BARRIERS TO SERVICE DELIVERY FOR YOUNG PREGNANT WOMEN AND MOTHERS

REPORT TO THE NATIONAL YOUTH AFFAIRS RESEARCH SCHEME (NYARS)

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THE NATIONAL YOUTH AFFAIRS RESEARCH SCHEME (NYARS) was established in 1985 as a co-operative funding arrangement between the Australian, State and Territory Governments to facilitate nationally based research into current social, political and economic factors affecting young people. NYARS operates under the auspices of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA).

NYARS reports published since the early 1990s are available free-of-charge on the website of the Australian Government department responsible for youth affairs. At the time this report was published, the website address was: http://www.facsia.gov.au/Internet/facsinternet.nsf/aboutfacs/programs/youth-nyars.htm
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# Abbreviations

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<td>ABA</td>
<td>Australian Breastfeeding Association</td>
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<tr>
<td>DOCS</td>
<td>The NSW Department of Community Services</td>
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<tr>
<td>FaCSIA</td>
<td>The Australian Government Department of Families, Community Services and Indigenous Affairs</td>
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<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
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<tr>
<td>MCEETYA</td>
<td>Ministerial Council on Education, Employment, Training and Youth Affairs</td>
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<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NYARS</td>
<td>The National Youth Affairs Research Scheme</td>
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<td>SMS</td>
<td>Short Message Services</td>
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<td>TAFE</td>
<td>College of Technical and Further Education</td>
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EXECUTIVE SUMMARY

The research project ‘Barriers to Service Delivery for Young Pregnant Women and Mothers’ commenced in June 2004. The project was awarded to the Research Centre for Gender and Health, now called the Research Centre for Gender, Health and Ageing, at the University of Newcastle by the National Youth Affairs Research Scheme (NYARS).

The following specific objectives were arrived at by taking into account the barriers identified by NYARS and past literature, and by allowing for the addition of barriers not yet identified. This project set out to:

1. Identify the covert and overt structures that exist within services that operate to prevent young women from accessing those services;

2. Identify the attitudes and beliefs that are perceived by young women to exist within services, policy, and the community and media, that deter them from accessing services;

3. Identify and describe the experiences that young women have had when accessing services;

4. Determine the barriers that service personnel perceive as acting to prevent young women from using their services;

5. Determine any specific barriers to service use that occur for women from subgroups nominated by NYARS. (The subgroups included: those who have experienced or are at risk of substance abuse; those who have been in foster care; those who have a
disability; those who come from diverse cultural/linguistic backgrounds; and those who are of Indigenous descent); and

6. Describe examples of models of best practice based on young women's experiences, and findings from current research literature.

For the purposes of this report, services were defined as being any service that could be of potential benefit to young pregnant women and mothers. Services included, but were not limited to, education services, social support (from NGO & government services, & from personal resources), health and welfare services (including government & NGO services), ante- and postnatal healthcare services (including early childhood healthcare) and other government services (e.g. Centrelink). Barriers were defined as any factor that could potentially act to prevent or deter young pregnant women and mothers from accessing or continuing to use a service. Facilitating factors were defined as those factors that could either encourage service access or overcome an identified barrier to service delivery.

Current literature pointed to a population profile of young pregnant women and mothers that included low socio-economic status, welfare dependence, low levels of secondary education, inadequate housing, depression, low self esteem, high levels of family and relationship conflict, and low social support. The reviewed literature indicated that the barriers to service provision for young pregnant women and mothers were manifested through inter-related environmental, socio-economic and psychosocial circumstances, and also pointed to some successful services, discussed later in this summary.

BARRIERS TO SERVICE PROVISION

Qualitative consultations with service providers indicated that the perceptions and expectations that young women hold about service providers underlie many of the barriers to service delivery. These perceptions are informed by fear, low self confidence, the expectation of being judged, and previous experience. We found that there was a fine line between providing services to young women that helped with problems existing at a population level, and being seen as making a judgement about the lives of individual young women. Where young women felt judged, they would not return to a service. Furthermore, past literature and consultations with service providers and young women indicated that many young pregnant women and mothers do not see themselves as being disadvantaged or as having ‘done the wrong thing’. Young women
often felt as though they were treated as ‘problem cases’ by policy makers, service providers and the community, which contributed to feelings of being judged and criticised.

Barriers to service delivery were classified into three main groups, described below.

1. Common barriers: Barriers that were common across service types for all young pregnant women and mothers included a lack of knowledge, literacy problems, structural barriers (e.g. lack of Medicare cards & bulk billing, insurance coverage, age limits), cost, transport, moving to a new area, characteristics of local neighbourhoods that discouraged service access, a lack of time or routine, previous negative experiences with service providers, and a lack of social and family support. A lack of available services constituted a major barrier, since the absence of a service necessarily means that the service will not be accessible. Supported accommodation and housing were specifically mentioned by participants as being unavailable, with child care also being scarce in some areas.

2. Barriers specific to particular services: Government and housing services were criticised for overly complex systems and forms. Barriers to secondary education included expulsion for behavioural and other problems, a lack of transport and/or child care, low social support, expenses, and a lack of motivation. Tertiary education was difficult for young women when the service delivery methods were inflexible or inconveniently located. Women’s attitudes to child care prevented some young women from using the service, for fear of being seen as a ‘bad mother’. Cost and local availability were other barriers to child care. Barriers to the use of early childhood health centres included feeling uncomfortable near older mothers in waiting rooms and finding individual nurses to be ‘too bossy’ and ‘judgemental’; in addition to feeling as though the service was unnecessary. Mothers’ support and play groups were not attended when young women feared joining a group where they knew no one or feared being the only young mother in the group, and where they had transport difficulties.

3. Vulnerable subgroups: Women from culturally and linguistically diverse backgrounds experienced barriers to service delivery that included language, legal obstacles, a lack of services that were equipped to provide for the needs of specific cultures and religions, social isolation, and cultural conflict between young women and their family. Our findings for young Indigenous women were limited, but barriers to service delivery were found to include a judgemental attitude, a lack of individualised service, a lack of family orientation, no Indigenous centres, a lack of counsellors, social workers and Indigenous health workers, and poor word of mouth.
Women with mental health and/or substance use problems, and/or intellectual disabilities were found to be in need of a multitude of services, and yet were the least likely to have consistently used services. Available services were not generally designed to cope with young parenting women with these issues, with one exception being the Red Cross program for young parenting women with substance use and/or mental health problems. Young women with these issues ‘slipped through the cracks’ because they did not fit the criteria for inclusion in services, because services were unable to cater for their diverse needs, or because their problems were a danger to other people who used the service. According to providers, young women who had lived in state care stopped using services because over the years they had become ‘fed-up’. One important point raised by providers was the lack of a parenting role model in these young women’s lives, leaving them without a template for parenting. Young women who experienced abuse faced potential homelessness, and were also prone to mental health problems. Barriers to service delivery included a fear of being found by violent family members and some services’ inability to accept young women with violence issues.

Multiple vulnerabilities acted to exclude some women from specific services and young women in these positions were particularly prone to ‘falling through the cracks’ and becoming disconnected not only from services, but from mainstream society. In addition, some vulnerabilities involved a high risk of losing custody of children, due to an inability to cope and a lack of support structures that might enable coping.

Barriers occurred in complex relationships with each other that could become self-perpetuating. The more barriers a young woman faced, and/or the more vulnerabilities that she experienced, the more difficult it was for her to access services, and the more difficult it would be for service providers to accommodate her needs.

FACILITATORS OF SERVICE PROVISION

Facilitators of service delivery to young pregnant women and mothers were also identified. The relationship between young women and their service providers was perhaps the most important aspect of service delivery. Positive relationships with service providers occurred where young women perceived that they were listened to, that the provider was warm and friendly, where they were remembered by name, where they had received praise for some aspect of their parenting or lifestyle, where they felt that providers were not judgemental, and where they felt they were respected. Because
most young women do attend birthing healthcare, providers of those services were found to be in the ideal position to provide information to young pregnant women and mothers about other services.

Facilitators were classified according to the barriers that they overcame, using the same three classifications as used above.

1. Facilitators that overcame common barriers included:
   - The provision of knowledge by:
     - trusted service providers;
     - word of mouth;
     - the internet;
     - Short Message Service (SMS or text messaging) by service providers;
     - inter-service referrals, facilitated by service networking;
     - high visibility within the community;
   - Literacy classes held by trusted service providers;
   - Assistance with procedures and forms provided by an advocate, support worker or service personnel;
   - Service networking that overcame barriers to healthcare delivery (e.g. no Medicare card);
   - Peer support programs that assisted with social support and overcame some age limits;
   - Free services;
   - Provision of free transport and/or free parking;
   - Home visits that overcame travel and psychosocial barriers to attending clinics;
   - Drop-in centres; and
   - Social and family support.

2. Facilitators of service delivery specific to particular services: Government services were facilitated by knowledgeable providers who had the ability to explain to young women how the system worked and by the provision of bulletins from Centrelink that explained recent system changes. However, not all services were in receipt
of these bulletins. Secondary education was best delivered by specific in-school programs that provided child care, social support and a supportive environment. Flexibility was key to successful tertiary and vocational education, including distance education, outreach courses and night courses. Classes in parenting, leisure, and basic life skills were successfully held by service providers who had a positive relationship with young women, and where the young women were consulted about the content of such classes. Where young women had social support or had heard of an early childhood nursing service or group beforehand, fears were overcome. Some young women preferred to use early childhood health nurse services offered by their local chemist, as this was seen as less intimidating. Home visits were also helpful in this regard. Group facilitators had found it useful to visit young pregnant women and mothers while they were in hospital. To enable pre-group meetings, service providers had networked with other service providers and gained their support.

3. Vulnerable subgroups: It was noteworthy that very few facilitating factors were mentioned by service providers for the women who belonged to one or more of the vulnerable subgroups. A number of suggestions were made, which were included in the recommendations. However, none of these suggestions came from actual experience. Language barriers were overcome by the provision of information in languages other than English, and the availability of translators and interpreters. Some antenatal classes were conducted in languages other than English, although these were not common. Service providers had facilitated health service access for young pregnant women and mothers without Medicare cards or financial support by securing charity funding, and by liaising with local health services to allow spaces for young pregnant women and mothers who were unable to pay. A key to successful service delivery for young pregnant women and mothers from other cultures was the presence of a service worker who was of the same culture, usually from a multicultural support service. This helped young women to become less isolated and to become better acquainted with other services. Successful service delivery in Indigenous communities included consultation with individual communities, the presence of Indigenous health workers and specific Indigenous health centres, a family orientation and good understanding of local culture.

Facilitating factors were found to be more successful when more of the factors were present. Just as some barriers form cycles that perpetuate young women’s isolation, so service facilitators act cyclically to encourage young women to become less isolated and more supported. For example, a young woman with a positive relationship with a service provider will be more open to using other services, the more services she uses the less isolated and more supported she becomes.
BEST PRACTICE

Taken together, the literature, barriers and facilitators of service delivery, indicated that by far the most striking aspect of successful service delivery was the relationship between the young woman and her service providers. A trusting relationship overcame various barriers that were inherent to many young women, including fear born of low self confidence. In addition, young women did not feel stigmatised when attending targeted interventions as long as they felt respected and consulted.

Best practice, then, must include the elements that will lead to a strong positive relationship with a service provider. These include:

- Non-judgemental attitudes;
- Active listening;
- Knowledge of the young woman and her circumstances;
- Warmth and friendliness;
- Appreciation (praise) for young women’s parenting ability;
- Respect;
- Providing accurate information;
- Explaining procedures;
- Continuity of care wherever possible;
- Confidentiality; and
- Smiling.

However in order to form a relationship with service providers, a young woman must first come into contact with a service. Young women were found to experience a great deal of difficulty with the ‘first visit’ to any service. Facilitators of a first visit included:

- Previous meetings with the provider;
- The presence or recommendation of a family member or friend;
- The recommendation of a trusted service provider, including information about:
  - what the service has to offer;
where it is held;

• when it is held; and

• Freely available information about the service.

Since the most commonly mentioned practical barrier to service delivery was a lack of knowledge about available services, pregnancy and childbirth healthcare providers are best placed to provide information to young women about other services. The provision of information about other services was best facilitated by inter-service networking which in turn was facilitated by:

• A physical space in which to meet;

• A focal point for contact (e.g. referral centre);

• Regular meetings between service providers;

• Willingness of service managers to release staff for inter-service meetings;

• Having time available for networking;

• Willingness of providers to work collaboratively; and

• Inclusion of services from many different service types, including services that were and were not exclusively available to young pregnant women and mothers.

Models of best practice included a ‘one stop shop’ that included group support, classes, referral and drop-in services for young women and a focal point for local service networking; peer support programs that decreased social isolation and increased confidence among young women; healthcare services; an integrated home visiting service for multiple types of service; and education programs. The elements of best practice for young women in one or more of the vulnerable subgroups are best summarised by noting that services that take account of the complexity of these young women’s lives at an individual level would be appropriate. We did not recommend a single model for young women in the vulnerable subgroups because these young women were particularly prone to falling through the cracks of generic service delivery models.
RECOMMENDATIONS

Based on the research findings the following recommendations were made:

1. **That the facilitating factors of a strong positive relationship with young pregnant women and mothers be distributed to service providers across a wide range of services, particularly those that do not offer services exclusively to young pregnant women and mothers.**

2. **That service networking be encouraged at a community level across all relevant services.**

3. **That consideration be given to the conduct of a scoping project to quantify the nature and extent of services that are available to young pregnant women and mothers.**

4. **That the feasibility of introducing more ‘one stop shops’ be examined.**

5. **That the feasibility of providing an information booklet to all women (including those over 25) who give birth be examined.** The booklet should be available in plain English and in other languages common to the areas in question, and should include contact details and a brief summary of the service and should include local support groups, mothers’ groups, playgroups, child care, education, multicultural, Indigenous, and health services, emergency services, national services (e.g. domestic violence hotline, Lifeline) and useful internet sites.

6. **That the use of communications technology (eg. SMS, internet) be exploited by service providers wherever feasible in order to advertise services and communicate with young pregnant women and mothers.**

7. **That review of the written information, including information available on the internet, that is currently available from government and non-government services.** While many of the forms and information pamphlets have been improved over the past decade, it appears that the complexity of rules and regulations surrounding support benefits and housing are still confusing for people with literacy problems.

8. **That a set of best practice principles for working with young pregnant women and mothers be developed and implemented.** The providers of government services where young women had positive experiences with prompt, respectful and informative service are to be complimented on their professionalism and courtesy. However, some individual government services were criticised.
9. That firstly, any government service information bulletins be advertised more widely, so that providers are aware of their existence and able to access them. Secondly, that a method of simplifying the government financial assistance systems be explored and thirdly, that information delivery about entitlements be simplified.

10. The provision of universal follow-up care that includes home visits, telephone calls and SMS which would be useful for young women who have little or no family support, including women from the vulnerable subgroups.

11. That existing service providers, particularly those who facilitate support groups, be encouraged to introduce formal peer support programs.

12. That services be funded to include the provision of transport and child care to young pregnant women and mothers, without the need for assets or income tests.

13. That the feasibility of introducing specialised in-school programs for young pregnant women and mothers into more schools be examined and that child care and support workers be made more readily available to alternative education providers who offer services that are of potential benefit to young pregnant women and mothers.

14. That cultural sensitivity training be introduced to services where this is not currently conducted. In addition, we recommend that multicultural services be made known to women from culturally and linguistically diverse backgrounds during their antenatal and birthing care, where this is not already routinely done. Further, we recommend that services endeavour to supply written material in languages (other than English) that are common to their areas.

15. That future research be conducted by and within individual Aboriginal and Torres Strait Islander communities. However, we would like to acknowledge that some Indigenous communities might consider that sufficient research has been carried out within their community. Therefore, this recommendation is made with the caveat that further research should only occur in communities where the research is assessed by the community as being of potential benefit to the community concerned. The results that pertain to Indigenous women included in this report are of a limited nature, and more research in this area is required, given the poor outcomes for young pregnant women and mothers who are of Aboriginal or Torres Strait Islander descent. Aboriginal and Torres Strait Islander communities are diverse and research needs to be designed by the people concerned in a manner that is suitable for the individual community culture. It is
therefore recommended that research funds be made available at a community level to those communities who see a need for such research to enable community members to ascertain the level and types of need that exist within their individual communities among young pregnant women and mothers.

16. That further research be conducted into the situations of young pregnant women and mothers who have mental health problems, substance use problems and/or intellectual disabilities.

17. That young women with mental health, intellectual disabilities and substance use problems have a single point of entry into a care based system that would then cater for their individual needs. Important in this system was the provision of a single caseworker who would oversee the care of the woman, coordinate services, and where appropriate, facilitate a positive, supportive relationship between the young woman and her family. In addition to recommendations 10 and 16, we recommend that a program that includes these elements is pilot tested for efficacy.
1. INTRODUCTION

The research project ‘Barriers to Service Delivery for Young Pregnant Women and Mothers’ commenced in June 2004. The project was awarded to The Research Centre for Gender and Health, now called the Research Centre for Gender, Health and Ageing, at the University of Newcastle by the National Youth Affairs Research Scheme (NYARS).

The purpose of the research was to determine the barriers to service use experienced by pregnant women and mothers aged less than 25 years. By using qualitative research methods, the project aimed to meet the aims as specified by NYARS, namely to:

- Identify and describe the issues that young pregnant women and mothers experience, including women from nominated sub-groups (i.e. young women who have experienced or are at risk of substance use and/or who have been in foster care and/or have a disability and/or come from diverse cultural/linguistic backgrounds, and young women of Aboriginal or Torres Strait Islander descent);

- Explore a range of related issues which have a critical impact on the well-being and quality of life experienced by young mothers and their children; and

- Document examples of best practice in socially inclusive and responsive policy initiatives and service delivery models for young pregnant women and mothers.

Underutilisation of services can affect women’s ability to access income support, employment and training opportunities, education, healthcare (including ante- & postnatal care), and child care. Services offered to young women have the potential to improve health and social outcomes for both mothers and their babies. However, as
pointed out by NYARS, the services need to be accessed in order to be able to provide young women with these benefits. This research project identified the services that appear to be most relevant to positive outcomes for young pregnant women and mothers. These included: education services, social support (from NGO & government services, & from personal resources), health and welfare services (including government & NGO services), ante- and postnatal healthcare services (including early childhood healthcare) and other government services (e.g. Centrelink).

NYARS identified a number of factors that might contribute to the underutilisation of services by young women who are pregnant, or who are mothers. These included covert and overt attitudes, beliefs, and assumptions of policymakers, service providers and society, the philosophical and religious bases of some community organisations and an absence of economic and cultural support. Cultural and language barriers were also nominated by NYARS, as were practical constraints such as mobility, social support and the availability of services. In addition, NYARS expected that a lack of maturity, psychosocial need and fear might prevent young pregnant women and mothers from accessing some services.

An initial search of the literature by the researchers identified a number of other service access barriers for young pregnant women and mothers in the United States (US) (Kinsman and Slap 1992; Cartwright, McLaughlin et al. 1993; Rhodes, Fischer et al. 1993; Perloff and Jaffee 1999) and Australia (Bull, Hemmings et al. 1997; Combes and Hinton 2005) including:

- Living in a ‘distressed’ neighbourhood (higher crime rates, lower socio-economic status);
- Living in a rural Australian area;
- Having a perception that services will cost money;
- Having a low level of social support;
- Having experienced sexual victimisation;
- Having health insurance (US);
- A negative perception of medical staff;
- Lack of clarity about available services;
- Lack of comfort in attending clinics where older women were present; and
- Concealment of pregnancy due to fear about telling family members.
However, both NYARS and the researchers noted a lack of current Australian research that specifically examined the barriers to service delivery experienced by young pregnant women and mothers from the perspective of the service workers or from the perspective of the young women themselves.

1.1 PROJECT OBJECTIVES

The following specific objectives were arrived at by taking into account the barriers identified by NYARS and past literature, and by allowing for the addition of barriers not yet identified. This project set out to:

1. Identify the covert and overt structures that exist within services that operate to prevent young women from accessing those services;

2. Identify the attitudes and beliefs that are perceived by young women to exist within services, policy, and the community and media that deter them from accessing services;

3. Identify and describe the experiences that young women have had when accessing services;

4. Determine the barriers that service personnel perceive as acting to prevent young women from using their services;

5. Determine any specific barriers to service use that occur for women from subgroups nominated by NYARS; and

6. Describe examples of models of best practice based on young women's experiences, and findings from current research literature.

1.2 POLICY CONTEXT

The purpose of NYARS is to provide the Australian, State and Territory Governments with nationally-based research to inform the development and implementation of policies and programs for young people. This project was commissioned by NYARS to fill a gap in current knowledge about the barriers to service delivery that exist for young pregnant women and mothers.
NYARS operates under the auspices of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA). A key stakeholder in this project was therefore MCEETYA. Other stakeholders identified by NYARS included Australian, State and Territory agencies developing policy and programs related to young people; the National Aboriginal Community Controlled Health Organisation (NACCHO); social inclusion, community and government youth services; and (but not least) young mothers and fathers.

The current project aimed to assist with goals identified by MCEETYA in the Adelaide Declaration on National Goals for Schooling in the 21st Century (http://www.curriculum.edu.au/mceetya/nationalgoals/natgoals.htm ‑ top ). In particular, Goal 3 states that:

Schooling should be socially just so that:

3.6 all students have access to the high quality education necessary to enable the completion of school education to Year 12 or its vocational equivalent and that provides clear and recognised pathways to employment and further education and training.

By determining barriers to further education for young pregnant women and mothers, recommendations were developed that might assist school‑aged mothers in accessing secondary education.

MCEETYA’s national strategic policy coordination responsibilities extend beyond schooling. They also cover vocational education and training, and the linkages between employment/labour market programs and education and training. As such, identification of barriers to these services for young pregnant women and mothers could assist with policies that encourage young women to develop their skill base and improve their employment prospects. It is noteworthy that one past study of young motherhood found that paid employment, along with social support, moderated the adverse impact of stress on parenting behaviour (Uno, Florsheim et al. 1998).

