

BABY AND ME

Exploring the development of a residential care model for young pregnant women, and young women with babies, in out of home care



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Executive Summary

Children and young people in out of home care (OHC) are widely considered to be some of the most vulnerable members of our community, with early experiences of trauma, instability and adversity associated with ongoing vulnerability into adulthood. The period when young people exit the care system (typically at 18 years of age or even younger) is a point of particular risk. In the absence of ongoing developmentally appropriate support, immediate outcomes too often include homelessness, unemployment, contact with the Criminal Justice System, poverty, drug and alcohol use, poor mental health, social disconnection, and, for young women in particular, early parenthood (Berzin, 2008; Courtney & Dworsky, 2006; Courtney, Hook & Lee, 2012; Hook & Courtney, 2011).

The *Baby and Me* project is an exploratory study whose aim is to better understand the incidence and experience of early pregnancy and parenthood for young women with current or recent experiences of the OHC system. From the perspective of practitioners, the project seeks to explore:

- how the OHC and community support systems are currently addressing the needs of these young women and their babies
- the frequency with which young women in care are becoming pregnant
- the perceived need and demand for a specialised model of residential care for young pregnant women and young women with babies, in and leaving OHC.

With respect to the development of a residential model of care, the project specifically seeks to investigate:

- a) The main drivers for such a model
- b) The factors to be considered in its design and implementation
- c) How the key concepts underlying a residential model might be applied to general OHC practice.

Method

A convenience sample of eight services, from which ten interviewees were recruited, participated in the study via qualitative interviews. Participants were able to provide anecdotal information on the number of young pregnant women and young mothers in, or leaving out of home care¹ with whom they had worked with over the past two years.

Analysis of the qualitative data resulted in identification of

- a) The challenges faced by the young women, including the lack of an available or appropriate parenting role model, poor understanding of sexual health and reproduction, misconceptions about the reality of pregnancy and parenting, tension between their pregnancy and their adolescent lifestyle, and the fragmentation of pre and post-birth pathways.
- b) Strengths exhibited by the young women, identified as a desire to parent differently, love of, and commitment to, their child, resilience and a willingness to learn.
- c) Issues concerning the experience of the fathers of the babies such as access to their child, and support to develop parenting skills.

From these practice reflections, key factors which inform a residential model of care are discussed, as are recommendations for integrating the findings into current practice.

¹ Throughout the report the term 'in and leaving care' will be used to refer to young women who are in, transitioning from, or who have recently left out of home care



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Introduction

Young people who have experienced out of home care (OHC) are widely recognised as some of the most vulnerable members of our community. The factors that contribute to this vulnerability are broad and varied, encompassing individual and environmental factors that interact in complex ways to affect their pre-care and in-care experiences (Maschi, Schwalbe, Morgen, Gibson & Violette, 2009; Murray & Goddard, 2014; Riggs, 2010; Schilling, Aseltine & Gore, 2008; Simmel, 2011; Yampolskaya, Sharrock, Armstrong, Strozier & Swanke, 2014). This cohort of young people are particularly at risk for a range of detrimental outcomes immediately upon leaving care, but also through later stages of their lives.

A considerable body of research is now accumulating showing that young people who exit care are at an increased risk of unemployment and underemployment, contact with the Criminal Justice System, economic and social hardship, poor mental health, social disconnection, and, for young women in particular, early parenthood (Berzin, 2008; Courtney & Dworsky, 2006; Courtney, Hook & Lee, 2012; Hook & Courtney, 2011; Keller, Cusick & Courtney, 2007; Lee, Courtney & Hook, 2012; Shook, Goodkind, Pohlig et al., 2011; Shook, Goodkind, Herring et al., 2013). Across multiple studies, researchers have identified that young people who 'age out' at 18 years of age experience greater difficulties across various life domains, compared to young people who are able to stay in care for longer periods of time (see for example the research produced by Courtney and colleagues), but also compared to young people who have experienced hardship and adversity but have not spent time in OHC (Berzin, 2008).

Explanations for these generally poor outcomes tend to coalesce around two interrelated factors, namely the long-term impact of early childhood abuse, neglect and maltreatment, and the lack of supports available to young people as they exit the OHC system. In this context, Horrocks (202) has argued that young people's trajectories out of care need to be contextualised within a social-developmental framework, whereby current transitions are fundamentally and inextricably influenced by previous experiences and transitions. The choices young people make as they exit care should therefore be understood as a product of their various experiences, as well as the resources that are available to them at the point of transition.

Such transitions are made more complicated by the emphasis on 'independence' and 'independent living' that begins when young people in care turn 16 years old. For this cohort of young people, unlike the broader population of Australian youth, the expectation to be independent and assume full adult roles and responsibilities at 18 years old exists in direct opposition to the acknowledgement that young people in care have experienced significant adversity and that they will face a myriad obstacles upon leaving care. The result is that young care leavers are expected to be independent at a time when other young people of a similar age are given latitude to explore their identities, make mistakes and return to the safety net of their parental home if (when) their life takes a wrong turn. In contrast, young people leaving care face a dominant 'duties discourse', where they are expected to grow up and make something of their life immediately upon leaving care. This discourse sits alongside a 'rights discourse' of independence, including for example, the right to make decisions that directly affect their lives, which is not always available to young care leavers. The situation is made more complicated by the perceived surveillance gaze of the State, which is experienced by many young people as omnipresent. This in turn increases their fear, antagonism towards and isolation from services that in many instances could assist in their adult trajectories (Adley & Kina, 2014; Berzin, Singer & Hokanson, 2014; Horrocks, 2002; Propp, Ortega & NewHearth, 2003; Samuels & Pryce, 2008; Singer & Berzin, 2015).

In this context, early parenthood emerges as an important area for research and policy. On the one hand, research and policy have typically positioned early parenthood as one marker within a broader range of 'poor' outcomes. On the other hand, however, there is some evidence that for young people themselves, early parenthood represents a choice, albeit one that is constrained by their past experiences and transitions (Barn & Mantovani, 2007; Pryce & Samuels, 2010; Samuels & Pryce, 2008). While both perspectives can comfortably co-exist, there is a need to better understand:

- a) the factors that contribute to early parenthood among young women in, and leaving care
- b) the supports that may best assist this cohort
- c) existing models that focus specifically on young people in and leaving care as parents rather than simply as care leavers who become and /or are pregnant.

