THE UNIVERSITY OF QUEENSLAND
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‘Every Child, Every Woman: Healthy and Safe Start’ Program Evaluation Final Report

Prepared for Micah Projects by the School of Nursing, Midwifery and Social Work at The University of Queensland

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Executive Summary

Every Child, Every Woman: Healthy and Safe Start (henceforth 'the HSS program') is an integrated response and support program for vulnerable high risk pregnant women, birthing people, and their families tailored to individual needs. It was established by Micah Projects in early 2023 in response to a growing number of women presenting to both homelessness and domestic violence services who were pregnant and/or cared for young children. The HSS program supports families to build healthy foundations to reduce the likelihood or extent of adverse experiences in childhood for their children. It provides support for domestic and family violence, homelessness and housing, and specialist family support with a perinatal and health focus. Between March 2023 and July 2024, the HSS program supported 90 pregnant women and their families.

The program is delivered by a multidisciplinary team of midwifery, housing, domestic violence, and child and family support workers. The team is small, with four staff members (across a full-time equivalent of 3 FTE) engaged in outreach and case management work, plus a team leader who works across multiple programs. Despite the small team and the relatively short time frame in which the HSS program has been operating, there is evidence that the program has supported positive outcomes for its participants and their families.

This report provides the findings of an evaluation of the HSS program conducted by a team at The University of Queensland (UQ) between August 2024 and February 2025. It provides insights into the families who have accessed the HSS program, the key features that have supported positive outcomes for HSS program participants, and areas where the HSS program has been limited in its ability to meet its primary objectives. In addition to a review of national and international literature, the report draws on deidentified administrative data of 106 participants who accessed the HSS program, interviews with five staff who are involved in managing and implementing the HSS program, feedback from five external stakeholders who have referred participants to the HSS program and/or are also involved in delivering services to the HSS program participants, and interviews with 13 participants who accessed the HSS program

Most of the individuals accessing the HSS program were single, pregnant women under 35 years of age who had current and/or previous experiences of family and domestic violence. More than half of the participants had entered the HSS program due to precarious housing or homelessness, of which several were residing in a motel or 'couch surfing' with family and/or friends. Few had strong informal support networks, with less than 20 percent noting family and/or friends as a source of support. Indeed, a significant number of program participants indicated that the HSS program and/or another Micah Projects program were their only source of support.

Most of the HSS program participants described in this report were referred to the HSS program from other Micah Projects programs, predominately via the Brisbane Domestic Violence Service (BDVS) or other domestic violence programs, such as the Safer Lives Mobile Service (SLMS). Most of the other internal referrals came via housing support programs such as Families to Home (FTH), Street to Home (STH), and the Hub. This indicates that, for this cohort, experiences of family and domestic violence and housing precarity are primary needs requiring support. Indeed, safety planning and support to find safe, secure, and affordable housing were the two main outcomes that HSS program participants described during the evaluation.

Most of the HSS program participants entered the HSS program during their pregnancy. However, over a quarter of the participants analysed as part of the administrative data entered the HSS program post-birth, indicating a strong need amongst this cohort for support in the postnatal period. The focus of the HSS program as providing specialised support for pregnant women and their

families was described as invaluable for the participants, as they described HSS program workers as being understanding and flexible in response to their current circumstances. This understanding and flexibility could extend further into the postnatal period with an expanded suite of workers who specialise in areas such as parenting support, mental health, and early childhood programs.

Overall, there is strong evidence that the HSS program is meeting its aim to provide a holistic and integrated response to vulnerable and high risk women who are pregnant and/or have young children and their families and who are experiencing family and domestic violence and/or housing precarity. The evaluation identified several key features of the program design and delivery that enhanced service access, utilisation, and positive outcomes for participants. These features include the multidisciplinary model of care, the outreach approach, the practical approach, the whole-of-service system approach, and relationship-based and trauma-informed models of care. However, the limited availability of secure, affordable, and appropriate housing for families posed a challenge to the HSS program's aim of improving the health, safety and housing stability, as did limited availability and access to other social services. While the multidisciplinarity of the team delivering the HSS program was viewed as a strength, there is scope for the specialist skill set to be further expanded, including in areas such as substance (mis)use and mental health. The team's relatively small size also meant that the HSS program was limited in its capacity to respond to the demand for services.

From these key findings, the report outlines five recommendations for the expansion and improvement of the HSS program. First, the report recommends expanding and diversifying the HSS program. The findings of this evaluation indicate that many more families would benefit from the program than can currently access the service. Second, there is an opportunity for both earlier contact and the provision of postnatal support. The findings suggest that providing earlier and longer support in the perinatal period would further enhance the health, wellbeing, and safety of vulnerable women and their children. Third, brokerage support, such as the capacity to access funds to pay for transport, basic food, and hygiene needs, was found to be essential for families to be able to access social and health services and meet their basic health and sustenance needs. The findings suggest that the expansion of these brokerage funds would also support increased health and wellbeing of vulnerable women and families. Fourth, there is a clear need to increase the supply of and access to affordable, safe, and appropriate housing for pregnant women and their families, especially those who experience housing insecurity and/or domestic and family violence. Finally, there is a strong need to engage Aboriginal and Torres Strait families and communities in the review and ongoing development of culturally responsive practice in social services programs. The report recommends further and proactive support to engage Aboriginal and Torres Strait Islander families and communities in social services and program evaluation.

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Acronyms, Abbreviations and Glossary

Term	Definition
ADHOT	Alcohol and Drug Homelessness Outreach Team
AHVTT	Australian Homelessness Vulnerability Triage Tool
ATSICHS	Aboriginal and Torres Strait Islander Community Health Service
BiOC	Birthing in Our Community
BUBS Collective	Program through Child Safety
BVDS	Brisbane Domestic Violence Service
BYS	Brisbane Youth Service
CHAMP Clinic	Specialised antenatal clinic at Mater Mother's Hospital providing support for pregnant women with substance-use issues
CS	Child Safety
DoH	Department of Housing
FDV	Family and Domestic Violence
FPP	Family Participation Program (through Child Safety)
FTH	Families to Home (Micah Projects program)
GP	General Practitioner
Hive	A social inclusion program delivered by Micah Projects
HSS Program	Every Child, Every Woman: Healthy and Safe Start program
HUB	Homelessness Hub (Micah Projects program)
Mater	Mater Mother's Hospital
MDT	Multidisciplinary Team
NDIS	National Disability Insurance Scheme
Public Space	Micah Projects program through Street to Home
QPS	Queensland Police Service

RBWH	Royal Brisbane Women's Hospital
SCUH	Sunshine Coast University Hospital
SLMS	Safer Lives Mobile Service
STH	Street to Home (Micah Projects program)
Targeted Families	Micah Projects program
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
YMYW	Young Mothers for Young Women program

1. Introduction

This report presents the findings of an evaluation study of *Every Child, Every Woman: Healthy and Safe Start* (henceforth the 'HSS program'). The HSS program has been delivered by Micah Projects since early 2023 to support a diverse community of high risk pregnant women, birthing people, and their families to build healthy foundations to reduce the likelihood or extent of adverse experiences in childhood (Micah Projects, 2024). Micah Projects is a non-profit organisation who collaborates with community and government partners to provide a range of integrated health and community supports, alongside advocacy services, tailored to each person's unique needs and capacity, particularly in the areas of homelessness and access to essential services.

The HSS program incorporates a multidisciplinary team who can provide responses to family and domestic violence (FDV) concerns and immediate needs of safety in circumstances of pregnancy or possible harm (Micah Projects, 2023). The main goal of this evaluation is to contribute to the evidence base of the HSS program by examining the features of the program, the extent to which the program is meeting its aims, the factors facilitating the attainment of program goals, and areas for development both within the program and the service system. This evaluation was led by Dr Glenda Hawley along with Prof Karen Healy, Dr Laura Simpson Reeves, Christy Gabiana, Bailey Malseed, and Karina Maxwell (henceforth 'the research team'), from The University of Queensland's School of Nursing, Midwifery and Social Work between August 2024 and February 2025.

The report begins with an overview of the history and features of the HSS program, followed by an analysis of Australian and international literature on the needs of pregnant women, parents, and families presenting with both FDV and housing concerns, and evidence of the features and effectiveness of various model of care. The report also presents an analysis of the perspectives of HSS workers, external stakeholders who interacted with the HSS program both as referrers and as service providers to HSS participants, and participants who were engaged in the HSS program. The report outlines the features and needs of participants, the features of the multidisciplinary and integrated service model, and how these features contribute to the achievement of the program goals, as well areas for further improvement.

1.1 Overview of *Healthy and Safe Start*

The HSS program was established at Micah Projects in early 2023 to provide an integrated response and support program for vulnerable high risk pregnant women, birthing people, and their families tailored to individual needs. It was developed in response to a growing number of pregnant women and their families presenting to both homelessness and domestic violence facilities. The program is delivered by a multi-disciplinary team including specialists in domestic and family violence, midwifery, housing, and working with children and young people. The total staffing complement is three (3) FTE, plus a team leader who work across multiple programs supporting women, children, and families. The team use a strengths-based, harm reduction and trauma informed approach to address the immediate needs associated with housing, navigating the health system, pathways to maternity care, and parenting support. Components of the HSS program include outreach to families residing in motels and temporary housing options; support for pregnant women and parents to navigate the health system, particularly in relation to antenatal and postnatal care; parenting support; and domestic and family violence safety planning. This includes ensuring that women are supported in transitions from pregnancy, birthing, and parenting in a safe environment, with support in decision-making about the engagement of other family members and informal support networks in parenting.

Further goals include strengthening families' access to the range of service systems including housing, health, and human services needed to secure their health, wellbeing and safety. This

includes working with service providers across sectors to improve the capacity of service systems to provide services in a respectful and trauma informed manner. It also involves working with parents to support them to engage with the service system. The goal of these connections is to create positive experiences with specific long-term outcomes of linking women to community resources, promoting educational opportunities for future growth, while improving childhood developmental outcomes.

1.2 Purpose of this evaluation

While numbers of success stories and testimonials from families supported by the HSS program offer good indications of outcomes, an important aim of this evaluation was to identify where adaptations or adjustments could be made to improve the program and the service systems impacting on the women, children, and families accessing Micah Projects services. With this information, resources can be refined, re-located, or supported to continue the positive outcomes already seen. The findings from this evaluation provide key data that contribute to the evidence base of integrated social service responses, and may be used to support future applications to amend and continue the HSS program.

This evaluation aimed to identify and analyse:

1. the demographic profile, housing circumstances, maternity and other health and community service access of participants in the HSS program;
2. the facilitators of, and barriers to, maternity and other health and community services among participants in the HSS program;
3. the features and approach of the HSS program;
4. the impact, strengths and limitations of the HSS program for improving participants' access to quality maternity care, health care, community services, domestic and family violence services and housing;
5. the cultural responsiveness of the HSS program with and for Aboriginal and Torres Strait Islander participants; and
6. the achievements of the HSS program and recommend areas for further development.

To achieve the aims of the evaluation, the research team employed an multi-method approach. The evaluation involved the collection and synthesis of deidentified administrative data as well as data from qualitative interviews with HSS program participants and HSS program workers, and written feedback from external stakeholders in involved in referring participants to the HSS program. The administrative data analysis focused on quantifying the characteristics and presenting needs of the participants; the frequency and scope of service provision; pathways to service access; and some of the health, housing, and social outcomes among the families engaged with the HSS program. The interviews with the HSS program workers explored their perspectives of service participants' needs; service effectiveness for addressing health, housing, and social needs; facilitators of and barriers to service provision in the HSS program; and any support needs for the health and safety of the HSS program workers. Feedback from external stakeholders included how they viewed the purpose of the HSS program; their understanding of the underpinning principles and key components of the HSS program; and what impact they felt the HSS program had had for the participants. Interviews with participants who accessed the HSS program included their pathways to service access; experiences of service provision; and the effectiveness of the HSS program in addressing health, housing, and support needs.

The evaluation was conducted over five phases. Phase 1 involved a rapid scoping literature review about the needs of pregnant women, parents, and families experiencing domestic violence and housing insecurity, as well as service models for responding to this population. Phase 2 involved the

synthesis of administrative data. Phase 3 involved interviews with staff and other stakeholders involved in the delivery of the HSS program. Phase 4 involved obtaining feedback from external stakeholders who interacted with the HSS program both as referrers and as providers to health and human services to participants in the HSS program. Phase 5 involved interviews with women and families who had engaged with the HSS program. Further details about the evaluation approach and methodology can be found in Chapter Three.

1.3 Structure of the report

The purpose of this report is to provide insights into the implementation and delivery of the HSS program, including discussion of the impact of the HSS program on the lives of the participants who accessed the service. This report summaries contemporary literature in relation to the HSS program's objectives and practice approaches, draws on the perspectives on the practitioners and managers involved in delivering the HSS program, external stakeholders who interacted with the HSS program, and participants who were engaged in the HSS program.

Following this introduction, the remainder of this report details the findings in relation to the evaluation objectives. Chapter Two reviews the contemporary national and international literature related to health and family support programs targeting families experiencing precarious housing conditions and/or family and domestic violence during pregnancy. Chapter Three outlines the approach and methodology used in this evaluation. Chapter Four reports the demographic profile of the participants in the HSS program, including their housing circumstances and maternity and other health and community service access needs. Chapter Five describes facilitators and barriers to implementation from the perspectives of the Micah Projects staff involved in the HSS program. Chapter Six outlines the feedback from some of the external stakeholders who interacted with the HSS program. Chapter Seven provides the perspectives of some of the HSS program participants. Chapter Eight summaries the key findings from across the report and provides some recommendations for the continuation and areas for improvement of the HSS program.

2. Literature review

This chapter provides insights from the rapid scoping literature review (see Chapter Three for further details about the methodology). It reviews the contemporary national and international literature related to health and family support programs targeting families experiencing precarious housing conditions and/or family and domestic violence during pregnancy.