By addressing issues that are pertinent to young Aboriginal and Torres Strait Islander women who are pregnant or who are mothers, the project results might assist with recommendations that could improve the accessibility of services, and the appropriateness of those services, to Aboriginal and Torres Strait Islander women. Therefore the project will contribute towards the NACCHO aim of assessing the health needs of Indigenous communities. This is particularly important, since young Indigenous women and their children have been found to experience poorer postnatal outcomes than other young Australian women and their children (Westenberg, van der Klis et al. 2002).
A significant number of programs existing at state and federal levels might be of assistance to young pregnant women and mothers. By determining access obstacles, both the outcomes for women and the efficacy of service provision could be improved. Teenage pregnancy was identified as a specific developmental problem by the Australian Government Department of Families, Community Services and Indigenous Affairs (FaCSIA) in the report entitled, 'Indicators of Social and Family Functioning'. This report also points out that the complexity of problems facing family functioning requires solutions that involve more than one service area. The current research addressed service barriers by approaching young motherhood in a holistic fashion, and by incorporating data from as many services as were willing to take part. These included educational institutions, health, community, and youth services.

1.3 YOUTH SECTOR AND YOUTH INVOLVEMENT

In accordance with guidelines provided by NYARS, the project method was subject to the involvement of and advice from youth and workers from the youth sector. The researchers are grateful for their input, which informed both the original research plan and the various alterations that were made to the method as the project progressed. As is detailed in the following chapter, initial response rates for focus groups with service providers and interviews with young women were quite low. The information, advice and assistance provided by youth sector workers and from young people who participated in the project led to the development of a variety of strategies. These variations to method allowed for the recruitment of a sufficient number of workers and young pregnant women and mothers so that the project was successfully concluded.

1.4 REPORT STRUCTURE

This report covers the project methodology, a review of relevant literature, research findings about the barriers and facilitators of service delivery, the elements of best practice, and recommendations for future service delivery. Specifically:

Chapter 2 describes the methods that were used to identify appropriate literature, and to collect information from service providers and young pregnant women and mothers.

Chapter 3 provides reviews of available overseas findings, Australian findings and summaries of identified barriers to services targeted by this report.
Chapter 4 includes the results of the current research project that pertain to barriers to service provision that were arrived at by consulting with young pregnant women and mothers and service providers.

Chapter 5 includes the results of the current research project that pertain to those factors that were found to facilitate service provision that were arrived at by consulting with young pregnant women and mothers and service providers.

Chapter 6 consolidates the conclusions reached by Chapters 3, 4 and 5 in order to present the elements of best practice that were identified by the project.

Chapter 7 offers recommendations that might assist young pregnant women and mothers in obtaining services.
2. METHODOLOGY

After reviewing the current literature, qualitative methodology was used to examine the barriers to service delivery experienced by young pregnant women and mothers. This chapter describes the scope of the literature review and then details the methods used to collect data from service providers and young pregnant women and mothers. The literature was reviewed first so that researchers were well-grounded in current practice and to ensure that participants were not subjected to redundant questions, in keeping with NYARS policy.

2.1 LITERATURE REVIEW PARAMETERS

Phase one of the literature review involved searching 16 academic databases using terms such as “teen mother”, “young mother”, “teenaged mother” or “adolescent mother”. The initial search yielded approximately 200 articles or papers that addressed the health and well-being of young pregnant women and mothers. Overall, the majority of papers concerned with young motherhood focused on adolescent or teenage pregnancy, although several articles defined ‘young motherhood’ as including women up to the age of 22 years. Papers that targeted women older than 25 years were not included in the review.

Phase two of the literature review followed feedback from the NYARS that requested inclusion of reports from non-academic sources, such as government reports. In
response, the second phase of the review included a broader internet-based search of Australian government and public policy data-bases and web sites. The qualitative study with service providers, described in the next section, led to further information about services that did not necessarily have a presence on the internet. Other comments from NYARS suggested that the literature review should also include relevant social justice and cultural issues for specific sub-groups, such as young women from culturally and linguistically diverse backgrounds, and this was also addressed.

Each phase of the search yielded important insights. For example, reports of policy and practice provide specific contextual examples of services from a grass roots perspective that is not always possible in research settings. However, these programs are often not rigorously evaluated, and if policy and practice are to be evidence-based, they must be informed by health services research. The literature review informs both researchers and policy-makers about inequalities in and within the sub-population of young pregnant women and mothers, and identifies interventions and strategies that have the potential to mitigate these differentials.

2.2 QUALITATIVE METHODS

Consultations with service providers and with young pregnant women and mothers were undertaken using a variety of methods. Originally, service providers were to be consulted in a focus group setting only, and young pregnant women and mothers were to be interviewed by telephone. However, early on in the research it became apparent that service providers faced time constraints that made it difficult for them to attend groups, and young pregnant women and mothers, especially those aged less than 20 years, were reluctant to take part in telephone interviews. While both the focus groups and interviews were conducted, additional methods were introduced to allow for the inclusion of a wider variety of service providers and young pregnant women and mothers.

2.2.1 Consultations with service providers

Service providers were invited to attend focus groups in six different areas, one in the Northern Territory and five in New South Wales\(^1\). A seventh focus group was conducted due to budgetary considerations, focus groups were not going to be held outside NSW. However, the researchers were attending a conference in the NT that was funded by another source. This allowed for a focus group to be held in this region. This was considered highly important, as the NT has the highest rate of teenage pregnancy in Australia.
at the invitation of service providers who were unable to attend any of the other groups. Focus groups were held between February and July 2005 in two rural areas, two inner urban areas, one middle urban area, one outer urban area, and one remote centre. Areas were selected for diversity in geographic locations, population size and socio-demographic characteristics. In order to make selections, distance from major cities, and coastal/inland distinctions were used to describe geographic location, population size and type (i.e. urban, rural, remote) were established, and socio-demographic characteristics were examined using Australian Bureau of Statistics 2001 Census data.

Service providers were identified by searching telephone directories, the internet, community group handbooks and information pamphlets, and by snowballing (asking service providers who responded to the invitation to invite other service providers). Personalised invitations were mailed and emailed to over 300 potential participants from health, education, non-government organisation, government, child care, youth, multicultural, English language, housing and disability support services (Service types are detailed in Appendix A).

Prior to the focus groups, all providers who could be contacted by telephone were called to ascertain the level of interest in attending the group. During this process, it became apparent that many providers who were interested in taking part would be unable to attend groups due to time constraints. These providers were offered the opportunity to submit a written response to the research questions. A total of 37 providers attended focus groups, and 20 provided written responses. Table 1 contains the details of service providers who took part in the research.

The sample of service providers was diverse, although it is noteworthy that government service providers who attended were limited to health, social work and education services. Service providers who did not attend mainly said they were unable to do so because they were unable to find the time. Problems with time appear to indicate that availability problems among service providers might form a barrier to service delivery due to a lack of available staff. This was confirmed in the focus groups and is discussed further in Chapter 4.

Participants who attended focus groups were asked questions about their experiences as providers of services to young pregnant women and mothers, the barriers and facilitators of service provision, and the role of family support in service provision. Participants who completed written submissions were asked similar questions, and all participants were asked to complete a demographic survey. Service provider study materials are provided in Appendix B. Focus groups were audio taped and transcribed verbatim, written submissions were also transcribed.
Table 1: Number of service providers who participated by area, client base, occupation, and length of time in service.

<table>
<thead>
<tr>
<th>Area</th>
<th>N</th>
<th>Client base¹</th>
<th>N</th>
<th>Occupation²</th>
<th>N</th>
<th>Time in service</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner urban</td>
<td>9</td>
<td>People with culturally &amp; linguistically diverse backgrounds</td>
<td>2</td>
<td>Family support worker</td>
<td>6</td>
<td>Less than 1 month</td>
<td>3</td>
</tr>
<tr>
<td>Mid-urban</td>
<td>4</td>
<td>People with mental health issues</td>
<td>1</td>
<td>Mental health worker</td>
<td>1</td>
<td>1-6 months</td>
<td>8</td>
</tr>
<tr>
<td>Outer urban</td>
<td>7</td>
<td>Tertiary students</td>
<td>2</td>
<td>Service manager/coordinator</td>
<td>11</td>
<td>7-12 months</td>
<td>2</td>
</tr>
<tr>
<td>Rural coastal</td>
<td>19</td>
<td>Young pregnant women/mothers only</td>
<td>8</td>
<td>Group facilitator</td>
<td>3</td>
<td>1-2 years</td>
<td>15</td>
</tr>
<tr>
<td>Rural inland</td>
<td>10</td>
<td>Youth</td>
<td>1</td>
<td>Caseworker/social worker</td>
<td>6</td>
<td>3-5 years</td>
<td>13</td>
</tr>
<tr>
<td>Remote centre</td>
<td>2</td>
<td>Children &amp; families</td>
<td>12</td>
<td>Youth worker</td>
<td>2</td>
<td>6-10 years</td>
<td>2</td>
</tr>
<tr>
<td>Missing data</td>
<td>6</td>
<td>Secondary students</td>
<td>5</td>
<td>Nurse/midwife</td>
<td>9</td>
<td>More than 10 years</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Young women (&lt;25)</td>
<td>1</td>
<td>Tertiary teacher/lecturer</td>
<td>1</td>
<td>Missing data</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Young women seeking accommodation</td>
<td>2</td>
<td>Accommodation manager</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pregnant women (all ages)</td>
<td>6</td>
<td>School counsellor</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women (all ages)</td>
<td>6</td>
<td>Visiting medical officer/GP</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>General public</td>
<td>3</td>
<td>Birth centre coordinator</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>People seeking child care</td>
<td>3</td>
<td>Ante-natal educator</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary school students/parents</td>
<td>1</td>
<td>Early childhood teacher</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Missing data</td>
<td>4</td>
<td>Missing data</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
</tr>
</tbody>
</table>

1. Many service workers provided services to clients who had multiple needs. The column denotes the primary client base of the service only.
2. Denotes primary position, however, many workers held more than one position, e.g. many caseworkers conducted support groups as part of their occupation.
2.2.2 Consultations with young pregnant women and mothers

Fourteen young pregnant women and mothers took part in in-depth telephone interviews and 93 young pregnant women and mothers took part in face to face interviews conducted in public spaces (e.g. shopping centres, ‘on the street’). It was originally planned to conduct telephone interviews only (Phase 1), however, low response rates to this technique resulted in the decision, on the advice of service workers and young women who did take part in interviews, to conduct anonymous face to face interviews (Phase 2).

Phase 1: Telephone interviews

In order to advertise the interviews to young pregnant women and mothers, posters were distributed to service providers who attended focus groups, to general practitioner surgeries, playgroups, educational institutions, libraries, child care centres, women’s health services, early childhood clinics and other public noticeboards where young women may have reason to visit. Many of the service providers who attended focus groups personally approached their clients, talked about the project and encouraged young women to take part. Some service providers offered young women child care and the use of service telephones (in private locations) to take part in the research. One general practitioner mailed information about the project to all of his patients who met the inclusion criteria, including his personal recommendation that young women take part in the project. The project was also advertised on internet discussion groups; this was the most successful method of recruiting used.

A press release was distributed to media in the areas that had been targeted for conducting focus groups. The press release was picked up by various news agencies and included articles and announcements on regional radio stations, Sydney suburban newspapers, regional newspapers and the Sun Herald newspaper. This method of recruiting was second only to internet advertising for generating enquiries from potential participants. All young women who participated were asked to pass on information about the project to anyone they knew who might be interested in taking part. However, most of the young women who took part in telephone interviews said that they did not know any mothers or pregnant women who were under 25.

Despite the wide range of recruiting methods used, only 14 young women took part in telephone interviews throughout 2005. Only one of the people contacted by service providers took part in the research. The results point to several potential barriers to service delivery, including a lack of trust in authority figures and a lack of peers among young pregnant women and mothers. These factors are discussed further in Chapter 4.
All of the women were aged over 20 years, all but one participant were living with a husband or de facto partner, and all but one participant were Australian born. Four of the participants were pregnant, and ten had already given birth to children. One of the women was of indigenous descent. Therefore, this sample should not be considered diverse. However, there was diversity in the sample with regard to economic status, education level and housing, as summarised in Table 2. It is also noteworthy that four participants were students at the time the interview took place.

Telephone interviews were audio taped and transcribed verbatim. Interviews included a demographic survey and a series of open ended questions that asked about the birth of their child, the services they had used (and those they had not), the barriers and facilitators to service delivery they had experienced, and the role of family support in accessing services. The demographic survey and interview schedule are included in Appendix C.

Table 2: Demographics of women who took part in telephone interviews

<table>
<thead>
<tr>
<th>Demographics</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sources of household income</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Wage or salary</td>
<td>11</td>
</tr>
<tr>
<td>Own business</td>
<td>4</td>
</tr>
<tr>
<td>Child Support Payments</td>
<td>1</td>
</tr>
<tr>
<td>Government Benefits</td>
<td>8</td>
</tr>
<tr>
<td>Austudy or Abstudy</td>
<td>1</td>
</tr>
<tr>
<td><strong>Income management</strong></td>
<td></td>
</tr>
<tr>
<td>Easy</td>
<td>1</td>
</tr>
<tr>
<td>Not too bad</td>
<td>1</td>
</tr>
<tr>
<td>Difficult some of the time</td>
<td>8</td>
</tr>
<tr>
<td>Difficult all of the time</td>
<td>2</td>
</tr>
<tr>
<td>Impossible</td>
<td>2</td>
</tr>
<tr>
<td><strong>Highest level of education completed</strong></td>
<td></td>
</tr>
<tr>
<td>Year 10</td>
<td>1</td>
</tr>
<tr>
<td>Year 11</td>
<td>1</td>
</tr>
<tr>
<td>Year 12</td>
<td>5</td>
</tr>
<tr>
<td>Certificate</td>
<td>2</td>
</tr>
<tr>
<td>Trade qualification</td>
<td>2</td>
</tr>
<tr>
<td>University degree</td>
<td>3</td>
</tr>
<tr>
<td><strong>Paid work participation</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>7</td>
</tr>
<tr>
<td>Part time</td>
<td>2</td>
</tr>
<tr>
<td>Casual</td>
<td>4</td>
</tr>
<tr>
<td>Full time</td>
<td>1</td>
</tr>
</tbody>
</table>

1. Categories were not mutually exclusive, women indicated all sources of household income.
Phase 2: Face to face interviews

Two researchers went into the field to conduct face to face interviews with young pregnant women and mothers during February and March 2006. Because asking only young women to take part might be viewed as prejudicial, all women who were in the area with children or who were noticeably pregnant were approached to take part in an interview. Only those women who were aged under 25 when they gave birth to a child were included in the research. The decision to include women aged over 25 who had given birth at a younger age was justified by the valuable information that these women provided.

The Phase 2 method was highly successful in recruiting 93 participants. Several factors were important, including the anonymity of the survey, convenience, and the personal presence of the researchers, who were able to give assurances of the confidential nature of the research. On the advice of the University of Newcastle Human Research Ethics Committee, participants were not asked questions that might be deemed 'personal'; such as the area that they lived in, their housing, economic circumstances and other demographic information. Participants were only asked their ages, and the ages of their children (shown in Table 3). Therefore, the information about the circumstances of these participants is more limited than that gained from those who took part in telephone interviews. Participants were interviewed in one regional city, two coastal shopping centres that were within 50 kilometres of a major regional centre, one inland semi-rural shopping centre and one semi-rural town. The make-up of the different areas ranged from quite low to middle economic status. Given the random nature of the interviews and the range of people interviewed, this sample can be considered diverse.

To orient the participants to the types of services the researchers were interested in, participants were asked to indicate from a list the services they had accessed. After the first five interviews, several more services and support types were added. Participants were then asked why they had not attended certain services, about barriers to services and about the services they had accessed. The face to face interview is included in Appendix C. Researchers noted the main points raised by participants, and, where possible, noted verbatim quotes. Verbatim quotes were transcribed for analysis.
Table 3: Number of face to face interview participants by area of interview, age, and children’s ages

<table>
<thead>
<tr>
<th>Area</th>
<th>N</th>
<th>Participant Age</th>
<th>N</th>
<th>Children's ages (years)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional city</td>
<td>5</td>
<td>16-19</td>
<td>9</td>
<td>younger than 1</td>
<td>29</td>
</tr>
<tr>
<td>Coastal centres</td>
<td>43</td>
<td>20-24</td>
<td>27</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Inland semi-rural centre</td>
<td>41</td>
<td>25-26</td>
<td>25</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Semi-rural town</td>
<td>4</td>
<td>27-29</td>
<td>15</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 or older</td>
<td>17</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6-10</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>older than 10</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>Total</td>
<td>93</td>
<td>Total</td>
<td>181</td>
</tr>
</tbody>
</table>

Note: Five women were not asked the ages of their children

2.3 DATA ANALYSIS

All demographic data were entered into Excel spreadsheets to produce summary information. Data from the fieldwork interviews were entered into an Excel spreadsheet to produce summary information about the services participants had accessed. Qualitative transcribed data from focus groups, written submissions and telephone and fieldwork interviews were entered into the QSR N Vivo software package for analysis.

2.4 LIMITATIONS

Data were collected during 2005 and early 2006. Therefore, policy and program changes that have taken place since data collection will not be reflected in these data. The methodology was designed to be exploratory, and therefore used qualitative methods to gain as much in-depth data and new information as possible. While the project did consult a diverse range of service providers and young pregnant women and mothers, the samples should not be considered representative. It should also be noted that young pregnant women and mothers from the nominated subgroups are not well-represented in the samples. However, information gained during the literature review and from service providers goes some way towards overcoming this limitation. Furthermore, it is likely that some of the women who took part in face to face interviews did indeed belong to one or more of the nominated subgroups. However, because these interviews were conducted in public spaces, issues of privacy prevented the researchers from asking participants about sensitive issues such as substance use.
3. LITERATURE REVIEW

The purpose of the literature review was to locate information relevant to this project, which seeks to identify access barriers and identify best practice for delivering services to young pregnant women and mothers aged 25 and under. It was expected that the findings would elaborate on the situations of young pregnant women and mothers, describe current knowledge in this area and provide examples of best practice in service delivery. A further aim was to avoid unnecessary questioning of participants in the focus groups and interviews, as requested by NYARS.

The research investigating adolescent pregnancy and its outcomes focuses almost entirely on young women and their babies. Although this literature search targeted young women aged less than 25 years, the majority of literature in the area focussed on adolescents or teens (i.e. under 20 years). It is also notable that there has been a lack of research conducted on the experiences of young fathers (Combes and Hinton 2005), although some interest is now being directed to these young males (Boulden 2001; Boulden 2001; NSW Government 2002; Slowinski 2002; Condon 2006). While the role of fathers and other significant family members is very important, the focus of this report is on young women.

Empirical studies of young pregnant women, mothers and their infants describe multiple levels of disadvantage, and a large number of studies report interventions aimed at reducing risks and improving the health and social outcomes for this sub-population. The research includes observational and interventionist designs, covering the fields of medicine, public health, epidemiology, sociology, psychology, social work,
nursing, education and child development. Both qualitative and quantitative methods are employed in data collection and analyses.

Service barriers and facilitators are described in the literature from a population risk perspective. Many papers describe the environmental and psychosocial circumstances that impede or inhibit service access. The literature includes reports of targeted interventions aimed at alleviating access barriers and also minimizing population risks and adverse outcomes. Accordingly this review firstly describes the contextual issues for young pregnancy and motherhood, and secondly reports interventions and facilitators (demonstrated both in research and practice settings) that mitigate barriers to service access.

At the outset it should be noted that although a vast body of literature describes the sub-population of young pregnant women and mothers in terms of socio-economic disadvantage, it is important to recognize that describing the group as ‘at risk’ can be offensive to young people (Rains, Davies et al. 2004). Some commentators in this field challenge thinking about how social service agencies’ assumptions and value judgments influence policy and practice, “Insofar as agencies for teen mothers want to secure their clients’ involvement, they can do so most effectively by acknowledging the full range of their clients’ concerns.” (Rains, Davies et al. 2004).

A related point concerns the finding that young pregnant women and mothers might not perceive their situation as a ‘problem’, ‘error’, or as a ‘mistake’ (Davies, McKinnon et al. 2001). Young Australian women in another study perceived that they were capable mothers, while, at the same time, they felt judged and condemned (Kirkman, Harrison et al. 2001). Therefore young women may not view themselves as being in need of services. Furthermore, these findings underscore the importance of the point raised by NYARS; crisis-response models of service for young women in this situation may be inappropriate. These two points are discussed further in Chapters 4 and 5.

### 3.1 CONTEXTUAL ISSUES AND POPULATION PROFILE

In this section we overview the literature describing the common predictors and outcomes of young pregnancy, both in Australia and overseas. Some Australian government departments have previously conducted extensive literature reviews on adolescent or teenage pregnancy and mothering, albeit with a broader focus including pregnancy prevention as well as pregnancy and parenting service provision (Slowinski 2002; Combes and Hinton 2005). Relevant papers and reports from these earlier reviews are cited here.
Although lower than the United States (US) and Great Britain, Australia’s teenage pregnancy rates are higher than Germany, France and the Netherlands (Skinner and Hickey 2003; Australian Broadcasting Commission 2004). Recent data show that Australia has the sixth highest teenage pregnancy rate among OECD (Organisation for Economic Co-operation and Development) countries (Skinner and Hickey 2003; Combes and Hinton 2005). Across Australia, teenage pregnancy rates are significantly higher in rural and remote compared with urban metropolitan areas (Bull, Hemmings et al. 1997).