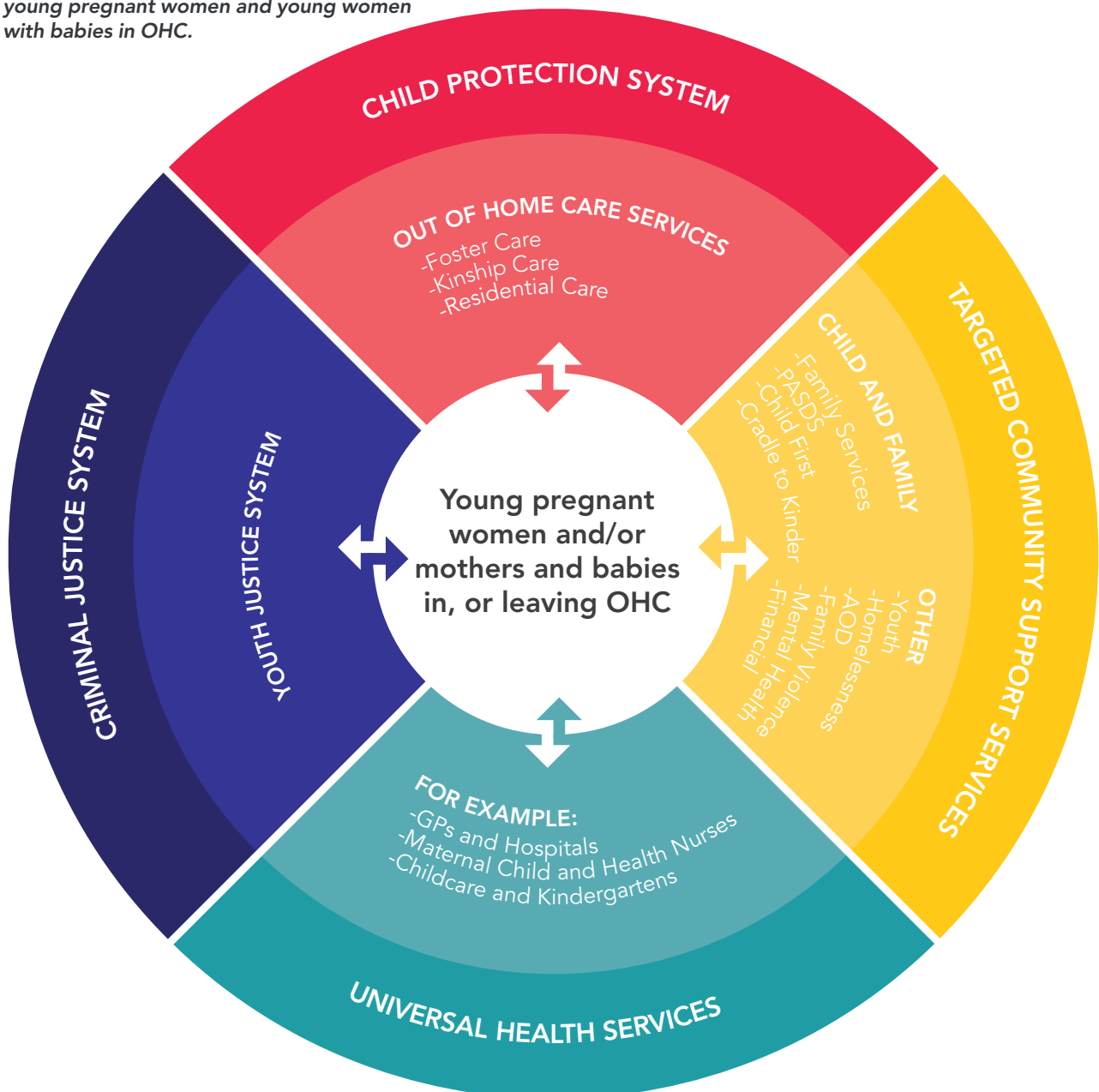
This report provides a starting point for discussions about residential models for young pregnant women and young women with babies, who are in or leaving care, and where safe and appropriate, models that are also inclusive of their partners. The report begins by providing some context around the current OHC system, before moving on to a brief review of the literature on early parenthood among disadvantaged young people, including those who have experienced OHC placements. This is followed by a brief overview of the existing family services programs and supports that are available for young women in Victoria. The results of an exploratory qualitative study are then presented, followed by a discussion of the main issues raised by interviewees, and the recommendations drawn from these analyses.

OUT OF HOME CARE: AN OVERVIEW

A child or young person's experience of care occurs in the context of government, community and universal service systems (see Figure 1). These include:

- The Child Protection system that manages investigations, assessments, removals, OHC placements and ongoing case management for children and young people at risk of experiencing harm and neglect
- The community service sector, which provides OHC placement programs and a range of family and parenting support interventions (both mandated and voluntary). The community service sector also provides a range of other complementary supports targeted to at-risk or vulnerable communities, such as youth, homelessness, mental health, drug and alcohol, education, employment and financial hardship services.
- The Youth Justice system, including community supervision and detention
- Universal Health Services, such as the post and pre-natal care available to pregnant women, families and babies through GPs, hospitals, maternal child health nurses and child care centres.

Figure 1: Systems and services impacting young pregnant women and young women with babies in OHC.



TYPES OF OUT OF HOME CARE SERVICES

In Victoria, the Department of Health and Human Services (DHHS)² contract community service organisations (CSOs) to deliver OHC programs in three main care environments: foster care, residential care and kinship care.

Foster care. Between 2012 and 2013 there were 1,531 foster care households in Victoria. Of these, 28% provided care and support for more than one child (Australian Institute of Health and Welfare (AIHW), 2014). Children and young people in foster care may experience more than one placement, due to placement breakdowns and changes in the foster carer's personal circumstances. Placements may also be at some distance from the pre-care community and involve the breakup of sibling groups (Department of Human Services (DHS), 2012).

In parallel with normative parenting activities, the foster carer role involves maintaining a professional relationship with the CSO through attending care meetings and training, completing tasks involved in providing care, communicating information about the child's progress (and any apparent concerns), and initiating and maintaining positive interactions with the child's family and social networks.

Residential care. In Victoria, the DHHS funds both non-therapeutic and therapeutic models of residential care. Residential care programs provide both short and long term accommodation and support in houses for approximately four children and young people at any one time. Care is provided by paid staff, and as with foster care, placement can be geographically distant from the child or young person's family.

Residential care is understood to be the most complex placement environment, with the highest level of risk. This results from the children and young people's extreme level of need being expressed through challenging behaviours such as, "self-harm, aggressive/sexualised behaviours, substance abuse, and behaviours that place themselves and others at risk" (Victorian Auditor General, 2014, pgs. ix-x).

According to multiple independent reports the residential care system in Victoria is experiencing a range of complex challenges that are undermining care outcomes, including safety and positive development. Recent reviews by the Commission for Children and Young People (2015) and the Victorian Auditor General (2014) have specifically identified that the residential care system is operating at over capacity, has poor performance monitoring processes, lacks sufficient staff expertise, and in many instances is unable to adequately meet the needs of children and young people.

Kinship care. Kinship care, where the child is generally placed with a family member such as a grandparent, or a close and trusted community member, is the fastest growing form of OHC in Australia (Paxman, 2006; Smyth & Eardley, 2008).

While there are a number of positive factors linked to the increase in kinship care, including the preservation of family identity and culture, and a reduction in the trauma of separation, it is widely acknowledged that the unregulated and unsupported nature of these placements is problematic. Specifically, the growth in kinship care is associated with an increase in the number of children and young people being placed in OHC more generally, the difficulty associated with attracting and retaining foster carers, and the fact that kinship care placements in their current form represent the least expensive and resource intensive placement option from the perspective of Government (Victorian Auditor General, 2014; Boetto, 2010).

² At the time of writing the 'Department' had been rebranded, from the Department of Human Services (DHS) to the Department of Health and Human Services (DHHS). Some of the references throughout this report were produced under the previous departmental name.

PREGNANCY, BIRTH AND YOUNG MOTHERS IN, AND LEAVING OHC

Research into factors contributing to young women becoming pregnant in care, and the experiences of young women with babies in and leaving care, is limited both nationally (Mendes, 2009) and internationally (Chase, Maxwell, Knight & Aggleton, 2006; King, Putnam-Hornstein, Cederbaum & Needell 2014; Moore, 2012; Putnam-Hornstein & King, 2014) by a lack of data on the number of pregnancies and births among this population.

In response to the lack of prevalence data, King et al (2014) developed a method of data collection which matches a child or young person's Child Protection records with their birth records. This method was used in California to investigate birth rates for 15-17 year old girls in foster care from 2006 to 2010. The results showed that the birth rate was slightly higher in the foster care population compared to the general population (3.2/100 compared to 2.0/100), with these young women representing 3.5% of the foster care population in that state (King et al., 2014).