2.1 Background

In 2021, women and girls were estimated to comprise 44.1 percent of the 122,494 people experiencing homelessness in Australia (ABS, 2023a). Difficulties with finances, experiences of family and domestic violence (FDV), substance use, and mental health issues are significant contributing factors to women's experiences with homelessness, resulting in numerous and intersecting disadvantages across health, social, and financial domains (Kirkman et al., 2014; Mann et al., 2022).

Pregnant and postpartum women who are experiencing homeless are a distinctly vulnerable population, with adverse experiences impacting not only their wellbeing but also the wellbeing of their children (Bray et al., 2022). For pregnant women experiencing homelessness, factors such as poverty, physical and mental health concerns, lack of access to antenatal and other health care services, and FDV can increase the likelihood of poor childbirth outcomes (Rayment-Jones et al., 2021; Wright et al., 2012). Experiencing persistent stressors associated with housing insecurity and poverty—in combination with substance use, mental health concerns, and/or domestic violence—can negatively impact parents' capacities to care for their own health and wellbeing, and that of their children (Bray et al., 2022). Further, service provision to this cohort often occurs in a siloed manner, leading to poor awareness of, and responses to, pregnant women and parents experiencing homelessness and FDV. For example, screening and interventions for domestic violence and trauma are a frequently overlooked aspect of antenatal care, despite its known links to poorer health, childbirth, and parenting outcomes (O'Reilly et al., 2010).

2.2 Identified Needs

Women experiencing homelessness often face barriers to accessing timely support. This may be due to fear related to community perceptions of homelessness as well as a lack of awareness and difficulties in navigating maternity and other health services (Kirkman et al., 2014; Salem et al., 2018). These experiences can be further complicated by the demands of pregnancy and parenting. Due to their increased vulnerability, meeting the needs of pregnant women experiencing homelessness is crucial to safeguarding their and their children's wellbeing (Mann et al., 2022). Such housing must be liveable, affordable, secure, and with options of continued tenure to adequately to their family's needs (ABS, 2023b). Additionally, supporting women's access to necessities, including food and hygiene, should be in conjunction with services that enable them to improve their circumstances, such as ensuring access to income support as they prepare for the birth of their child (Mann et al., 2022; Puccio, 2023).

Education and support in addressing the use of alcohol and other substances have also been identified as an urgent need for pregnant and parenting women and their families (Bray et al., 2022). Alcohol and substance use is frequently linked to mental health challenges, while mental health support remains a recurring need for many mothers experiencing homelessness (Kirkman et al., 2014). Mental health challenges and housing precarity can have a bidirectional relationship: mental health concerns can increase the likelihood of experiencing homelessness, while persistent stress

around housing insecurity can exacerbate mental health conditions and create challenges in maintaining service access (Mental Health Council of Australia, 2009).

FDV is widely recognised as major contributor to homelessness and to adverse pregnancy outcomes (Rayment-Jones et al., 2021). Pregnant women who are experiencing homeless face a range of barriers to accessing antenatal care and meeting basic needs, such as rest and nutrition, that is critical to the wellbeing of both the mother and child. Early screening for, and encouraging self-reporting of, FDV during antenatal care has been found to be crucial in promoting the wellbeing of pregnant women experiencing homelessness (O'Reilly et al., 2010). Prioritising relationship building and fostering an environment where people accessing services feel respected and valued has thus been identified as foundational to effective antenatal care for women experiencing multiple vulnerabilities related to their health and housing circumstances (Salem et al., 2018). Such components of care can be particularly beneficial to women's access to, and engagement with, support services (Hauff & Secor-Turner, 2014; Puccio, 2023).

2.3 Models of Care

The model of antenatal care received by pregnant women experiencing multiple vulnerabilities can significantly influence health, birth, and parenting outcomes. A harm reduction approach to antenatal care can be particularly advantageous for supporting pregnant and parenting women with a history of substance use (Wright et al., 2012). A harm reduction approach incorporates a spectrum of strategies to reduce the negative impacts associated with substance use while promoting the dignity and wellbeing of people of people who are using substances (National Harm Reduction Coalition, 2024). A harm reduction approach can be likened to the Continuity of Care model commonly used in midwifery care, as it aims to promote the health of the mother and child through collaborative relationships between organisations, midwives, practitioners, women, parents, and their support systems (Homer, 2016; Macrory & Boyd, 2007). In a Continuity of Care model, a team of caregivers work within the same philosophy and framework, and share information related to a patient's care (NSW Health, 2023). Such approaches emphasise the role of health education, self-determination, and relationship-building to nurture pre-existing capacities and encourage goals and actions that are beneficial for pregnancy and parenthood, producing positive outcomes across diverse populations of pregnant and parenting women (Homer, 2016; Puccio, 2023).

Several evaluations of programs that worked with women experiencing disadvantage and substance use suggest that adopting a harm reduction approach to antenatal care can be effective in reducing substance-related health challenges for newborns, such as Neonatal Abstinence Syndrome and Foetal Alcohol Syndrome, and contribute to positive health outcomes for mothers and children (Poole, 2000; Wright et al., 2012). Components of harm reduction for pregnant women experiencing multiple vulnerabilities include supporting their nutrition and physical activity; abstinence from alcohol, nicotine, and other drugs; breastfeeding; encouraging social relationships; and continued engagement with antenatal care and community programs (Macrory & Boyd, 2007). Minimising barriers to women's engagement with services (such as childcare and transport), providing different modes of care participation (such as individual, partner, and group activities), and targeting support towards distinct areas of need (such as classes about healthy relationships, infant bonding, motherhood, and nutrition) are also conducive to a harm reduction approach to antenatal care (Wright et al., 2012).

A trauma-informed approach can also be beneficial for supporting pregnant women and parents with experiences of abuse and violence at any point in the life course (Bray et al., 2022). A trauma-informed approach recognised that traumatic experiences could contribute to a decreased or negative engagement with the health, child safety, and justice systems (Hopper et al., 2010). A

trauma-informed approach to antenatal care aims to foster professional interactions and environments that are sensitive and responsive to the impacts of traumatic experiences on women and their families (Chemtob et al., 2011; Gokhale et al., 2020; Hopper et al., 2010). A trauma-informed approach to services and interventions can improve service providers' responsiveness to the challenges facing pregnant women and their families by fostering positive relationships between midwife and women, where women and their families can feel safe in discussing their experiences (Bray et al., 2022; Gokhale et al., 2020). Current practices and suggestions that are conducive to a trauma-informed approach to antenatal care include asking women about experiences of abuse or violence as a standard part of ongoing understanding of participants' needs; building trust through the appropriate use of confidentiality; increased involvement of the service users' support system; timely referrals to other services; and ensuring that all staff are trained in, and supported to provide, trauma-informed care (Bray et al., 2022; Gokhale et al., 2020; Wright et al., 2012).

2.4 Gaps in Current Literature

There is limited research regarding the needs and effective models of care for pregnant women experiencing homelessness in Australia and internationally. While there is a growing body of literature on the lived experiences of people experiencing homelessness and health care access (e.g., Plage et al., 2023), little is known about intersections between homelessness and the experiences and needs of pregnant women and parents. Further, there are gaps in knowledge about the numbers of pregnant women and families affected by homelessness and FDV, geographical concentrations, and the families' preferred model(s) of care. While Continuity of Care models are well established in Australia, little is known of their impact on pregnant women and/or parents experiencing homelessness. Addressing these knowledge gaps is important for informing social policies as well as targeting programs and services to reach their communities.

3. Evaluation approach

The evaluation of *Every Child, Every Woman: Healthy and Safe Start* (the 'HSS program') was conducted between August 2024 and February 2025. Ethical approval for this evaluation was granted by The University of Queensland (UQ) Human Research Ethics Committee (HREC). Phases 1 to 4 were approved under Ethics Application 2024/HE001201. Phase 5 was approved under 2024/HE001853. This chapter outlines the evaluation approach and study design including an overview of data sources, data collection methods used, and analysis undertaken.

3.1 Overall evaluation design

This evaluation used an exploratory multi-method approach, involving a rapid review of relevant literature, the analysis of administrative data, data from interviews with staff and families engaged with the services, and feedback from stakeholders who interacted with the program. Data collection and analysis was conducted over five phases (see Figure 1). These phases happened largely concurrently throughout the evaluation.

Figure 1: Evaluation approach by phase

Rapid scoping literature review: The first phase of the evaluation involved a rapid scoping review of the Australian and international literature on the prevalence of homeless among women, particularly pregnant and parenting women and their families and the factors contributing to homelessness in this cohort. The review also considered evidence of best-practice approaches which highlighted the importance of harm reduction, trauma-informed and holistic responses to the multiple and complex needs of pregnant women, parents, and families experiencing homelessness and domestic violence.

Review of administrative data: The second phase involved the synthesis and analysis of administrative data. This analysis focused on identifying and quantifying the features and needs of the families accessing HSS; the frequency and scope of service provision; the pathways to service access; and health, housing, and social outcomes among participants engaged with the HSS program.

Qualitative interviews with workers: The third phase involved conducting semi-structured interviews with five staff members engaged in delivering the HSS program. These interviews explored the workers' perspectives of service participants' needs; service effectiveness for addressing health, housing and social needs; facilitators of and barriers to service provision; and any support needs for health and safety of the workers.

Feedback from external stakeholders: The fourth phase involved collating feedback that Micah Projects had received from five external stakeholders who interacted with the HSS program as referring agencies and/or service providers.

Qualitative interviews with participants: The fifth phase involved conducting semi-structured interviews with 13 women and/or their families who have been involved in the HSS program.

The five phases collectively contribute to an understanding of the impact the HSS program has had on improving participant access to quality maternity care and community services while also addressing issues related to domestic violence and housing scarcity.

3.2 Phase 1: Rapid scoping literature review

To be able to embed the evaluation findings in the broader context, the research team conducted a rapid scoping literature review of the Australian and international literature on studies of best practice with pregnant and parenting women experiencing homelessness or at risk of homelessness and/or had experience(s) of FDV. Search terms were developed in conjunction with a specialist research librarian, and included 'pregnancy', 'parenthood', 'family support', 'model of care', 'vulnerable families', 'housing support', 'drug and alcohol', and 'domestic and family violence'. A full list of the key terms and concepts can be found in Appendix A-1. The review included peer-reviewed publications and grey literature from Australia, Canada, New Zealand, the United Kingdom, and the United States. Nine (9) papers met the inclusion criteria (see Table 1), and these were analysed thematically. The themes and related findings are detailed in Chapter Two.

Table 1: List of articles included in the rapid scoping literature review

1	Bray, J. H., Zaring-Hinkle, B., Scamp, N., Tucker, K., & Cain, M. K. (2022). MIRRORS Program: Helping pregnant and postpartum women and families with substance use problems. *Substance Use and Addiction Journal, 43*(1), 792-800. https://doi.org/10.1080/08897077.2021.2010254
2	Kirkman, M., Keys, D., Turner, A., & X. (2014). 'I just wanted somewhere safe': Women who are homeless with their children. *Journal of Sociology 51*(3): 722-736. https://doi.org/10.1177/1440783314528595
3	Macrory, F., & Boyd, S.C. (2007). Developing primary and secondary services for drug and alcohol dependent mothers. Seminars in Fetal & Neonatal Medicine, 12(2), 119–126. https://doi.org/10.1016/j.siny.2007.01.005
4	Mann, C., Vichta-Ohlsen, R., & Baker, L. (2022). *Young women experiencing homelessness and pregnancy: Pathways into and barriers out of homelessness.* Brisbane Youth Service. https://brisyouth.org/wp-content/uploads/2022/08/Young-women-navigating-homelessness-and-pregnancy-Pathways-into-and-barriers-out-of-homelessness.pdf
5	O'Reilly, R., Beale, B., & Gillies, G. (2010). Screening and Intervention for domestic violence during pregnancy care. *Trauma, Violence and Abuse 11*(4): 190-201. https://www.jstor.org/stable/10.2307/26638082
6	Puccio J. (2023). They will never forget how you made them feel: Implementing harm reduction in the perinatal setting. *Maternal and Child Health Journal, 27*(1): 122–127. https://doi.org/10.1007/s10995-023-03795-1

7	Rayment-Jones, H., Dalrymple, K., Harris, J., Harden, A., Parslow, E., Georgi, T., & Sandall J. (2021). Project20: Does continuity of care and community-based antenatal care improve maternal and neonatal birth outcomes for women with social risk factors? A prospective observational study. *PLoS ONE, 16*(5): e0250947. https://doi.org/10.1371/journal.pone.0250947
8	Salem, B. E., Kwon, J., & Ames, M. (2018). On the frontlines: Perspectives of providers working with homeless women. *Western Journal of Nursing Research*, *40*(5): 665-687. https://doi.org/10.1177/0193945916689081
9	Wright, T. E., Schuetter, R., Frombonne, E., Stephenson, J., & Haning III, W. F. (2012). Implementation and evaluation of a harm reduction model for clinical care of substance-using pregnant women. *Harm Reduction Journal 9*: art. 5. https://doi.org/10.1186/1477-7517-9-5

3.3 Phase 2: Review of administrative data

To identify the demographic profile of the HSS program participants, the research team drew on deidentified administrative data sets collected by Micah Projects. Micah Projects collects data about the people accessing their services upon intake and throughout their engagement with its programs. For the HSS program, this included demographic information, pathways into and through the HSS program, and the maternity service provision and support accessed by the HSS program participants, including other health and community service provision. The team at Micah Projects provided deidentified administrative data for 106 HSS program's participants at the time of data extraction (November 2024). All administrative data used in the project has been deidentified, with no individual participant or user information used in the analysis or reporting.

The research team analysed these data sets to assess the HSS program participants' demographic characteristics; map their pathways into and through the HSS program; understand access to the maternity service provision and support, including linkages to antenatal and postnatal clinics, general practitioners, and allied health workers; and identify some of the health and social inclusion outcomes for the participants over the duration of the HSS program. A complete list of variables used in this analysis can be found in Appendix A-2. The findings from this analysis are detailed in Chapter Four.