3.1.1 International findings

A vast body of empirical research has been conducted in the US and the findings are consistent with other western developed countries such as Canada, Great Britain and Australia. The research shows that women who become single adolescent mothers are more likely to be socio-economically disadvantaged. For example, adolescent mothers tend to have less education, income and social support, and are more likely to suffer postnatal and other clinical depression, domestic violence and drug abuse, compared with women who delay pregnancy (Saldañini Perino 1992; Field, Grizzle et al. 1996; Scafidi, Field et al. 1997; Baldwin, Rawlings et al. 1999; Smith and Greyer 1999; UK Social Exclusion Unit 1999; Bissell 2000; Misra and James 2000; Agurcia, Rickert et al. 2001; Bensussen-Walls and Saewyc 2001; Kaplan, Feinstein et al. 2001; Carter and Spear 2002; Clemmens 2002; NSW Health 2002; Evans 2003). Research in the US demonstrates high levels of relative disadvantage for young mothers in Hispanic (Uno, Florsheim et al. 1998; Chandra, Schiavello et al. 2002; Harris and Franklin 2003; Scott, Amodeis et al. 2004) and African American populations (Seaborn Thompson and Peebles-Wilkins 1992; Rhodes, Fischer et al. 1993).

Studies of adolescent mothers describe increased postnatal complications, such as low birth weight and restricted growth of infants (Chandra, Schiavello et al. 2002; Creatsas and Elsheikh 2002). Compared with older mothers, adolescents rate their babies as having higher activity levels (Andreozzi, Flanagan et al. 2002), and report more parenting stress and child abuse potential (Smith and Greyer 1999) and lower rates of breast-feeding (Misra and James 2000).

A major report, presented to Prime Minister Tony Blair in the British Parliament in 1999, found that the risks of teenage parenthood were greatest amongst those who grew up in poverty and disadvantage and among those with poor educational attainment (UK Social Exclusion Unit 1999). It is common for teenagers falling pregnant not to have been involved in education and/or vocational training in their post compulsory school years, and this can greatly disadvantage future employment opportunities and
workforce participation (UK Social Exclusion Unit 1999; Sercombe, Omaji et al. 2002; Butterworth 2003).

Low intellectual functioning is also a serious risk factor for adolescent pregnancy. US research found that adolescents with intellectual disabilities become pregnant in disproportionate numbers and leave school at earlier ages, compared with higher ability adolescents (Kleinfeld and Young 1989; Levy, Perhats et al. 1992; Kaplan, Feinstein et al. 2001).

There are special issues to be considered when addressing adolescent pregnancies in rural areas. They include lack of access to urban-based services, relatively lower socio-economic status, high concentrations of Indigenous populations, shortages of service providers, and factors related to confidentiality and anonymity. In the US as in Australia, many rural areas have disproportionately fewer services to meet the needs of pregnant and parenting adolescents in their communities (Anderson, Smiley et al. 2000).

3.1.2 Australian findings

Birth rates among teenagers vary across the states and territories; they are highest in the Northern Territory and second highest in Tasmania. While Queensland has relatively lower rates compared with the other states and territories, there are marked variations between areas described by socio-economic disadvantage. Birth rates to teenagers who live in disadvantaged areas are two to four times higher than the rates for all of Queensland, and 10 to 20 times higher than rates in affluent areas (Coory 2000). These differentials can in part be attributed to high adolescent pregnancy rates in Indigenous communities (Combes and Hinton 2005).

Births to teenage mothers carry a higher risk of medical complications, including prematurity, low birth-weight, the need for neonatal intensive care, and neonatal death. Babies born to Aboriginal and Torres Strait Islander teenagers have a greater risk of medical complications (NSW Health 2002; Skinner and Hickey 2003; NSW Health 2004).

Teenage mothers face all the usual stresses of adolescence as well as those of pregnancy and motherhood. Factors such as poverty, low levels of education and mental health issues, including postnatal depression, often exacerbate these stresses (Kenny 1995; Wheeler 2002). Australian research demonstrates that young motherhood and adolescent pregnancy are associated with smoking, residing in low socio-economic and rural areas, having low income and educational aspirations, psychological distress, substance abuse, and poor infant outcomes (Smith and Greynyer 1999; Myors, Johnson et al. 2001; Slowinski 2002; Skinner and Hickey 2003; Combes and Hinton 2005). Studies have shown that the babies of teenage mothers have poorer outcomes (compared with
the babies of older mothers), and that these teenage mothers are more likely to drop out of school, be sole parents in receipt of government income support and have few family supports (NSW Government 2002).

Longitudinal studies provide insights into the experiences and perceptions of young women over time (Littlejohn 1996). In a prospective cross sectional study conducted in Melbourne, Quinlivan et al. (2004) investigated the impact of demographic factors, early family relationships and depressive symptomatology on teenage pregnancy, and demonstrated that a history of parental separation/divorce or exposure to family violence in early childhood, illicit drug use, low family income and low levels of education, were all predictive of teenage pregnancy.

In Perth, an exploratory study to determine stress levels and describe the psychosocial factors contributing to stress among a group of young mothers (average age 17) at eight months post-partum (Lindsay, Harrison et al. 1999). The findings highlight the vulnerability of these women and their babies to major stress.

Compared with other young Australians, adolescents leaving the care of the state have more personal and social difficulties in making the transition to adulthood, and are more likely to experience homelessness, unemployment, poverty and early parenthood (Maunders, Liddell et al. 1999). A high proportion of young women discharged from state care in Australia become pregnant or have a child soon after leaving institutional care (Maunders, Liddell et al. 1999). Homeless young women are a particularly vulnerable group, characterised by transient lifestyle and high risk sexual practices (Slowinski 2002). Australian research shows that housing is the single most powerful factor influencing young women's adjustments to and experiences of parenting (Rogers and Allwood 2005). As a group, young pregnant and parenting women who are homeless or at risk of homelessness are further disadvantaged by the lack of access to appropriate support services to meet their numerous and complex needs (Phillips 2003).

Disadvantage and poverty experienced by young mothers and pregnant adolescents are reinforced where low socio-economic groups overlap with ethnic and racial sub-groups (Jones Harris 1998). In some areas of Australia, teenage pregnancy rates are about five times higher among Indigenous women compared with all adolescent mothers (NSW Health 2002; NSW Health 2004; Combes and Hinton 2005). Indigenous teenagers and their babies have much poorer pregnancy outcomes than non-Indigenous teenagers whose outcomes are in turn poorer than those for older mothers (Westenberg, van der Klis et al. 2002).
Indigenous people are the most disadvantaged sub-group in Australia, with high levels of unemployment, domestic violence, homelessness and substance abuse impacting upon Indigenous women and their families. Compared with other young Australians, Indigenous youths generally have relatively poor access to mainstream services, particularly in rural and remote areas (Westbury and Sanders 2000). Given the high birth rates for adolescent Indigenous women, it is surprising that very little research has been undertaken in this area (Slowinski 2002). A few select studies of young pregnant and mothering Indigenous women are providing insights (Dorman and Perkins 1996), albeit in relation to particular communities and settings (Slowinski 2002).

Risks for pregnant and parenting adolescents are often higher in non-metropolitan areas (Carter and Spear 2002). Rural and regional areas in Australia are reported to have high rates of sexually active adolescents and insufficient services to address pregnancy and parenting outcomes (Combes and Hinton 2005). For example, lack of access to female doctors is cited as a barrier for young pregnant women in rural areas (Combes and Hinton 2005). Wagga Wagga in New South Wales has one of the highest teenage pregnancy rates in Australia (Combes and Hinton 2005) and studies of adolescent pregnancy have been conducted in this regional area (Bull, Hemmings et al. 1997; Smith and Grenyer 1999; Makin and Butler 2002).

Many Indigenous Australians reside in rural and remote areas in which geography combined with socio-economic disadvantage results in poor service access. For Indigenous mothers and babies, health disadvantage reflects the broader social and economic inequalities and inequities faced by Indigenous peoples (NSW Health 2002). Adolescent pregnancies are more likely to be the outcome of poor life opportunities and expectations rather than insufficient and inadequate contraceptive knowledge (Combes and Hinton 2005). It is the combination of risk factors that increases the likelihood of poor outcomes, rather than the presence of any single factor (NSW Government 2002).

Teenage mothers in Australia are often welfare dependent (Fountaine 2001). Butterworth (2003) demonstrated the prevalence of multiple barriers to workforce participation amongst Australian lone mothers (with children under 16) receiving welfare, as well as the extent to which these barriers co-occur. The findings support US research (Danziger, Kalil et al. 2000; Kalil and Danziger 2000) showing that lone mothers in receipt of welfare can experience multiple personal barriers to workforce participation, and these barriers are associated with education deficits, lack of work experience and skill-base, and poor mental and physical health. The findings are also relevant to younger women.
A recurring theme is that decision-makers must develop and implement appropriate and accessible services to meet the needs of young mothers and their babies. The premise is that early childbearing results in social and economic disadvantage and although a view disputed by some social commentators (SmithBattle 2000; SmithBattle 2003; Rains, Davies et al. 2004), this cultural mind set influences mainstream policy and practice responses to young parenting.

3.1.3 Summary

Teenage pregnancy has been found to correlate with social exclusion and adolescent parents and their children are an often marginalised sup-population (UK Social Exclusion Unit 1999). Socio-economic circumstances are correlated with both the incidence and outcomes of teenage pregnancy, and risks and barriers are inter-related. Without effective interventions to facilitate service access, adverse outcomes will continue to reinforce barriers and perpetuate cycles of disadvantage.

The empirical findings are similar in Australia to other western developed countries. Teenage birth rates are relatively higher in rural and disadvantaged areas, among Indigenous women and among homeless adolescents. Related factors include low income and socio-economic status, poor educational achievement and aspirations, welfare dependence, substance abuse, domestic violence and poor mental health, including depression and low self esteem (Combes and Hinton 2005). At a population level, barriers to service access are implied by social, economic, educational, environmental, psychosocial, geographic, and cultural risk factors.

Table 4 outlines the population risk profile and associated service access barriers for young pregnant adolescents and mothers as described in the literature. The relationships are not discrete and a number of areas overlap. These factors were examined by this project during consultations with service providers and young pregnant women and mothers (see Chapters 4 & 5).
<table>
<thead>
<tr>
<th>Population risks for young pregnant women and mothers</th>
<th>Barriers to service access</th>
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</thead>
<tbody>
<tr>
<td>Low income, welfare dependence</td>
<td>Transport costs of attending services</td>
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<td></td>
<td>Costs of services</td>
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<td></td>
<td>Availability of affordable child care</td>
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<td></td>
<td>Welfare stigma</td>
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<tr>
<td>Low levels of secondary education</td>
<td>Low educational aspirations</td>
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<td></td>
<td>Poor literacy</td>
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<td></td>
<td>Inability to interpret information on services</td>
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<td></td>
<td>Low self esteem and confidence</td>
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<tr>
<td>Inadequate housing</td>
<td>State or foster care</td>
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<td></td>
<td>Homelessness</td>
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<td>Depression and self esteem</td>
<td>Low confidence</td>
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<td></td>
<td>Embarrassment at attending clinics with older women</td>
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<td></td>
<td>Inability to take initiatives or control</td>
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<td></td>
<td>Lack of counselling</td>
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<tr>
<td>Family and relationship conflict</td>
<td>Domestic violence</td>
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<td></td>
<td>Sexual abuse</td>
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<td></td>
<td>Other family conflict and violence</td>
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<td></td>
<td>Relationship breakdown</td>
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<td></td>
<td>Judgmental attitudes of family and peers</td>
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<td></td>
<td>Lack of family support</td>
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<td></td>
<td>Concealment of pregnancy</td>
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<tr>
<td>Low social support</td>
<td>Inadequate child minding</td>
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<td></td>
<td>Inadequate social and family support</td>
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<td></td>
<td>No role models or mentors</td>
</tr>
<tr>
<td>Area of residence</td>
<td>Lack of available services especially in rural &amp; remote areas</td>
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<tr>
<td></td>
<td>Large travel distances to access services especially in rural &amp; remote areas</td>
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<tr>
<td></td>
<td>Low socio-economic neighbourhoods with high crime rates</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Substance addiction</td>
</tr>
<tr>
<td></td>
<td>Poor physical and mental health</td>
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<td></td>
<td>Inability to take control of life matters</td>
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</tbody>
</table>
Table 4: Population risks and associated potential barriers to service access (continued)

<table>
<thead>
<tr>
<th>Population risks for young pregnant women and mothers</th>
<th>Barriers to service access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>Domestic violence</td>
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<td></td>
<td>Cultural barriers</td>
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<td>Poverty</td>
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<td>Remote areas</td>
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<td></td>
<td>Lack of culturally sensitive services</td>
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<td></td>
<td>Large travel distances</td>
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<tr>
<td>Culturally &amp; linguistically diverse backgrounds</td>
<td>Cultural barriers &amp; language barriers</td>
</tr>
<tr>
<td>Community attitudes</td>
<td>Prejudice</td>
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<td></td>
<td>Stereotyping</td>
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<td></td>
<td>Social stigma</td>
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3.2 SERVICES AND BARRIERS

The population of young pregnant women and mothers is diverse and geographically widespread, resulting in complex issues for policy and service development. There are a range of socio-economic and psychosocial barriers to service access such as: transport; social stigma; embarrassment; lifestyle and relationships (Allwood, Rogers et al. 2001); lack of choice; limited access to services (particularly in rural areas), and lack of information, peer support, mentoring and privacy (Combes and Hinton 2005). Other barriers include: inappropriate settings and locations, cultural inhibitors, prejudice and judgmental attitudes of professionals and the community generally, and lack of flexibility in service delivery.

The issues surrounding young pregnancy and parenting are complex, and in order to implement effective interventions that address service access barriers, the unique issues for young women must be understood within the context of local communities, knowledge, attitudes and behaviours, as well as existing service structures (Carter and Spear 2002). In this section we describe research-based interventions as well as programs and services delivered in practice settings.

Interventions are discussed here in relation to the types of research or policy responses, for example education, social support, targeted health and welfare services. Some interventions were aimed solely at pregnancy prevention and they have not been included here. Health promotion strategies that are primarily concerned with the
provision of information and/or resources are not included here unless they have a major service delivery component.

This section has been divided into specific services and interventions. Within each subsection, overseas and Australian services and interventions are first described, followed by concluding comments in relation to service access barriers and facilitators. A large body of the research was implemented in the US, and although not necessarily directly relevant to Australian settings, the studies have been included to provide evidence for the effectiveness of some strategies that might be applicable to Australia.

### 3.2.1 Education

**Overseas experience**

Completing secondary education contributes to better long term outcomes for young pregnant women and mothers, and a range of interventions have been designed to encourage school retention beyond the compulsory years (Kaplan, Feinstein et al. 2001). Various secondary school-based models have been implemented, both in Australia and overseas (in particular in the US), with the aim of supporting secondary school retention for adolescent mothers. It has been widely demonstrated that young pregnant women and mothers who take part in targeted school-based programs experience improved outcomes in completing secondary school with lower absenteeism, compared with young pregnant women and mothers who have not taken part (Ruch-Ross, Jones et al. 1992; Crean, Hightower et al. 2001; Harris and Franklin 2003). In general, these programs have demonstrated positive outcomes for pregnant and mothering adolescents (Kaplan, Feinstein et al. 2001; Carter and Spear 2002; Harrison, Angwin et al. 2002).

The success of school-based interventions was also influenced by students’ pre-pregnancy academic achievement. Low achieving students require longer and more intensive interventions than high achieving students. Specialised school-based programs can deliver multidisciplinary services to pregnant adolescents and improve school retention rates (Kaplan, Feinstein et al. 2001). Adolescents who appear to have minimal academic promise prior to their pregnancy are very responsive to school-based interventions (Seitz, Apfel et al. 1991).

**Australian experience**

A publication set by the Association of Women Educators (Australia) (Boulden 2001; Boulden 2001) explores what secondary schools can do and documents good practice examples around Australia. The first of these, *Present, Pregnant and Proud* (Boulden 2001)
shares young women’s stories and encourages schools to explore the various ways in which young pregnant women and mothers can be encouraged to stay at school. The authors argue that it is critical that young Indigenous women, and also young women from non-English speaking backgrounds, have access to culturally appropriate support. The companion publication, *Step by Step Side by Side* (Boulden 2001) offers a guide for schools that want to ensure that their pregnant and parenting students have the best possible chance of completing high school. The booklet is divided into two sections: a step by step outline of a process for developing and implementing a policy and strategy to improve school completion rates for pregnant and parenting students, and a professional development program for staff and school communities.

These publications also showcase examples of outstanding achievement by Australian secondary schools for pregnant and parenting students. They recommend that schools adopt a comprehensive policy specifying their commitment to pregnant and parenting students. Suggestions include: flexibility in the curriculum and assessment; support for dress codes and attendance; an open door approach whereby young women who do leave are encouraged to return at a later date; professional training and development for staff; a positive school culture which discourages harassment and discrimination, and the inclusion of the fathers in the activities and education regarding pregnancy prevention (Boulden 2001; Boulden 2001; Combes and Hinton 2005).

Education Queensland’s *Pregnant and Parenting Students Policy* facilitates year 12 completion by pregnant and parenting students through: curriculum flexibility, classroom management, a supportive learning environment, and professional development and support for staff to access information to enhance pregnant and parenting student retention (Department of Education and the Arts Queensland 2002; Department of Education Queensland 2005).

A *Young Mothers in Education Program* has been running at Plumpton High School in Sydney’s inner western suburbs. It is a flexible, non-judgmental, confidential program that provides support for the whole family. Intensive support is given to pregnant students and mothers to assist them to maintain their academic workload. This program, which is run by a social worker and a designated coordinator, demonstrates high success rates, with many students going on to university. Since the program was introduced in 1994, pregnancy rates have dropped, and this is attributed to the fact that other students recognize that combining school and parenthood is a major life challenge (Boulden 2001; Kitson 2001; Australian Broadcasting Commission 2004; Combes and Hinton 2005).

Claremont College in Tasmania also has a number of supports in place for students who are pregnant or parenting to encourage them to stay at school (Combes and Hinton...
In addition to providing a counsellor and a social worker to support students, the school has initiated the Young Mothers Program to reconnect young mothers in the local area with the education system and make it easier for students to move into the mainstream education program later. Child care is also provided by the College (Boulden 2001; Combes and Hinton 2005).

Brisbane School of Distance Education formed a young parents’ group in the late 1990s to identify students who were pregnant or parenting and would benefit from specialized support. The School produces a regular newsletter that gives students encouragement to stay on at school, offers tips for combining motherhood and study as well as information on agencies and services. The newsletter also invites feedback and responds to students’ requests (Boulden 2001; Brisbane School of Distance Education 2006).

Programs need to enhance the self esteem and self-sufficiency of young student mothers and encourage them to stay in school (Fountaine 2001). There are a number of important facilitators for successful school-based programs. They include: accessible child-care services; support and education provided by child-care teachers; social work and informal case management, and information about and referrals to support services and networks. Successful school-based programs both encourage the ongoing participation of the adolescent as a student, and also provide support and education to the adolescent as a parent (Crean, Hightower et al. 2001; Kaplan, Feinstein et al. 2001; Australian Broadcasting Commission 2004; Combes and Hinton 2005). Schools also need to be flexible in their curricula and provide programs that relate to pregnant and parenting skill development (Fountaine 2001). Some programs also include classes on creative coping strategies, physical fitness, and also role modelling for positive parenting (Sadler and Cowlin 2003).

Conclusions

Lack of educational attainment beyond compulsory schooling is often cited as a socio-economic inhibitor for young pregnant women and mothers to achieve outcomes comparable to older mothers. Australian researchers identified specific barriers that prevent young or pregnant women from completing their high school education (Fahey and Vale 2002). The barriers are grouped into: pregnancy related barriers (such as self consciousness); parenting related barriers (such as child care and financial problems); personal barriers (including emotional and stress related issues); family related barriers associated with family support; relationship barriers involving peers and partners; community attitude barriers, and practical barriers covering issues such as housing and transport. Family support was cited as the most important of these.
In addition, if schools are to be effective in the delivery of services to young pregnant women and mothers and improve school retention rates, they require improved access to community services as well as clearer policies and guidelines (Fahey and Vale 2002).

Although the practical barriers faced by many pregnant and parenting adolescents in accessing health and welfare services can be addressed through school-based or linked centres (myDr Health Information 2003), it is important to acknowledge that many students who drop out of school early in their pregnancy are missed by school-based programs (Pope, Whiteside et al. 1993). Attendance at some school-based classes has been described as sporadic, and it has been suggested that content and teaching strategies should be adapted for community as well as school-based settings (Sadler and Cowlin 2003). Adolescents can face psychological and practical barriers in accessing school-based or school-linked health centres (Skinner and Hickey 2003). To this extent the school campus may be a barrier for some young women who no longer feel they belong in this setting.

The policy focus has been on secondary school retention because early school leaving is seen as a major factor in shaping circumstances that can disadvantage young mothers. Given that many students are moving onto further education and training post secondary school (Australian Broadcasting Commission 2004; Combes and Hinton 2005), there is also a need for vocational and tertiary-based services and support programs.

### 3.2.2 Social support and mentoring

#### Overseas experience

A number of studies have shown that both lay and professional supports are important contributors to the psychological well-being of young mothers (Seaborn Thompson and Peebles-Wilkins 1992). Using adolescents as role models may enhance self-efficacy in both the adolescent instructors, and the adolescents being instructed (Kaplan, Feinstein et al. 2001). Innovative approaches in the US have used technology to advance the parenting skills of adolescents (Black and Teti 1997), or monetary incentives to promote peer-support group participation (Stevens-Simon, Dolgan et al. 1997).

One innovative mentoring program introduced in the US in the early 1990s, involved the training of young mothers as peer support workers for future young mothers (Saldarini Perino 1992). This program was successful in preventing teen pregnancies, improving birth outcomes for teen mothers, and also building adolescent parenting skills. The program incorporated ante- and postnatal care, counselling and child
development, and was particularly innovative in that the young mothers in training lived on the premises, attended high school during the training period, and were also paid an income. Graduates of the program worked as counsellors, advocates and mentors for other young pregnant women and mothers in the community, and assisted in the design of future pregnancy prevention strategies (Saladini Perino 1992).

While most of the interventions that deliver social support focus on the mother and/or child, one US study supports the need for programs that include the extended family members in the design of intervention programs (Pope, Whiteside et al. 1993). In the US, Flynn demonstrated positive outcomes from an intensive home visitation program based on mentoring adolescent parents (Flynn 1999).