In a second study utilising this linked-records methodology, Putnam-Hornstein and King (2014) investigated the rates of first and repeat births among 17 year old girls placed in foster care in California between 2003 and 2007 (n= 20,222). Results showed that 11.4% had given birth prior to turning 18 years of age, 19% prior to turning 19 years of age, and 28.1%, prior to turning 20 years of age.

However, in Australia the main statistics collected through the Child Protection National Minimum Dataset (CP NMDS), and analysed by the AIHW, do not include information about the number of pregnancies or births occurring in the in OHC population. Nor, after an extensive search of the literature, has prevalence data at a whole of population level been found nationally, or for specific states or territories.

FACTORS CONTRIBUTING TO EARLY PARENTHOOD IN OHC

The likelihood of teenage pregnancy and early parenthood occurring in the general population has been conceptualised as existing on a continuum of risk that arises from a child or young person's individual life experiences, family circumstances, community and social relationships, and personal characteristics (Faber, 2014). Poverty and economic disadvantage are also seen as major contributing factors. The outcomes for pregnant teenagers and early parents often include long term isolation, disengagement from schooling, and unemployment (Basch, 2011; Faber, 2014; Putnam-Hornstein & King, 2014).

Young women in OHC form a particularly high risk subset of pregnant young women and mothers due to the compounding effects of experiences trauma, poor performance at school, acting out distress through challenging behaviours, insecure attachment styles, and exposure to negative peer pressure (Saewyc, 2000; Faber, 2014). Pre-care experiences of abuse and neglect, and the young person's often limited understanding of relationships and sexuality have been shown to be major factors that increase the risk of unwanted sexual experiences, early intercourse and pregnancy (Carpenter, Clyman, Davidson & Steiner 2001; Mendes, 2009).

These risk factors are further compacted by in-care experiences, such as the existence of highly sexualised behaviours (Carpenter et al., 2001), a lack of sexual health education in OHC due to the attitudes of individual carers, an assumption that schools will provide this information, and a lack of staff and/or care giver training (Constantine, Jerman, & Constantine 2009). In-care experiences that contribute to the risk of pregnancy in care leavers have also been identified as multiple placements, poor quality caregivers, high mobility between schools, and a lack of continuity with case managers (Mendes, 2009).

Experiences such as multiple placements and insecure attachment styles may lead young women to perceive pregnancy and parenthood as a way of seeking a stable relationship and an avenue for unconditional love (Faber, 2014). Early pregnancy has also been identified as providing young people with a sense of choice and control (Saewyc, 2000; Moore, 2012), and a potential source of healing from past experiences (Pryce & Samuels, 2010). From the perspective

of the eight adolescents in foster care who were interviewed in the Saewyc (2000) study, pregnancy was viewed as a positive experience, providing young women with a chance to mature and settle down, be loved and not abandoned, and to access support services that may not have otherwise been available to them.

Related to the perceived positive experience of pregnancy and early parenting, is the impact of the pregnancy on the projected life course of the young person. For young women in OHC, whose future outcomes after leaving care can encompass poor physical and mental health, disengagement from educational opportunities, unemployment, substance abuse and homelessness (Saewyc, 2000; Faber, 2014) an early pregnancy may offer a meaningful way forward. This is supported by Barn & Mantovani (2007), whose study of 55 young mothers leaving care indicated that, although their pregnancy was unplanned, young women had chosen to keep their child. This stands in contrast to the largely negative impact that pregnancy in adolescence or early adulthood is perceived to have for young women across the general population.

THE ROLE AND INVOLVEMENT OF FATHERS

In the United Nations report (2011) 'Men in Families: Family Policy in a Changing World' attention is drawn to the changing role of fathers from primarily protectors and providers, to now encompassing caregiving and the provision of emotional support to their children. This is highlighted in recent policy shifts around paternity leave, and documents such as the Convention on the Rights of the Child, which states that, "laws and policies must ensure that children are protected and cared for by both parents, including under conditions of adoption, fostering, custody and maintenance" (United Nations, 1989, pg. 3).

The report also identifies that one of the major issues for men is separation from their children, noting that despite difficulties in the relationship with the mother, fathers are initiating and attempting to maintain contact with their children and, "may need support when they are met with difficulty in fulfilling their aspirations in this regard" (United Nations, 2011, pg.5).

Contextual factors which lead to the disengagement of fathers include an inability to support the mother and baby through lack of income, safety concerns due to prior experiences of substance abuse and/or domestic violence, and a lack of connection to mainstream supports (Wilkinson, Magora, Garcia, & Khurana, 2013). Although the current project has a primary focus on young women in or leaving care, it also seeks to explore practitioners' experiences of working with the fathers of the babies born to these young women.

FAMILY AND PARENTING SUPPORT SERVICES

As previously indicated in Figure 1 (Page 8), there are a range of community-based services available to families at risk of involvement with the Child Protection System. These include mandated family support services as directed by the Courts and Child Protection, family support interventions targeted to vulnerable families and children where engagement is voluntary, and universal services targeted to the wider community, such as maternal child and health nurse services and play groups. Few services however are specifically targeted at young pregnant women and mothers in, or leaving care, despite their perceived heightened vulnerability. It therefore remains unclear whether the current system can effectively and appropriately support this group of the OHC population.

The following provides a brief summary of some of the early parenting and family support services that may be available to this cohort of young pregnant and young mothers in and/or exiting care:

- Residential 'Parenting Assessment and Skill Development Services' (PASDS). PASDS works with families where there is generally a high level of risk. There are nine state-funded residential PASDS operating across Victoria. There is both an intensive ten day program for high-risk families referred by Child Protection, and a five day voluntary program for families in need of more general support. In the ten day program, parenting capacity and child development is continually supported and assessed, and a report provided to Child Protection and the Children's Court of Victoria, including recommendations regarding parental capacity. The program also provides intensive and strengths-based parenting support and skill development to the young parents, in particular as a means of preventing entry into statutory OHC. In contrast, the five day residential program provides a less intensive parenting service, with an emphasis on building parenting skills and family resilience, and supporting parents to work on identified issues and infant care challenges.
- In Victoria, a range of family support programs are delivered by CSOs which provide a combination of parenting education, case management, emotional support, and material and practical assistance consistent with the needs of children and families. Access and referrals are co-ordinated through centralised 'Child First' community intake and assessment teams. Programs typically work with families who have some contact with Child Protection. Service engagement may be intensive, long term or short term, and will largely have a focus on family stabilisation, family strengths and independence, prevention of child removal into care, support for reunification, and in many cases early intervention. Program examples include broad-based 'Integrated Family Services', and more targeted programs such as 'Families First', 'Stronger Families', 'Cradle to Kinder (C2K)', 'Parenting Plus', the home-based PASDS program, and local innovations for young parents such as 'Hey Babe', 'Starting Out', 'Cara House', 'The Lighthouse Foundation's Mums and Bubs' program and Anglicare Victoria's 'Choices' program.
- For young pregnant women and mothers in, or leaving care, the state-funded 'Cradle to Kinder' (C2K) program is of particular relevance, as women in OHC are one of the program's key target groups. C2K is funded to support young mothers and families for up to four years, and wherever possible seeks to intervene prior to, or as soon possible following the infant's birth. The program is available to mothers under 25 years of age, and the service includes: parenting education and support, case management, emotional support, assistance to attend appointments, linkages to maternal child and health services, material support, parenting interventions for other children in the family, and ongoing support with housing, study and work. A further key differentiating feature of C2K is the inclusion of a mothers'/ family group that provides opportunities for peer-to-peer support, education and infant socialisation.