3.4 Phase 3: Qualitative interviews with workers

Perspectives from HSS program workers was important to build an evidence base of the achievements, program outcomes, and areas for improvement. Five (5) workers involved in the delivery of the HSS program were invited and agreed to participate in a semi-structured interview conducted by a member of the research team. Worker roles encompassed multiple delivery areas including maternity care, housing, domestic violence, health clinics, and management. The interviews were held face-to-face in September 2024 and explored HSS program workers' perspectives of the needs of the HSS program participants; the extent to which they felt the HSS program was effective in addressing health, housing and social needs; the facilitators of and barriers to service provision; and any support needs they felt were required to ensure the health and safety of the staff delivering the HSS program. HSS program workers also responded to demographic questions including their qualifications and the length of time working in maternity, homelessness, and/or domestic and family violence services. The question guide for the semi-structured interviews can be found in Appendix A-3.

The interviews were audio-recorded and then transcribed using a professional transcription service. The transcripts were entered into NVivo, a software commonly used to support qualitative analysis. Members of the research team analysed the transcripts using reflexive thematic analysis, following

principles from Braun and Clarke (2022). The research team members familiarised themselves with the transcripts and then developed an overarching coding framework based on the evaluation aims. Three members of the research team independently coded one of the transcripts. These codes were compared and discussed, and then the coding framework was further refined. The remaining four transcripts were coded using the refined framework. This process highlighted key themes that were common across the interviews. The findings from this analysis are detailed in Chapter Five.

3.5 Phase 4: Feedback from external stakeholders

In addition to the staff working directly on the HSS program, it was important to obtain the views of other stakeholders who had worked alongside the HSS program. Feedback was received from five external stakeholders, including those who referred participants to the HSS program (see Chapter 4.2.1 below) and those who worked with the participants at support services (e.g. maternity hospital units). Micah Projects distributed a short survey to key external stakeholders (see Appendix A-4). This feedback was collated and sent to the research team, who then thematically analysed the data in relation to the key evaluation objectives (see Chapter 1.2 above). This analysis was then categorised in relation to the strengths of the HSS Program and any suggested areas for improvement. The findings from this analysis are detailed in Chapter Six.

3.6 Phase 5: Qualitative interviews with participants

The perspectives and views of HSS program participants is a vital aspect of the evaluation. Phase 5 involved qualitative semi-structured interviews with 13 participants who are currently or were recently enrolled in the HSS program. These interviews were conducted between December 2024 and February 2025. These interviews explored their involvement with the program, accessibility of maternity and hospital services, the impact of the program on their health and life, relationship with their worker, and frequency of their involvement with the program. The question guide for the semi-structured interviews can be found in Appendix A-5.

Participants were supported by Micah Projects staff if requested and were compensated with a $50 Coles gift card at the end of their interviews. Any participants who identified as Aboriginal and Torres Strait Islander were provided with an option of being interviewed by a researcher from an Aboriginal and Torres Strait background. Unfortunately, no HSS program participants who identified as Aboriginal and Torres Strait Islander participated in the interviews for the evaluation.

As with Phase 3, the interviews were audio-recorded and then transcribed using a professional transcription service. Using NVivo, a software commonly used to support qualitative analysis, the research team then analysed the transcripts drawing on reflexive thematic analysis following principles from Braun and Clarke (2022). The research team members familiarised themselves with the transcripts and then developed an overarching coding framework based on the evaluation aims. Three members of the team independently coded one of the transcripts. These codes were compared and discussed, and then the coding framework was further refined. The remaining transcripts were coded using the refined framework. This process highlighted key themes that were common across the interviews. The findings from this analysis are detailed in Chapter Seven.

4. Characteristics of HSS program participants

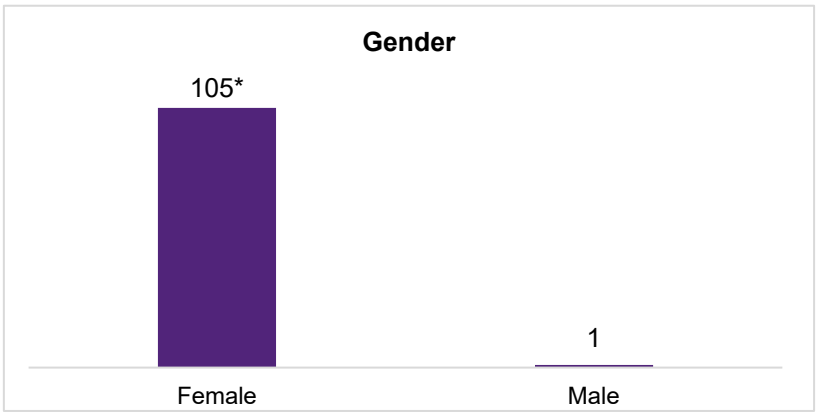
This chapter provides key insights into the characteristics of 106 current and previous participants in *Every Child, Every Woman: Healthy and Safe Start* (the 'HSS program'; see Chapter Three for further details about the methodology). It describes the key demographics of 106 HSS program participants, their housing pathways, their support systems, and their access to antenatal and postnatal care. Please note that this analysis draws on deidentified administrative data provided by Micah Projects in November 2024; the total number of women, men, and families who have participated in the HSS program is higher.

4.1 Participant demographics

4.1.1 Participant individual characteristics

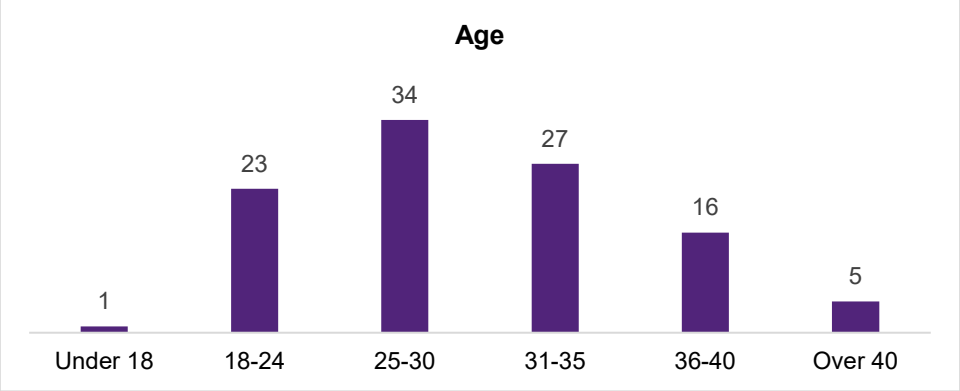
The HSS program participants were predominately female (*n*=105), with one participant who was biologically female identified as non-binary. One participant was male (see Figure 2). Approximately half of the participants were aged under 30 (*n*=55), with one participant aged only 17. A further 44 participants were in their 30s, with the remaining participants (*n*=7) aged 40 or older (see Figure 3).

Figure 2: Gender distribution of HSS program participants



*1 participant was biologically female but identified as non-binary

Figure 3: Age distribution of HSS program participants



The cultural background of the HSS program participants was diverse. Almost half of the participants identified as Caucasian (*n*=50), however there was a large representation of Aboriginal and Torres Strait Islander Peoples (*n*=37*).* Other participants identified with a range of cultural backgrounds, including African, Southeast Asian, Pacific Islander, and Latin American (see Figure 4).

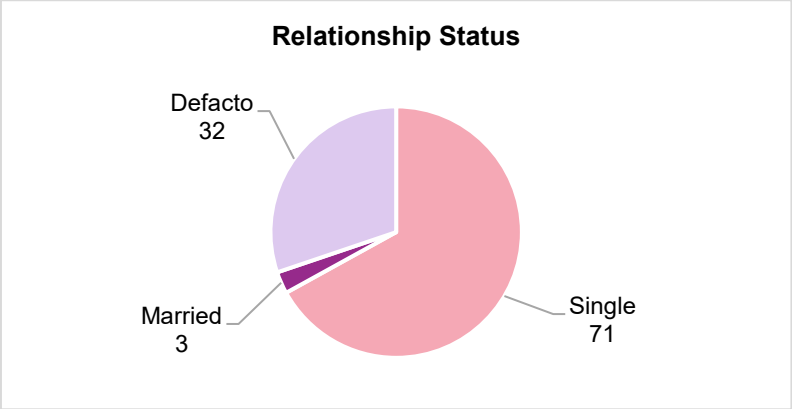
Figure 4: Cultural background of HSS program participants

15 of the HSS program participants identified as having a disability, mostly related to mental health. A further 3 participants did not identify as having a disability but were currently undergoing treatment for a mental health condition.

4.1.2 Participant family characteristics

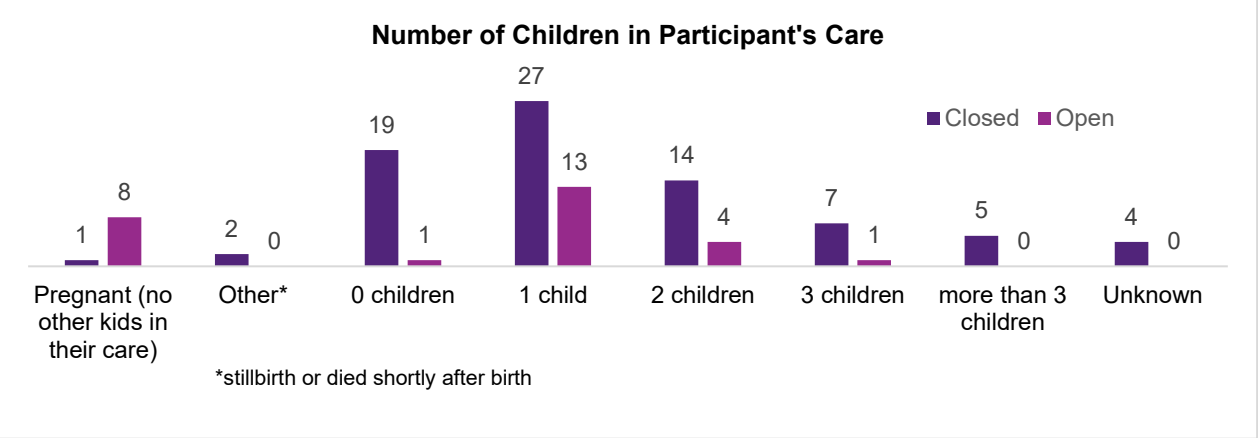
Most of the HSS program participants identified as single (*n*=71). 32 participants stated that they were in de facto relationships, with a further 3 participants married (see Figure 5). No program participants identified as being divorced or widowed. This distribution highlights a significant proportion of single participants within the group. All participants who stated they were married or as part of a de facto relationship were with a partner of the opposite sex.

Figure 5: Relationship status of HSS program participants



Of the 106 participants in this sample, 79 participants had completed their engagement with the HSS program. Of these participants at the time their engagement with the HSS program ended, 53 participants had at least one child in their care (see Figure 6). For the 27 participants whose engagement in the HSS program was still ongoing at the time of data extraction, most had at least one child in their care (*n*=18) and/or were pregnant at the time (*n*=8). The children in the participants' care (for both closed and open cases) ranged from 2 weeks old to 18 years old, with a median child age of 1 year old. 42 HSS program participants had at least one child under one year old. 10 participants indicated that they had a child with a disability. 26 HSS program participants indicated they had at least one child currently involved with Child Safety.

Figure 6: Number of children in HSS program participant's care



4.2 Program engagement

4.2.1 Referral pathways

Participants were referred either directly to the HSS program or via the Brisbane Domestic Violence Service (BDVS). A significant number of referrals to the HSS program (*n*=65) came internally from other Micah Projects programs, including BDVS (see Figure 7). Other referrals largely came to the HSS program via the Mater Mother's Hospital (*n*=30) and Royal Brisbane Women's Hospital (RBWH, *n*=5). Four of the referrals from the Mater Hospital were via the CHAMP Clinic. Internal referrals were largely via BDVS (*n*=27), or a Micah Projects program focused on providing housing support such as Families to Home (FTH, *n*=17), the HUB (*n*=5), or Street to Home (STH, *n*=4, see Figure 8). Of the referrals via BDVS, these largely came from the Queensland Police Service (*n*=8), Child Safety (*n*=4) or a hospital (Mater Hospital *n*=2, RBHW *n*=2, see Figure 9).