Knowledge of child development is seen as important in the prevention of child abuse and also as a way of building confidence and self esteem in young mothers. A study in the US demonstrated the value of a short term intervention program that allowed adolescent mothers to have major input in identifying knowledge concerning their children’s growth as well as their own parenting skills (Fulton, Murphey et al. 1991). Other US programs for young mothers use peer groups to provide education on child development and child health as well as emotional support (Ruch-Ross, Jones et al. 1992).

Australian experience

A regional study (conducted in Wagga Wagga) demonstrated that the degree of social support among pregnant adolescents was positively associated with self esteem and improved long term outcomes for young pregnant women and mothers (Smith and Grenyer 1999). An innovative program, also based in Wagga Wagga, trained adolescent parents as peer educators. In addition to delivering education on contraception and the reality of being a teenage parent, one of the outcomes from this approach was that the peer presenters gained confidence and formed support groups (Makin and Butler 2002).

The Talking Realities Program in South Australia provides accredited peer education and training to young parents (19 years and under) and their children (Kovatseff and Power 2005). The project evaluation demonstrated that young mothers improved their life skills and had greater confidence and assertiveness, organizational ability, leadership and knowledge about services. They also demonstrated increased capacity to make informed choices about parenting and health. The peer educators also reported benefits including increased confidence and personal development.
Conclusions

Policy and decision-makers are becoming increasingly aware of the importance of addressing psychosocial service barriers through social support and mentoring (Smith and Grenyer 1999). However the timing of support is important. Lindsay et al found that support interventions were particularly crucial during the first 12 months post delivery (Lindsay, Harrison et al. 1999).

Informal network formation, peer support and opportunities for socializing and relaxation are all seen as important for pregnant and mothering adolescents (Slowinski 2002; Combes and Hinton 2005). However social practices vary across cultures and different approaches may be needed. For example, regular visible presence in the street has been identified as an appropriate strategy for outreach services for indigenous youth (Slowinski 2002). Providing culturally appropriate social support for young pregnant women and mothers can contribute to dismantling barriers that inhibit service access.

3.2.3 Targeted health and welfare services

Overseas experience

Young pregnant women and mothers face specific barriers in relation to their utilization of health care and other services, including ante- and postnatal care. In addition to adverse outcomes, these barriers include isolation, social stigma, reluctance to seek care for matters to do with reproductive or mental health, concern about confidentiality, limited financial independence from parents, and lack of transport (Stiffman, Earls et al. 1988; Anderson, Smiley et al. 2000; Ley 2005).

A qualitative study conducted by Ginsburg et al in the US (Ginsburg, Menapce et al. 1997) found that adolescents seek health care providers who treat them honestly, respectfully and confidentially. While this study looked at the factors affecting decisions to seek health care by adolescents generally, it has implications for young pregnant women and mothers.

In the US, geographically accessible community-based multi-disciplinary clinics have been implemented as a way of meeting the special needs of this target group by providing primary medical care, psychological support and training in other life skills for adolescent parents as well as improving employment prospects in the longer term. One of these, called Project Redirection, was a large scale comprehensive program designed to redirect the lives of disadvantaged teenage mothers into a path of economic self-sufficiency (Polit 1989; Kaplan, Feinstein et al. 2001).
Despite evidence of positive outcomes, specialist health clinics for pregnant adolescents have not become standards in the US, probably because of the perception that they are not cost-effective. In a US study published in 2001, Bensussen-Walls and Saewyc addressed this issue by demonstrating the cost-effectiveness of comprehensive, interdisciplinary teen-centred antenatal care clinics, when compared with traditional adult-centred obstetric clinics (Bensussen-Walls and Saewyc 2001).

As an outcome of research examining ecological factors associated with adolescent pregnancy and parenting, Corcoran et al. (2000) argued that in order to intervene effectively, pregnancy prevention programs must move beyond delivering sex education and health information, and more directly address adolescent needs. Their study identified key needs such as: coping with stress; communication and skill building, and improved resources attainment and opportunities. While this research was primarily concerned with pregnancy prevention, it has broader policy implications in that understanding the key needs of the target group is crucial if effective services are to be developed and implemented (Corcoran, Franklin et al. 2000).

**Australian experience**

There is increasing evidence that young pregnant or mothering women feel intimidated by mainstream services and that they perceive judgmental and sexist attitudes among many service providers (Phillips 2003). A qualitative study conducted with 33 women aged 15 to 19 years in South Australia, identified a number of barriers to service access. The most significant of these were transport, stigma, embarrassment, and lifestyle (Allwood, Rogers et al. 2001; Combes and Hinton 2005). Additionally the young women in the study, who were either pregnant, already mothers, or had recently terminated or miscarried, indicated perceptions of anticipated future vulnerability in areas such as income, education, living situation and family background.

An innovative program operating in the Blue Mountains delivers an inter-agency approach in working with pregnant and parenting young people. The service incorporates the provision of health, support and recreational services through a structured group process aimed at addressing isolation, social stigma and some of the negative consequences associated with teenage pregnancy. The model demonstrates improved psychosocial outcomes for young mothers and has facilitated “connectedness” for young parents, their partners and their children in their community. A comprehensive manual has been compiled to assist with the implementation of the model in other areas (Ley 2005).

Pregnant adolescents and teenage mothers in rural communities face particular difficulties in accessing appropriate and adequate support and services. Models of
integrated multi-disciplinary primary health care have successfully operated in rural and regional areas of New South Wales (Bull, Hemmings et al. 1997). A rural support service for pregnant and parenting adolescents in New South Wales aims to provide an innovative primary healthcare service to young women that is safe, accessible and non-judgmental. The service recognises the complex needs of young mothers, and addresses these needs through support, advocacy, and community education, and also by providing access to resources and relevant service information (Bull, Hemmings et al. 1997). This innovative model operates in a town with a population of approximately 10,000.

The rural-based program (Bull, Hemmings et al. 1997) offers short to medium term accommodation for young women (aged 12 to 20) who are pregnant or parenting. In addition to ante- and postnatal education, the young women in the program receive coaching in personal development, literacy and numeracy skills, gaining employment, budgeting, parenting, sewing and cooking. Transport is provided to and from appointments, and the service also provides legal support and advocacy. Project staff accompany women to visits with drug and alcohol and sexual assault counsellors (Bull, Hemmings et al. 1997). This program demonstrates outstanding success from the perspective of both clients and staff.

Another successful innovative model, this time in a large inland regional city in New South Wales (population approximately 88,000) operates as an information and referral service for young women aged 12 to 25 years, offering support, counselling, health promotion, general information, workshops, and referral to other welfare agencies. A young mothers group meets regularly and parenting classes are conducted at the centre. The aim is to offer innovative primary health care services that are safe, accessible and non-judgmental. Like the previously cited rural model, this service also recognizes the complex psychosocial needs of young pregnant women and mothers. Their needs are met through support, advocacy, community education, access to resources and information dissemination (Bull, Hemmings et al. 1997). The strengths of the program lie in its philosophical base in which acceptance of the individual and the right to informed choice is paramount. The provision of no-cost laundry and shower facilities is also seen as an important practical feature.

In another Australian study, Healy examined the support needs of young mothers from a child protection perspective. The absence of child care was seen as a significant issue contributing to parenting stress and the findings showed the importance of informal family support networks. The recommended response involves providing reprieve from the daily stresses associated with parenting babies and young children (Healy 1996; Slowinski 2002).
Smith and Grenyer proposed community-based adolescent antenatal clinics as a way of providing psychosocial as well as medical support to young pregnant women (Smith and Grenyer 1999). General Practitioners (GPs) often lack the confidence and skills to engage with adolescents and identify issues of importance to them. However some programs are educating GPs about ways of better relating to adolescents in clinical settings (Skinner and Hickey 2003). The crucial factor is that professionals delivering services must be trained to understand the reality of young mothers' lives and respect their choices and priorities (SmithBattle 2003).

Australian teenagers are generally reluctant to confide in GPs about personal issues and confidentiality is often a major issue. At the same time many GPs are criticized for failing to embrace adolescent health (Rowe 2005). A youth specific multi-disciplinary practice in Geelong, run co-operatively between GPs, a community health nurse, and a psychologist, delivers adolescent-friendly services. While the service targets adolescents generally, it has relevance to issues for pregnant and parenting adolescents (Rowe 2005).

**Conclusions**

Targeted support services that address the complex needs of young pregnant women and mothers can go a long way towards breaking down access barriers commonly experienced by these young women in relation to mainstream services. One of the key ingredients for success is that the multi-disciplinary professionals working in these services must be caring and non-judgmental, respect confidentiality, and engage honestly and directly with their young clients.

Bull et al (1997) suggest a best practice rural model that addresses barriers in the delivery of support services for pregnant and parenting adolescents and is suitable for both urban and rural/regional areas. The model comprises five key themes: flexibility, accessibility, continuity, acceptance, and confidentiality. Additionally Bull et al suggest best practice means developing strong community ties, good networking and support for staff. The model in the Blue Mountains is built upon community development and a key success factor is that it respects the vulnerability of the target group, facilitates connections with both service providers and other young parents, and offers a universal, integrated and coordinated service without social stigma (Ley 2005).

**3.2.4 Ante- and postnatal home visiting**

Home visiting has been commonly used as a way of assisting young pregnant women and mothers to access ante- and postnatal health care. This section focuses on home
visiting as a potential service access facilitator that might help to overcome some of the problems young pregnant women and mothers experience when accessing traditional clinic and hospital-based services.

**Overseas experience**

Home visitation nursing for pregnant adolescents and young mothers has been demonstrated as an effective intervention strategy for at risk antenatal mothers in the US, reducing isolation, linking adolescent mothers to community resources and providing general information and support (Ruch-Ross, Jones et al. 1992; Fetrick, Christensen et al. 2003). Pregnant adolescents benefit from public health nursing care in terms of both antenatal and postnatal outcomes. US research has found that home nursing is associated with lower infant morbidity in the first six weeks of life and decreased high school drop out rates among young mothers (Koniak-Griffin, Anderson et al. 2000).

A US study conducted with Hispanic adolescent mothers and their infants found that visits by home nurses positively influenced outcomes (Nguyen, Carson et al. 2003). Other researchers recommend that future studies designed for Hispanic teens may benefit from home visitation components (Scott, Amodeis et al. 2004).

The results of a widely cited 20 year research program in the US showed that antenatal and postnatal home visits by public health nurses and midwives were associated with reductions in: subsequent adolescent pregnancies; use of government assistance; child abuse and neglect; and antisocial behaviours and substance abuse by offspring in later life (Olds, Eckenrode et al. 1997; Olds, Henderson et al. 1998; Olds, Henderson et al. 1999). This long-term program, called the 'Antenatal and Early Childhood Nurse Home Visitation Program', was designed to help low-income, first time parents many of whom include young mothers. The researchers concluded that policies in this area should be targeted to the neediest populations, where the largest gains are to be made (Korfmacher, O’Brien et al. 1999).

**Australian experience**

In a Melbourne study, Quinlivan et al showed that postnatal home visits by midwives reduced adverse neonatal events and improved contraception outcomes for mothers younger than 18 years (Quinlivan, Box et al. 2003). In Queensland, home visiting has been used as a strategy for addressing the multiple needs of pregnant adolescents (Women’s Health Queensland Wide Inc 2003). Home visiting by certified midwives can be an important contributor to antenatal care, particularly in rural areas (Smith and Grenyer 1999). Studies in the US and Australia involving home visits by
para-professionals rather than nurses, have demonstrated that nurses forge stronger therapeutic relationships with families than para-professionals (Korfmacher, O’Brien et al. 1999; Quinlivan, Box et al. 2003). A UK study of general practice confirmed the importance of the role of nurses by demonstrating that general practices offering more nurse time to adolescents have lower pregnancy rates (Hippisley-Cox, Allen et al. 2000).

Home visiting services for young pregnant Indigenous women and mothers is incorporated in an integrated service for young Indigenous women based at Rockhampton Hospital in northern Queensland. This innovative program works closely with the extended midwifery service at the hospital whereby new Indigenous mothers are visited in the maternity ward and offered home visiting. As part of the same program, home visiting is also provided in the postnatal period. When an Indigenous mother does not attend the postnatal clinic, an Indigenous health worker and midwife make a home visit (Dorman 1997; Slowinski 2002).

Public health nurses and midwives are an important resource in the delivery of these services. It is important that nurses listen to the voices of their young clients and provide mentoring and guidance in ways that are non-judgmental and supportive (SmithBattle 2003).

**Conclusions**

Home visiting can reduce the barriers of geographic and psychosocial isolation and provide both clinical and psychosocial support for young pregnant women and mothers both ante- and postnatally. A major advantage of home visiting is that it can conveniently bring services to clients in their homes. However for home visitation to be utilized and have the desired outcomes, clients must be comfortable in their home environments, and willing to accept visits by professionals (who are usually strangers). Many young pregnant women and mothers are homeless and therefore home visiting will not reach the entire target population. In the same way that the school-based interventions can exclude school leavers, home visiting interventions can overlook young women who are homeless, itinerant or suffer embarrassment or shame in relation to their living arrangements.

### 3.3 VULNERABLE SUB-GROUPS

This section discusses the findings from academic and government sources that describe the issues and barriers to service delivery that are faced by sub-groups of young pregnant women and mothers. The sub-groups included in the current project (young women from culturally and linguistically diverse or Indigenous backgrounds,
those with a substance abuse history, those with mental and physical disabilities) were identified by NYARS as being particularly vulnerable to experiencing barriers to service delivery.

Although young Australian women who have emerged from the state care system (e.g. foster care) appear to be at greater risk of early pregnancy, limited information was found about their experiences of services or the barriers they face in accessing services (Maunders, Liddell et al. 1999). In addition, no Australian research was found concerning the particular issues faced by young mothers with physical or developmental disabilities. However the issues faced by women who have experienced state care and/or who have physical disabilities were examined in the consultations with service providers, and are therefore discussed further in Chapters 4 and 5.

This section has been divided into sub-groups, and as previously, within each subsection, overseas findings are described first, followed by Australian findings, and finishing with conclusions regarding the barriers identified for the particular sub-group.

### 3.3.1 Young women from culturally diverse and Indigenous origins

Race, ethnicity and culture have been identified as key determinants of adolescent sexual behaviour (Slowinski 2002). International surveys of adolescent sexual attitudes and experiences highlight differences between countries; for example Japanese adolescents have been identified as having less sexual experience compared with their American counterparts (Slowinski 2002). There is limited research looking at the sexual practices of young Indigenous people, although an Australian psychological anthropologist has conducted a critical psychosocial and anthropological perspective of teenage pregnancy amongst Indigenous Australians (Burbank 1996).

There is implicit acknowledgment in the Australian policy and practice literature that young pregnant women and mothers from non-English speaking backgrounds need to have access to appropriate support services (Boulden 2001; Department of Education and the Arts Queensland 2002; Slowinski 2002; Combes and Hinton 2005; Department of Education Queensland 2005). However despite the fact that the delivery of appropriate and culturally sensitive services is seen as an important policy agenda (Rahmanovic 2005), we located very few examples of Australian interventions that specifically target young women from culturally diverse or Indigenous backgrounds.

**Overseas experience**

In the US, various interventions have been implemented with populations of Mexican/Hispanics and African American adolescents (Levy, Perhats et al. 1992). Harris and
Franklin (2003) demonstrated a cognitive-behavioural school-based intervention for Mexican American pregnant and parenting adolescents as an effective method for helping these young women work towards high school graduation. Scott et al (2004) studied Hispanic pregnant and parenting female adolescents enrolled in US high schools over two years, and showed that a school-based curriculum intervention had a positive impact on high school retention. This intervention included both school and home based management services. Using data from a survey of African American teenage mothers, US researchers demonstrated the importance of both formal and informal support networks within different ethnic and cultural groups (Seaborn Thompson and Peebles-Wilkins 1992). Black and Teti showed that the use of brief culturally sensitive videotapes may be effective strategies to promote parenting skills among African American adolescents (Black and Teti 1997).

A study in the US compared the relationship between ethnicity and parenting between 50 Caucasian and 49 Mexican-American teen mothers with children between the ages of one and three. The researchers found that Mexican-American teen mothers engaged in more negative parenting behaviours than Caucasian teen mothers, but that the relationship between ethnicity and parenting was mediated by the combined influences of financial, parenting and other social stresses (Uno, Florsheim et al. 1998). These results support other findings that show stress and social support are significant predictors of parenting behaviours.

**Australian experience**

Generalist services are not always equipped to deal with sensitive cultural issues that arise when clients come from culturally diverse or Indigenous backgrounds. Research undertaken by Working Women’s Health in Victoria, with culturally and linguistically diverse pregnant women, recommends a set of strategies to help bring culturally and linguistically diverse women into mainstream services (Rahmanovic 2003). The strategies include: developing awareness by service providers about the needs of culturally and linguistically diverse women; ensuring co-ordination across existing services; delivering community and school-based education about the needs of culturally and linguistically diverse women; targeting culturally and linguistically diverse groups through information dissemination strategies; providing outreach services directed at culturally and linguistically diverse women, and providing cultural competency training for primary care service providers such as GPs (Rahmanovic 2003). Although this research with culturally and linguistically diverse pregnant women was not age restricted, the principles apply to younger women.

A few interventions around teenage pregnancy for Indigenous people are being piloted although there are, as yet, no evaluations that demonstrate the long term impact
of these projects (Slowinski 2002). However, there is some evidence from programs developed for Indigenous women of all ages that could point the way to successful service delivery to young pregnant and parenting Indigenous women. The physical and atmospheric characteristics of clinics appear to be crucial to appropriate attendance by Indigenous women and children (Atkinson, 2001; Nel, 2003; Benoit, 2003). The Townsville Indigenous and Islander Health Service (TAIHS) is one of several across Australia that have initiated programs to address these issues with outstanding success. A separate clinic, staffed by Indigenous health workers, dedicated female doctors, a child care worker and a driver are all located adjacent to an Indigenous health service medical centre. This reduces waiting time, solves transport difficulties, and encourages other children to accompany the mother. Most importantly the service welcomes Indigenous women into a community owned environment (Eades, 2004; AMA “The Good News, 2005). It would appear that a less hierarchical staff structure, in a dedicated space, with ease of access and less formal and more holistic service delivery reduces many of the barriers to service (Benoit, 2003; Eades, 2004; AMA “The Good News”, 2005).

The Indigenous definition of health is not just “physical well-being but the social emotional and cultural well-being of the whole community” (National Aboriginal Health Strategy 1989 in the NSW Aboriginal Perinatal Health Report, 2003, p.22). Antenatal clinics can be an interface between the community and the health system (The NSW Aboriginal Perinatal Health Report 2003; Benoit, 2003).

Attention to more than the physical needs of Indigenous women in antenatal clinics can be achieved by staffing clinics with Indigenous health workers and Indigenous or culturally aware technicians, nurses and counsellors who can address a range of issues wider than just pregnancy. There is evidence that providing these types of support in these settings is working well. Programs such as the Alkura Birthing Program have seen the Alkura midwives working between Indigenous health centres and main stream hospitals. As all the Alkura midwives have obtained the Australian College of Midwives Independent Practicing Midwife Accreditation, they will be able to re-establish a birthing program at the Alkura centre (CAAC Annual report, 2003). Organisations such as Yapatjarr Medical Centre, TAIHS, and Strong Women Strong Babies Strong Culture Program and the Nganampa Health Council Antenatal Care Program in South Australia all emphasize a combination of traditional practices (i.e. holistic approach to care) and western medicine (AMA “The Good News”, 2005). Congress Alkura Women’s Health Program has also incorporated Traditional Grandmothers into their support teams to help provide spiritual and traditional supports (CAAC Annual report, 2003). Each of these programs has successfully reduced the number of low birth weight babies being born in their communities (AMA “The Good News”, 2005).
Another successful program was developed to solve problems and barriers faced by young Indigenous mothers attending birthing services at Rockhampton Hospital (Dorman, 1997). The women interviewed in this study indicated the need for wide ranging antenatal and postnatal services, and in response, a community midwifery program was established. Women in the local community worked with the project team to develop the program with the aim of delivering quality continuing ante- and postnatal support and health care for pregnant Indigenous mothers and babies. Home assessments by midwives and support networks of both older and younger women were established to encourage the young Indigenous women to attend clinics during and after their pregnancies (Dorman and Perkins 1996; Dorman 1997).

The outcomes of this program include improved knowledge of birth, pregnancy and contraception as well as better understanding of medical terms and confidence in communicating with health professionals and hospital staff. There is also a wider use of other health services beyond this program. While the program was designed to meet the specific needs of Indigenous women, non-Indigenous women are also invited to access the services (Dorman and Perkins 1996; Dorman 1997).

Aspects of this program which are seen as crucial to its success include: location close to Indigenous people; home visiting; intensive promotion of the service; provision of transport; ante- and postnatal support; involvement of the client group in setting directions for the program and provision of a wide range of support. For those most at risk, such as homeless Indigenous youth, highly mobile and flexible outreach services, with some drop-in services, were identified as being appropriate. The program is successful in the way that it builds the capacity of a local Indigenous community. Local Indigenous women are involved in planning, developing and delivering the services. Ongoing participation and support from the women and their extended family are essential for sustainability (Dorman and Perkins 1996; Dorman 1997; Westenberg, van der Klis et al. 2002).

Despite the apparent success of this program, it is important to acknowledge that it is applicable to a particular Indigenous community in North Queensland, and therefore the model may not be directly transferable to other communities, or suitable for urban Indigenous women. Clearly more research is needed to develop appropriate strategies to address the needs of young pregnant Indigenous women and mothers across different settings (Slowinski 2002).

**Conclusions**

It is critical to recognize that young women of culturally and linguistically diverse and Indigenous origins can face significant cultural barriers in relation to accessing
mainstream services. While issues relating to teenage parenting are common across many cultures, the dominant social and political construct of young women pregnant and parenting in Australia may not correspond to the beliefs and practices of other young Australian women from ethnically diverse and Indigenous cultures. The limited programs described here attempt to address some of these issues. There is a need for some of the innovative policies and practices already in place (Boulden 2001; Department of Education and the Arts Queensland 2002; NSW Health 2002; Department of Education Queensland 2005; Ley 2005) to implement and evaluate effective culturally appropriate strategies.