AIMS AND OBJECTIVES

The *Baby and Me* project originated from the experiences of senior practitioners in Anglicare Victoria who had been involved with young women who had become pregnant, or had a baby while they were in, or leaving out of home care (OHC). In particular, the project was informed by their reflections on the support and care options available to this population of young women. As such, this is an exploratory study that aims to understand and identify the key issues, as perceived by practitioners, regarding i) the type and adequacy of the current supports available to this cohort of women and their babies, ii) the frequency with which young women in or exiting care are becoming pregnant, and iii) the development of a specialised model of residential care for young pregnant women and young women with babies, in and leaving OHC.

With respect to the development of a residential model of care, the project specifically seeks to explore:

- a) The main drivers of, and demand for such a model
- b) The factors to be considered in its design and implementation
- c) Avenues to translate knowledge into current practice in OHC.

Method

PARTICIPANTS

A convenience sample frame was utilised and recruitment occurred over a four week period. The recruitment process involved a phone call to target agencies, at which time a brief overview of the project was given, and an enquiry made asking if the organisation was willing to participate. Where a positive response was received, the organisation was asked to nominate a potential participant. Once the participant was identified an e-mail containing the Plain Language Statement and a Consent Form was sent to the nominated person.

In total, three agencies took part in the project. Across these three agencies 10 staff from eight programs were interviewed, including Anglicare Victoria services, other community service organisations, and the Lighthouse Foundation 'Mums and Bubs' program³. Permission was also sought from the Department of Health and Human Services to interview the managers from two Placement Co-ordination Units, however by the close of the interviewing period no response had been received, and the interviews were not conducted. The sample, while small, provides representation across the OHC, post-care and family services continuum. Table 1 provides additional information about the sample. All names have been changed to protect the identities of individual participants.

Table 1: Organisational characteristics of the sample.

	Organisation	Region	Program Type	Pseudonym
1	Anglicare Victoria	Northern Metro	OHC	Rebecca
2	Anglicare Victoria	Southern Metro	OHC	Kate
3	Anglicare Victoria	Western Metro	OHC transition program	Zoe
4	Anglicare Victoria	Latrobe Valley (Regional)	Cradle to Kinder PASDS (community-based)	Christina Margaret
5	Anglicare Victoria	Latrobe Valley (Regional)	OHC	Belinda
6	The Queen Elizabeth Centre	Latrobe Valley (Regional)	Cradle to Kinder	Ava Josie
7	The Queen Elizabeth Centre	Southern Metro	PASDS (residential)	Maria
8	The Lighthouse Foundation	Eastern Metro	Residential program for mothers and babies	Alex

³ The 'Mums and Bubs' program is a privately funded residential program for young pregnant women and young mothers who are either homeless or at risk of homelessness.

DATA COLLECTION

An exploratory research design was implemented which involved the collection of qualitative data through in-depth interviews. The interview schedule consisted of items developed through an inductive process that drew from an understanding of the current literature and practice in OHC. The items grouped into three main areas of enquiry:

- 1) their experiences of supporting young women and babies in this population, for example: intake, referral patterns and pathways, prevalence, support offered, service collaboration
- 2) practitioner observations regarding the situations, experiences and characteristics of the young women, for instance challenges faced and strengths exhibited
- 3) consideration of the benefits of, and key issues to be addressed in, the development of a model of residential care.

Six of the interviews were conducted with individual participants, and the remaining two involved two participants being interviewed together. The interviews were conducted by two research officers at the service location of the interviewee, in a room nominated by the latter as suitable. Interviews were audio recorded for manual transcription and analysis.

It should be noted that the responses offered by the five interviewees from the Latrobe Valley were informed by practice knowledge gleaned from their previous employment across a number of parenting and family support programs, particularly the Cradle to Kinder program.

ANALYSIS

The interviews were manually transcribed, after which each transcript was read in order to identify the main issues, perspectives and suggestions of the interviewee. Once this was completed, groupings of similar issues across interviews were identified and coded for analysis. The results are presented in three major sections. The first section provides anecdotal information about the prevalence of early parenthood in care and among young women who have exited care. The second section constitutes the main analyses, and is structured around the over-arching theme of 'strengths, challenges and needs' of the young women who become pregnant in or upon leaving care. The final section articulates the benefits and key factors or components of a residential model for young pregnant women and young women with babies, as perceived by the practitioners.

Results

THE ISSUE OF PREVALENCE

Specific prevalence rates for pregnancy and early parenthood in OHC, or among care leavers, are difficult to locate. Without a firm understanding of the scope of this issue, demonstrating the need for increased services and/or targeted supports becomes increasingly difficult. As the following indicates, interviewees across every program had direct experience with young women who had become pregnant while in care. More common, however, was the experience of working with young women who had become pregnant shortly after exiting the OHC system.

Prevalence within residential care programs

The two interviewees based in residential care described their programs as providing accommodation and support to young people. Rebecca managed four houses with 16 young people who had been referred from other OHC placements, while Kate managed six houses with 24 young people.

With respect to the question of prevalence, over the past two years Rebecca recalled two cases where a pregnancy had occurred within the placement setting. In each of these cases the young women were 15 and 16 years old respectively, at the time of conception. Kate recalled one recent emergency placement, where drug use was involved and the pregnant young woman (aged 13) was moved to a secure setting. Similarly, Ava reported another case involving a young person who was currently thought to be pregnant.

In response to the program's capacity to support the young women after the birth of the baby, interviewees indicated that the birth had ended the residential placement, due to the unsuitability of the care environment. Kate shared the following:

"the main reason why the next option like lead tenants⁴ and accommodation models are found so quickly for pregnant females is because everyone freaks out and just thinks 'oh, this is just such an unsafe environment they need to be out of there'".

In the case of the two pregnancies that occurred in the residential unit, support of the young women continued to the point of birth, after which time they and their babies were placed (following referral to the placement co-ordination unit) as follows: one, due to a high risk of homelessness, at the Lighthouse Foundation Mum's and Bub's program, and the other in a lead tenant program.

Prevalence in the post-care transition program

The post-care transition program was described as a general case management program aimed at supporting young people who had exited OHC to achieve independence. The program has the capacity to work with young people aged 18 to 21 years old for a time-limited period of three years or until the young person turns 21, whichever occurs first. Referrals are received from OHC programs within Anglicare Victoria, from other CSOs, and from the Royal Women's Hospital. A small number of young people also self-refer into the program. The program itself refers out to Cradle to Kinder. The only two provisions that are imposed by the program are that the young person lives in the North West Metropolitan area of Melbourne and is engaged with a housing worker.

The interviewee indicated that in June 2014 the program had been downsized from five to two workers. With respect to prevalence, of the 19 current clients, three were pregnant and two had children under 4 years of age. However, prior to the downsizing Zoe recalled that 10 of the 30 young women in the program were pregnant, or had a young baby.

⁴ Lead Tenant is an accommodation and support option for young people aged between 16 and 18 years, who are transitioning from the OHC system into independent living. It provides medium-term accommodation where a group of young people live together with support from volunteers.

Prevalence in early parenting support services

The majority of interviewees drew on their experience of the Cradle to Kinder (C2K) program, with the exception of one worker whose perspective related to her experience in the paediatric ward at a regional hospital. The two participants actively involved in the C2K program described C2K as able to provide support to 24 young women or families. Of these, the participants estimated that there were 10 young pregnant women, or young women with babies, who were either in, or had recently left OHC; with the youngest aged 14 at the time of her pregnancy (Ava).

Within the residential PASD service, anecdotal evidence was provided that approximately three referrals had occurred in the last month, and 10 in the past 19 months for young women in care, or leaving care. The interviewees further suggested a much higher proportion of young women referred to PASDS, potentially close to 30-40%, would have been in OHC at some point in their lives.