Figure 7: Referral pathways to the HSS program

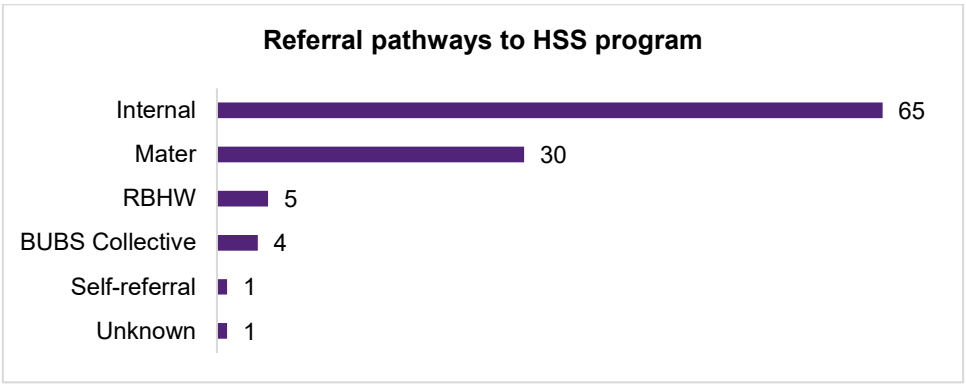


Figure 8: Internal referral pathways to HSS program

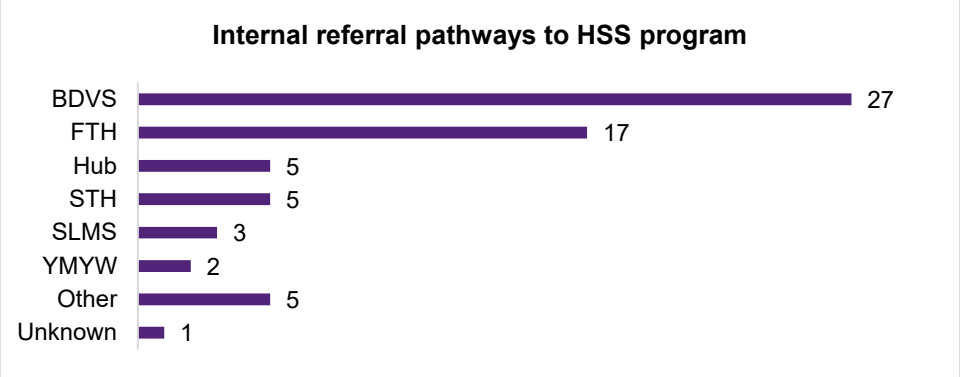
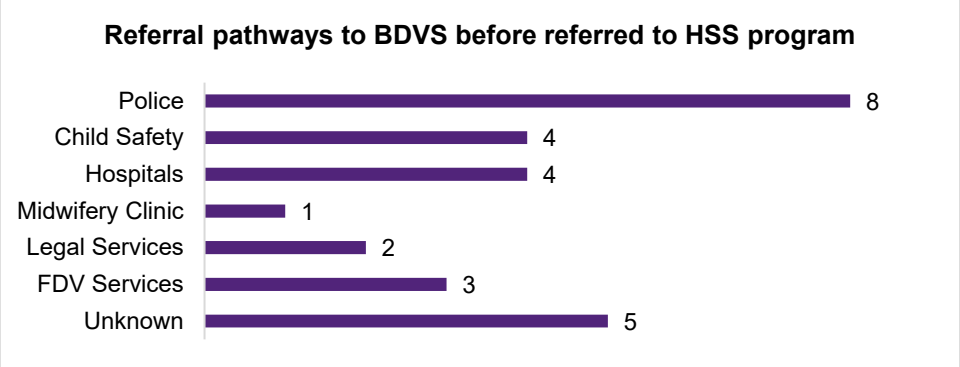


Figure 9: Referral pathways to BDVS before referred to HSS program

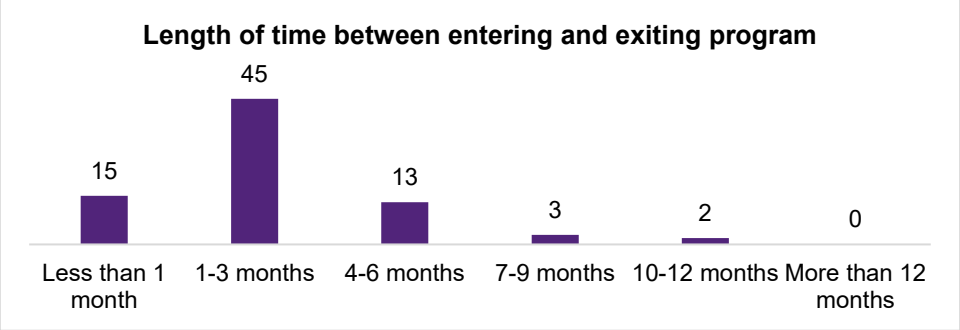


Of note is that 30 of the 106 participants were referred to the HSS program post-birth (see Chapter 4.4 below).

4.2.2 Length of HSS program engagement

A quarter of the 106 HSS program participants sampled for this report (*n*=27) were still engaged with the HSS program at the time Micah Projects extracted the administrative data. Most of these participants had been engaged with the HSS program for less than two months (*n*=14), with a further eight participants engaged since July 2024. Of the 79 participants who had exited the HSS program, the median time of engagement with the HSS program was 77 days, but there was huge variation: the shortest engagement was recorded as less than 1 day, with the longest period of engagement covering almost one year (348 days). Most participants engaged for 2-3 months (see Figure 10).

Figure 10: Length of time participants engaged in the HSS program

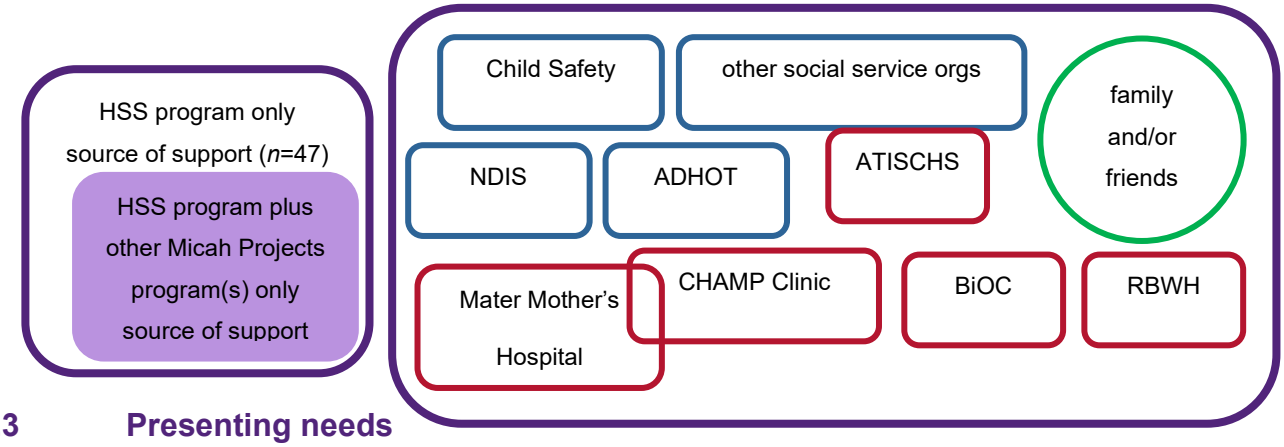


4.2.3 Support Systems

Data related to family support systems reveals that a varied landscape of assistance. A significant number of participants (*n*=41) reported having no support system other than the HSS program, while a further four (*n*=4) participants indicated their only other support system was another Micah Projects program (e.g. YMYW). There was no data for two participants.

The remaining 59 participants indicated (often multiple) sources of support outside of Micah Projects and/or the HSS program (see Figure 11). Family and/or friends were mentioned as a source of support for 21 HSS program participants. Other sources mentioned by HSS program participants included Child Safety (*n*=13), NDIS (*n*=4) the Alcohol and Drug Homeless Outreach Team (ADHOT, *n*=7), and other local social services organisations (*n*=7). Health care providers, clinics, and hospitals were also frequently cited as sources of support, including the Mater Mother's Hospital (*n*=5) and the CHAMP Clinic (*n*=11), the RBWH (*n*=2), ATISCHS (*n*=2), and BiOC (*n*=2).

Figure 11: Sources of support for HSS program participants



4.3 Presenting needs

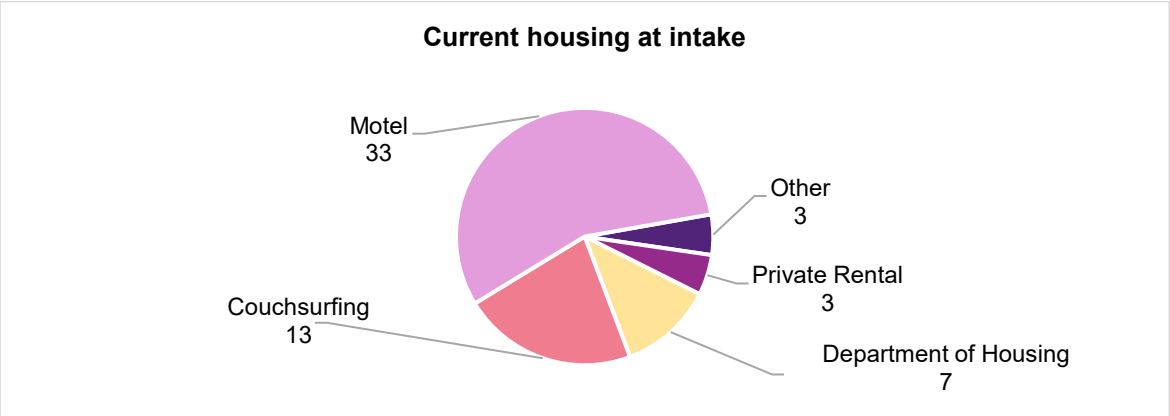
Participants were referred to the program via various service pathways related to the families' or service providers' assessment of the priority need of the participant and their family.

4.3.1 Housing

Housing pathway data indicated that more than half of the participants (*n*=59) entered the HSS program due to requiring assistance with housing. Of these 59 participants, 33 were residing in a hotel when they entered the program, and another 13 were "couch surfing", meaning that they were

residing temporarily in homes usually of family, friends or acquaintances (see Figure 12). Seven participants were residing in Department of Housing accommodation but required support for a more suitable residence (e.g. long-term lease, larger premises). During the support period, 11 participants were housed, and a further 31 participants had their applications for housing approved.

Figure 12: Housing at intake of housing pathway HSS program participants



4.3.2 Family and Domestic Violence

Over 85% of program participants (*n*=91) were known to be currently experiencing or had previously experience family and domestic violence (FDV, see Figure 13). A further nine participants did not disclose a history of FDV. Of those that did disclose experiences of FDV, the majority (*n*=86) identified a previous and/or current partner(s) as the main person who used violence against them (see Figure 14). 24 of the HSS program participants disclosed that they were experiencing family and domestic violence from a current partner. Of these, the HSS program directly supported 19 participants to engage a FDV provider. The remaining five participants either declined or did not engage in HSS support for FDV.

Figure 13: Known experience(s) of domestic violence amongst HSS program participants

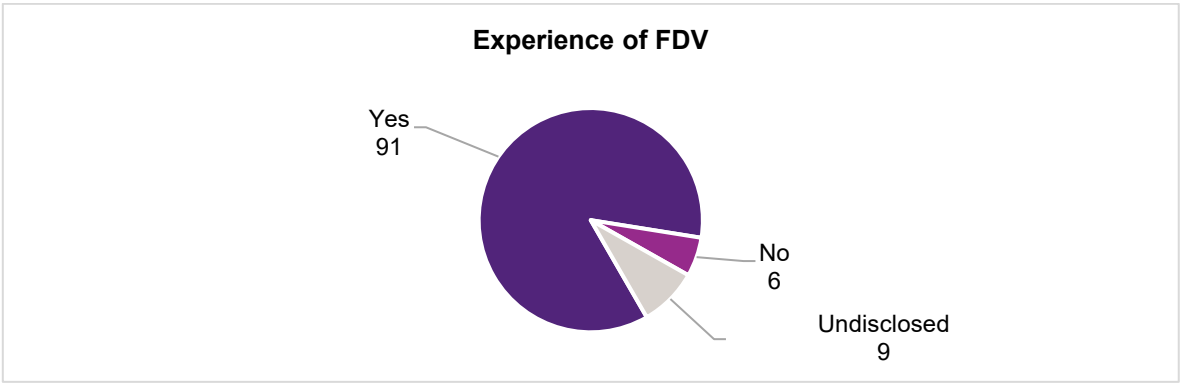
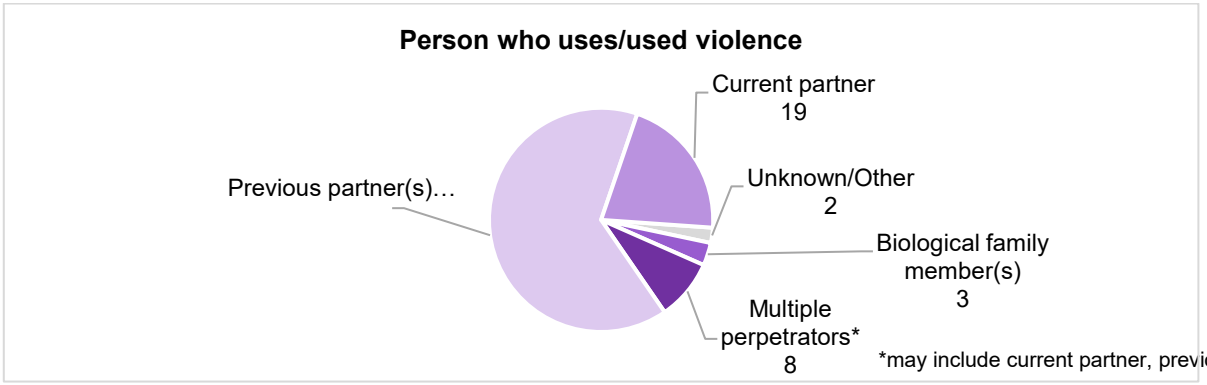


Figure 14: Person who uses/used violence against HSS program participants

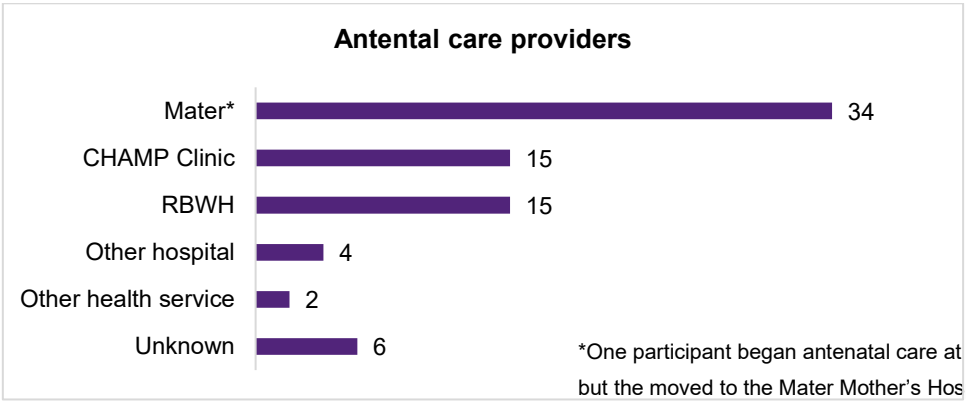


4.4 Perinatal care

4.4.1 Antenatal care

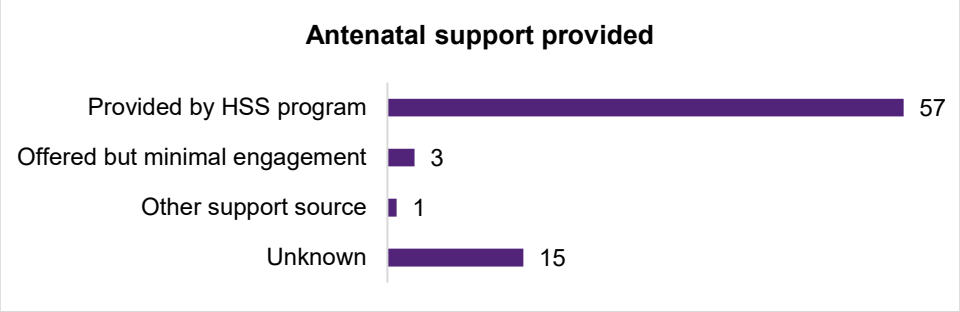
A referral was received for 30 of the HSS program participants in this sample post-birth, and so the locations for antenatal care for these participants has not been systematically recorded. For the other 76 HSS program participants, two-thirds received antenatal care at either the Mater Mother's Hospital (*n*=34) or the CHAMP Clinic (*n*=15), a specialist antenatal clinic within the Mater Mothers' Hospital that provides care to pregnant women with substance-use issues. A further 15 participants received antenatal care at the RBWH. The remaining participants received antenatal care at another hospital in the Greater Brisbane area (*n*=4), or via another health service such as BiOC (*n*=2, see Figure 15).