3.3.2 Young women with substance abuse and mental health problems

Overseas experience

Substance abuse patterns in pregnant adolescents are associated with mental health status and problematic family and peer relationships (Scafidi, Field et al. 1997). In the US Baldwin et al. (1999) demonstrated a community-based intervention that included participative education regarding life skills, resource information, group support and provision for child care. The intervention, led by public health nurses, was aimed at mothers, 18 to 33 years, who were also substance abusers. While the target group included older mothers, the results have implications for the 25 and under age group.

In this study, Baldwin et al identified perceptions and behaviours of the women participants. The young women's stories contained indications of perceived barriers including lack of control, low self worth, guilt, lack of resources and living with the consequences of drug abuse. The researchers claimed that the success of this program was in the way that it delivered innovative action in response to the needs of these mothers, as well as the leadership demonstrated by public health nurses (Baldwin, Rawlings et al. 1999).

A program in the US addressed the needs of two sub-groups of pregnant teens that are rarely studied. They are young pregnant teens (aged 11 to 15) and African American and Hispanic pregnant teens with mild to moderate mental retardation (aged 11 to 19). One US study by Levy et al. (1992) demonstrated that both of these groups benefited from the same school-based education program. The research underscores the importance of addressing the specific needs of pregnant adolescents who are young, or who have mild mental retardation.
**Australian experience**

In New South Wales the Australian Red Cross, in conjunction with South East Area Health in Sydney, runs a three stage comprehensive program for homeless young pregnant women and mothers who suffer from drug and alcohol problems and/or mental health problems. During the first stage of the program, individual learning is developed through formal and informal meetings that address a range of social issues. The second stage offers supported accommodation and support, and the third stage offers transitional support to young women who are moving into their own accommodation. Ongoing support continues after this stage but is phased out, as community supports are developed and greater independence achieved. The outcomes of the program include improved physical and emotional health for the young women and their babies (Australian Red Cross 2006).

Conventional ante- and postnatal services are not accessed by homeless young women and some of the reasons for this are lack of transport and a transient lifestyle (Sageman and Cook 1995). In response to this gap, an outreach midwifery program has been established for homeless young pregnant women in Melbourne (Sageman and Cook 1995; Slowinski 2002). The aim of the service is to access women in appropriate settings (e.g. a school, a refuge, a special accommodation centre, detention centre). The visiting midwife provides antenatal and postnatal education and support that is tailored to individual needs, makes referrals to appropriate agencies, provides transport and other practical assistance, and acts as an advocate on behalf of the women where necessary. The main achievements of the program have been in providing accessible and appropriate ante- and postnatal care to a group of young women who would have otherwise experienced significant service access barriers (Sageman and Cook 1995).

**Conclusions**

Substance abusers face a complex suite of physiological and psychological barriers and young pregnant women and mothers with a history of substance abuse are a vulnerable sub-group. When developing strategies to address barriers in this high risk group it is important to provide a safe non-judgmental and non-threatening environment in which the adolescents can develop confidence and life skills, and break the cycle of substance abuse dependence. Similarly, sub-groups with special needs, such as those developmentally or mentally challenged, require targeted interventions that address their special needs. Young pregnant women and mothers are a diverse population and it is important that interventions reflect this diversity (Healy 1996).
3.4 CHARACTERISTICS OF SUCCESSFUL SERVICE PROVISION

In order to address service access barriers, programs and services for pregnant and parenting adolescents should be distinct from mainstream parenting and obstetric services (Bensussen-Walls and Saewyc 2001). The literature described in this chapter has identified common elements that have led to successful service provision, including: peer support workers acting as role models and mentors; school-based programs; parenting classes and other support services; informal support networks; home visiting; child care and transport to services, special purpose clinics for ante- and postnatal care; networks for inter-agency support, and service provider training. The features of successful services include confidentiality, flexibility, continuity of care, convenience and easy access, and non-judgmental staff and providers (Slowinski 2002). These are discussed further in Chapters 5 and 6, where facilitative factors and models of best practice are described.

3.5 UNRESOLVED ISSUES

It is important to recognize that young pregnant and mothering adolescents are a diverse group with a wide range of needs and so a ‘one size fits all’ approach is not appropriate. Targeting interventions too narrowly can advantage some, and at the same time disadvantage others, resulting in inequalities. Pfitzner et al (2003) identified sub-groups of young mothers at risk of repeat pregnancies, and argued that policy and practice should not focus solely on identifiable at-risk sub-groups but rather on the entire population of adolescent mothers (Bensussen-Walls and Saewyc 2001; Pfitzner, Hoff et al. 2003). It must be remembered also that this population is mixed and varied, comprising young women from diverse backgrounds, and that, despite good intentions, policies and programs aimed at the middle group may be inequitable and further marginalize those on the fringes.

There is debate in the equity and policy literature regarding whether interventions aimed at reducing health and social inequalities are more effective if they exclusively target sub-groups with identified needs, rather than make universal adjustments to services. There are pros and cons for each of these general viewpoints. On one hand it can be argued that targeted interventions can further stigmatize and marginalize disadvantaged sub-groups, while an alternative view is that, despite attempts to remove barriers and address inequalities on a universal basis, individuals inevitably
“fall through the cracks”. A third line of thinking argues that targeting sub-groups and improving access to available services is a “band aid” solution that does not address the causes which are rooted in social, economic and political structures. Proponents of this view argue that progress toward reducing inequalities must be accompanied by structural change (Harris, Sainsbury et al. 1999).

While the bulk of research on teenage pregnancies includes value judgments about teenage pregnancy and mothering in terms of disadvantage, Lee SmithBattle (2000) challenges mainstream views, arguing that to the extent that policy-makers and others cling to the problematic nature of teenage parenting, they will not discover the strengths, struggles, possibilities and resilience of young mothers. SmithBattle argues that “the deficit-finding focus of empirical-rational studies have exaggerated… the negative consequences of early pregnancy and…obscure…how teenage mothering is often a rite of passage to adulthood, particularly in the absence of middle-class resources and aspirations” (SmithBattle 2000). The current research aims to assess the relative values of targeted as opposed to mainstream interventions from the perspective of young women and their service providers. In this we are aiming to avoid the notion that young parenting is inherently problematic while acknowledging that there are aspects of many young pregnant women and mothers' lives that pose particular challenges for the young women involved. Finding a balance between appropriate accessible services and not stigmatising young women as ‘problems’ is as important to research as it is to service provision.

3.6 CONCLUSIONS

The barriers to service provision for young pregnant women and mothers are manifested through inter-related environmental, socio-economic and psychosocial circumstances. The literature reports upon these barriers in numerous contexts and from a range of perspectives. Consequently there are many permutations of service barriers and facilitators variously described in the literature.

While pregnancy and mothering places physical, emotional and lifestyle demands on women of all ages, some of the many inter-connected barriers faced by of young pregnant women and mothers are listed here:

- Low socio-economic status (in terms of education, income, welfare dependence, housing);
- Low socio-economic area of residence (social problems);
• Low levels of literacy and high school education;
• Homelessness or inadequate housing;
• Lack of transport to services;
• Reluctance to accept home visiting services;
• Educational pressures and workload;
• Low levels of family and social support;
• Absence of role models and mentors;
• Emotional scars from sexual victimisation and domestic violence;
• Substance abuse;
• Transition from state or foster care;
• Mental health problems (depression, low self esteem, stress);
• Geographic isolation from services (lack of outreach services);
• Lack of access to female practitioners such as GPs;
• Lack of culturally appropriate services (Indigenous & culturally and linguistically diverse);
• Negative experiences with mainstream services;
• Lack of understanding and knowledge about available services, resources and networks;
• Experience of prejudice and negative attitudes (by family, school, community and service providers);
• Lack of respite and child care when attending high school; and
• Lack of flexibility in school curricula.

From a service delivery perspective, barriers include: lack of sensitivity to the specific needs for this sub-group; judgmental attitudes; inadequate cultural awareness and sensitivity; workforce issues (e.g. insufficient providers in rural and remote areas and limited access to female GPs). It has been suggested that some of these barriers could be addressed through training and professional development that focuses on the issues for young women who are pregnant and mothering.
While the literature makes limited references to young pregnant women and mothers from culturally and linguistically diverse backgrounds, young women who lived in state care, or those with developmental or physical disabilities, very few papers report upon the experiences of these sub-groups in relation to service access. Similarly, there was little information covering tertiary or vocational education for young pregnant women and mothers. Most of the research in relation to education focuses on secondary schooling and strategies for high school retention. Our research aimed to fill these gaps.

With some notable exceptions (Rogers and Allwood 2005; Allwood, Rogers et al. 2001; Phillips 2003; Combes and Hinton 2005), the voices of young pregnant women and mothers, and also those of service providers, were largely absent from the research described in this chapter. As some of the research has demonstrated, consulting with young pregnant women and mothers was crucial to successful service provision. Therefore, we consulted with young pregnant women and mothers to identify barriers to service delivery and to further elaborate on the barriers that have been previously identified. Furthermore, we felt it was important to consult with service providers in order to gain a perspective on the barriers that service providers face in delivering services to young pregnant women and mothers. The findings from these consultations are reported in the following two chapters.

Most studies reported in this chapter focussed on adolescent motherhood and did not tend to include the experiences of pregnant women and mothers in the 20-25 years age group. While many of the problems that face teenage mothers, such as secondary school completion and developmental issues, are not directly relevant to young mothers in their early twenties, there are also major challenges for pregnant women and mothers in this age group. For example, women who have children in their early twenties might not have finished tertiary education and will also face an early interruption to any career plans they may have. They are also likely to have accumulated less in the way of financial resources compared to older mothers, and this can greatly disadvantage future employment opportunities and workforce participation (UK Social Exclusion Unit 1999; Sercombe, Omaji et al. 2002; Butterworth 2003). Furthermore, with the average age at first parenthood reaching 31 years for Australian women, women who give birth before age 25 could be isolated from their age-peers, as fewer women now opt for younger parenthood. These factors and other issues relevant to women aged 20-25, are examined in the qualitative research reported in Chapters 4 and 5.
This chapter reports on the findings from consultations with service providers and young pregnant women and mothers that pertain to barriers to service provision. We start with a description of the perceptions and expectations that young pregnant women and mothers had about services and the barriers associated with these perceptions. We then provide some background information regarding the types of services that women had accessed and the availability of these services, followed by a section that describes common barriers that deterred service access to any type of service. The next section covers barriers that were particular to specific services, and the final section includes findings that were particular to the vulnerable subgroups identified by NYARS.

The data that were analysed to determine the barriers to service delivery were collected using qualitative methods. As such, the results should not be considered representative of the populations to which they refer. It is also worth noting that the recruitment difficulties referred to in Chapter 3 might have led to the inclusion of participants who were the most motivated and most able to talk about service delivery to young pregnant women and mothers. As with most research, the characteristics of non-respondents are unknown. However, as was discussed in Chapter 3, the samples were diverse in nature. Furthermore, the consultations provided valuable insights into both the barriers and facilitators of service delivery to young pregnant women and mothers.
4.1 YOUNG PREGNANT WOMEN AND MOTHERS

We defined young mothers as being under 25 years, but a clear distinction was drawn by both service providers and young women between being a ‘young mother’ and being a mother who was ‘too young’. Young women who were aged less than 19 were generally seen as being too young to have children, while those 19 or over were seen as young mothers. This distinction was echoed in the research literature, where adolescent parenting research is common and research with mothers in their early twenties is uncommon. By labelling mothers as too young, and by focussing research and specialist services on this group there is an assumption that becoming a mother before the age of 19 is inherently problematic.

While past evidence suggests that young mothers are more prone to economic, social and personal problems, the view of service providers and young women went beyond those factors. Nearly all of the people who consulted with us, felt that young mothering was viewed by the community as ‘bad mothering’, a view that was at least partly informed by a lack of positive portrayals of young mothers in the media. There was agreement between providers and young women that the stereotype of a young mother was negative and not representative of the young women they had met who were mothering at a young age.

The stereotype of a young mother was thought to include welfare dependency, having children to receive the Baby Bonus, sole motherhood, stupidity for getting pregnant, irresponsibility, a lack of education, and above all else an inability to parent a child responsibly and well. Less commonly, service providers and young women thought that young mothers were viewed as ‘drug addicts’; and as people who had experienced abuse. The majority of the service providers who consulted with us did not make these assumptions about young mothers. In fact, some providers commented that their clientele included young women who were responsible and generally coping well with parenthood despite the social and economic difficulties that many of the young women experienced. Providers also pointed to positive aspects of young parenting, such as high levels of resilience and energy.
I’ve also found that age doesn’t seem to be a factor in whether a young person is or isn’t able to parent their child, there’s lots of other factors that feed into that, and the age range is wide too, um, I’ve found you can have a fifteen, sixteen year old who’s a very accomplished mum, yet you could have a thirty five year old that had no idea whatsoever.

_Service provider_

Nevertheless, all service providers felt that young mothers, especially those under 19, were in need of support. Young mothers, however, often felt differently. Most of the young women who participated had an expectation that they would be seen as the stereotype of a young mother, rather than as an individual. As a result, many well intended interventions and supports were viewed with suspicion. Furthermore, targeted interventions were sometimes seen as a judgement that they were ‘not as good’ as older mothers. Unfortunately, the belief that they would be judged as an inferior parent formed a major barrier to service delivery.

Ironically, it is often the judgement of young women that service providers will judge them that keeps young women from using services. Fear of being judged by service providers appears to be related to a general lack of confidence among young mothers. Similarly, service providers recognised low self esteem as a common element of young motherhood. Fear that groups would not include ‘anyone like me’ also kept young women from attending groups. A combination of fear and low self confidence acted to prevent young women from making the first visit to a service. These factors were set aside when the service was perceived as essential, such as antenatal and birthing healthcare, or when a child was ill and in need of medical attention. Similarly, fears were allayed if the young woman had heard previous positive reports of a particular service, if a friend was going with them, or where they had family support. It should be noted, however, that many young women had become isolated from their age peers and did not always have family support.

And your young friends don’t really want, I mean they love the baby and everything but they don’t want to sit and listen to you say, “I didn’t sleep last night.” They just don’t understand what I feel like. They’ll talk about, “My boyfriend this, my boyfriend that, oh, work this, work that.” And I’ll just go, “Oh well I got bit on the nipple today and I got about three hours sleep.” And they’re just like, “Oh, ok.”

_23 year old mother of one_

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2 Where possible the type of service provider will be noted. However, the nature of the data (i.e. audio taped interviews) sometimes precluded identification of the participant who was speaking, which did not allow for their occupation to be determined.
Once young women attended a service, they were found to judge the service quickly, with little room for error on the part of the service concerned. Where service delivery was found wanting, young women tended not to return to the service. Importantly, young women generally lacked the confidence to take steps to improve the service they were receiving. For example, young women were unlikely to complain to a service manager, ask for an alternative provider (e.g. change of counsellor), or to tell the provider what it was about the service that they found distressing or unacceptable.

Being, you know, eighteen and not knowing what has to be done when you go in for your checks and everything, and (the doctor) wanted to feel my boobs all the time. And at the time I thought, “Gee, I don’t know whether this is right.” And...I left there and never went back...I wasn’t happy, was not happy and I mean being in a profession where they are respected, there was no way I was going to open my mouth and say anything.

27 year old mother of four

While the majority of the providers we interviewed did not make assumptions about young women’s ability to parent, many had experienced occasions where young women had been the subject of discrimination. It was the opinion of the providers and the young women participants that the stereotype of young mothers was a commonly held view among some service providers. The negative attitudes towards young mothers that service providers reported were racism, seeing young women as a problem or as immature, and expectations that women would fail, would return to violent relationships, or would return to using harmful substances such as illicit drugs. When young women experienced these attitudes the results included reinforcement of fears, further erosion of self-confidence and ultimately acted to deter young women from trying other services.

I was nineteen and I knew all about pregnancy basically, well most of it, but (the midwives) would talk to me like a five year old, as (if) I wasn’t ready to have a child yet, and like I wasn’t thirty five and married and it was wrong... their attitude towards me was like I was five, “Stay here, go there, sit over here.” And half of them didn’t tell me what was wrong or anything, because I was back and forwards to the hospital so. But they’d go and explain to my mother instead.

21 year old mother of one
As with many stereotypes, there are elements of the stereotypical young mother that have their origins in truth. As was described in the previous chapter, past research has indicated that young pregnant women and mothers are more likely to experience financial stress, lower education levels, less social support, lower self-esteem, and family conflict than other women their age. However, there is a fine balance between providing services to young women that will help with these problems which exist at a population level, and being seen as making a judgement about the lives of individual young women. By far the most successful services were those that were able to offer individual programs and that developed strong positive relationships with their clients, discussed further in the following chapter. The point here is that young pregnant women and mothers, whether delineated as ‘young’ or ‘too young’, appreciated personalised treatment and reacted negatively to being treated solely on the basis of being a young parent.

(At) the antenatal clinic where they recognized that young women weren't coming to the clinic and certainly weren't coming early in their pregnancy, and instead of talking to young women about that, they decided a good thing to do would be to make one morning where they booked only young women on that morning. And they did that with the best of intentions and in the hope of being more accessible. It was interpreted by the young women as them being difficult clients and all being put in at the same time, and it raised a whole lot of anger amongst young women, that continues even now that we've tried to sort some of that out.

Support group facilitator

Young pregnant women and mothers are a diverse group that require a corresponding diversity in service delivery. What one young woman perceives as helpful, another will perceive as a judgement that she is an inferior parent. It is therefore contingent upon service providers that young pregnant women and mothers be treated as individuals with varying strengths and weaknesses, differing personal circumstances and different levels of knowledge.

...with the people that I've not enjoyed seeing I think it’s been a bit like, “Oh, you’re a young mum so you don’t know what you’re doing”.

22 year old pregnant mother of one
It just wasn’t enough to see my nurse every fortnight and just be left to it after that…I didn’t really feel like the day-to-day this, you should put the baby down at this time, and this and that, was covered very well…I just didn’t have any friends with babies and I’m the oldest and (my partner is) the oldest in his family so neither of us have nieces or nephews, so we’re really inexperienced…we got home from the hospital and had no idea how to change a cloth nappy and that’s all we had.

23 year old mother of one

The perceptions and expectations that young women hold about service providers that we have described underlie many of the barriers to service delivery. These perceptions are informed by fear, low self confidence, the expectation of being judged, and previous experience. In the following sections we discuss the types of service that young women access and then elaborate on the specific barriers young women have experienced in accessing these and other services. Throughout this discussion is the implicit assumption that young pregnant women and mothers are in need of services. While it is true that some services would be classified as ‘essential’, such as healthcare, other services should be viewed as potentially useful to some young pregnant women and mothers.

4.2 TYPES OF SERVICE AND AVAILABILITY

In this section we briefly review the types of services that young pregnant women and mothers might use. These include education services, social support, health and welfare services, ante- and postnatal healthcare services (including early childhood healthcare) and other government services (eg. Centrelink). In addition, we discuss the availability of services, defined as the presence of a service in the local community.

As a cue and conversation starter, young pregnant women and mothers who were interviewed in public spaces were asked to indicate the types of services they had used. While we were not initially intending to collect quantitative data, the results of this survey were informative and are presented in Figure 1. Please note, however, that we had insufficient data to determine the representativeness of the sample, so results should be interpreted with caution. The young women we interviewed were most likely to have accessed healthcare and government services and least likely to have accessed education services and support groups. The exception to healthcare was obstetrician services, with only 38% of women accessing an obstetrician. In part this was due to financial cost, but in most cases women said they did not require this
type of specialist service. Just over 60% of the women had attended prenatal classes, with many reporting cost as the reason they did not attend (discussed further in the following section). Of some interest was the 27% of women who had not visited an early childhood health centre. Many of these women said they preferred to visit the nurse at the chemist, rather than the centre.

**Figure 1: Percent of young pregnant women and mothers who had accessed different service types**

![Figure 1: Percent of young pregnant women and mothers who had accessed different service types](image)

Service availability was discussed by young women who lived in rural areas: this was largely limited to specialist medical services, such as obstetrician services, specialised sonography, and diabetic services. In most cases young women had been able to access these services by travelling to regional centres. Standard antenatal care was not locally available to many women who lived in rural areas and women needed to travel in order to access antenatal classes, healthcare and birthing care. Travel is discussed later in this report as a barrier to service delivery. While all the young women interviewed appeared to have postnatal baby health checks available to them, not all women had used this service. Breastfeeding support was reported by some women as being unavailable in their area. The availability of provider choice was mentioned by young women in rural areas. For instance, general practitioners had closed their books resulting in limited choice in health and obstetric care.

The availability of child care services was widely varied. For example, in one outer metropolitan area, a service provider reported high vacancy rates at local child care centres, while at another outer metropolitan area it was common for child care centres
to have long waiting lists. These two areas were not far from each other and so the problem with accessing child care in this case can be seen as a problem of travel, and the time taken to travel, as much as it was a problem of availability.

The availability of a particular service was also reliant upon there being vacancies within a service. Supported accommodation services in particular were short of places.

*We get around a hundred and fifty referrals in a year, we can only do between twelve and fifteen referrals in a year...*

**Accommodation support manager talking about housing young women**

Access to housing was problematic for young pregnant women and mothers. It would not be fair to say that housing was unavailable, it was more the case that accessing housing was precluded by cost, literacy problems and other issues to do with mental health and abuse. The services to help young women with housing were available, although barriers to their use existed and are discussed in the next section.

In summary, young pregnant women and mothers were found to have accessed a variety of services, particularly those which we have called essential and those that involved accessing financial support (e.g. Centrelink). Availability of services was felt by young women to be adequate, although often inconvenient. In the opinion of service providers, young women’s knowledge about available services was quite low. Furthermore, we noted that many young women had not sought out certain services, particularly family support services and mother’s groups, because they had not felt that they ‘needed’ them. Therefore, our report on the availability of services should not be considered a comprehensive assessment of the types of services that are available to meet the needs of young pregnant women and mothers.

