs and survival, rather than health care, and often little time or energy to address other issues.

'Due to a lack of a safe, secure environment young women's priorities shift i.e. the need to survive day to day versus other needs. Parenting is then difficult in this situation.'

'Being homeless means a lot of time and energy goes into the search for a place to stay. Finding a place to live is the priorty.'

Transience and frequent moves were noted to result in lack of continuity of care, missed appointments, lost health records and problems in follow-up. It also prevented young women becoming familiar with the services in the area. Homeless young women often connect with health care late in pregnancy: examples were reported where young women had no antenatal care, and their first presentation was at hospital when in labour.

Transport issues were consistently identified. Homeless women are reliant on public transport and even the costs of tickets can be prohibitive. Public transport is also difficult to manage with a baby and/or young children.

Some services reported that young women lacked **information and knowledge about antenatal and postnatal services, and the confidence to seek advice**. The response of services and their environment was agreed to be crucial in accessing care. Young women were often fearful and confused by the medical system and uncomfortable in hospital clinics, anxious they would be judged by services and fearful disclosure of their circumstances would lead to removal of their child.

> *'Young homeless people, pregnant, tired, scared and unsure find antenatal waiting times a burden. After such a wait the appointment is often short and the young person feels staff are uncommunicative.'*

Post-natal management and referral were frequently identified as problematic. Examples were provided where identified 'high risk' young women with infants were discharged from hospital without follow up appointment/s and no recommendations for the ongoing care of the child. Health agencies which have a relationship with the mother and are prepared to be involved in ongoing support and management found such situations and the lack of feedback frustrating, particularly when they had identified their involvement via detailed referral information.

Other issues related to antenatal care included:

- **Motivation** – particularly if the young woman is suffering from depression, poor self esteem or drug and alcohol problems
- **Domestic violence** – restrictions can be imposed by partners, which makes it difficult to attend appointments
- **Lack of support** in attending appointments.

9.6 The children

> *'(The) majority of the young women have good intent regarding motherhood, however all the factors of homelessness makes it hard to face the reality and demands of motherhood and deal with those demands.'*
>
> *'Being homeless makes it difficult for the mother to focus on or prioritise the children's needs.'*

Children were described as affected by the same issues as their mothers: lack of stability, poverty, risks to safety and high stress. The children's emotional well-being was directly linked to that of their mother, and it was agreed that they were at a high risk of abuse and neglect. It was widely reported that homelessness significantly compromised the relationship between parent and child and affected their ability to develop healthy attachments.

An inevitable product of homelessness is that children are deprived of stable and secure environments, and lack consistency and routine. Social and emotional development were also compromised through:

- Restricted play and learning opportunities
- Little access to playgroups and kindergartens
- Limited or no exposure to opportunities to positively interact with adults and develop motor and social skills

- Lack of secure boundaries due to constantly changing environments
- Poor nutrition
- Inadequate clothing (especially warm clothing).

Service providers frequently reported that children were delayed in one or several areas of development. Speech and cognitive delays were most commonly reported and concern was expressed that developmental issues often remained undiagnosed for a considerable time.

9.7 Improving access to services

Finally, services were asked their opinions about what could be done to increase the use of antenatal and early childhood services. Themes in their responses are identified below.

Home visiting or mobile services

Nearly all called for increased home visiting, mobile and outreach services.

> *'Provide one to one service where the client is living or arrange to meet somewhere suitable.'*
>
> *'There needs to be parenting workers who can visit high risk clients on location to provide intensive parenting assistance.'*
>
> *'It would be invaluable to have a sessional specialist peadiatrician, with an interest in child development and early intervention.'*
>
> *'Services to be provided at youth friendly services where young homeless people frequent.'*

Transport and Incentives

Most respondents said transport issues needed to be addressed, and consideration should be given to providing financial or material incentives to attend antenatal, post natal and early childhood health checks. Suggestions included:

- providing transport or meeting costs for young women to attend appointments
- a financial incentive similar to the one provided for childhood immunisations or vouchers (e.g. for childcare, baby/child equipment) or 'baby packs' after attendance at post natal or infant/child health and developmental checks
- providing food or meals as part of an incentive to attend antenatal groups, information and parenting groups.