Figure 15: Antenatal care providers accessed by HSS program participants



Of the 76 program participants who were referred to the HSS program before birth, 57 were supported to attend antenatal appointments by the HSS team (see Figure 16). Three participants were offered support but chose not to engage with the HSS program, and one participant received support from another organisation. The remaining 15 participants either declined or did not require antenatal support through the HSS program.

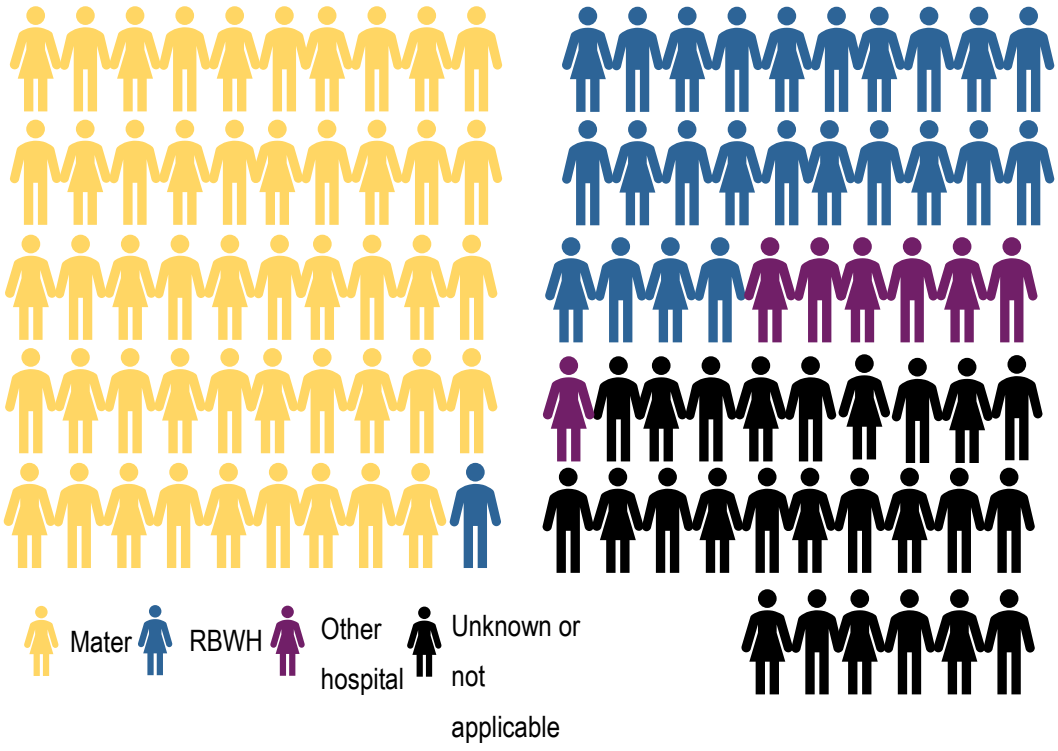
Figure 16: Antenatal support provided by HSS program staff



4.4.2 Birth outcomes

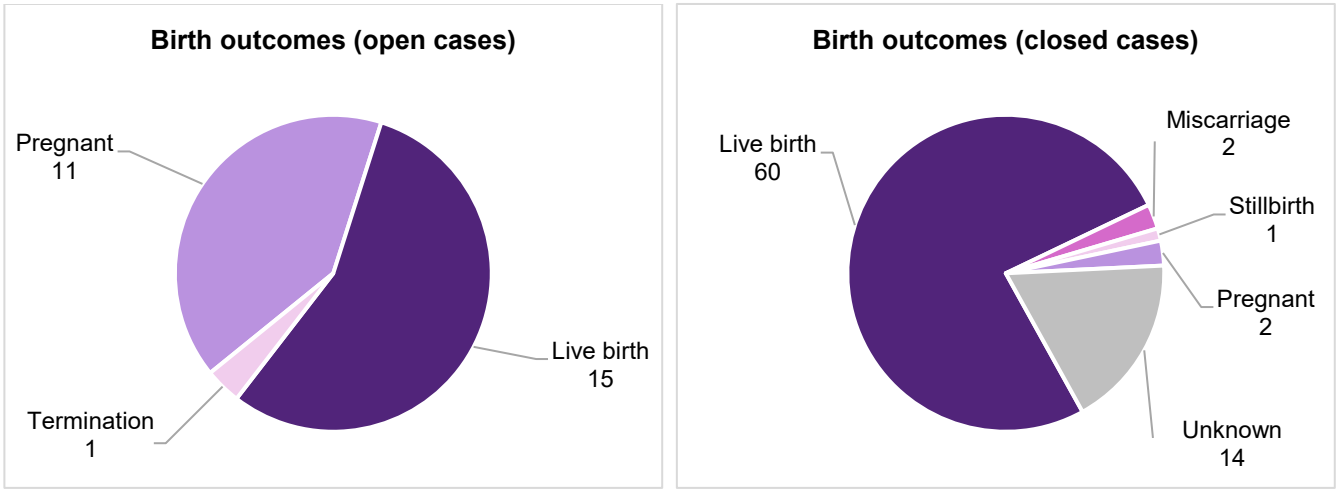
The birthing location of Most program participants (*n*=49) birthed at the Mater Mothers' Hospital, including one who presented at the hospital after attempting a home birth. 15 women birthed at the Royal Brisbane Women's Hospital (RBWH), and a further seven women birthed at other hospitals in the Greater Brisbane area, including the Sunshine Coast University Hospital (SCUH), Redcliffe Hospital, Logan Hospital, and Redlands Hospital (see Figure 17). 35 program participants were either referred to the HSS program post-birth or the location of birthing was not disclosed and/or unknown.

Figure 17: Birthing location of HSS program participants



Of the 27 participants still active in the HSS program at the time of data extraction, 11 were still pregnant. The remaining 16 participants either had a live birth (*n*=15) or chose to terminate the pregnancy (*n*=1). For the 79 participants who had exited the program, 60 participants had a live birth, including six who had an elective caesarean and five who birthed prematurely. Two of the participants experienced a miscarriage and one participant experienced a stillbirth. Two participants were still pregnant when they exited the program and the birth outcomes for those participants are unknown. Birth outcomes for 14 participants whose cases were closed were unknown.

Figure 18: Birth outcomes of HSS program participants



4.4.3 Postpartum support

Details about postpartum care and support was not available in the administrative data. This is described in Chapter Five from the perspective of the HSS program workers and Chapter Seven from the perspective of the HSS program participants.

5. Workers' perspectives

This chapter outlines the perspectives of Micah Projects staff who were involved in the delivery of *Every Child, Every Women: Healthy and Safe Start* (the 'HSS program'). This chapter draws on data from five semi-structures interviews with HSS program workers. The HSS program workers who interviewed either played a leadership role and/or were front-line staff members responsible for direct service delivery. The HSS program workers were trained in varying disciplines, including psychology, social work, nursing, management, and midwifery. All HSS program workers had experience working with the people accessing the HSS program and/or other stakeholders who interacted the HSS program. The findings presented in this chapter demonstrate the value and ongoing need for an integrated approach to service provision drawing on a multidisciplinary team.

5.1 Program strengths

The HSS program workers identified several strengths across the HSS program. These included providing a holistic and integrated response, using a person-centred and flexible approach, and maintaining strong relationships with other social service providers.

5.1.1 Integrated and holistic responses

The HSS program was designed to provide an integrated response to the needs of vulnerable families through the provision of adequate housing, support to respond to FDV, and linking to antenatal and postnatal health care services. The HSS program workers emphasised that while there are other organisations working with disadvantaged populations in Queensland, resources specifically dedicated to targeting the needs of vulnerable pregnant women and their families are still largely limited. The workers stressed that the HSS program is a crucial means of holistically responding to the distinct challenges experienced by pregnant women and their families. The importance of working across silos was frequently emphasised as central to the program's success.

> *We're very mindful that we're working as an integrated team… a roof over your head and health [needs] and [addressing] domestic violence, they're all as important as each other and we work closely for [all of these] to be addressed. (W4)*

The multidisciplinary composition of the HSS program team enabled a holistic response to the complex needs of the HSS program participants. In one example, a housing worker on the team supported the HSS program participant and their family to find temporary accommodation, while the FDV worker provided safety planning to ensure they were secure.

Indeed, in line with the integrated response to service provision, the team indicated a strong collaborative approach. Frequent and open communication was seen as central to a successful program. For example, workers highlighted the importance of weekly meetings to discuss referrals and opportunities for different members of the team to provide insights and specialist knowledge.

> *[We] have weekly team meetings, supervision, and things where we'll chat about [different families and their needs] so we work out where there's a little bit of a gap and then use those weekly team meetings to say, 'Would you like to come out with me on the next time I see this family and see if there's any support that you can offer in that space?' (W3)*

Workers also noted that they do this on an informal basis through ongoing discussions, both within the team and with other teams across Micah Projects. One HSS program worker, for instance, described how one of the housing outreach teams interacted with a woman who was pregnant and sleeping rough, and then referred the woman internally to the HSS program team.

> *We [Micah Projects] are an agency that works where people are at. So if the woman's in the park and she chooses to stay in the park, then we can do that outreach with our Street to Home Team [another Micah Projects program team], we can take one of the [HSS program] workers down just to meet the woman at her tent and talk to her about [how] we can still support her, even if she's choosing to be in the tent. (W2)*

The value of working across disciplines and teams to provide an integrated and holistic response to that met the complex needs of the HSS program participants was evident throughout the interviews with the HSS program workers.

5.1.2 Person-centred and flexible approach

The importance of engaging with HSS program participants in flexible and person-centred ways was highlighted as key to the HSS program's success. HSS program participants highlighted the complexities of the cohort that the program was targeting, noting that there were often several compounding needs and barriers to service access.

> *But there will always be that issue with our cohort of missing antenatal appointments and things because there's other things in their life, aka looking for a home and a roof over their head. So they're a complex cohort. (W4)*

Consequently, the HSS program workers emphasised the need to be flexible in their approach to social service provision. This was seen as particularly important for families that interact with multiple service systems and who may be feeling overwhelmed. HSS program workers stressed the value of being outreach focused and meeting HSS program participants where they are—physically and emotionally. HSS program workers explained that this approach helped maximise HSS program participants' access to services.

> *Because a lot of our families have had so many services in their life, and that service overwhelms them and [they have] service fatigue. We're really trying to … be flexible so that we are not just adding to their pile.… we understand a mum [who is] 32 weeks pregnant, they're really feeling crappy. [We don't want to ask] them to come into our office when we can meet them at a motel, a coffee shop, or a park. (W3)*

HSS program workers also described how a large part of their role involved supporting the HSS program participants to make an informed decision about the services with which they engaged. Throughout the interviews, the HSS program workers demonstrated a commitment to supporting HSS program participants' self-determination about goals, service access and use. For some HSS program participants, this meant providing the resources and support they needed immediately. For others, involved providing access to the resources and support they may need in the future.

> *…because it's likely when the woman is not quite ready to leave that relationship. Most of them know something is not right but [they may be concerned that they] will have no money to survive on [their] own… or it's not even safe to leave just yet. So, then we can work towards getting a safety plan or just even some psychoeducation around what DV*

means. So then maybe, at some point later in her life [she will have the resources to leave if she wants]. (W1)

As such, the HSS program workers described how they supported participants to meet their own goals. This often included facilitating access to services that would otherwise be unavailable to HSS program participants. A frequent example was providing transportation, such as via a taxi voucher, so that HSS program participants can attend medical appointments that they would otherwise be unable to attend. The understanding and respect for the lived experiences of the participants in the HSS program was evident.

5.1.3 Relationships with other social services

The relationships that the HSS program workers have developed with other service providers enabled them to provide an integrated and holistic response to HSS program participants' needs across a range of service systems. For instance, an informal partnership between the HSS program workers and the Child Safety Liaison Team at a local hospital provided a key referral pathway for vulnerable families. One HSS program worker indicated that the HSS program was one of the first contact points for many of the local hospitals when they receive a patient who may have a complex history or present with a few challenges. HSS program workers also described strong relationships that have been developed with motels and other temporary accommodation options. Limited social housing and private rental availability continues to pose challenges to providing secure, appropriate, and affordable housing. However, strong relationships with alternative accommodation providers, such as motels, alongside feedback on their suitability for families, was described as one way to help to mitigate the risk of homelessness.