### 4.3 COMMON BARRIERS TO SERVICE DELIVERY

This section includes the results of our consultations that pertained to barriers that can occur for all services for all young pregnant women and mothers. We have separated the barriers into the themes that emerged from the consultations. However, no one barrier acted in isolation from other barriers. For example, a young woman experiencing financial difficulties would experience a barrier to services that cost money, and a barrier to any service for which she had to spend money on travel.
4.3.1 Knowledge

All service providers talked about a lack of knowledge as being a major impediment to service access. Lack of knowledge encompassed a lack of knowledge about what services were available, when certain services should be accessed, how services were accessed and, once services were located, what the services had to offer.

*I think there still must be hundreds and thousands of young women out there who get pregnant and have no idea what to do, no idea where to go, 'cause some of them, if they happen to go to the doctor that’s ok but a lot of them don't go to the doctor...they're so frightened... If they are unfortunate enough not to have family support, they run away, they lose their whole network, they lose everything.*

*Service provider*

Most young women that we interviewed said that they found out about services from their antenatal and birthing care providers. This information was sometimes comprehensive but most frequently included only the contact details of the postnatal and early childhood health nurses. In turn, these nurses provided other information about mother’s groups and breastfeeding support to young women. However, if a young woman did not see an early childhood health nurse or was generally disconnected from services, she had no access to these information sources.

During metropolitan focus groups many service providers exchanged contact details with each other and mentioned that there were services represented at the group that they had not known about. Given that young women tend to learn about services from providers of different services, a lack of knowledge among providers about local services can be viewed as a barrier to service delivery. By contrast, the two rural groups were well informed about local services. In fact, the services offered by the rural providers were well coordinated and referrals from one service to another were common. Service networking was found to be a facilitator of service delivery and is covered in more detail in the following chapter.

Knowing when and how to access services was also seen by the service providers as a problem for young women. This was of concern if young women did not recognise when their children were ill, although this was uncommon and most likely to occur for young women with intellectual problems. Of equal concern was young pregnant women’s entry into the healthcare system.
...they don’t know what to do, I mean they’re children, a lot of them, and they just haven’t got a clue how you work your way through the health system, they don’t know yet, they’ve often had no other contact...

*Service provider*

Young mothers talked about being isolated from their peers and of feeling lonely, but were largely unaware that mothers’ groups and playgroups could help them connect with other women. This is indicative of a lack of knowledge about what a service might have to offer. Furthermore, young women and service providers said that young women learned about services by word of mouth. If a young woman is isolated, then opportunities for learning about services in this way are limited to contact with whatever healthcare workers she may see, who may or may not be well informed.

One further point about knowledge was the quality of the knowledge that was passed on to young women. It appeared insufficient to suggest that a young woman go to a play group or a mothers’ group. It was much more useful if details about the particular service were provided. For example, saying who coordinated a group, where and when it was held, and how the group could be contacted. Therefore, insufficient information about the service constituted another barrier to service delivery.

*The midwife we had was a lactation consultant and she said to get along to the (Australian Breastfeeding Association) meetings but she could have said anything because I didn’t really know what she meant by that. And my mother actually went to nursing mothers years ago and told me that I should go to that. But there wasn’t any specific information, or go to this website, or call this number, or anything like that...*

*23 year old mother of one*

### 4.3.2 Literacy

Literacy was named as a barrier to services by providers who had adolescent women as clients. Limited reading and writing skills interfered with women’s ability to learn about services, to apply for support benefits and/or housing, and to follow written directions. Since many services are advertised by posters, flyers and pamphlets, and most government services require some type of form to be completed, young women with literacy problems could well be missing out on beneficial services.
4.3.3 Structural barriers

A number of barriers to service delivery involved policies and procedures that precluded access to services for young pregnant women and mothers. Medicare cards were mentioned as a major problem for young women who were still attached to their parent’s cards, and for women who had no access to the Medicare system, such as recent refugees and illegal immigrants. Without a Medicare Card young women were unable to access local health services, including general practitioners.

The provision of bulk billing was a facilitator to service for those young women with Medicare cards. The reverse was also true, the lack of bulk billing was a barrier to general practitioner services, especially where young women did not have an income. Bulk billing is much less likely to occur in rural areas, and so this barrier is more likely to occur for rural compared to metropolitan young women.

_I am much more inclined to Bulk Bill under 16 year olds and pensioners since addition of Medicare (enhancement) for these groups. Young pregnant women fall through this gap._ **General practitioner**

Insurance was another issue for some services. For example, one service was unable to provide child care for its members because the insurance did not cover children aged less than 18 years. Another service reported that providing services, such as child care, for young women with children was not possible because of the nature of the funding that the service received, which was specified for youth aged 12-25 years. Both of these service providers said that young women stopped attending their services once they had given birth to their children.

Although previous research had suggested to NYARS that the religious basis of some organisations might result in attitudes that were not conducive to young pregnant women and mothers, only one young woman mentioned a religious bias at a service she was using. This woman felt that the organisation did not make allowances for pregnant unmarried young women because it was a situation that ‘should not occur’. Despite difficulties with using the service, this young woman continued to attend.

Structural barriers for young pregnant women and mothers who belonged to one or more of the vulnerable subgroups were varied and serious, often resulting in young women ‘falling through the cracks’. Due to the complexity of their situations, these issues are covered in a later section (Multiple vulnerabilities).
Arbitrary age limits were mentioned by young women in their early twenties, who felt as though they were not catered for. One young woman commented that she was a ‘young mum sometimes and then sometimes not’ after seeing a poster for a young mother’s group that was limited to under 21 year olds. Service providers had also noticed this gap in services, which was especially difficult when women with children passed an age limit and were no longer able to access services they had been using, such as young mothers’ support groups.

Structural rules were also responsible for the withdrawal of some services from young women - for example, where young women had not conformed to the rules of a service. It should be noted, however, that rules are necessary for services to function. For example, violence was mentioned by supported accommodation workers as a reason for instant removal of the young woman from the service. While the service did provide for the young women in this situation, by placing them in a hostel or hotel, young women would no longer have had access to the other supports, such as counselling, that were available at the accommodation service. In this way, anti-social behaviour among some young women could be seen as a barrier to service delivery.

Other rules such as age limits mentioned above, and instances where young women were making non-conforming rather than dangerous choices, might be seen as less imperative. For example, one young woman chose to leave hospital very soon after giving birth and became ineligible for an early release visit by a postnatal midwife.

So I wasn’t actually eligible for (home visits) because I’d left (hospital) because I’d taken my baby home against medical advice.

22 year old mother of two

4.3.4 Cost

As was mentioned in the previous chapter, young pregnant women and mothers are likely to experience financial distress. It was not surprising to find that cost was a major barrier to service delivery. One of the main reasons that young pregnant women and mothers had not attended antenatal classes was due to cost, when free classes had not been available. Furthermore, experiencing financial difficulty affected women’s ability to undertake travel, either by public transport or private car.

Cost also precluded many young women from having private health insurance, which stopped them from having, or from believing that they had, a choice of health service providers. The cost of prescriptions was out of reach for some young women, while others were unable to access general practitioners who did not bulk bill and required
up front payments. The cost of child care was also noted by young mothers as being an unaffordable luxury, in some cases women who wished to return to paid work had decided it would not be economically profitable to do so because of the cost of child care.

*I think everything offered to young parents has to be as cheap or free, they’re just not going to go if they have to pay.*

_Service provider_

Young women also felt that having limited finances contributed to their isolation, as they were unable to afford to go out with friends, take part in activities where they might meet people, or to afford a babysitter so they could take part in social activities.

### 4.3.5 Transport

The most frequently mentioned barrier to service delivery by service providers was transport. As has previously been reported, young pregnant women and mothers might be too young to have a driver’s licence, unable to afford a car and find public transport difficult to manage, both physically and financially. For young rural women, accessing essential services required access to transport, most often to a private car, since public transport was inconvenient or unavailable. Group facilitators noted that it was seen by young women as ‘too difficult’ to attend groups when transport was not provided.

### 4.3.6 Mobility

Young pregnant women and mothers who moved away from an area were vulnerable to a lack of knowledge about local services. In addition, young women would be faced with making ‘first visits’ again, which they often viewed with trepidation. Where young mothers had already given birth to their children, they might not be in contact with health services, which were found to be the most common providers of service information. Service providers also talked about young women being ‘transient’ and the difficulty they experienced in maintaining contact with some of their clients. Escaping from abusive situations, finding more affordable accommodation and paid employment were the most common reasons given for moving house.

Moving house also involved a structural problem for services whereby they found it difficult to provide services ‘out of area’.
We have situations where someone moves out of the (local) area and then you’re stuck. They still want to come to the group, and in reality that, you know, it’s supposed to be for the (local) area. So then you have a problem of a girl who has a one year old and has just had a premmie baby, with prams and trains and steps. So one of two things happen, we either try and arrange transport for them to get there and back or they don’t come, which leads us back to isolation.

*Group facilitator*

4.3.7 Local neighbourhoods

The character of the local area was not mentioned by many young women, although service providers did comment that some areas of their communities were not ‘good’ areas. Past research had indicated that ‘distressed’ neighbourhoods could act as a barrier to service delivery and we found some support for that finding.

...when you’re in the mall it’s not too bad but when you walk out there’s like junkies and there’s lots of mentally ill people around that you’ve got to sort of watch out for all the time.

*24 year old pregnant woman talking about why she did not like to go out alone in her neighbourhood*

We also found that living in a high socio-economic area involved difficulties for young mothers with limited financial resources. Services in these areas were expensive which prevented the young women from attending and meant that they had to travel in order to obtain services in a less affluent neighbourhood.

*It’s a lovely place to have your service but there are drawbacks in as much as our clients are living in an economic area that’s way outside of what they would even dream of getting in, which really is way outside most of our dreams of living...that precludes them accessing local services so you’re going further outside that area to access services that they can afford or that those services will provide for them.*

*Supported accommodation manager*
4.3.8 Time and routine

One barrier to service delivery that was common for pregnant women, mothers and service providers was a lack of time. Service providers talked about not having ‘enough time’ to spend with young women, and young women talked about ‘not having the time’ to attend some services. For service providers time was limited by the extent of their responsibilities and inadequate staffing levels. Insufficient time occurred for young women mostly in the context of paid work or studying responsibilities. Both groups who were time pressured experienced stress around timing issues. Young women found waiting times at antenatal clinics to be frustrating and uncomfortable. However, this did not seem to deter them from attending.

Service providers thought that many young women, particularly those under 19, had difficulty with establishing routines, and in living with a routine. This led to missed appointments and difficulty in attending services that were held at set times or on set days. Young women in this position might avoid services with set times, and might also experience a further reduction in confidence for not being able to maintain a routine or meet appointments.

4.3.9 Previous negative experiences and adverse word of mouth

We previously mentioned that many young women were quick to judge a service as being inadequate. This section covers a related finding, that young women will avoid services that are similar to services where they have had a previous negative experience.

The common elements of a negative experience included not feeling heard, feeling pressured to breastfeed, a lack of individualised service, a sense they were being discriminated against on the basis of their age, a lack of sympathy, feeling rushed, not receiving adequate explanations of procedures, and a feeling that assumptions were being made about their personal circumstances.

*Midwives made you feel like a statistic, no personal service. No one knew my name or if they did they never used it.*

24 year old mother

*(The midwife) just treated me like I was, I don’t know, a stupid little pregnant girl...who knew nothing and I didn’t like it at all...it was just really condescending, things like... “Oh, you should be eating a lot better, you should know this and you should be reading, do you read?” And just stuff like that, asking me whether I read, of course I read!*

24 year old pregnant woman
Perhaps because many young women had limited experience of pregnancy, childbirth and parenting they were particularly sensitive to receiving conflicting information from different sources. For example, being told two different ways to breastfeed a child. Young women were also distressed when they felt as though they had been ‘left alone,’ or when given information that was later found to be incorrect. Conflicting information, being ignored or being given incorrect information led young women to lose confidence in service providers.

A lack of discretion from providers of services that might stigmatise young women also constitutes a barrier to service delivery. For example, one young woman talked about being approached in a crowded hospital corridor by a drug and alcohol counsellor who loudly offered her services to the young woman. This indiscrete and public approach failed and permanently cut-off a potentially useful service.

One service provider noted that a young woman’s family might have bad past experiences with service providers, and might then pass these feelings on to young mothers. Negative word of mouth did act to deter young women from attending services, just as positive word of mouth facilitated service access.

### 4.3.10 Social and family support

Many young mothers received support from family that was beneficial and this is described in more detail in the next chapter. We were surprised to find, however, that some young women did not access services that might have been helpful because they felt that their family offered sufficient support. Services that were deemed unnecessary included antenatal classes, early childhood health nursing, and breastfeeding support.

Non-family social support appeared harder for young women to come by. As was mentioned earlier, many young women become isolated from their age peers. Often their lives were characterised by feeling as though they did not ‘fit in’, which led to loneliness and a lack of informal support. Because young women tended to find out about services by word of mouth, being isolated also decreased the likelihood that they would know about services, in addition to not having social support from age peers or other mothers.

Formal social support was available from family support services and other non-government organisations but was only used by 32% of the young women we interviewed in public spaces and none of the young women who completed telephone interviews. However, many of the service providers we spoke with worked in these types of organisations and had full client lists. Generally the services offered included one-on-one counselling, group facilitation, parenting education, and other classes
that were designed in response to the needs of the group concerned. Where support workers were well informed they were able to put young women in touch with many useful services and also advocated for their needs from other services, such as the Department of Housing. However, after speaking with young women during fieldwork, we were left with the impression that many young women had no idea what family support services were, let alone where they might find them. This problem was recognised by some family support workers, who were addressing the problem.

_We’re learning that the client can’t find us unless we’re visible and so we’re learning to network with the hospitals, with the police service, the schools, or whoever, so that is giving, probably, access to a lot of women that previously wouldn’t have known we existed._

*Family support worker*

## 4.4 SPECIFIC SERVICES

This section includes the barriers that were specific to particular services. Noticeably absent from the following services are antenatal and birthing care. There were no specific barriers to these types of care beyond those that have already been mentioned. For the most part, young women were able to access antenatal and birthing care, although they were not always satisfied with their experiences and rural women had to travel, which was difficult where financial distress was apparent.

### 4.4.1 Government services

Although young women were specifically asked about government services, the only government service named was Centrelink. Findings for Centrelink were mixed. Some young women felt that they had been well treated and fully informed, while other young women had experienced long waiting times and confusion with forms. Service providers were concerned about the amount of paperwork that was required of young women seeking income support and felt that the complexity of some services meant that they were inaccessible. We contacted Centrelink to try and determine the benefits that young pregnant women and mothers were entitled to, our results are presented in Appendix D.
(The paperwork) needs to be...more plain English that the average person can understand, rather than they read one part and it tells them one thing, but if you do this, or this, or this, it affects this and this and this. Nobody understands it. I mean, I don't think the people who work there even understand it half the time to be honest, sorry.

**Support group facilitator**

Service providers mentioned that the NSW Department of Community Services (DOCS) was often hard pressed to find accommodation for young women with multiple vulnerabilities (discussed further later). Furthermore, providers thought that young women had a fear of DOCS taking their children into care that prevented them from attending some services.

### 4.4.2 Housing

Housing services include government services (e.g. Department of Housing) and non-government organisations (e.g. charity operated supported accommodation). Specific barriers to housing services included the need to complete forms that were perceived as too complex, and not knowing how to go about accessing such a service. Barriers to actual housing included financial stress and a lack of knowledge about rental procedures.

*I think just getting housing for young parents is really difficult ...they don’t necessarily hold, have a disability... It’s very, very, very difficult to access houses through Department of Housing for young parents...Then we get told they have the support from Centrelink, so then they should be able to afford private rental, but then they’re often paying off other debts as well, which sometimes leaves them with an income of fifty dollars a week, which is appalling...*

**Service provider**

### 4.4.3 Education

Young pregnant women and mothers of secondary school age were unlikely to continue with their schooling in a traditional setting, in the opinion of service providers. Barriers included: expulsion for behavioural problems, expulsion for other reasons, transport, child care, lack of social support, expenses, and lack of motivation. Some service providers felt that their clients had been expelled for being pregnant, although pregnancy was not the reason given by the schools in question. This warrants further investigation.
A lack of motivation to attend school was related to focussing on children’s needs, having other problems (e.g. financial, relationship & family stress) and to not feeling as though secondary school was relevant at that time. Secondary education is available to young pregnant women and mothers through distance education in NSW, which overcomes some of the financial and transport problems. However, distance education was not seen as a satisfactory solution by service providers, who said that young mothers had difficulty finding the time and motivation for independent study.

*The option that’s often pushed is the distance education done through TAFE. And to be a young person, pregnant and then with a child and doing distance education, the failure rate’s huge... You’re locked away, you’re not, you’re not having contact, you’re not interacting with people, especially other young mothers.*

**Service providers**

Outreach education services were helpful for some courses but were limited by some structural limitations in some areas. Service providers reported that outreach education was often aimed at assisting students to be in a position to undertake further study, and suggested that outreach courses could be more vocationally structured. As examples, providers suggested that associate diploma courses might be offered by outreach programs.

One young woman talked at length about the difficulty she was experiencing as a pregnant university student. Her university did not have child care, and she felt it provided no infrastructure support for pregnant women. The need to undertake work placement and timetabling problems further complicated her study and was likely to increase the time it would take her to finish her degree.

*It just seems like I’m the only one at university who, my age, who is pregnant... in the last month or so I’ve just been feeling so tired and working and travelling an hour and a half to uni everyday and an hour and a half back...I needed a bit of leeway, I think, for assignments and stuff, cause I just wanted to go home and collapse...It’s like it’s assumed that if you’re getting educated you’re infertile.*

**21 year old pregnant woman**

For the most part, those young women who wished to study were doing so despite the difficulties they experienced. Of the young women who participated in fieldwork interviews 26% were studying and 31% of telephone interviewees were studying.
Although neither sample should be considered representative, it is encouraging to find so many young mothers undertaking further education. Difficulties in obtaining child care, not having time or not wanting to spend the time studying, expenses, and needing to undertake paid work were the most common reasons given for not studying by those women who wished to study.

4.4.4 Child care

We did not assume that child care was a positive or a negative undertaking, but were interested in finding out whether young women felt that they could use child care if they wished. Local availability and affordability were the most common barriers to child care but we also noted a reluctance to use child care due to perceptions of what child care might say about the ability of young women to parent. A fear of being seen as a ‘bad mother’ prevented some young women from using child care services, while service providers said that young women feared they would be bad mothers if they used child care services. It is likely that fear of being perceived negatively might prevent young women from using child care, rather than the belief that they would actually be bad mothers. A fear of judgement ties in closely with low feelings of self worth and confidence that were discussed earlier.

Some child care services were criticised by young women for not providing enough detail about the day their children had experienced, for not welcoming children appropriately, and for not paying personal attention to mothers and children. As with other services that did not measure up to the young women’s expectations, children were withdrawn from care and either sent to alternative child care or not returned to child care.

4.4.5 Early childhood healthcare

Early childhood healthcare was provided by home visit nurses, nurses based in centres or clinics and nurses who visited chemists. The early childhood healthcare experiences of young women varied from very good to quite poor. Barriers to this service included feeling uncomfortable near older mothers in waiting rooms and finding individual nurses to be, ‘too bossy’ and ‘judgemental’, and feeling as though the service was unnecessary. Young women also talked about feeling ‘bullied’ into using techniques with which they were uncomfortable, which pertained mainly to controlled crying techniques.3

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3 Controlled crying is a technique whereby babies are left to cry for varying periods of time, with the aim of teaching the baby to sleep for longer periods.
Home visiting services were generally well received by young women, with the positive aspects of not needing to travel and feeling comfortable in their own homes being stressed. However, not all young women were happy to have a stranger in their home.

(The home visit nurse) said, “Oh I have to ask about any spousal abuse.” And I’m like, “Oh, there is none,” and she said, “No you have to honest.” And I said, “I am being honest” and (my husband) was like in the next room, like not paying any attention, and she’s like, “Oh you can whisper,” and I said, “I don’t need to whisper.” And she said you know, like just trying to extract, extract, extract and I’m like, “There really is no problem,” and she said, “Oh well if you need to ring me when he’s not at home to let me know.” And I’m like, “Okay,” ...she seemed hung up on that, I don’t know whether that was because we seemed young to her to be having child...I don’t know whether maybe she’s had instances of people not saying...she just seemed hung up and that rubbed me the wrong way and I just didn’t worry about getting anyone to come back to my house, I just found my own sister to weigh (my child) and everything.

22 year old mother of one

Every young woman we interviewed had intended to breastfeed their child. Where breastfeeding had been difficult or impossible, young women felt that they had been harshly judged by early childhood nurses, which, again, did not help with their confidence or self esteem and discouraged them from attending the service in the future.

4.4.6 Groups

Groups included young parenting support groups, playgroups and mothers’ groups. These appeared to be very difficult for young mothers to find and were also prone to arbitrary age limits when a group was for ‘young’ women. Other factors that prevented young women from attending were a fear of joining a group where they knew no one, a fear of being the only young mother there and of having nothing in common with older mothers, and transport difficulties. There was also a feeling among some young women that attending a group was unnecessary.

4.5 VULNERABLE SUBGROUPS

Up to this point we have discussed barriers to service delivery that could potentially apply to all young women. In this section we describe those barriers that are specific to particular groups of young pregnant women and mothers. To those groups nominated
by NYARS we have added young women who have experienced abuse. The following issues did not occur in isolation, the combined effect of experiencing multiple vulnerabilities is discussed at the conclusion of this section.

4.5.1 Young women from culturally and linguistically diverse backgrounds

Included among the clientele of service providers were women with culturally diverse backgrounds who did and did not speak English, who were temporary residents, permanent residents, Australian citizens, first generation Australians, and refugees (including illegal immigrants).

The most obvious barrier to service delivery for non-English speaking women was language. Although some services provide pamphlets and information in languages other than English, these were not always adequate. Furthermore, such linguistically diverse services were not always widely known. For women who did not speak English, every service access was problematic. There were few antenatal classes available in languages other than English and group facilitators were often monolingual. Uncommon languages were an even more difficult barrier for service providers to overcome, when translators and interpreters were not readily available. Women who did not speak English tended to be reliant on family for support, and where available, on local communities where their spoken language was more common. It is noteworthy that these problems will exist for all women who do not speak English, not just those who are young.