Prevalence within an existing residential model – the Lighthouse ‘Mums and Bubs’ program

The Lighthouse Foundation interviewee (Alex) described the overall program as consisting of 10 houses providing accommodation in the community, with a focus on the support of homeless youth. In one of these houses the ‘Mums and Bubs’ program provides residential care for three young mothers and their babies, for a period of up to three years. The program is based on establishing relationships between the young person, the baby and the live-in carers through modelling secure attachment.

The intake age range for the program is between 15 and 22 years, with an estimated average client age of 17-19 years. Although the majority of referrals come from refugees and homelessness services, self-referrals and referrals from community service organisations such as Anglicare Victoria are also accepted. The intake process involves extensive psychosocial screening, and matching the applicant to the other house occupants. Care is provided through the employment of two carers: one primary carer who sleeps over, and a secondary support carer.

With respect to prevalence, it was estimated that of the seven young women who had accessed the ‘Mums and Bubs’ program over the past two years, a high percentage were either in, or had been in OHC (although no exact figures were available).

THE STRENGTHS, NEEDS AND CHALLENGES OF YOUNG PREGNANT WOMEN AND YOUNG MOTHERS IN OR LEAVING CARE

Interviewees’ reflections on the characteristics of the young women, the situations that they encountered, and how the current system may be changed, fell into three broad areas:

- 1) The challenges encountered by these young women
- 2) The strengths they brought to their role as new mothers
- 3) The role of the father.

Challenges experienced by young mothers in or leaving care.

Within this category five interrelated issues were identified by the interviewees: lack of parenting role models, inadequate sexual health education, a poor understanding of pregnancy and unrealistic expectations regarding parenthood, barriers to engaging with services, and a general instability in placements and lifestyle. All of these issues were linked, either explicitly or implicitly to young women’s pre-care experiences, which in many cases were compounded by the instability they experienced while in care.

Lack of parenting role models. The absence of an appropriate parenting role model was identified as a major issue by the majority of participants. As Zoe stated *"a lot of them don't have family support, a lot of them at some stage have been clients of Child Protection; they haven't had that nurturing, mothering experience to then parent themselves"*. Fractured family relationships in combination with Child Protection involvement and the young women's stage of development was seen to result in:

"not understanding when to change the bottles or the feeding and you know how to get them to sleep and when to feed them and what to feed them... They are not sure, like the baby has a rash and it's like 'oh, he's had a rash for a few days' and it's like 'oh, have you taken him to the doctors. It's things like this that they are just not sure about." (Zoe)

This was perceived to undermine the young person's confidence in their parenting capacity, and to further compound their perceived inexperience particularly with respect to child development, issues that a supportive parenting role model would have the potential to address.

Both the lack of a parenting role model and compromised self-esteem were seen as factors that could precipitate the removal of a young woman's child, as indicated by Maria who stated that *"they just don't have their own parenting to fall back on, they don't have any foundation, or limited foundations, the ones I'm thinking of they also end up with a recommendation of removal."*

Inadequate sexual health education. A lack of knowledge about sexuality and sexual health was a common observation:

"the knowledge about sexual intercourse and sexual health and development - it probably isn't given to them or not enough, and so yeah, they come to the program and they have no idea, like they are 18 and they have no idea about contraception or STDs or diseases or things like that." (Zoe)

As a result, provision of education on sexuality, contraception and sexual health was identified as one way that OHC services could play a stronger early intervention and/or preventative role, as articulated by Maria:

"Yes (services can be improved) by providing sex (health and education) in residential care - with on-site workers (having) the capacity to educate, provide education on human development, not just about life skills." (Maria)

Perceptions of pregnancy and parenthood. Related to the perceived lack of parenting role models and sexual health education, interviewees indicated that the young women largely had little understanding of pregnancy, and often had unrealistic expectations of parenthood. Interviewees described that it was common for young women to engage in poor nutrition and lifestyle behaviours whilst pregnant, without understanding the impacts of these behaviours on their babies' development in-utero.

"Some of them are only eating one meal a day even though we can provide food...the understanding that what they eat does not just fuel their body, but also the baby's... and the needs of the pregnant mum - that the pregnancy actually consumes a lot of energy besides the foetus and getting them to actually even understand that." (Christina)

For Margaret, the result of this lack of understanding was seen in the number of babies being born with low birth weight:

"We have a lot of low birth weight babies and...I have just come across it in both...they're not robust and the nutrition of these young girls is quite poor...you know we had a baby born at 1700 grams, which is about half the weight of a regular baby and which should be 3000 ... a lot of these babies are born in respiratory distress and that just goes with the low birth weight and lungs not quiet developed".

For many of the respondents there was a clear relationship between a young mother's poor nutrition and their overall lifestyle. In most instances, this relationship was perceived to be exacerbated by the OHC environments, especially for young women in residential care.

"And there's the lifestyle that they you know, usually you know in residential care they're disengaged a bit from education, they substance use, absconding, the people that they hang around... don't have the most healthy of diets." (Rebecca)

The influence of environmental factors, including peer groups within residential care was further perceived to contribute to an escalation of parenting practices and behaviours that were detrimental to the young pregnant women and their babies. For example, in a group interview, Ava and Josie provided the following reflections:

"...sometimes they struggle to move away from that peer group." (Ava)

"...and they are smoking and they are chronically smoking or they are using marijuana or other drugs." (Josie).

Barriers to engaging with services. The past experiences of the young pregnant women, and young women with babies, were also identified as a significant challenge for accessing the support they needed and engaging with services. Respondents noted that having multiple workers and OHC placements can leave the young women *"quite standoffish, which is completely understandable"* (Zoe). Moreover, past experiences of their own removal often leads to feelings of mistrust and suspicion, especially of the Child Protection system.

The fear felt by some young mothers that their own babies would be removed was highlighted by Ava:

"I remember one girl saying that she hoped the hospital door would have a lock on it because she was frightened that she would go to sleep and they'd come in and... they would come in and take her baby."

A couple of respondents also indicated that past experiences were perceived as hindering the development of self-advocacy and effective decision making:

"If they've been on Child Protection orders they've been told where to live, they've been told what they have to do, these rights are very fundamental to the ability to make their own choices." (Kate)

The impact of placement instability. Placement instability was identified as a characteristic of the pathway of the pregnant young women and young women with babies in, or leaving care. While this instability is evident across the OHC system, there was a consensus that for young women in particular, pregnancy was seen as a trigger for placement breakdowns. This instability was compounded by the lack of available placements during and post-pregnancy.

"...there's no or very limited placements available in the foster care setting for mothers and their babies, and there was a Cradle [to Kinder] family that we had, and the mother said, 'I would like to just to go into a foster care placement with my baby – but of course we couldn't do it...and that will probably stay with us forever.'" (Margaret)

"The youth refuge won't take them once they've got their baby." (Belinda)

Placement breakdowns and the absence of suitable alternatives often resulted in isolation from support networks, especially those established with carers and supportive peer groups. This 'knifing off' of support networks was seen as one important factor contributing to overall poor outcomes for this group, as articulated by various respondents:

"...staff who have been their only support, they [the mothers] are then moved away from that at one of the most vulnerable times." (Josie)

"...or they move away from the peer group for the baby, for the benefit of their baby, born or unborn, and then they're isolated because they don't have many friends who aren't part of the [original] peer group." (Ava)

The complex and complicated factors that exert an influence on young pregnant women, and young women with babies in or leaving care can most clearly be seen in the following extract from Christina:

"They still might be hanging around the residential [unit] because that's where they've attached to – that's where their friends are, that's where the community is. So often, that's when they end up getting into trouble, or they are associating with inappropriate people, I suppose. And the reality is single older men do hang around residential units because they know that there are young girls there, and the young girls sort of... You know... Sort of migrate back there because that's where their connections are, but that's still where there is risk. The risk behaviours are still there. So even though they have to move out at that particular point in their pregnancy they still gravitate back there because that's what they know. And finding a foster placement for a young girl and her baby is extremely difficult – they are few and far between. So they do end up at relatives' houses. Or some of them, who have been removed from their own parents at 15 or 16 [years old] actually end up going back to their parents. So then you get a child who potentially is on an order, residing with a parent who's got... where there's an order in place, with a baby who's going to be born subject to an order, which makes it all very messy."