These cross-system relationships also provided an avenue for HSS program workers to be advocates for their participants. For example, one HSS program worker described a multistakeholder meeting with representatives from across State Government departments, Queensland Police, and other social service providers. They explained that being able to represent the voice of the HSS program participants in these settings was essential to helping the participant to meet their own goals.

I think the common goal is definitely the woman's and the family's safety but how it looks like is very different to all the stakeholders. So, for example, for police they will think for the woman's safety is having a domestic family violence order, tick all the boxes for the paperwork then that means this woman is safe. But that doesn't mean the woman feels safe. (W1)

This indicates the importance of the program not only for direct social service provision but also for providing insights into broader social policy and program decisions.

5.2 Suggestions for program improvement

While the HSS program was seen to be working well overall, HSS program workers identified a few areas where the HSS program could be strengthened or expanded. HSS program workers indicated that expanding the team to include other complementary specialists would be useful, such as a drug and alcohol worker, a mental health worker, or a specialist who works with people who are gender and sexually diverse. Given the multidisciplinary makeup of the team is a core component of the HSS program, expanding the areas of service in response to the needs of the cohort would further strengthen service delivery.

HSS program workers also highlighted that the needs of the cohort currently outweighed the capacity of the team. They indicated that some of the frontline workers were employed part-time, and that there were often concurrent demands on their time, requiring prioritisation of crises. An expanded team that included both additional FTE and additional specialist knowledge and skills would help the HSS program to meet the demand they were seeing in the community.

Finally, HSS program workers noted that referrals were not always received at optimal times for ideal support provision. This meant that service provision may have been limited to responding to a pressing crisis rather than being able to take the time to build rapport and enact a more trauma-informed response.

6. External stakeholders' perspectives

This chapter describes the feedback from five external stakeholders who interacted with the workers and participants involved in *Every Child, Every Women: Healthy and Safe Start* (the 'HSS program'). The feedback was received from staff who worked with or alongside hospitals in Greater Brisbane, including in child protection, and were a mix of social workers, nurses, and midwives. Their engagement with the HSS program included providing referrals, supporting the team with complex child protection or other matters, and sharing information about and joint case management of vulnerable families. The findings indicate overall high satisfaction with the HSS program, provide evidence of the impact of the HSS program, and suggest the continuation and expansion of the HSS program for providing an effective response to women and their families who are experiencing multiple vulnerabilities.

6.1 Overall perceptions of the program

6.1.1 External support for the program

All stakeholders expressed an understanding of the HSS program's purpose as primarily to support women and their children during and post pregnancy. The HSS program focuses on women experiencing vulnerabilities experiencing multiple vulnerabilities related to housing insecurity, health needs and challenges in accessing support services. External stakeholders clearly identified the HSS program's aim as supporting women and children to help them achieve safety and stability, through providing the support and resources they needed. Additionally, stakeholders described the HSS program as facilitating connections with other and ongoing community supports designed to improve access to services and outcomes for vulnerable families. As one stakeholder wrote:

> *[The HSS program aims] to support families to have [the] best chance at a healthy, safe, and stable start, [which is] often inaccessible to people experiencing multiple psychosocial barriers such as homelessness, DV, child safety, social isolation, mental health and substance use. (S4)*

Across all external stakeholders who provided feedback, there was unanimous support for the HSS program, with strong feedback that it supported positive outcomes for the program participants (see Figure 19). External stakeholders described the program as "*excellent, comprehensive*" (S4), "*a great asset*" (S3), and "*invaluable*" (S4).

Figure 19: Stakeholder perspectives of the HSS program

6.1.2 Improved outcomes for vulnerable women, children, and families

External stakeholders viewed the HSS program as central to supporting HSS program participants to improve their situation for themselves and their children. They described the impact of the HSS program in relation to improved outcomes for the HSS program participants. For example, multiple external stakeholders provided examples of women who had been supported to keep their baby post-birth rather than the child being placed into out-of-home care.

> *The program has been a great asset to our women and our work … to enhance birth outcomes from women and their babies. Through the combined work that have been undertaken in partnership with [the HSS program], more women have been able to take their babies home after birth, where previously they might have had their babies removed by Child Safety. (S3)*

Other examples provided by the external stakeholders included HSS program participants being housed in safe accommodation, engaging with alcohol and drug treatment, and accessing mental health care. One external stakeholder described how safety planning and provision of safe accommodation provides children with the best chance at positive life outcomes. From the perspectives of the external stakeholders who provided feedback, the HSS program has contributed to improved outcomes for many women, children, and their families.

6.2 Program strengths

6.2.1 Holistic and integrated response

The external stakeholders described the HSS program as "*a very holistic approach and response*" (S2). Indeed, the integrated and holistic nature of the HSS program was frequently highlighted as a strength. Practical support was frequently provided as an example, such as helping pregnant women to obtain adequate housing, attend antenatal appointments, and prepare their home for the arrival of a newborn. External stakeholders also described HSS program workers as providing social and emotional support for participants, such as assisting with feelings of isolation, and safety planning for those with experiences of family and domestic violence.

Advocacy was also identified as a key aspect of the holistic nature of the HSS program, particularly where there was Child Safety involvement. One external stakeholder stated that the engagement of the HSS program workers directly improved the chance that a woman will take her baby home after birth and minimise intervention from Child Safety. External stakeholders stressed that this was strengthened by the partnerships the HSS program workers had "*with families, and with agencies and services*" (S2). Indeed, several external stakeholders highlighted the way in which the workers interacted with other agencies and services as a key strength of the HSS program.

Working alongside mothers and families to provide resources and education was raised by several external stakeholders as a key component of the HSS program. This included building knowledge and confident in HSS program participants' parenting skills and ability to care for their children. The broad and holistic nature of the HSS program was clearly highlighted across the stakeholder feedback.

6.2.2 Person-centred and flexible approach

The underlying principles of the HSS program were described by external stakeholders as person-centred, flexible, and "*providing a nurturing environment*" (S5). One stakeholder saw the underlying principles of the HSS program as being:

> *Trauma informed – Respectful and sensitive to complex and holistic needs of families [as well as being] non-judgmental, minimising [the] stigma and disillusionment often experienced by families working with other services. (S4)*

A focus on choice, autonomy, and empowerment was also mentioned as core to the HSS program's approach, alongside a respect for the lived experiences of each HSS program participant. This was highlighted as evident even when the participants chose not to engage with the HSS program. Indeed, several external stakeholders explicitly stated that the skills and experience demonstrated by the HSS program workers were central to the program's success. HSS program workers were noted as being highly committed and experienced in being able to "*provide a sense of safety to the families they work with*" (S2), and in persevering "*to maintain rapport when things get messy and in complex situations*" (S4).

6.2.3 Filling a gap and meeting a need

The external stakeholders who provided feedback for the evaluation commented on how the HSS program filled a much-needed gap in social service provision. It was described as "*a really unique model*" (S1) with "*nothing else in this space offering the same comprehensive and holistic support needed to both women and children*" (S4). Stakeholders explicitly stated how the HSS program filled a much-needed gap for vulnerable women, children, and their families.

> *This program is vital and [without it there would be] a very large gap for women and families. This is [a] necessary early intervention for vulnerable women, and increases safety and reduces harm to women and children, which hopefully results in less children entering out of home care and the trauma that this creates. (S5)*

The broad eligibility criteria for engagement with the HSS program was seen as a strength by the external stakeholders, allowing more families to access the service. They indicated that by not restricting eligibility by age or relationship status, women who would normally fall outside of the 'young person' catchment or are in a relationship are still able to access the service. The flexibility eligibility criteria was seen by external stakeholders as a strength of the HSS program, indicating that this mean the program was flexible enough to be better able to meet the needs of those who accessed the service. The feedback provided by the external stakeholders who have interacted with the HSS program demonstrated the strength of the program's approach and its necessity.

6.3 Suggestions for program improvement

Suggestions for improvement from external stakeholders primarily focused on increased funding to expand the HSS program. External stakeholders recognised the HSS program was currently restricted in its ability to deliver more services due to limited staff capacity. External stakeholders suggested that increased funding would mean that the program could be accessed by more families, including those that required higher levels of intensity. These suggestions also included expanding the multidisciplinary of the HSS program team to include other specialist areas, such as a mental

health worker. It was evident that the external stakeholders who provided feedback felt that the HSS program should not only continue but be expanded to include more staff and specialist areas.

7. Participants' perspectives

This chapter describes the perspectives of service users on *Every Child, Every Women: Healthy and Safe Start* (the 'HSS program'). The data presented in this chapter was gathered from 13 semi-structured interviews with current and previous HSS program participants. The participants who were interviewed described diverse pathways prior to becoming involved with the HSS program, but were largely consistent in their support for the program.

7.1 Pathways to the program

While reflecting on their journey prior to engaging with the HSS program, the participants shared their histories of intersecting domains of disadvantage, including their experiences with FDV, job loss, mental health issues, and financial challenges. They described experiences with the criminal and justice system, child protection services, and welfare programs. Many of the participants disclosed that they felt disconnected from their community or indicated that they had limited access to informal sources of support, such as family or friends. Prior to their involvement with the HSS program, many of the participants explained that they were involved with other services and resources but that these were unable to meet their needs during pregnancy.

> *I was in a really, really difficult patch because I'd been homeless for a while, and I [wasn't eligible for] any Centrelink payments … I was just using soup kitchens and things like that to survive. But once I became pregnant, I found it really difficult to just eat anything that was given [to me], and I became quite [malnourished]. (P10)*

For many of the participants, experiences of FDV and difficulties finding affordable and stable housing were cited as recurring experiences that increase the complexity of their pregnancy and parenting. Unemployment, unaffordable housing, relationship breakdown, and deteriorating mental, emotional, and physical wellbeing were common experiences amongst the HSS program participants.

> *I was always stable until maybe two, nearly three years ago now. … But when I found myself pregnant, I had to [leave an abusive relationship]. I actually had two years of homelessness. It was just so hard… Even when I got back into employment, it was just hard to get a place. (P2)*

Several participants described experiences of homelessness or housing precarity in the months leading up to engagement with the HSS program. Often this was in the context of FDV, where pregnancy was indicated as the main factor in the decision to leave the relationship.

> *I was in a domestic violence relationship [so] I had to move from one motel to another. Trying to get space [away from] that environment. But I have to say being homeless is… It's not very nice, especially when you have [another child] with you. (P4)*

Many of the participants explained that they were connected to the HSS program through their maternity treating team or were referred after presenting to hospital emergency departments or crisis services. Few of the participants who were interviewed indicated that they were introduced to the HSS program through family, friends, or their community.

> *I was referred to Micah Project by the [hospital] because I had a little bit of family domestic thing kind of going on. My midwife referred me… and that's when they started*

helping me with homelessness and baby things and finding a house to kind of settle in and things like that. (P3)

All of the participants who were interviewed as part of the evaluation described a positive shift in the circumstances following engagement with the HSS program.

7.2 Impact of the program

7.2.1 Safe and suitable housing

For many of the participants, finding stable and affordable housing was both their priority and an indicator of the biggest impact that the program had on them and their family. Several participants disclosed that, prior to joining the HSS program, they were couch surfing or rotating through different motels. For some, they would describe staying in a motel until it became too unsafe for them and their children, or they were no longer able to afford the cost. Having access to safe housing, even if it was transitional or temporary, was frequently described as significantly increasing participants' sense of security and wellbeing. The desire to obtain and sustain suitable housing was often linked by the participants to maintaining a healthy pregnancy.

I feel like living in a safe place or a place that I'm happy about – it affects me mentally, emotionally. I feel like it will affect my baby as well and I do it for him. So, living in a place that I like or feel safe, it does help me very much for my pregnancy. (P1)

The participants often directly thanked or praised the HSS program workers during the interviews for their support and assistance in finding and securing suitable accommodation. One participant described how she had reached out to the doctor who was supporting her pregnancy, but that they had limited capacity to help.

But the trouble is, he [the GP] is just a doctor. He couldn't help me out about housing or where I'm supposed to live. (P1)

Support to secure housing was frequently described as broader than the physical structure. Multiple participants shared that the HSS program had supported them to attend educational courses to develop tenancy skills. Participants shared their learnings regarding maintaining a clean home, keeping up to date with rental payments, and effectively communicating with rental organisations to increase their likelihood of being approved for private rentals. The participants felt that the advocacy and support provided by the HSS program workers also helped them to advocate for themselves.

I felt like I had some support … especially with the housing … I had some advocacy. So I had [the HSS program worker] going in with me to housing appointments with me. So that helped a little bit. I have tried to do housing stuff before by myself when I was looking for a place, and it is very tough, but when you have that advocacy, it makes it a little bit [easier]. (P2)

Participants emphasised the importance of permanent and sustainable housing for their physical and mental health, as well as for financial stability. Multiple participants described the challenges and stress of frequently moving location, indicating high levels of anxiety and poor mental health as a result. Even with the assistance of the HSS program, many participants described being in short term or temporary housing, due to increasingly limited housing availability in the Brisbane area. However, participants were always quick to clarify that HSS program workers were battling systemic

issues around housing availability, and that the shortage of safe and affordable housing was not due to the HSS program or a lack of effort by the HSS program workers.

7.2.2 Practical and emotional support

Many of the interviewed participants emphasised the value of the practical support provided to them by the HSS program workers throughout their engagement with the HSS program. The participants explicitly linked the impact of being provided with practical support to being able to meet their pregnancy and parenting needs. This practical support included financial assistance, food baskets and vouchers, transport to medical and other appointments, and the provision of maternity and baby items, such as nappies.