Service Issues

Service approach and staff attitudes were consistently identified as fundamental to engaging and working with this vulnerable population, particularly

- youth friendly services with a flexible approach and accessible hours, including drop in services
- staff (including nurses, midwives and doctors) who are empathetic, don't use jargon, are non-judgmental, and take into account the overall situation of the young woman

Specific strategies and services to identify and work with young women and children at 'high' risk, were called for, including:

- information packages at confirmation of pregnancy including 'next steps', support services and health information
- as a public patient, access to the same midwife and doctor for antenatal visits
- planning for postnatal care and support commencing during pregnancy, with services introduced as part of the antenatal care process
- 'high risk' young women remaining in hospital for a longer period post-birth
- comprehensive discharge planning
- a team approach to planning, case-management and care to ensure continuity, especially between health services and the community
- Prompt access to post natal, paediatric and developmental assessments
- Affordable childcare and respite.

SUMMARY OBSERVATIONS

- **Services in Adelaide regularly have contact with a significant number of young women who are homeless whilst pregnant and parenting.**

- **Surveys confirmed the complex, multiple issues which confront these young women; the difficulties of breaking out of homelessness and abusive life patterns; and the negative and compounding impact of homelessness on the wellbeing and safety of mother and child and on the mother-child relationship.**

- **Major concerns include the destructive impacts of homelessness on the emotional wellbeing of young women and children (including depression, stress and low self-esteem). Highlighted were patterns of unstable and violent personal relationships around the young women; ongoing issues of poverty; poor nutrition; poor health; drug and alcohol abuse; limited supports; and the impact on parenting of backgrounds of abuse and vulnerability. It was a common concern that young women are forced into or choose dangerous and inappropriate housing arrangements (such as a return to violent relationships) rather than risk renewed homelessness or coping on their own.**

- **Children are at a high risk of abuse, neglect and poor developmental outcomes; and the relationship between parent and child is significantly compromised.**

- **A range of service issues currently impede responses, including insufficient housing options; poor identification of high-risk young women and children in the health system; poor coordination and follow-up; service gaps and waiting lists; and service culture.**

- **Client-related issues also impact, including hostility, suspicion, mobility, shame, reluctance to engage and difficult behaviour.**

- **Antenatal and post-natal care become a low priority when a young woman is homeless: there is a natural focus on immediate needs and survival rather than health care and planning. Transience, lack of transport and lack of information are also barriers to attendance.**

- **The lack of coordinated care around these high-risk young women and children is highlighted.**

THE WAY AHEAD

- **Strategies to improve the identification and follow-up of high-risk young women through the health system and provide coordinated and consistent service delivery would improve outcomes.**

- **Increased home-visiting and outreach services, and services with a flexible modality of delivery and youth-friendly approach, are consistently identified as the most needed responses.**

- **The needs of homeless children should receive special consideration in homeless and child protection strategies and services, early childhood responses and primary care.**

10 Final comments

Every year a disturbingly high number of young women in Adelaide experience homelessness whilst pregnant or parenting. It is impossible to quantify the extent of this problem, but it is known that over 700 young women, accompanied by approximately 1000 children, were accommodated in SAAP services in the metropolitan area during 2001/2. Many other homeless young mothers would not have been in contact with SAAP; and it is not possible to identify the number who experience homelessness whilst pregnant.

It is clear from this study that the single most powerful intervention likely to make a difference to homeless young women and children is housing, coupled with the support to maintain it. Homelessness has a profound destructive impact on every aspect of a person's life. It impacts on health: inadequate shelter; poor access to health care; poor nutrition and inadequate food intake; unhealthy lifestyles (including smoking, alcohol and substance abuse) and increased exposure to violence all result from homelessness. Further, homelessness leads to stress, depression, anxiety, despair, low motivation, and loneliness. Homeless young mothers cannot plan for the future, take control of their lives, or accumulate possessions. And, despite good intentions, it is very difficult to be a good parent when homeless or tenuously housed: to focus on children and their emotional well-being; provide for their physical and developmental needs; ensure a safe environment and consistently nurture, love and protect, requires personal and other resources which homeless families are deprived of. Homelessness has a cumulative and spiraling effect and thus over time negative impacts feed on each other and compound, making it increasingly difficult to break the cycle and succeed in housing and other life domains. Homelessness itself is, therefore, the fundamental issue which must be addressed.