From the practitioners' perspectives, this cohort of young women experience multiple challenges, some that can be located in their early experiences of abuse and maltreatment, some that most closely result from the environments they have experienced while in OHC, and others that are clearly located within a system that is ill-equipped to provide the necessary supports for a group of particularly vulnerable young people. The end result is that in some instances, young women find themselves enmeshed in a system that simultaneously perceives them as in need of protection and as a potential risk to their unborn or newborn babies.

Young women's strengths

Despite the many challenges faced by young pregnant women, and young women with babies in and leaving OHC, practitioners were also quick to identify a range of strengths that these young women brought to their role as parents. These strengths clustered into three main categories, which are described below.

A desire to parent differently. Despite the absence of positive parenting role models within the young women's families of origin, practitioners identified that for some young women the desire to be better parents, or to parent their children differently was apparent.

"She was quite a high risk adolescent... I didn't know him [the father] as well, but he had been incarcerated for some really nasty offences. So really poor start in life for both of them. And they were adamant, these two, this couple... they had discussed what their baby's life was going to... this is pre-birth, they had discussed what their baby's life was going to be, what their expectations of their child was going to be. And she [the young woman] said 'I don't want my son growing up thinking that's what happens...' So sometimes the experiences they've had, you know, really makes them protective – they come out the other side so committed to not letting that happen to their own children." (Josie)

Resilience. As the statement by Josie above indicates, the 'desire to parent differently' was inextricably linked to the young women's (and often their partners') experiences of adversity, maltreatment and neglect. In this context, such a desire was also seen as further evidence of resilience – that is, their capacity to change and adapt in the face of multiple, often long-term obstacles.

"There's incredible resilience in some of these young people, incredible resilience. You know... you hear some of their stories... it's incredible that they're even getting up every morning. Some of them have a real, absolute commitment to their child and to make sure that their life is going to be better." (Ava)

"There have been times where it's been 'oh my goodness, it's just the same old, same old', but there's somebody [who] will always... there will always be a sparkling moment, and they surprise you and they will do amazing things, and you think 'oh my goodness, I'm so proud of them, they do a great job.'" (Christina)

A willingness to learn and adjust. Another strength identified by practitioners, which closely aligns to the concept of resilience, was the perceived willingness of young women to learn about, and adjust to parenthood. Kate, for example, described one young woman who became a source of support for other young, pregnant women in the program:

"One of the mums, who was having her 4th baby when she came into the program, she will come in and say 'Go to Target, everything's on special' you know, or 'Go here and get your meat'.... And they [the young mums] talk about saving, how they can save money, and so they kind of... it's coming from each other".

A willingness to learn, and the resilience to cope must be contextualised however, against the significant challenges these young women have experienced. As such, a number of practitioners highlighted that part of the young women's strength lay precisely in acts, desires and decisions that, while not quite aligned with normative expectations of parenting, nevertheless represented a palpable shift in these young women's perspectives.

"So it's their values and their decisions around what... like, 'I'm going to smoke cigarettes, but I'm not going to smoke marijuana', those types of things. And professionals, with our own values, we might think 'well, that's not ideal', but they have still thought 'ok I'm pregnant, this is a decision I have to make, what am I going to do?' And they were able to do that, and so those were real strengths." (Zoe)

The role and experience of fathers

Interviewees practising in the family services programs and the Lighthouse Foundation 'Mums and Bubs' program, also shared experiences of engaging fathers, and the importance of service flexibility for this engagement to occur:

"We're aware that for the babies, to cut the father out of the picture isn't healthy, so if the mother is wanting contact, or wanting the baby to have the support of the father, so you know if they are in a relationship or if they just want the support to have a relationship with the father, we fully support that. So we have had mums in the past in which the father can visit the home, or on weekends they can go visit the father, so there's different things that we can make flexible within the program for the father to have a relationship with the baby. But if the father doesn't have a relationship with the baby then we support that as well." (Alex)

"I think the long term thing works better for dads... like it took probably a good six months before I had a real conversation with that dad, and then I went to pick up the children from childcare one day and the mum came out and she said 'oh he [the father] said to say hello to you'. [I thought] 'that's weird - he's never done that before', and that was the start. And then when he got his licence he came here - he drove the car to say to [one of the case workers] that he had got his licence." (Margaret)

This is in contrast to interviewees' reflections on the role and experience of fathers, where either the mother, or both parents, were in OHC. Interviewees identified two major barriers to the father's participation and engagement, namely the level of parenting support and education they received, and issues around access rights. For practitioners who worked within the OHC system, supporting the father was perceived as an important, though neglected area. As Rebecca indicates below, part of the difficulty was associated with broader perceptions of risk associated with fathers, where the system was seen to consider them tangential to pregnancy, and secondary to the need to support the young pregnant woman or young mother:

"When the young women are in care they've got the baby so there's all these supports put in, all the referrals. The link to Child Protection is made for them and their unborn baby, but quite often [for] the dad, you can put a referral in for him, and even if you know the dad, [Child Protection] don't even need or want the dad's name, whereas they are just as important." (Rebecca)

Kate echoed a similar sentiment, highlighting that in some instances involving the father and understanding the role that fathers play in the lives of the young women and their children, is just as important:

"Don't leave dad out... if it's a placement of say a foster care, to recruit, train, accredit foster carers - specifically you know to support through pregnancy and birth. Then there would need to also be a clear-cut strategy if dad wants to be involved. How do we support dad in that as well without isolating him? 'Cause I think that a lot of the time it is a focus on mum and baby whereas if there's a dad ...how do we support that dad to have a great relationship with his baby?" (Kate)

An associated issue, related to the rights of fathers to have access to their children. These discussions were contextualised against a background of risk assessment and management, with the clear acknowledgement that family violence and antisocial behaviour more generally were important issues to consider when advocating for greater father involvement. Nevertheless, OHC practitioners highlighted that in many instances, fathers are routinely marginalised.

"They really have very little ability to make sure that their rights are heard, which has been really unfortunate. Both of these boys that I know that I still hear about, both have very little -one of them no contact - from when their child was born. So the same thing needs to happen with dad and if they have done the right thing up until then they need to have the same support, living environment, support workers to be able to have the ability -yeah- if they're allowed to have access over the weekend just because they are in residential care, shouldn't stop them, so they need to have a house, living arrangements that allow them to have contact [with their child]." (Rebecca)

A RESIDENTIAL MODEL FOR YOUNG PREGNANT WOMEN AND YOUNG WOMEN WITH BABIES

All interviewees were asked to consider the relative merits of developing a residential model for young pregnant women, or young women with babies in and leaving care, and to articulate the key components of such a model. This section begins with an analysis of interviewees' perceptions of the benefits that may accrue from the implementation of a residential model, followed by an analysis of the main components that such a model should include.

Specific benefits of a residential model

The provision of a model of residential care was seen to be beneficial in its ability to alleviate the isolation of young pregnant women or young women with babies. Specifically, practitioners identified the potential benefit of a community-style model, where young women could interact and form connections with, as well as learn from other young women.

"And being with others and you know that sense of community, networking, role modelling-learning from others - it's very isolating for some young people who don't have support and have a child and they're 17 [years old]." (Zoe)

Such a model was also perceived as capable of providing a secure and safe environment, grounded on the premise of continuity of care, until such a time as the young woman, or the family unit, was able to live independently.