> *There were appointments that I had to attend [but] I didn't have a car… [The HSS program worker] would call a taxi, organise transportation for me to and from wherever I needed to go. (P5)*

The participants explained that receiving this practical support was crucial for them to maintain good nutrition, afford medications and pregnancy supplements, and have continuity of care throughout their pregnancy and postpartum. They described HSS program workers delivering items like bassinets, prams, and baby clothes as well as consumables like baby formula, wipes, and nappies; these were noted to ease some of the financial pressures many of the participants were experiencing postpartum.

> *[The HSS program workers] were always in contact, always checking in on us. Especially because I was the only one getting income at the time and it wasn't really as much. So they would check on me if I needed baby food or baby nappies or food vouchers, and they were always helpful with that. (P3)*

Sustaining good nutrition during pregnancy and postpartum was frequently raised as a challenge for participants. They described how the HSS program workers helped by providing "*some frozen meals*" (P10), providing "*meal plans for when the baby is born*" (P6), or bringing "*a bag of something like milk*" when visiting (P2).

In addition to practical support, the participants described the emotional support that they received through the HSS program.

> *It takes a village to raise a family. It's extremely isolating to not have that… Every time I ask for help or something like that [people] would just literally drop off bags and bags of clothes or things like that… It's not stuff I need. It's the time and support. (P10)*

Both the practical and the emotional support provided to participants through the HSS program had a significant positive impact on the lives of the participants.

7.2.3 Supportive relationships with workers

Having a positive and meaningful relationship with the HSS program workers was identified as a core component of the participants' experiences. Most of the participants noted that the impacts described above would not have been possible without the HSS program workers spending the time and energy to build and maintain a relationship with them. The participants described HSS program workers building and maintaining a relationship wherein they felt respected and understood; this was

seen as crucial for the participants to feel safe and motivated to continue their engagement with the program.

> *[The HSS program workers] were quite good, they didn't make me feel judged at all… [They've] been really great in terms of wrapping around the fact that I'm on my own, and I'm just trying to make sure I stay as engaged as possible. (P9)*

Particularly, women distinguished that they had a working relationship with their worker if the worker took the time to understand their circumstances and support them in self-identifying their needs.

> *[The HSS program workers] haven't made me feel pressured in any way, but they've responded effectively with anything that has presented… I've said, 'Look, I really don't want to go there right now. I don't have the capacity.' So they said, 'Look, if you want to, in future…' [and] they're giving me lots of information about what [supports and resources are] there. Not excessively. They're not too wordy with everything. They just offer - they're great with rapport and making sure that they're [responding to] where I'm at (P9).*

Indeed, HSS program workers being available and willing to provide the support that the participants themselves felt they needed was often discussed by the participants.

> *They were always just there to help me … [When] I was worried, I would always reach out to [the HSS program worker] and she would always be there, telling me if need to take [the baby] into hospital, or if it's just a normal thing babies go through at that age. (P3)*

Participants described the HSS program workers as "*approachable*" (P7) and "*really friendly and welcoming*". This meant that participants felt that "*it was quite easy…to just open up*" (P6). This was seen as essential for participants to disclose sensitive information related to complex issues, such as FDV. Another participant highlighted how they felt 'listened to' by the HSS program workers in comparison to other services and/or support networks.

> *That was something that was probably the most trauma[tic] of my time being homeless, just no one taking me seriously or listening to me about what was going on… Every support network… they couldn't help me. (P10)*

The participants described HSS program workers as accessible, making clear and regular efforts to 'check in', but emphasised that they always had a choice as to the amount and mode of engagement with the HSS program. This was seen as beneficial for participants to both preserve their autonomy but also receiving individualised and flexible care.

> *[If] I want it, I'll be able to ask [the HSS program workers], and they'll do it [provide transportation and/or attend appointments with the participant]. (P1)*

Several of the participants described the HSS program workers as a welcome constant within their support system and an integral part of safeguarding wellbeing during their pregnancy and postpartum period.

7.2.4 Access to other services and resources

The participants viewed an increased understanding of the services and resources available and relevant as a key part of ensuring a safe pregnancy. They described how this knowledge enabled them to receive the support they needed not only to address their perinatal needs but also other life stressors. This included receiving timely and contextually appropriate information around finances, nutrition, mental health, and caring for newborn children.

> *I was a first-time mother and I didn't really know much about babies, so [the HSS program worker] was always there, helping with baby clothes or help me do [the baby's] first shower. (P3)*

Participants also described the HSS program workers as taking on an advocacy role. This was seen as vital not only for helping participants receive the immediate support they need, but also helping participants to have the confidence to advocate for themselves.

> *[The HSS program workers] gave me hope to pick myself up as a mother and keep going. (P5)*

Some participants indicated that the HSS program workers were able to provide connections to other specialist support services as and when needed. Other participants also described being referred to other services for legal advice related to FDV and child safety.

7.3 Program strengths

7.3.1 Multidisciplinary teams

Having access to a range of program workers with diverse specialisations was seen as a key strength of the HSS program. Participants noted that they may have been introduced to multiple HSS program and other program workers throughout their involvement and were encouraged to reach out to specific people depending on their current needs. Most of the participants knew the HSS program worker(s) they were involved with by name and indicated a close, professional relationship. This included knowing who to contact in relation to their housing, maternity, legal, or transport needs.

> *Being able to talk to [the HSS program worker who provides antenatal support] and having her check up on me has helped a lot… Then having [the HSS program worker who provides FDV support] supporting me on the DV side has helped a lot because it was quite overwhelming and [there were] a lot of emotions, not understanding how the process of once the police report has been filed and then what my next steps are. [The HSS program worker who provides housing support] did a really great job [helping me understanding the processes]. (P6)*

Participants also noted that the HSS program has a focus on information provision and providing referrals where necessary. Participants highlighted that if a HSS program worker was not able to directly assist them with a certain concern or need, there was value in reaching out to them to be connected to other workers or services that may be able to help.

> *[The HSS program workers] are doing referrals that are well placed. They're not just referring you to everything and catchall kind of thing. They're making sure that you're very suitable to have that conversation with and that your need is there. (P9)*

They explained that the HSS program workers supported them in practical ways, including helping them navigate the systems with which they are involved. Providing information that was useful rather than overwhelming was a strength noted by several participants.

7.3.2 Flexible and individualised support

Several participants indicated that being informed and supported to participate in decision-making activities regarding their care was advantageous in meeting their self-identified pregnancy needs. Participants noted that they had control over the frequency, location, and manner of interactions with HSS program workers. Some of the participants—particularly who were experiencing FDV, were actively involved in legal matters, or had mental health and wellbeing concerns—viewed weekly contact with their HSS program worker as required to meet their complex needs. Other participants disclosed that since obtaining stable and secure housing or in the postpartum period, they preferred to only initiate contact with workers when needed.

> *I think that the level that they've provided services at has been right where it needed to be, not too much, not too little. I didn't feel isolated or unsupported in any way, and I didn't feel over hassled or over contacted or anything. (P9)*

Many of the participants described the quality of rapport-building and communication skills of HSS program workers, particularly in relation to other services or programs with which they've been involved. This ranged from interactions with hospitals and healthcare clinics, police, child safety, and other crisis services. They expressed that the reliability, approachability, and connection with the HSS program workers as one of the most crucial aspect of supporting them throughout their pregnancy and postpartum journey.

> *Feeling like someone is helping you, speaking for you, putting your name out forward and putting your needs forward, I think that's very important. I think it's hard - like I said, I tried before on my own and you don't really feel very heard with [some other] organisations... But when you have someone there with you, it makes all the difference. (P2)*

Participants expressed the trust they felt in the HSS program workers, noting that they felt the staff genuinely wanted to support them to achieve their own goals. Participants shared that this promoted their own sense of connection, trust, and willingness to seek help not only from the HSS program, but from other programs with Micah Projects and other organisations.

> *It's like a gamechanger… It really changed me. It helped me… If it wasn't for [the HSS program workers], I probably would have been – I don't know where I'd be. Without my kids. I would have lost them to Child Safety. (P5)*

Participants who described complex needs requiring long-term support shared that the HSS program's staggered approach to decreasing the involvement of workers was beneficial. They reflected that having majority of control over the frequency and extent of their engagement with the program prevented feelings of loneliness and sudden loss of support after giving birth or attaining stable housing. Some participants discussed feeling cut-off from previous services due to their, or

their children's, age or completely losing contact with their caseworkers after some of their needs had been met.

> *In the beginning, [contact between me and the HSS program workers] was quite frequent. It was at least once a week, [with the HSS program worker] coming over to [my] home…. seeing how I am, how baby is… Once baby got to about three months, [the contact] kind of drifted slightly, which was fine, because we were at the stage where we were quite stable…. [But] if I needed something tomorrow, or need someone to talk to, I can just text or call [one of the HSS program workers], which is really helpful. (P6)*

The flexible and person-centred approach to the HSS program thus helped support program participants to provide a more stable base for themselves and their children.

7.4 Suggestions for program improvement

The ability to accommodate the housing needs of women with experiences of FDV was raised as an area where the HSS program could provide further support. Specifically, multiple participants voiced their desire for more focus on the location and quality of security in the accommodation or housing in which they and their children were placed. While participants recognised that the process of finding stable and appropriate housing can be challenging and lengthy, they viewed that being able to consider certain features—such as the distance from the person using violence or closer to their children's schools or the services with which they were engaged—in securing accommodation would benefit their wellbeing and their ability to raise their children safely. One participant noted that having security cameras and limited access to the floor of her apartment building had significantly improved her sense of safety, her mental health, and her ability to relax at home. Another participant noted that difficulties in finding appropriate housing that met her safety needs will likely prolong her involvement with the HSS program.

Many of the participants expressed some of the disadvantages of being placed in motel rooms or shared accommodation rather than having their own secure housing. In particular, the absence of a functioning kitchen, small rooms with little personal space, and being exposed to disruptive guests were raised as a recurring challenge. One participant disclosed that she had to give away the majority of her belongings to make room for a bassinet in the motel room, and that she will have to wait to be relocated to a bigger room before shopping for other items for the baby.

Participants also shared that their sense of safety was negatively impacted by sharing a bathroom, kitchen, and/or laundry facilities. Feeling isolated or anxious within the shared areas was also raised as an issue. Moreover, participants expressed that they were less likely to be able to use kitchens to save money and meet their nutritional needs in shared accommodation, especially when cooking facilities had been damaged or left unclean.

> *The crisis accommodation [that the HSS program helped me access] was okay. However, the difficult thing about it is they pretty much take the majority of your money and they are not really fit for purpose. They don't really have cooking facilities… I was getting more and more pregnant, and getting to [quality and nutritious] food was becoming really tricky. Sometimes, even just getting to the food was exhausting the energy that I got from eating the food… it was huge finally having a door, somewhere to probably get some proper rest. But with regard to the nutrition side, that became extremely challenging. (P10)*

While the flexible nature of the HSS program was frequently cited as a strength, a few participants indicated that this caused them some confusion in relation to their eligibility for ongoing support. While these participants expressed the HSS program's purpose as supporting them during pregnancy and postpartum, they wanted further clarification on whether there were time limits for this support.

8. Key findings and recommendations

This chapter outlines the key findings from the evaluation of *Every Child, Every Women: Healthy and Safe Start* (the 'HSS program). It reports the key findings against each of the evaluation objectives (see Chapter 1.2). The chapter begins by describing the demographic profile and experiences of the HSS program participants (Evaluation Aim 1), as well as the facilitators of and barriers to maternity and other health and community services for these families (Evaluation Aim 2). It then describes the features and approach of the HSS program (Evaluation Aim 3), provides insights into how and where these features improved HSS program participants' access to the services they needed (Evaluation Aim 4), highlights the HSS program's achievements (Evaluation Aim 6), and identify where there were some limitations in the service that the HSS program could provide. It notes the limitations of this evaluation, particularly in its ability to comment on the cultural responsiveness of the HSS program with and for Aboriginal and Torres Strait Islander families and communities (Evaluation Aim 5). The chapter concludes with five recommendations for how the HSS program can be improved and expanded to support future participants.

8.1 Key findings

8.1.1 HSS program participants' characteristics and pathways

Between January 2023 and November 2024, the HSS worked with at least 106 families. Most of the individuals accessing the HSS program were single, pregnant women under 35 years of age who had current and/or previous experiences of family and domestic violence. More than half of the participants had entered the HSS program due to precarious housing, of which several were residing in a motel or "couch surfing" with family and/or friends. Few had strong informal support networks, with less than 20 percent noting family and/or friends as a source of support. Indeed, a significant number of program participants indicated that the HSS program and/or another Micah Projects program were their only source of support.

Most of the HSS program participants described in this report were referred to the HSS program from other Micah Projects programs, predominately via the Brisbane Domestic Violence Service (BDVS) or other domestic violence programs, such as the Safer Lives Mobile Service (SLMS). Most of the other internal referrals came via housing programs such as Families to Home (FTH), Street to Home (STH), and the Hub. This indicates that, for this cohort, experiences of family and domestic violence and housing precarity are primary needs requiring support. Indeed, safety planning and support to find safe, secure, and affordable housing were the two main outcomes that HSS program participants described as part of this evaluation.

Most of the HSS program participants entered the HSS program during their pregnancy. Of the 76 participants who entered the program while pregnant, the majority (*n*=57) received antenatal support through the HSS program. Over a quarter of the participants analysed as part of the administrative data entered the HSS program post-birth, indicating a strong need amongst this cohort for support in the postnatal period. The focus of the HSS program as providing specialised support for pregnant women and their families was described as invaluable for the participants, as they described HSS program workers as being understanding and flexible in response to their current circumstances. This understanding and flexibility could extend further into the postnatal period with an expanded suite of workers who specialise in areas such as parenting support, mental health, and early childhood programs.

8.1.2 HSS program features that enhanced service access, utilisation, and outcomes

The evaluation identified several key features of the program design and delivery that enhanced service access, utilisation, and positive outcomes for participants. These features included the multidisciplinary model of care, the outreach approach, the practical approach, the whole-of-service system approach, and relationship-based and trauma-informed models of care.