Homelessness is seldom voluntary, and none of the young women in this study actually wanted to be homeless. All aspired to stable housing, decent relationships, safety and a positive future. They also wanted to be 'good' parents and do the right thing by their children. There were, however, many obstacles. Their pathways into homelessness were all via violence, abuse and family breakdown: the profound negative impacts of this history were then exacerbated and compounded by homelessness. Years spent in extreme poverty, abusive environments and stress, where the most basic of human needs are repeatedly unmet, are not easily put aside.

The concept of '***recovery'*** has received little attention in the homelessness literature. Assisting people to move out of homelessness is often conceptualized in terms of housing, support, and life-skills. Yet it is clear from the stories recounted in these pages that recovery – emotional, psychological, financial, physical – from the trauma of homelessness and past abuse is fundamental. A recent study exploring the stories of homeless women at Catherine House in Adelaide concluded that long-term homelessness left women *'shattered, scattered, physically and emotionally weak, and in a state of despair, devoid of hope and power'* (Owens & Ressom 2003, p. 33). The researchers argue that women need the right environment to begin to heal and recover, usually in safe, supported accommodation where they can rest and begin to form positive relationships. This is quite a significant addition to the concept of 'case management'.

An equally challenging concept is that of ***social inclusion and connection***. Homeless people have experienced long periods of alienation and exclusion from family, community, work and education, and have formed an identity based around this exclusion. The young women in this study were lonely, isolated, with few resources or opportunities, and with little meaningful activity in their lives. There has been minimal research into what it takes to successfully achieve stability after long-term homelessness, but it would seem that social inclusion and participation, combined with opportunities for recovery and reformation, are essential companions to housing. From this perspective, childcare, and interventions which include education, employment and social integration, become an essential part of homelessness intervention.

One of the main issues this study set out to explore was access to antenatal, post-natal and early childhood services by homeless young women and their children. It is clear that there are significant barriers to access, including the woman's mobility and lack of a stable base, and her preoccupation with issues other than health and childhood care. However, the experience of marginalisation; feelings of shame and stigma; lack of information and transport; inappropriate responses from services, and the complexity of the service system, were also shown to be factors.

On the positive side, existing services were found to make a substantial difference to the lives of homeless young women and children. Support can mitigate some of the destructive impacts of homelessness, improve access to services and increase capacity to cope. Particularly notable was the impact of involvement with SAAP, which brought marked benefits in terms of housing, safety, nutrition, emotional and physical health, support, service access and connectedness.

Similarly, other services with the right 'culture' for homeless young people, with a flexible approach, and using modes of service delivery including outreach, home-visiting and drop-in, made a significant impact. Improvements to the health and well-being of homeless women and children will, therefore, include more investment in these modalities of service delivery, and the broadening out of mainstream services to be inclusive of and targeted towards at-risk youth. This should be accompanied by strategies to improve identification of homeless and insecurely housed young women and their children; and then systems to ensure coordination, through-care and continuity of care, especially in the health system and between the health, community services and homelessness sectors.

It is noteworthy that services were far more important in the lives of these young women than is usually the case, and substituted for support and assistance normally provided by family and friends. Valued support extended to areas such as transport and the personal sharing of baby clothes and other goods. Young women spoke highly of staff at various agencies and in different sectors who not only provided a service, but help above and beyond the professional role.