"I think that model of a home and a secure base, for the mother/families to know... particularly the young ones we work with, that they don't, that they wouldn't only be welcome for 9 weeks or 3 months. So rather than thinking 'we can come in and we can stay here, but we can only be here for three months - gosh! What's going to happen in three months?' So I think then no matter what length of time it is, but for the families to know that someone's there to hold them at that stage." (Ava)

A residential model would also offer the potential to integrate service provision within the residential environment:

"When you break it down what we are actually trying to do is make sure that there is somebody there all the time. So in an ad hoc way [we are] currently trying to provide as much service as possible but the only way that you can do it is by bits and pieces. Because there isn't any service that's going to be able to provide all of that together outside of having a residential service." (Zoe)

"Something that could support young people you know 12 months post-birth or whatever it takes with those linkages, whether it be in a group home type of facility where you have the services come in - you have your trauma health nurse coming in, you have those people coming there to support these young people - but they get to stay there for an extended period of time 'cause with the trauma history they might be 17 chronologically but developmentally they might be 13-15 [years old]. And you could have leaving care coming in and working to support that transition but in a really planned and safe, slow manner." (Josie).

The perceived need for a residential model to support young pregnant women and young mothers in, or leaving care was continually reinforced by participants. The extended extract from Maria provides an example of how this perceived need was expressed:

"Where we are lacking right across our community is, I think, there is a need for residential services for mothers and babies and for mothers and children. There used to be those services a long time ago, as in the Canterbury family model and that kind of thing, and there used to be one in East Melbourne. They had units and you have young mothers with a baby, with a staff member present and they were available, and they [the young mothers] could have some supervision and support but they don't exist anymore. Those sorts of models don't exist, and I think there's a huge gap."

Key factors for a residential model

One of the main issues identified for consideration was the provision of a model that is explicitly trauma informed. Such a model would, for example:

- acknowledge the impact of past experiences on current parental functioning
- incorporate principles of therapeutic care and work within a continuum of care framework
- recognise that the developmental trajectories of young women are marked by significant disruption in relationships
- work from a developmental perspective, by acknowledging that chronological age is not always a strong marker of current functioning or capacity.

Further, there was recognition among practitioners that pregnancy and early parenting occur across a prolonged period, necessitating a service model that is long-term and incorporates flexible entry and exit points. The model would also emphasise the need for safe physical environments. This was seen as contrary to the current system, where housing for this cohort was viewed as extremely difficult to secure.

"Sometimes you are just at an absolute loss as to where these people could possibly be safe." (Ava)

Finally, there was agreement that a residential model should support both communal and independent living. Consistent with the ethos of therapeutic care, Christina and Margaret articulated a proposed model that would include *"a couple of units, staff 24/7, shaped in a circle with a courtyard in the middle, community rooms and garden, working towards independence. A home-type setting."*

A second area for consideration focused on the development of parenting skills. Here too, Christina and Margaret provided an indication of the type of model that would be suitable for young pregnant women and young women with children:

"Units (that) are very much [focussed on] parenting and community parenting. And parenting routines and things like that for babies and what's expected and what's not expected for a baby of a certain stage of development."

Other interviewees spoke of the provision of on-site integrated services and programs including an "outreach midwife to go into the setting." (Belinda) Ava also highlighted the importance of the following key elements: "advocacy, support, material aide, education is so important, a chance to interact and bond with other young mums to educate them about their past, their future and the child's needs...and first aid."

A third factor was the need to create an environment and processes for the engagement of fathers and babies. For example:

"A new model, two bedroom units, mother and father could both stay, interaction could happen – the father to baby relationship can be independent of mother to father relationship" (Rebecca)

"[employed qualified staff] who actually have a degree behind them, who actually understand attachment. Who understand [that] the 14 year old is going to push the boundaries." (Kate)

Participants also referred to models that had previously been available (i.e. those that they had worked in, or had knowledge of), which had the potential to inform the development of any new residential model. An example was the 'Sure Start' program:

"In the UK we have 'Sure Start'...they would put council houses on particular estates and they would provide a parenting group and there would be a massage every Tuesday and they [the young mothers] would stay and play and chat and they would have all these different baby groups that would be going on, and people would be allocated workers depending on need, others would just be coming to see people." (Christina)

The other two examples relate to two residential houses currently operating in Victoria, that could form the basis of a residential model for young pregnant women, and young women with babies in or leaving care. Kate described the following:

"A four-bed purpose built house – it has what they call a zipper unit so we use that once again for leaving care kids – kids that are getting ready [to exit from the care system]. They can cook, they have a lounge room – all that kind of stuff. I think that using those houses and environments would be great because for me if we were going to have one of our long term kids pregnant then I would advocate for them to be in that house. We would move their support staff with them and then they could be... they could have their own safe area and they could learn all of those skills but also be supported, because the reality is that the staff are there so if they don't cook a meal that night, staff are going to go 'we've cooked for you, you need to eat'. I think that would be, that could be really used as that."

Ava provided a similar example that contained elements of independent and communal or supported living:

"So the actual way that the house is set up is that it has all your living area and has four bedrooms and a staff area, and each of those bedrooms have their own ensuite and have a door, and depending on how old that young person is – when they are ready to move on the door opens up to a little living area, kitchenette and lounge area."

Some interviewees provided elaborate descriptions of potential models, as seen in the extended extract below, indicating that this is a salient issue that many have devoted considerable and thoughtful attention to.

"So it would be a transition that occurs from when we know 'ok, they are pregnant', they are in residential care. We are not going to move them to lead tenant or supported accommodation when they have this child. We are going to keep them in residential care until they are ready. We would then start the transition to the house straight away, because in a full bed residential care you can't have all these babies there. So, start the transition once they are pregnant if they want to keep the baby, and then they will build over that nine months the relationship with the staff, and they continue to have the relationship with people that have cared for them, so that the transition can have occurred before they have the baby. Then, they have moved but they are still in residential care, and they stay in residential care until they have had their assessments in hospital, the care plan has come out – that three, six and 12 month monitoring which is so important. And when things break down, they are still in residential care with those supports, so if things don't happen.... And it protects the baby a lot more too, because if things aren't happening you've got residential staff that are there for the young person who is the mum, and also for the baby. So that's what I think should happen. And that also can be a system for the dad. There's no reason why the dad can't be referred to this program as well, even if they are not with the mum, or we don't have the baby, they can move to one of these residential homes and they have, you know, every second week, you know, access arrangements happen when parents aren't together. It can happen in that home, and they can learn and be part of all of the programs in there. But it's based on being a parent, not just being a mum." (Rebecca)

Discussion and recommendations

The *Baby and Me* project sought to explore the perceived demand among practitioners in OHC and family services, for a residential model of care for young pregnant women and young women with babies in, or leaving, OHC.

Across all interviews, practitioners identified a range of challenges that these young women experience, but also various strengths that they bring to their role as mothers. Importantly, in discussing the importance of providing supports for this particularly vulnerable cohort of the OHC population, the interviewees identified a range of elements that would be important to consider when developing a residential model of care. Consistent with evidence-based practice in the sector (Connor, Melloni, Miller & Cunningham, 2002; Hawkins-Rodgers, 2007; Jackson, Frederico, Tanti & Black, 2009; Whittaker, del Valle & Holmes, 2015; however, see Knorth, Harder, Zandberg & Kendrick, 2008 for criticisms of the current state of knowledge), there was a strong emphasis on trauma-informed, therapeutically grounded models of care that can support the on-going development of mother and baby.