Our longest resident was an asylum seeker who was with us for two and a half years, from (a non-English speaking country), arrived here pregnant with her first and then, anyway she ended up having two kids and was here for a very long time. We’ve had numerous girls, predominantly from (non-English speaking) countries, and we don’t have anyone on staff that can speak any (of those) languages but the girls have all, just developed this kind of, um, language that staff and the girls can communicate with...

Supported accommodation worker

Some temporary residents, refugees and illegal immigrants were unable to access health and financial support services because they did not qualify for Medicare cards or government assistance. Service workers had obtained support for women in this position by obtaining financial sponsorship from charity groups, but it was unclear how women in this position would have fared if they had not been in contact with any services.
...accessing services that can help a woman that’s not entitled to any funding at all, so we are, and the (charity) are sponsoring her, we provide the accommodation, they provide the food...

...Ours was supported by (charity) and we provided the accommodation. Anytime she went to hospital with a sick child she was refused entry to the children’s emergency centre, anytime they would not see her because she did not have a Medicare card...One time there was two, two staff members standing there, and this poor triage nurse saying, “What are we going to do with this very sick child?” The child had pneumonia and they just wouldn’t. In the end we ended up seeing the CEO who gave us a letter that we could produce. But that took a couple of weeks, very, very difficult.

Two service providers discussing clients who were seeking asylum and who were not entitled to funding

In addition to language and legal barriers, young women from other cultures experienced barriers to service delivery that involved cultural beliefs and religious aspects of their lives. For example, a multicultural support worker explained that asking for help from a service was not done in her culture, there was instead an expectation that help would be offered and would not need to be requested. For some women, available medical services did not include providers who were acceptable to their religious faith.

One of the main issues for younger women or (religion) women to access services such doctors, in finding female doctors especially relating to woman issues, that is not just gentleman, for us we have this issue, finding the right female doctor. It is hard to find one.

Multicultural centre women’s support worker

Social isolation was a problem for some women from culturally diverse backgrounds, especially where they had left their country of birth to marry. Other young women were isolated from their cultural communities and families when they fell pregnant. This occurred where pregnancy outside of marriage was culturally unacceptable.

...another issue with those girls, is that they’ve often come out from (non-English speaking country) or wherever and they’ve got no family themselves here. I mean they’ve the husband’s support family, but they are very, very isolated...they’ve their extended family but not their own mum.

Service provider
Managing cultural conflict between a young woman and her family was especially challenging for service providers. Barriers to service delivery occurred where a young woman’s family felt that the service was culturally inappropriate. Some young women would access a service in secrecy, while others would not return to a service that their families did not approve of. Difficulties for providers arose when a young woman’s wishes were overruled by the cultural expectations of the family.

*I have actually had to discipline a worker, because the worker, because of the culture, has said the girl needs to stay with her family and needs to marry. And I said, “Hang on wait a minute, no, no, no we don’t work that way here. That girl has a right, and if she wants to be with the father of her child but doesn’t want to marry, that’s her right.” So I’ve actually gone against the culture, um, to support what the girl wanted, which was extremely difficult because of the girl’s issues.*

Service provider

In summary, cultural diversity involved barriers to service delivery that included language, legal obstacles, a lack of services that were equipped to provide for the needs of specific cultures and religions, social isolation and cultural conflict between young women and their family.

### 4.5.2 Young women of Indigenous origins

Service providers mentioned several strategies that had been successful in encouraging young Indigenous women to attend services. From these findings we have inferred that a lack of these elements of successful service might act as barriers, however, these findings require further research in order to be confirmed (see Recommendation 15). Barriers to service delivery for young Indigenous women might include a judgemental attitude, a lack of individualised service, a lack of family orientation, no Indigenous centres that provide counsellors, social workers and Indigenous health workers and poor word of mouth. We did not have any findings for Torres Strait Islanders and only one Indigenous woman took part in a telephone interview for this project. This woman did not mention any barriers that were specific to her as an Indigenous woman.\(^4\) One young woman who took part in a fieldwork interview said that she had discontinued using family services due to ‘racism’ but did not elaborate on this situation.

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\(^4\) The young Indigenous women who participated did not refer to cultural issues, and, as the interviews were not designed to elicit Indigenous cultural issues, and furthermore, had not been approved by the HREC for this purpose, cultural issues were not pursued by the interviewer.
4.5.3 Young women with disabilities

Intellectual and mental health disabilities were found to constitute a major barrier to service delivery. No young women with mental health and intellectual disabilities consulted with us. However, service providers had experience with women from this vulnerable group.

Young women with intellectual disabilities and children were at risk of not parenting appropriately when not under supervision. While they might have been more able to cope in a group home with other intellectually disabled adults and supervision, this type of accommodation was not available for young women with children. Supported accommodation services could only accept young women in this position if they had an overnight worker on the premises, and this was not always possible due to financial constraints and a lack of space.

Service providers felt that family support was essential for young women with intellectual disabilities. Where possible this was encouraged and supported, living with family members could help these young women to successfully parent. However, providers also talked about ex-clients who had been placed with their families who had then run away from home with the child or children. This posed a safety risk to the mother and children, and often resulted in the children being removed from the care of the mother. Providers reported that the majority of their clients with intellectual disabilities who did not have family support did not parent successfully and had their children removed from their care. As one provider commented, ‘Intellectual disability is a big barrier to success with safe parenting.’

We’ve had numerous mums with intellectual disabilities and out of the five I can remember, three have had their children put into care because they weren’t able to parent consistently...

Supported accommodation worker

We had one client, her assessed age was four to five and she had a baby... she came to our service to be assessed as to whether or not she could parent her baby... We provided twenty four hour staff one-on-one for her. While the baby was tiny and could be put in the cot or the pram and had bottles on the clock, that was ok. She knew she could tell the time on the clock, it’s one o’clock the baby has the bottle now, I’ve changed the baby’s nappy and I’ve put the baby to sleep. If the baby smells I change the baby’s nappy, the baby’s fine, you know. Those things were learnt by rote and by, she couldn’t read, she couldn’t write. Thankfully she could look at pictures, so we had all charts up
with all these pictures, so that was fine. But the baby got to start to roll over, that became a problem because you can’t leave bubba on the bed because the bubba can roll off. So that became the first instance of a problem. Then when bub started to crawl and move about, she would recognise baby crawls to a step, don’t go there or you’ll fall down. She would recognise that, but if baby didn’t turn around and come back she’d say, “Oh well fall down then.” So she could recognise danger but she couldn’t remedy it... So it became obvious by the time the child was eighteen months old that she would not be able to safely parent her child.

Supported accommodation manager

Mental health issues also posed a threat to the wellbeing of children and to their mothers. As with intellectual disabilities, services were not generally designed to cope with mental health problems and parenting issues. Young women ‘slipped through the cracks’ because they did not fit the criteria for inclusion in services, because services were unable to cater for their diverse needs, or because their problems were a danger to other people who used the service.

It then stops us and makes me think twice about, um, taking on the clients with mental health issues. Even if they are managed...but you’re sitting there thinking do I need this? Does the service need this? We could take care of our own needs.

Supported accommodation manager

Physical disabilities were not talked about by service providers very often. Where they were mentioned, physical disabilities appeared to be easier to overcome than mental or intellectual problems. For instance, specialised support services could be contacted to provide assistance. However, a barrier to service delivery occurred when premises were not designed for wheelchair access.

From our point of view our building isn’t even structured for a client with a physical disability, we are not ramped...so that just doesn’t work.

Supported accommodation manager

4.5.4 Young women who had lived in state care

Service providers had some experience with young women who had been in foster and/or state care. According to providers, these young women felt that they had been moved around a lot, and stopped using services because over the years they had told
their stories many times and become ‘fed-up’. One important point raised by providers was the lack of a parenting role model in these young women’s lives, which left them without a template for parenting.

_With the ‘wards of the state’ mums, I’ve dealt with mums who’ve now got adolescents, and they’ll sometimes say to me, “I don’t know what else to do because I didn’t have a mother and I don’t know what to do.” And they’re really sad some of these people, really, they just, they really can’t do anything else. They just feel really helpless and powerless...they then go back to saying, “Well I never, I was never loved as child and my mother never cared about me…”_

_Service provider_

### 4.5.5 Young women who had experienced abuse

Service providers reported that the presence of abuse in the young woman’s family of origin led to her having a lack of social support. In some cases, young women in this position became homeless when they sought to escape the abuse. Similarly, providers said that young women who experienced partner abuse were at risk of becoming homeless, in addition to the myriad of other problems that accompany partner abuse.

Supported accommodation workers talked about the difficulties experienced by young mothers who experienced abuse. Some young women had their children removed by the authorities due to violence in the home, and where a support program was not in place they were at serious risk of losing custody of their children. Some accommodation services were unable to accept young women who were escaping violence, due to insufficient security to protect the young woman and the other residents from violent partners who might seek them out. Past abuse was also blamed by service providers for causing relationship difficulties in supported accommodation.

_I think a lot of our girls have been abused, um, you know sexually, physically, and then came to our unit and try to set up a dynamic in the unit...they’ve got no skills with relationships and communication...sometimes you can see it a mile off that one of them is manipulating someone else to do something to somebody else, and it’s really hard to work…_

_Supported accommodation worker_

Where couples were escaping from abusive families of origin, there were few services available that could take both partners (where partners were a woman and a man). Therefore, young families in this position were split up, with the young woman and child going to one service, and the young man to another.
Among the problems experienced by young women who have experienced physical, sexual, or emotional abuse from partners and/or families of origin are problems of substance use and abuse and mental health problems, including post-traumatic stress disorder, depression and anxiety. Therefore, young pregnant women and mothers who have experienced abuse are often in need of psychological health services, which they might find difficult to access. Furthermore, they could be unaware that there are services that can help them.

4.5.6 Young women with substance use problems

The use of alcohol and in particular the use of illicit drugs was thought by service workers to form a very strong barrier to service delivery. Young women with substance use problems were found to be reluctant to ‘engage with services’, often from a fear of having their children removed. Illicit drug use was also seen as a major expense, which interfered with women’s ability to cope financially. In addition, young women experienced poor health as a result of alcohol and drug problems. Past illicit drug and alcohol problems were also seen by service workers as a barrier to service delivery. As one youth worker commented, healthcare workers assume that, “If they’ve been on drugs once, they’re always on them, that it’s not possible for them to get off.”

4.5.7 Multiple vulnerabilities

Having more than one vulnerable characteristic led to young women being particularly vulnerable to a low level of service use. Women who have multiple vulnerabilities might benefit from accessing a range of services. However, no one service appears to exist that can accommodate all of her needs. Considered in the context of the common barriers previously discussed, it appears unlikely that these young women will be able to access a range of different providers to have their needs met.

I mean the problem is that there’s one service that will look after this aspect and then there’s another service that will look after that aspect but when they’ve got two (problems) they sort of just get bounced backwards and forwards don’t they? Because no-one takes responsibility for the whole picture, the whole person.

Service provider

Multiple vulnerabilities acted to exclude some women from specific services. For example, where women had a substance abuse problem and a history of abuse she would be unable to access refuge accommodation. Cultural barriers to service access
also contributed to young women not seeking help for partner abuse. This becomes even more complex where the young woman is socially isolated and might be unaware that help is available.

_A lot of women from cultures, other cultures, see it as being an absolute failure or absolutely outside the picture to leave their (domestic violence) situations. To leave their family home, to leave whatever, and access a service. So I see that as a barrier to them accessing health (care) because they’re too frightened of the repercussions. And if they do make that step and come, you have to hide them. Not only from their partner, but from their community because the community will tell them where they are. So they’re frightened of you accessing an interpreter even, because that interpreter knows the community and may tell someone._

_Service worker_

4.6 SUMMARY AND CONCLUSIONS

Young pregnant women and mothers experience a wide range of barriers to service delivery, many of which are dependent on their personal circumstances and backgrounds. Barriers included the personal characteristics of young mothers, in particular fear of being seen as an ‘inferior’ mother, lack of confidence and self esteem, and making quick judgements about service providers. Other barriers involved external issues, such as a lack of knowledge about service availability, access and content, and practical problems of transport, time, cost and literacy. Some services involved particular problems. Interactions with early childhood nurses were especially problematic, where advice was easily construed as a judgement. Government services were criticised for complexity and paperwork, while groups were a particularly hard service for young women to access due to their personal fears and a lack of knowledge.

Young women who belonged to a vulnerable subgroup experienced a multitude of personal, external and structural barriers to services. These young women were particularly prone to falling through the cracks and becoming disconnected not only from services, but also from mainstream society. In addition, some vulnerabilities resulted in a high risk of losing custody of children, due to an inability to cope and also a lack of support structures that might enable coping.

None of the barriers mentioned in this chapter occurred in isolation. Barriers occur in complex relationships with each other. For example, having financial problems led
to non-use of services that charge money, transport problems, and non-use of child care. As a result of the non-use of these services, women may find they are unable to access education, which might have assisted them to gain paid work and improve their financial circumstances. Similarly, a young woman who moves to a new area might have little social support. This woman will not hear of services by word of mouth, and might be unlikely to attend a ‘first visit’ without the moral support of a friend or family member. Both of these situations become self-perpetuating.

In conclusion, young pregnant women and mothers experienced a wide range of barriers to service delivery. Generally speaking, we found that the more barriers a young woman faced, and/or the more vulnerabilities that she experienced, the more difficult it would be for her to access services and the more difficult it would be for service providers to accommodate her needs.
5. FACILITATORS OF SERVICE PROVISION

This chapter reports on the findings from consultations with service providers and young pregnant women and mothers that pertain to facilitators of service provision. We have only classed a factor as facilitative if service providers or young pregnant women and mothers reported the successful use of the factor. Other ideas for successful service delivery were incorporated into the recommendations and are included in Chapter 7.

We start by describing the constructive impact of positive relationships between young women and service providers. We then discuss some specific practical facilitators that had been used to overcome the common barriers and barriers to specific services that were described in Chapter 4. Finally we identify facilitating factors for service delivery to young pregnant women and mothers who were members of vulnerable subgroups.

5.1 RELATIONSHIPS WITH SERVICE PROVIDERS

Young women were most likely to attend services that they saw as being essential. Ante- and postnatal and birthing healthcare were used by the young women we interviewed, even where they had experienced problems with accessing these services. Service providers said that young women would benefit from attending antenatal care at an earlier stage of pregnancy, and that fear was the most common barrier to earlier
attendance. Nevertheless, the finding that young women do come into contact with health services during pregnancy and birthing offers an ideal opportunity to put into place mechanisms to overcome some of the barriers to the delivery of other services.

In particular, knowledge about available services was identified as a barrier to service delivery. Some postnatal and birthing services had introduced the provision of information booklets that described local services. Some of these service providers also offered information about other services verbally. Another aid to service delivery occurred where young women were assured that a service was useful in some way. There was a risk that recommending other services would be perceived by young women as a judgement that they were an ‘inferior mother’ in need of services. This risk was minimised when service providers had fostered a strong positive relationship with young women.

Positive relationships with all service providers, not just those involved with pregnancy and childbirth, occurred where young women perceived that they were listened to, that the provider was warm and friendly, where they were remembered by the provider by name, where they had received praise for some aspect of their parenting or lifestyle, where they felt that providers were not judgemental, and where they felt they were respected.

(\textit{The midwife has}) just been lovely, really caring, just been really warm and lovely, (\textit{asking}) you whether you feel comfortable, like that was a big thing for me. Just the really little things, even just smiling and asking whether I’d been looked after...just greeting me as I walk in the door, just being really nice...(l) had to have some needles and um the lady that’s there the whole time just asked about my family support after I have the baby, and just sort of told me about a few other services, cause I don’t um have much family support...I thought that was excellent because she didn’t have to elaborate on anything but she just told me a few other things that I probably wouldn’t have known about...\textit{Like mother’s group, and about how to get babies to sleep, and like just different little courses...that can get you out of the house and um, and can help you interact with other people with children, yeah, so I thought that was really, really nice.}

\textbf{24 year old pregnant woman}

It was important that service providers demonstrated that they saw young women as individuals and not just as a young parent. The actions taken by providers that conveyed to young women that they were seen as individuals included active listening, demonstrating knowledge of the woman and her life, complimenting her on an aspect
of her parenting, giving information or finding out information that was asked for, remaining non-judgemental, explaining any procedures that the young woman was about to undergo, and smiling. Positive relationships with providers were found to help young women with their confidence as parents and to overcome many of the fears that young women had about attending different services.

5.2 OVERCOMING COMMON BARRIERS

In addition to the findings for a positive relationship with service providers, we found a number of facilitating factors for service delivery for the common barriers described in the previous chapter. Beyond the provision of a positive relationship, and those facilitators shown below under ‘knowledge,’ no additional facilitators were found for access problems that were due to mobility or the status of the local neighbourhood.

5.2.1 Knowledge

In the context of a positive relationship, pregnancy and childbirth service providers had successfully provided information to young women about a range of services. Having individual knowledge of the women concerned allowed providers to mention relevant services and to encourage and support young women in their attendance. It was important that information included details of the service, what it did and where and when it was held. Booklets provided when women left hospital after having their babies were also found to be useful by some young women. However, not all young women had received these types of booklets.

Word of mouth was a common way that young women found out about services. Friends, family and service providers gave them information in this way. If a person known to the young woman recommended a service, fear was lessened and they would be more likely to attend.

Many young women had accessed the internet to find out information about services, parenting, birthing and other relevant issues. Others had sought information from books and magazines. The advantage of using the internet was that it allowed young women to access chat rooms and discussion groups for young parents that put them in touch with other young mothers, without the need to travel or make a ‘first visit’. Another form of technology that had been used by service providers was the Short Message Service (SMS or text messaging) used with mobile telephones. Providers had used SMS to remind young women of appointments, provide information about
upcoming services, check on their wellbeing and to encourage contact and to build rapport. Mobile telephones can be expensive but most service providers felt that the vast majority of young women would have a mobile phone, even those who were experiencing financial difficulties. The qualitative nature of the current study precluded an examination of the number of young pregnant women and mothers with mobile telephones and internet access. However, it would seem that these are efficient methods of reaching and staying in touch with young pregnant women and mothers.

Service networking was another successful way of spreading knowledge. Where services were well known to each other, referrals from one service to another were common. Service networking worked well where local services had interdisciplinary and cross-service meetings. Service networking was less successful when services perceived that they were in competition for the same funding.

Being visible in the community was also helpful. One service had opted to hold free community barbeques as a way of encouraging local young women to use their drop-in, group and referral service. This proved to be a successful strategy, where doing a letterbox drop and putting up posters had failed. Also, this service was a focal point for other services in the area, and provided a ‘one stop shop’ for referring young women to other services.

5.2.2 Literacy

One young mother had overcome her literacy problems with the support of a worker who was teaching her to read and write. The young woman was highly motivated to achieve this goal and felt that it was her relationship with the service provider that allowed her to accept this help. The completion of forms was assisted where young women had an advocate, and where the service offered to help with form completion. Plain language brochures were recommended by service providers as potentially assisting with literacy problems.

5.2.3 Structural barriers

Service networking was responsible for overcoming structural barriers to healthcare delivery. Providers who had fostered relationships with general practitioners and other health services had negotiated for bulk billing spaces to be left for young pregnant women and mothers who might not have had Medicare cards and in those areas where bulk billing was rare.
Arbitrary age limits had been overcome by one service that had developed a peer support program. This innovative support group structure encouraged young mothers who had reached the age where they were no longer eligible to attend the young mother’s support group, to attend an older mother’s group, and to act as mentors to the young mothers who attended the support group. This kept the older mothers involved, acted as a milestone in their lives and assisted the young mothers by providing positive role models.

5.2.4 Cost and transport

Cost was not a problem where services were known to be free. However, no facilitating factors were found that could overcome the barrier of cost, beyond finding a comparable free service, which was not always possible. The provision of free transport and free parking did assist with the cost of travelling to services and was successfully employed by some services.

One service provider had organised for the local council bus, usually used for elderly and disabled people, to transport young pregnant women and mothers to a mother’s group. Similarly, a bus in a non-urban area was provided by the local high school to collect any students, including young pregnant women, who were having transport problems that prevented school attendance.

Home visits by ante- and postnatal nurses, and by early childhood health nurses and social workers had been offered by some services and these helped to overcome transport barriers and reduce social isolation for some young women. One drop-in and referral service was located in an area where many young pregnant women and mothers lived. While this was helpful for those women who lived within walking distance, it was not helpful to young women who lived further away and did not have transport.

5.2.5 Time and routine

Overcoming young women’s difficulties with time and routine was very difficult. Some services determined when young women were most likely to attend and ensured that they were holding services within this timeframe. Other services had a drop-in approach, whereby young women were able to come to the service whenever they liked. However, this degree of flexibility was not common, with most services understandably needing to schedule their staff’s working hours and rosters.
5.2.6 Previous negative experiences and adverse word of mouth

The best method of overcoming previous bad experiences was a positive experience with a service provider. A positive experience enabled young women to feel vindicated and helped to improve damaged confidence. Furthermore, young women became more open to attending other services.

5.2.7 Social and family support

The presence of social support was found to enable service use as well as assist young women with other aspects of their lives. Social support from family and friends helped young women by the provision of information about parenting and services, transport, housing, financial assistance and by preventing social isolation. One service provider said that family support gave young women, “confidence, self esteem, a feeling that they belong somewhere.”

*The one’s that do have support from families do better, much, much better than those who are isolated and don’t have that support. We sort of find that very much with our girls, that those who have a supporting mother themselves like a grandmother of the baby...do much, much, do much better.

*Family support worker*

*A supportive family educates women and provides shelter, love, emotional support and therefore increases self esteem and decreases risk factors.

*Service provider*

5.3 OVERCOMING BARRIERS TO SPECIFIC SERVICES

This section includes facilitators that had assisted young women in accessing particular services. Service providers and young women did not mention any factors that had facilitated their access to child care and housing beyond those that have previously been mentioned.