The continuing poverty-traps in homelessness were powerfully evident in this study: debt; the near impossibility of acquiring and keeping property whilst moving from place to place; the high risk of theft. This limited capacity to prepare for the baby and provide for children after birth. Moving into a house is very expensive, and set-up costs can be simply unaffordable. Thus, one young women in the study chose to house herself and her children in sub-standard and unsatisfactory accommodation in a caravan park because the financial costs of establishing a house were simply beyond her.

Other major messages from these stories include the extent of inadequate food intake; poor nutrition; depression and stress; the disturbing fact that, for many, the negatives of escaping domestic violence (renewed homelessness and housing uncertainty; loneliness; single parenthood) are viewed as greater that the positives; the young women's unachieved aspirations to breastfeed; the importance of childcare; and the many compromises in safety, parenting and relationships that are made when homeless in order to have shelter.

Despite clear evidence of the links between homelessness and poor health, insufficient attention continues to be given to health issues for this population. One way ahead may be to explore the concept of a homelessness health strategy. Such a strategy should incorpate population health surveilance and monitoring initiatives; targeted health promotion; better identification in the health system; throughcare and case management, including the exchange of information and better referral processes; primary care and early intervention strategies; disease and illness management; and differentiated responses to different population groups. Nutrition and food security are issues that require particular attention.

And then, finally, the children. If infants and young children are to have the proper start in life they need to be housed, safe, fed, and receiving consistent care and nurture. It is almost impossible for their primary needs to be met when homeless. Before birth, homeless infants are disadvantaged by poor nutrition, poor health care, their mother's stress and trauma, and risk factors such as smoking, substance use and exposure to violence. Post-birth, disadvantage is compounded by lack of stable, safe housing; poor nutrition; poverty; limited social and developmental opportunities; exposure to risk and violence; poor access to health care; constant disruption, and compromised parenting.

There are thus serious implications for all children born into homelessness and/or experiencing homelessness in their early years. These children are some of the most vulnerable in our community, and are at a high risk of poor health, development and well-being across their lifespan, as well as of immediate abuse and neglect. It is also clear that the longer a child or infant is homeless, the more damage will be done, and the more cumulative and compounding the effects. Homeless children and their families must be rapidly identified and rehoused.

In conclusion, the evidence points to the need for a sense of urgency and priority in all responses to homeless pregnant and parenting young mothers and their children, across the health, education, welfare and housing sectors. Quite simply, the ongoing homelessness of pregnant girls and young mothers with children should not accepted.

SUMMARY OBSERVATIONS:

- **The single most important intervention needed by homeless young women and children is stable housing, coupled with support.**
- **Homelessness has a destructive impact on every aspect of the lives of young women and children. These impacts are cumulative and compound over time.**
- **Parenting, quality of care, and children's basic needs are inevitably compromised by homelessness.**
- **The profound negative impacts of the factors which lead to young people becoming homeless (violence, abuse, family breakdown) are also exacerbated and compounded by homelessness.**
- ***Recovery* is an important component in moving out of long-term homelessness. People need opportunities to recover (emotionally, psychologically, physically and financially) from the trauma of homelessness.**
- ***Social inclusion* is another important element in successful rehousing: homeless young people have long and compounding experiences of exclusion and marginalisation; and need opportunities to participate and be included socially, and through education, work and activities.**
- **There are significant barriers to accessing health services for homeless young women and children. Some of these are related to the experience of homelessness; others to the nature of services and the service system.**
- **Existing services, especially SAAP, make a significant difference to the lives of homeless young women and children.**
- **With the 'right' approach, service modalities and culture, services can engage homeless youth.**
- **Support from services can mitigate some of the destructive impacts of homelessness and make a significant difference to service access and coping with pregnancy and parenthood.**
- **There are particular poverty traps associated with homelessness that make it harder to 'get out'.**
- **Homeless children experience extreme disadvantage, and their health and wellbeing is significantly compromised. The longer their exposure to homelessness, the more destructive, cumulative and compounding will be its impacts. Re-housing is a matter of urgency in the life of the child.**

THE WAY AHEAD:

- **The considerable achievements of SAAP and other innovative services should be recognised, rewarded and built on.**
- **There is a need to strategically consider the provision of care and support, particularly in the areas of health and nutrition, for homeless young women who are pregnant and/or parenting.**
- **A health promotion approach to the population of young women who are homeless or insecurely housed should be considered.**
- **A key challenge for health services is to develop systems to identify homeless and insecurely housed young women in a way that is non-threatening and non-judgmental.**
- **Better links should be built between the health, homeless and other community services sectors to enable through-care, continuity of care, improved referral and case management processes, and better services.**
- **Consideration should be given to the development of a Homelessness Health Strategy. For this population group, such a strategy would incorporate better identification of homeless and insecurely housed young women in the health system; targeted health promotion and health education; nutrition and food security strategies; through-care and coordinated care initiatives; and a shift in service delivery modalities.**
- **A sense of urgency and priority should guide responses to homeless children.**

11 Bibliography

Adelson, P., Frommer, M., Pym, M., Rubin, G. (1992) 'Teenage pregnancy and fertility in New South Wales: An examination of fertility trends, abortion and birth outcomes' *Australian Journal of Public Health* vol. 142, 247 – 251.

American Academy of Pediatrics (1999) 'Adolescent Pregnancy – Current Trends and Issues: 1998' *Pediatrics* vol. 103, 516 – 520.

Booth S (work in progress) 'Eating Rough – an investigation of food intake patterns and food insecurity amongst homeless people in Adelaide'.

Buchholz, E & Korn-Bursztyn, C (1993) 'Children of adolescent mothers: Are they at risk of abuse?' *Adolescence* Vol.28, 361-382.

Chamberlain, C & MacKenzie, D (1992) 'Understanding Contemporary Homelessness: Issues of Definition and Meaning', *Australian Journal of Social Issues* 27 (4) pp 274-297.

Chamberlain, C & MacKenzie, D (1998) *Youth Homelessness: Early intervention and prevention,* Australian Centre for Equity through Education.

Chan, A., Scott, J., Nguyen, A., Keane, R (1999) *Pregnancy Outcome in South Australia* Pregnancy Outcome Unit, DHS, Adelaide.

Chan, A., Keane, R., Robinson, J. (2000) 'The contribution of maternal smoking to preterm birth, small for gestation age and low birth-weight among Aboriginal and non-Aboriginal births in South Australia' *Medical Journal of Australia* Vol. 174, 16 April 2001, 389 – 393.

Cunnington, A. (2001) 'What's so bad about teenage pregnancy?' *The Journal of Family Planning and Reproductive Health Care* vol. 27, 36 – 41.

Efron, D. et al. (1996) 'Children in homeless families in Melbourne: health status and use of health services' Medical Journal of Australia, Vol. 165, 630 –633.

Harrison, L. & Dempsey, D. (1997) *Keeping Sexual Health on the Agenda: Challenges for Service Provision to Young Homeless People in Australia National Centre in HIV Research,* LaTrobe University, Victoria.

Hay, S. (1992) 'Pregnant Adolescents: Influencing Factors on Nutrition and Outcomes', *Journal of the Home Economics Association of Australia* vol 24, 66 – 69.

Howard, J. (1995) 'Risk Behaviour of Sydney Street Youth' in Kenny, D. & Job, S. (eds) *Australia's Adolescents: A Healthy Psychology Perspective* University of New England Press.

McDonald, C. (1992) *Nowhere to go: A review of the housing and support needs of homeless, young, pregnant women and young mothers in the north east region of Melbourne*. Carlton, Publicity Works.

Owens H & Ressom J (2003) *Like a mouse in a wheel: A study of homelessness for women – the challenges and the successes*, DfaCS, Australia.

Robinson C (2003) 'Understanding iterative homelessness: the case of people with mental disorders,' *Positioning Paper*, AHURI

Wanger, J. et al. (1993) 'Homeless pregnant mothers who abuse chemical substances' *Substance Abuse* 14 (3), 148 – 158

Wood D et al (1990) 'Children in sheltered homeless families and housed poor children', *Pediatrics* Vol 86, pp 858 – 866.