The emphasis on trauma-informed and therapeutic models further reflects the range of challenges young mothers in and leaving care experience. These challenges are also consistent with the broader literature on the pre-care and in-care experiences of young people with histories of abuse, maltreatment and adversity, and reflect the growing understanding of the long-term and pervasive effects of trauma. From the perspectives of the practitioners in this study, these young women are typically unprepared for motherhood, both emotionally and practically. Disrupted and fractured family relationships result in the absence of appropriate, parental role models that can help navigate the transition to motherhood. These absences are further impacted by the instability associated by OHC placements that undermines the development of positive networks of social support. Such instability can have also the unintended consequence of greater connection to peers and environments that are detrimental to the young pregnant woman/young mother.

Despite the challenges faced by these young women, there was a general sense that their strengths were apparent and could be harnessed to influence positive parenting practices. A common theme across most interviews was resilience, which manifested in a desire to be a different type of parent to what the young women had themselves experienced, and to learn and adapt to the changing circumstances associated with pregnancy. At times, these strengths coalesced into what was perceived as meaningful change, even in the face of housing instability and a lack of certainty or clarity about the future. For some young women, decisions to move away from established networks of support, in particular peer groups, was also perceived as evidence of the commitment to 'do better'. However, such 'knifing off' of negative or potentially destructive peer networks can lead to increased isolation for the young women and further disruption to their sense of place and belonging (Adley & Kina, 2014; Cashmore & Paxman, 2006; Propp et al., 2003; Samuels & Pryce, 2008).

In discussing the findings of the *Baby and Me* project, and the recommendations that follow from them, it is acknowledged that the small sample size, and the reliance on anecdotal evidence for an understanding of prevalence of young pregnant women and young women with babies in OHC, are important limitations. However, this limitation is also reflected in the broader literature where an understanding of this population can only be gleaned from qualitative studies with small samples, case studies and accounts of individual experience (Saewyc, 2000; Mendes, 2009). Whilst this work is very valuable in understanding young women's experiences, a broader picture of the prevalence and characteristics of the population is needed in order to (a) open discussion of the needs of this cohort at a state and national level, (b) identify population trends, (c) develop policies and procedures and, (d) plan and evaluate interventions.

Moreover, the interview sample was constrained by a small number of services, selected specifically for their work with young, vulnerable women. The absence of Child Protection workers, who may have provided different insights into their experiences of working with young pregnant women, and young women with babies, in and leaving care, also needs to be considered.

Within this wider context the issues identified from the practice experience of the interviewees are consistent with the broader literature. Our data suggest avenues for further research, areas of adjustment for current practice, and key factors to be considered in the development of a residential model of care. The results of interviews with practitioners specifically pointed to a number of practice modifications that can be implemented in existing OHC practice, with little cost to agencies. These are described below, along with a set of recommendations.

ADJUSTING CURRENT PRACTICE

In the current study the interplay of experiences such as the lack of parenting role models and appropriate sexual health education in OHC, and misperceptions concerning the reality of pregnancy and parenthood, create a context which may both predispose the young women to, and/or precipitate pregnancy.

With regard to the young women's lack of understanding of sexual health, contraception, conception and pregnancy (an issue identified in the wider research; see Carpenter et.al 2001: Mendes, 2009) there is a potential positive role for early intervention and prevention in current practice. This would involve the provision of education to young people, staff and care providers in OHC and may also contribute to the prevention of repeat, unplanned pregnancies. The following recommendations are made with respect to addressing this issue.

Recommendation 1a. That training in the areas of understanding relationships, sexual health, contraception and conception be routinely provided to all residential, foster and kinship carers, and OHC case managers.

Recommendation 1b. That as per the above, all children and young people in care receive respectful, age and developmentally appropriate sexual health education and information to strengthen their understanding of their own development, and their capacity to make healthy, informed and safe choices.

Related to the occurrence of early pregnancy, are the subsequent challenges of the lack of appropriate parenting role models, unrealistic perceptions of parenting, engagement with negative adolescent peer groups, and fear of the Child Protection system. In consideration of current practices in OHC, and in the development of a model of residential care, the following recommendations are made:

Recommendation 2a: That holistic and comprehensive care planning occurs as early as possible once it is identified that a young woman in, or leaving OHC has become pregnant. This must include:

- Supporting the mother (and the father where appropriate) to become settled in an appropriate supported placement prior to the birth of the baby. This requires strong early planning and availability of dedicated resources.
- Provision of antenatal and ongoing parenting education and support, particularly in the child's first year of development when parental need and infant risk are potentially greatest. Antenatal education should include information about nutrition, lifestyle, alcohol and drugs, and safety during pregnancy, infant and child development, first aid, key parenting skills/life skills and how to access support. This may incorporate presentations from within the peer group of young mothers, and should be provided to fathers where appropriate.

Recommendation 2b: That parenting peer support groups, specifically designed to support young pregnant women, and young women with babies in, and leaving care are provided from the beginning of the third trimester of their pregnancy.

Recommendation 2c: That a series of focus groups involving young people in OHC, Child Protection workers, DHHS, care givers and CSO staff are conducted in order to research and inform strategies to address the perceived level of fear of these young women, in particular with respect to engaging with services.

The strengths identified among these young women such as the desire to parent differently, their resilience, willingness to learn, and the love of their babies, is in keeping with the research of Saewyc (2000), Barn and Mantovani (2007) and Faber (2014). Such strengths provide positive means of engaging young women in programs, groups and training, consistent with recommendations 2a, 2b and 2c.

With respect to the role of fathers, the issues of access to their babies and their engagement with the parenting process, are similar to those identified by Wilkinson et al. (2013). These are areas that can be addressed in the immediate future, through policy development, research, and the integration of further research findings into current practice.

Recommendation 3: That further research is undertaken in Victoria concerning fathers in care, such as their perceptions, expectations and experiences of parenting, and the access they have to their children.

Recommendation 3a: That the research with fathers detailed above be shared with DHHS and other CSOs, to inform discussion and greater awareness of the role and needs of all parents in care.

KEY FACTORS IN THE DEVELOPMENT OF A RESIDENTIAL CARE MODEL

There was a perceived need for a targeted residential model of care for this cohort of young women and babies by all practitioners.

Drawing from interviewee practice reflections, the following key features were perceived as necessary for a model of residential care:

- a) the provision of a safe and secure physical environment, that addresses the material and physical needs of the young pregnant woman, mother and baby
- b) stability of accommodation, and flexible entry and exit points which acknowledge the psychological, developmental and physical processes involved in pregnancy and the transition to motherhood, and that provide service beyond the mandated age of exiting the system at 18 years old
- c) a proactive and planned strategy for supporting the relationship between the father and the baby
- d) the provision of parenting groups, peer support and education
- e) the provision of trauma informed, therapeutic practice to assist young women to process past experiences and understand how these may be impacting on their current situation and relationships
- f) the implementation of a strengths based model that enables the young person to build their confidence and self-advocacy in engaging with services (see recommendations 2a, 2b and 2c).

Consideration of these factors indicates a similarity with the therapeutic model of residential care which is implemented in Victoria and to recent discussions on the extension of OHC to the age of 21. In order to further develop a model of care for this population of young women, it is recommended:

Recommendation 4a: That a series of wider consultations, which involve the voice of the young women, are conducted with key stakeholders (which may incorporate the above identified factors as a starting point), in order to consolidate understanding of the design, availability and feasibility of implementing a model of residential care for young pregnant women and young women with babies in, and leaving care.

Recommendation 4b: That in order to provide the research evidence needed to inform the development of policy, legislation, and the evaluation of interventions (such as the provision of a residential model of care), commitment is needed by state and national governments for the collection and provision of population level data for young women who become pregnant, and young mothers who are in, or leaving OHC.



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