Multidisciplinary model of care

Having a multidisciplinary team meant that the HSS program was able to respond holistically to the multiple needs of the parents and families accessing it. The provision of responsive and flexible care was pivotal to improving health and wellbeing outcomes for children and families. The multidisciplinary team model enabled families to receive services that responded to their multiple needs, thus reducing the burden associated with navigating multiple service systems. This model was effective in including families in immediate and long-term solutions to housing, health care, and safety needs. The integration of a midwife alongside housing and domestic violence service providers, enabled a holistic response to families with complex needs. These involved family and domestic violence, health issues including substance use concerns and care in the perinatal period. care. The multidisciplinary nature of the team was also suggested by external stakeholders as improving infant outcomes. The multidisciplinary team model adopted by the HSS program has filled the gap of continuity of care for this highly vulnerable population that was identified in the literature.

Outreach approach

The HSS program team used an outreach approach for families living in precarious and insecure housing, such as motels and transitional housing. The HSS program workers met families in their home or at another location of the participant's choice, such as a café or library. The provision of care within the home and community benefited the HSS program participants by facilitating service access, while offering the HSS program workers the opportunity to gain insights into families' circumstances. This improved the capacity of the HSS program team to tailor service delivery to meet both the family's and the HSS program's objectives.

Practical approach

The HSS program prioritised the practical needs of families, including the provision of support for nutrition, hygiene in the home, and hurdles to service access. The HSS program's access to brokerage funds enabled the HSS program workers to promptly address the practical needs presented by HSS program participants, such as access to transport to attend antenatal appointments, or providing nappies for infants. Participants in the HSS program appreciated the use of brokerage funds to support them in addressing their practical challenges to achieving health, housing, and safety outcomes.

Whole-of-service system approach

The success of the HSS program relied on the strong links between service systems across health, housing, and human services. The HSS program workers actively maintained these links and facilitated a two-way referral process: services were able to refer eligible families to the HSS program, and HSS program workers referred program participants to other services as needed. This was seen by both HSS program participants and external stakeholders to have enhanced the holistic response to the multiple and complex needs of families.

Relationship-based and trauma-informed models of care

The HSS program workers were highly skilled at engaging with people who have experienced trauma associated with childhood abuse, family violence, and structural disadvantage. Features of this approach included focusing on family decision-making, preferences and goals in all aspects of service provision. This led to enhanced trust between HSS program workers and participants.

8.1.3 Cultural responsiveness in the HSS program

An aim of the evaluation was to examine the cultural responsiveness of the HSS program to Aboriginal and Torres Strait Islander families. The relatively high representation of Aboriginal and Torres Strait Islander people (approximately one-third) of participants in the HSS program may be an indicator of cultural responsiveness. However, beyond the date of representation of Aboriginal and Torres Strait Islander people among the participants accessing the HSS program, we are limited in the extent to which we can report on the HSS program's cultural responsiveness. We made substantial attempts to engage Aboriginal and Torres Strait Islander participants in the evaluation, including appointing two Aboriginal and Torres Strait Islander research assistants who were available to interview any HSS program participants who identified as Aboriginal and Torres Strait Islander. One interviewed HSS program participant described the HSS program in relation to their Indigenous partner, however no interviewed HSS program participants identified as Aboriginal and Torres Strait Islander. External stakeholder feedback was requested from partners and referral agencies who specialise in working with Aboriginal and Torres Strait Islander families, however a response from these stakeholders was not received. As such, we are unable to comment on the cultural responsiveness of the HSS program with and for Aboriginal and Torres Strait Islander families.

8.1.4 Challenges in achieving the HSS program's objectives

The evaluation identified several challenges that posed barriers to the HSS program achieving its objective of improving the health, safety, and housing stability for vulnerable women and their children. These included the limited availability of secure, affordable, and appropriate housing; the relatively small size of the HSS program team compared to the demand for services; and the need for specialist services outside of the scope of the HSS program workers.

Limited availability of secure, affordable, and appropriate housing

The first challenge was the limited availability of secure, affordable and appropriate housing for families. This lack of suitable housing poses substantial challenges for families' capacity to meet fundamental needs, achieve safety, and access health care including antenatal care. Families and service providers acknowledged that while crisis accommodation met the immediate, short-term housing needs, it was not appropriate nor sustainable for families. For example, families living in motels lacked access to the cooking and laundry facilities they needed to prepare meals and maintain hygiene for their families. Further, many social housing options did not provide sufficient security to meet the safety needs of women and children fleeing domestic and family violence.

Relatively small program team

External stakeholders emphasised that the HHS program's approach was important and indicated that there were many more families who could be referred and benefit. However, the level of demand exceeded capacity of a relatively small team to respond. This raised some concerns that the families with complex needs and who, for a variety of reasons, required more assertive outreach would not

be engaged despite the potential benefits to them. This was also noted by the HSS program workers, who explained that the small size of the HSS program team limited the program's capacity to respond to the demand for services. The HSS program team comprises five workers, one of whom manages multiple teams. Two of the four HSS program workers engaged in program delivery work part-time, and the full-time equivalent for the HSS program delivery is only 3 FTE. External stakeholders and families engaged with the program shared a view that many more families would benefit from the HSS program if the team was larger and had greater capacity.

Need for further specialist areas

A third challenge concerned the need to further diversity the HSS program team skill base to better meet families' needs. The evaluation has highlighted the value of the multidisciplinary team, particularly in the integration of antenatal care alongside housing, domestic and family violence, and children's support services. However, the evaluation noted that other areas of specialised knowledge and skills are needed to optimise the HSS program. It was identified that the inclusion of specialists in areas such as substance misuse and mental health could further enhance the capacity of the HSS program to improve the health, safety, and housing stability of vulnerable women and their children.

8.2 Recommendations for the *Healthy and Safe Start* program

The HSS program aims to improve the health, safety, and family wellbeing of parents and children experiencing homelessness and/or domestic and family violence. The program offers a holistic response to families and is delivered by a small multidisciplinary team of midwifery, housing, domestic violence, and child and family support workers. The team is small, with four staff members (across a full-time equivalent of only 3 FTE) engaged in outreach and case management work, plus a team leader who works across multiple programs. Despite the small team and the relatively short time frame in which the HSS program has been operating, there is evidence that the program has supported positive outcomes for its participants and their families.

1. Expand and diversity the HSS program multidisciplinary team

The findings of this study indicate that many more families would benefit from the program than can currently access the service. The view of workers and external stakeholders is that demand for service exceeds capacity to meet supply. The current composition of the team, particularly the presence of midwifery services alongside housing and family support services needs to be scaled up to meet demand. Further, alongside the scaled-up service provision, the addition of specialist workers in Alcohol and other Drugs and in mental health would improve this program.

2. Extend families' opportunities for earlier antenatal contact and postnatal support

Many women were referred to the service relatively late in their pregnancy thus limited their access to accessible antenatal care and other supports. Further, given the positive relationships the service providers achieve with families, there is potential for the service to provide support into the postnatal period to enhance the health, wellbeing and safety of vulnerable women and their children.

3. Expand brokerage funds

'Brokerage funds' refers to workers' access to discretionary funds to meet immediate and practical needs of the families. Participants in the program face a range of practical obstacles, such as lack of access to transport and to adequate incomes, that severely compromises their capacity to meet

fundamental needs of their families. Brokerage support, such as the capacity to access funds to pay for transport or pay for basic food and hygiene needs, is essential to families to accessing services and meeting basic health and sustenance needs.

4. Improve supply and access to affordable, safe and appropriate housing

Access to suitable housing is a foundational building block to achieving both immediate and long-term health and wellbeing goals of the program. Many of the families first engaged with the program during a period of significant housing insecurity and much of the initial stages of engagement focus on securing appropriate housing. Improved access to safe and affordable housing for pregnant women and their families, especially those who experience housing insecurity and/or family violence, would allow these families to engage more fully with maternity, health, and other services.

5. Further evaluation of culturally responsive practices

The HSS attracts a high proportion of Aboriginal and Torres Strait Islander families. Despite extensive attempts to engage with the families during the evaluation, no identified parents participated in the study. Continued attempts must be made to engage Aboriginal and Torres Strait families in the review and ongoing development of culturally responsive practice.

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Appendices

A-1 Search terms for the rapid scoping literature review

	Concept 1	Concept 2	Concept 3	Concept 4	Concept 5
Key concepts	Maternity models of care	Housing insecurity/ homelessness	Supporting pregnant women	Psychosocial issues impacting pregnant women experiencing homelessness	Child safety
Free text terms / natural language terms (synonyms, UK/US terms, medical/ laymen's terms, acronyms/ abbreviations, drug brands)	Health care services; support services; community services; integrated care	Homelessness; rough sleeping; vulnerably housed; housing insecurity; housing service; ill-housed persons; transitional supported accommodation	Maternity services; support services; safe housing; early interventions; community services; women and children	Domestic and family violence; drug/alcohol use; substance use; mental health issues; poverty; financial insecurity; stigma	Domestic and family violence; child abuse; child safety concerns; parenting support; model of care for mothers with neurodevelopmental needs
Controlled vocabulary terms / Subject terms (MeSH terms, Emtree terms)	"Model of Care"[tiab] OR "health service*"[tiab] OR "community service*"[tiab] OR "service*"[tiab] OR "care"[tiab] OR "Delivery of Healthcare" [MeSH Terms]	"Vulnerable Populations" [Majr] OR sunhoused[tiab] OR homeless[tiab] OR ill housed persons (tiab) OR "precariously housed"[tiab]	"Maternal Health Services"[MeSH Terms] OR perinatal care [MeSH Terms] OR prenatal care [MeSH Terms] OR postnatal care [MeSH Terms] OR antenatal care [MeSH Terms] OR Maternity Care [MeSh Terms]	"domestic violence"[tiab] OR "intimate partner violence"[tiab] OR "drug and alcohol use in pregnant homeless women"[tiab]	"Domestic and family violence" [tiab] OR "child safety concerns"[tiab] OR "parenting support for mothers with neurodevelopmental needs"[tiab]

A-2 Administrative data variables

Demographics of HSS program participants

- participants
- cultural background
- relationship status
- disability status
- housing status
- experience(s) of family and domestic violence
  - person who uses/used violence
  - FDV disclosure pathway
- VI-SPDAT score

Children in participant's care

- number of children
- ages of children
- whether children are known to Child Safety
- disability status

HSS program specific

- referral pathway into Micah
- length time with the HSS program
- support persons of participants
- antenatal providers
- supported antenatal contact visits
- outcome of pregnancy

A-3 Interview guide for interviews with program workers

Demographics

- Current role
- How long have you worked with women experiencing maternity services, homelessness or domestic violence?
- How long have you worked in your current role?

Program purpose and practices

1. What do you see as the purpose or goal of the HSS program?
2. Who is the target group for the HSS program?
3. What do you see as the underpinning principles of the HSS program?
4. What are the key components of the HSS program?

Partnerships and integration

5. Who is involved in delivering the HSS program?
6. Who are the partner organisations?
7. Are there other stakeholders that you frequently engaged with in the course of delivering the HSS program?
8. Are there any stakeholders that are not currently involved in the HSS program but you think should be?
9. How would you describe the management and/or organisational support for the HSS program from partner organisations?
10. How would you describe the approach to communication, decision-making and reporting between the partner organisations?

Impact of the program

11. When does the program work well for women and children?
12. When does the program not work so well for women and children?
13. How does the service delivery model provide integrated maternity support for people experiencing domestic and family violence and/or risk of homelessness?
14. How does the service delivery model provide system navigation support for people experiencing domestic and family violence and/or risk of homelessness?

Overall perceptions

15. What have been the greatest strengths or opportunities for the program so far?
16. What has been the greatest challenge in implementing the program so far?
17. What strategies could enhance the success of the program?
18. Any other comments?

A-4 External stakeholder feedback survey

Demographics

The following demographic questions will be used to aid the analysis of the feedback. This information will not be used to identify you in any reporting of findings associated with the project.

1. Please list your professional qualifications.
2. How long have you worked with women experiencing maternity services, homelessness or domestic violence?
3. What is your current role?
4. How long have you worked in your current role?

About the HSS Program

The following questions ask about your understanding of the Every Child, Every Woman: Healthy and Safe Start program. Please note that there are no right or wrong answers.

5. What do you see as the purpose/goal of the Program?
6. What do you see as the underpinning principles or role of the Program?
7. What do you see as the key components of the Program?
8. Can you describe how you engaged with the Program?

Impact of the HSS Program

The following questions ask about your perspectives on the impact of the Every Child, Every Woman: Healthy and Safe Start program.

9. On a scale of 1-5, how much of an impact do you think the Program makes for women?
10. On a scale of 1-5, how much of an impact do you think the Program makes for children?
11. When have you seen the Program work well for women and children?
12. When have you seen the program not work well for women and children?

Overall satisfaction with the HSS Program

The following questions ask about your overall satisfaction with the Every Child, Every Woman: Healthy and Safe Healthy Start program.

13. On a scale of 1-5, how satisfied are you with the Program?
14. What do you think are the strengths of the Program?
15. Where do think the Program could be improved?
16. On a scale of 1-5, would you like to see the Program continue?
17. Can you please provide some further details on why you answered the above?

Any other comments?

A-5 Interview guide for interviews with participants

- What is your story of being involved in the program?
  - What has been different since your involvement for you?
- What is your experience of accessing maternity services and hospitalisations?
- How was your health and life before you engaged with this program, and how is it now?
  - What do you think has made a difference?
- How often do workers visit you or be in contact?
  - Have there been times when you've seen them more often than usual?
- The goal of the program is to sustain a healthy pregnancy, and to attain to safe and sustainable housing. What does this mean for you?
- What is your relationship like with your program worker?
  - In what ways has your program worker supported you?
- What else would you like to see in the program?

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