5.3.1 Government services

In the previous chapter we pointed out that the findings for government services were limited to those for Centrelink. It would appear that experiences with Centrelink were widely varied, with some young women having difficulty and others finding the service
providers to be helpful. Successful service provision was apparent when young women were treated non-judgementally and with respect, as with any successful service provision. However, it was also apparent that successful delivery of Centrelink services included the knowledge of the provider and the ability of the provider to explain to young women how the Centrelink system worked. Some service providers had been receiving bulletins from Centrelink that explained recent system changes. These had been very useful, but not all services were in receipt of these bulletins.

5.3.2 Education

Secondary education programs that provide child care, social support and a supportive environment to young pregnant women and mothers have had great success, and would overcome many of the barriers to secondary education mentioned in the previous chapter. While structure is very important to secondary education delivery, flexibility is key to successful tertiary and vocational education. Flexibility included the option, but not the mandatory use of distance education, which allowed some women to complete tertiary courses. Outreach courses were helpful because they were held in convenient locations and sometimes included the provision of child care. Night courses were helpful for those women who had partners because this allowed them to leave the children at home and meant that child care expenses were not incurred. One young woman had been allowed to take her new baby to college classes with her, which allowed her to finish her trade qualifications. The relationship between the provider and the student was paramount to successful education delivery, as with all other services.

Many of the support group facilitators had encouraged their clients to undertake classes in parenting, leisure, and basic life skills such as budgeting and cooking. In the context of a positive relationship, these providers had consulted with young women about the topics they would like covered and had then set about finding a tutor for the subjects the young women were interested in.

(The group has been) very informative actually, um they pretty much go through everything, your normal antenatal classes go through, just sort of aimed at younger people. So it’s sort of a lot more relevant to us...just everything from um how to take care of ourselves, to how to take care of baby, to relationships with family and financial stuff and everything, they just let you know pretty much everything you need to know.

21 year old pregnant woman
5.3.3 Early childhood healthcare and groups

Among those services that young women found difficult to visit for the first time, early childhood health centres and groups were the most commonly mentioned. Where young women had social support and had heard of the service or group beforehand, fears were overcome. However, fear of being surrounded by older mothers in early childhood health centres was persistent and many young women had not heard about groups.

Some young women preferred to use early childhood health nurse services offered by their local chemist. This was seen as less intimidating, since there were shorter queues and often no waiting rooms where they felt scrutinised. Home visits were also helpful in this regard, however, these services are often limited to the first few weeks of a baby’s life.

Group facilitators had found it useful to visit young pregnant women and mothers while they were in hospital and to meet them at other services. To enable pregroup meetings, service providers had networked with other service providers and gained their support. For the young women, meeting the group facilitator beforehand helped to alleviate fear of the unknown.

*I’ve sort of tried to have the approach of, of meeting up with (young women) before they actually have their children, so that rather them ringing and saying, “Yeah I want to find out about a group or whatever.” And then having to worry about turning up on their own, and they don’t know anyone... sometimes they won’t turn up and for that reason, so my thoughts were it was better to just go to their home or meet them at a coffee shop or somewhere and say this is what we do, explain what it’s about and generally you will find they’re quite happy to (come along).

Young mother’s group facilitator

5.4 OVERCOMING BARRIERS SPECIFIC TO VULNERABLE SUBGROUPS

It is noteworthy that very few facilitating factors were noted by service providers for the women who belonged to one or more of the vulnerable subgroups. A number of suggestions were made, which have been included in the recommendations, however, none of these suggestions came from actual experience.
5.4.1 Linguistic and cultural diversity

Language barriers were overcome by the provision of information in languages other than English, and the availability of translators and interpreters. Some antenatal classes were conducted in languages other than English, although these were not common. Service providers had facilitated health service access for young pregnant women and mothers without Medicare cards or financial support by securing charity funding, and by liaising with local health services to allow spaces for young pregnant women and mothers who were unable to pay.

A key to successful service delivery for young pregnant women and mothers from other cultures was the presence of a service worker who was of the same culture, usually from a multicultural support service. This helped young women to become less isolated and to become better acquainted with other services.

5.4.2 Indigenous origins

Successful service to Indigenous communities included consultation with individual communities, the presence of Indigenous health workers and specific Indigenous health centres, a family orientation and good understanding of local culture.

(What helped our service was) much community building work and informal education brought to the community or transport provided to get women to the service. Working with the Aboriginal health worker and involving women in planning of care and empowering them to take on running of their own groups.

Birthing healthcare provider

5.5 CONCLUSION

We began this chapter with the most important element of successful service delivery: the relationship between the young woman and the service provider. Because most young women will attend a service that is deemed 'essential' we have stressed the importance of the relationship between the young woman and her healthcare service providers, particularly those that provide pregnancy and birthing care. Most of the service providers who consulted with us were well aware of the importance of building a positive relationship with young women. However, time constraints and staff turnover interfered with their ability to build rapport with young women. The provision of
information was also of great importance, and we noted a number of innovative strategies that have been used by providers, including the use of technology (i.e. internet and SMS), local barbeques and networking with other services.

Facilitating factors were found to be more successful when more of the factors were present. For example, the provision of information in the absence of a positive relationship was not as likely to succeed as the provision of information from a trusted service provider. Just as some barriers form cycles that perpetuate young women’s isolation, so do service facilitators act cyclically to encourage a young woman to become less isolated and more supported. For example, a young woman with a positive relationship with a service provider will be more open to using other services - the more services she uses the less isolated and more supported she becomes.
6. BEST PRACTICE

This chapter draws together the findings of the literature review and the previous two chapters to provide a summary of the models of best practice for service delivery to young pregnant women and mothers. We start by discussing the elements of best practice that would apply to any service, followed by the actual models of practice that were found to be successful. For some types of service and for some women in vulnerable subgroups no models of best practice were found. For these services, we have identified the elements that might contribute to successful service delivery.

6.1 ELEMENTS OF BEST PRACTICE

We determined the elements of best practice based on past research and the findings from consultations with young women and service providers. By far the most striking finding was that successful service delivery depended on the relationship between the young woman and her service providers. A trusting relationship overcame various barriers that are inherent to many young women, including fear brought about by low self confidence. In addition, young women did not feel stigmatised when attending targeted interventions as long as they felt respected and consulted. This calls into question some of the arguments presented earlier where targeted interventions were seen as being at risk of stigmatising young women, and furthermore, undermines the notion that targeted interventions are ‘band aid’ solutions. The third line of argument concerned the use of universal measures for marginalised groups, in this
case young mothers, and stated that young women would still fall through the cracks of service delivery. This last point was supported by the research we conducted, and is discussed further in the penultimate section (Best practice with vulnerable subgroups). Nevertheless, young women seemed less likely to fall through the cracks if they had a strong connection with a service provider.

Best practice, then, must include the elements that will lead to a strong positive relationship with a service provider. These included demonstrating:

- A non-judgemental attitude;
- Active listening;
- Knowledge of the young woman and her circumstances;
- Warmth and friendliness;
- Appreciation (praise) for young women’s parenting ability;
- Respect;
- Providing accurate information;
- Explaining procedures;
- Continuity of care wherever possible;
- Confidentiality; and
- Smiling.

However in order to form a relationship with service providers, a young woman must first come into contact with a service. Young women were found to experience a great deal of difficulty with the ‘first visit’ to any service. Facilitators of a first visit included:

- Previous meetings with the provider;
- The presence or recommendation of a family member or friend;
- The recommendation of a trusted service provider, including information about:
  - what the service has to offer;
  - where it is held;
  - when it is held; and
- Freely available information about the service.
The most likely time for contact with a provider was during pregnancy and childbirth healthcare. Therefore the relationship with the provider of those services is pivotal and sets the scene for future service access. That is, a positive experience will encourage further use of services, while a negative experience will deter future service access. Since the most commonly mentioned practical barrier to service delivery was a lack of knowledge about available services, pregnancy and childbirth healthcare providers are best placed to provide information to young women about other services.

The provision of information about other services was facilitated by inter-service networking. Networking allowed for the integration of services, which led to young women becoming aware of a range of useful services. Furthermore, provider’s knowledge of other service providers allowed them to make personal recommendations to young women, which facilitated the first visit. Where networking was facilitated by a ‘one stop shop’ (discussed in the next section), service providers had a hub around which service provision could be organised. Furthermore, young women were then able to access a range of different services from a single entry point, thus reducing the degree of complexity around accessing many different services. Networking was facilitated by:

- A physical space in which to meet;
- A focal point for contact (e.g. referral centre);
- Regular meetings between service providers;
- Willingness of service managers to release staff for inter-service meetings;
- Having time available for networking;
- Willingness of providers to work collaboratively;
- Inclusion of services from many different service types, including but not limited to:
  - pregnancy healthcare;
  - childbirth healthcare;
  - postnatal healthcare for mothers and babies;
  - support groups;
  - mother’s groups;
  - general practitioners;
– social workers;
– psychologists & counsellors;
– multicultural services;
– Indigenous services;
– supported accommodation services;
– education providers; and
– government and non-government services.

Frequent practical barriers to service delivery were a lack of transport and/or child care. A common element to these barriers was financial distress. When child care and transport were provided by a service, young women were more likely to attend. Similarly, if a service was conveniently located, young women were more able to use the service. Home visits also helped with these barriers and are discussed further in the next section.

6.2 MODELS OF BEST PRACTICE

In this section we describe the models of best practice that we found for some services. Each of these included the elements of best practice previously described.

6.2.1 The ‘one stop shop’ approach

The use of a ‘one stop shop’ as a focal point for services and young women was a very successful enterprise that had been undertaken by one group of service providers who consulted with us. This facility allowed young women to drop-in when they felt like it; conducted classes on parenting, vocational, leisure and life skills activities in response to the stated needs of the young women; referred women to other services; and offered group support in the form of mother’s groups and playgroups. The service had reached out to the local community by running free barbeques, which encouraged young women to attend. For service providers, the centre offered a place for networking to occur, both in person and by telephone. This allowed the service to be a connection point for referrals and information for both service providers and young women. The collaborative atmosphere allowed services to complement, rather than compete with each other, and furthermore, facilitated joint funding applications to provide integrated,
rather than overlapping services. The one drawback of this particular service was that it was not centrally located, so that young mothers not located in the immediate vicinity were at a disadvantage. At the time of the focus group, providers were attempting to set-up a transport service for young women who did not live nearby. The one stop shop approach was the best practice we found for service networking.

The Child Care Links (CCL) project also warrants mention. CCL workers are attached to targeted child care services and work with families, community services and government agencies to build community networks and to put parents in touch with other support services. Although not specifically targeted at younger parents, this service also has the capacity to improve service networking.

### 6.2.2 Peer support

No one program of peer support appeared to be better than others. In fact, those that had evolved within communities or services in an idiosyncratic way were quite successful. Past research had indicated that the timing of peer support was important, and should occur within the first 12 months of birth. Peer support helped to increase confidence among the supporters and those who were being supported. Successful peer support occurred within a service and involved the young women in developing the structure of the program. For peer support to occur a facilitator was required (usually a service worker) and physical space for group activities was also needed. Although peer support programs appeared to be successful, formal peer support programs were not common among the service providers who consulted with us.

### 6.2.3 Healthcare services

Our findings for healthcare provision were in line with those of Bull et al. (1997) and Ley (2005). Successful healthcare provision, including ante- and postnatal healthcare, required a positive relationship with young women, flexibility, accessibility, and confidentiality. Healthcare services that networked with other services were more able to offer integrated services and to provide appropriate referrals and recommendations for other services. The provision of bulk billing and allowance for those young women without Medicare cards would further facilitate service provision. Furthermore, the availability of a service such as this needs to be advertised in the community, so that young women are aware that it is available.
6.2.4 Home visits

Home visiting services appeared to work well when services were integrated, which related back to service networking. One area had a home visiting team that included a young mother’s social worker, an antenatal nurse, a postnatal nurse and an early childhood nurse. In addition, these workers had planned a program of birthing and parenting education that was delivered as part of the routine home visit. By engendering trust, these workers were able to connect young women with other services in the community.

6.2.5 Secondary education

Best practice for secondary education was found to be specialised in-school programs such as the Young Mothers in Education Program conducted by Plumpton High School. The results of other secondary programs, such as distance education or attendance at a regular school, were inconsistent and involved barriers that were difficult for young women to overcome. Plumpton High School was found to offer the elements of other best practice models, including fostering a positive relationship with young women, integrated service provision, networking with other services, and peer support. Furthermore, follow-up included home visits by support staff for those who had been absent, and individualised service for young women experiencing problems. The involvement of family members, such as the young woman’s mother, also helped young women to remain in touch with school. The ability to refer young women to other support services was also beneficial, and was facilitated by networking between the school and other services. From a practical viewpoint, the secondary schools that offered child care and transport assisted young women to continue attending school.

Past research indicated that a school setting might prevent some young women from attending. Outreach programs had been found to assist some young women by providing a bridge from secondary to further education. Again, these were most successful when offered in conjunction with child care and where other support services were available.

6.2.6 Tertiary and vocational education

Flexibility in service delivery was key to the delivery of tertiary and vocational education. No one model of best practice was determined, and it is unlikely that any one model would be suitable. Elements of successful delivery included variable hours of delivery, the provision of distance education, outreach courses, the provision of child care and being conveniently located.
6.2.7 Child care services

Provision of child care was an important factor for young pregnant women and mothers, with just over half of the participants who took part in face to face interviews reporting that they used child care services. While no facilitating factors that were specific to child care were mentioned by the participants, several child care schemes warrant inclusion in this report. The Jobs Education and Training (JET) program offers subsidies to parents on low incomes who wish to increase their participation in the paid workforce by studying, undertaking or seeking paid work, or undertaking rehabilitation programs, through the JET Child Care and JET Child Care Fee Assistance programs. These child care subsidies could help young women overcome barriers to child care that occur due to cost.

**JET Crèches** are run in conjunction with education and training programs for targeted groups and provide child care at or near the site where parents are undertaking education, where other child care is not available. **Sustainability Allowances** are available for Long Day Care and Outside School Hours Care organisations that are not-for-profit and located in areas of need, such as remote areas. The Jet Crèches and Sustainability Allowances schemes have the capacity to overcome barriers of distance, availability and transport.

**Inclusion Support Agencies** coordinate a team of Inclusion Support Facilitators (ISFs) who specialise in inclusive practices in child care so that all children, including children with a disability, children from culturally and linguistically diverse backgrounds, or children from Indigenous backgrounds, are accepted, belong, interact, learn and succeed. ISFs assist child care services to build their capacity by providing advice and practical support. Their role is to help child care services to increase access and respond appropriately to the needs of children with additional needs and their families. As noted by the National Agenda for Early Childhood it is important to ensure that child care workers are properly trained to respond to the needs of vulnerable families, including young mothers. As the results of this report have shown, young mothers are quick to cease using child care or to change providers should they feel the service is not meeting their needs.

Indigenous child care programs are available in some areas and are being established in other areas by the Child Care Support Program. NYARS has noted that the barriers identified in the current report are consistent with issues emerging from the Indigenous Child Care Plan (ICCP) consultations. The ICCP is envisaged as a mechanism for coordination of programs and services across all levels of government with the aim being to inform policy to better respond to the needs of Indigenous families.
6.2.8 Parenting, life skills and leisure classes

The best such service that we found was conducted by the ‘one stop shop’ mentioned earlier but other support groups had instituted similar programs. It was pivotal to the success of classes designed to help young women learn about parenting and to teach them life skills, that the women who took part in the classes also helped to design their content. This required that the young women have a pre-existing relationship with the service provider. By consulting with the young women, no judgements were made about their parenting ability or their level of life experience. Programs were then tailored to meet the needs of a particular group under the guidance of an experienced facilitator. Providers sought teachers in the local community and this was achieved more easily when services were highly networked. The inclusion of leisure classes (e.g. craft, yoga) allowed young women to explore activities that were not related solely to parenting and coping with life. In this way, classes had a holistic approach and lessened the stigmatising nature of classes that were directed at ‘young parenting’. As with most other services, provision of child care and transport assisted young women to attend.

6.3 BEST PRACTICE WITH VULNERABLE SUBGROUPS

With the exception of substance use and mental health problems, no model of best practice was found that catered for the diverse needs of young pregnant women and mothers who belong to one or more of these groups. The complex nature of their lives and the highly individual nature of their problems infer that models of best practice would not be easily developed. In fact, our findings lead us to the conclusion that for most of these groups, a generic model of best practice would be inappropriate. We found that many of the young women in these groups were ineligible for certain targeted services due to other aspects of their lives. Recommending or developing a model of best practice that is based on membership of a group or groups runs the risk of creating more cracks for women to fall through. We therefore point to the areas of service delivery that could be especially useful for young women who belong to these subgroups.

6.3.1 Young women from culturally and linguistically diverse backgrounds

Aspects of service provision that were successful for women from culturally and linguistically diverse backgrounds included the provision of services in their own
language, the presence of a support person who was of their own culture, provision of written information in their own language and an understanding of cultural differences among the service providers with whom they came into contact. These factors would be included in a model of best practice for women from other cultures.

6.3.2 Young Indigenous women

There was no one model of best practice found for young Indigenous women, and this reflects the diversity of communities that exist in Australia. The elements of best practice for providing services to young pregnant women and mothers of Indigenous origins include consultation with the community and family concerned, the presence of Indigenous health workers who are well acquainted with the community, Indigenous health service centres or clinics, and a strong network with other health workers in the region.

6.3.3 Young women with substance use and/or mental health problems

Service delivery for young pregnant women and mothers with substance use and/or mental health problems was especially problematic. Issues of child protection and provider’s beliefs that women could not stop using substances, complicated service delivery to these young women. One program offered by the Red Cross (reported in the literature review) addressed these problems in a three phase program that included consultations with young women, supported accommodation, intensive counselling and social support, and reintegration into the community. We conclude that this is the model of best practice for young pregnant women and mothers with substance use and/or mental health problems. However, further research into the situations of these young women is warranted, including some evaluation of home visits and outreach programs.

6.3.4 Young women with physical disabilities

Our findings for young women with physical disabilities were limited. However, one obvious point was made; if a service has no access for wheelchairs then young women, or indeed anyone, including staff, who require assisted access in the form of ramps, toilet facilities and correct doorway and corridor size, will not be able to access the service. Furthermore, it would seem that a lack of wheelchair access would also impede access for young women with prams. Young women with hearing problems experience
similar difficulties in communication as those women who do not speak English, and may require interpreters. Ideally, services would have a member of staff who could sign.

**6.3.5 Young women who had been in state care**

All of the models described previously would assist young women who have been in state care to access services. In particular peer support programs and home visiting might be particularly useful in providing them with avenues to extend their support network.

**6.3.6 Young women who had experienced abuse**

In addition to those factors that assist young women generally, some aspects of service delivery need to be stressed for those young women who have experienced abuse. It is important to maintain a positive relationship with women who have experienced abuse, and to connect these young women with appropriate services. Service networking is, again, important in achieving this goal. Young women might need refuge accommodation, counselling, income support, and if they have fled a violent relationship might also need clothing and other basic needs. It is also possible that these young women will be in need of help from the police and social support in obtaining Apprehended Violence Orders.

**6.4 CONCLUSIONS**

Best practice with young pregnant women and mothers is achieved by providing individual service in the context of a structured program that incorporates flexibility. Providers of services engender trust and enable service provision by demonstrating a non-judgemental attitude, respect, knowledge and interest. Services are most successful when they are well acquainted with other local services and where inter-agency referral occurs. Furthermore, networking occurs where there is a physical space for services to meet, and a structure, such as regular meetings, that permits networking to occur.

We found that the elements of best practice would be of assistance to women who belonged to the vulnerable subgroups. We further pointed to additional services that might be of use to young women from these groups. We did not recommend a single model for young women in the vulnerable subgroups because we found that these young women were particularly prone to falling through the cracks of generic service delivery.
7. RECOMMENDATIONS

We have identified barriers to and facilitators of service delivery to young pregnant women and mothers. In addition, we have determined the elements of best practice and some models of best practice for service delivery. Accordingly, we make the following recommendations.

1. Given the importance of the relationship between the provider and the client, it is recommended that the facilitating factors of a strong positive relationship with young pregnant women and mothers be distributed to service providers across a wide range of services, particularly those that do not offer services exclusively to young pregnant women and mothers.

2. Because service networking facilitated knowledge and service delivery, it is recommended that service networking be encouraged at a community level across all relevant services. It is further recommended that a focal point for each community be established, giving services and young women a single enquiry point.

3. In Chapter 4 we presented a brief discussion about the availability of services. Our project method was not designed to capture the many services that might be of use to young pregnant women and mothers. However, given that our results indicated that young women are largely unaware of available services and that service providers can also be unaware of other useful services, we recommend that consideration be given to the conduct of a scoping project to establish the nature and extent of services that are available to young pregnant women and mothers.
4. **The success of the ‘one stop shop’ leads to the recommendation that the feasibility of introducing more of these services be examined.** Our experience with locating young women to take part in the research leads us to recommend that a one stop shop should be located in or close to a shopping centre, where public transport is readily available. Service providers also pointed out that any service for young women should be ‘attractive’ and welcoming. It is likely that a one stop shop could be formed by existing services.

5. Some young women had received information packages (in the hospital after giving birth) that they found very useful. However, this service does not appear to be universal. Lack of information was noted by service providers and young women as a barrier to services, while provision of information had led many young women to use services that they had not previously known about. **It is therefore recommended that the feasibility of providing an information booklet to all women (including those over 25) who give birth, be examined.** The booklet should be available in plain English and in other languages common to the areas in question, and should include contact details and a brief summary of the service and should include local support groups, mother’s groups, playgroups, child care, education, multicultural, Indigenous, and health services, emergency services, national services (e.g. domestic violence hotline, Lifeline) and useful internet sites. It is likely that a private organisation would provide sponsorship of such a document in return for advertising. The booklet could be included in the bag of sample products commonly given to new mothers as they leave hospital.

6. **Use of communications technology was seen as valuable by both young pregnant women and mothers and service providers.** The internet was used to build social support networks and to find information and mobile telephones were used by service providers to keep in contact with young women. Even though internet access can be expensive to set up, many of the young women had connections at home. In addition, internet services are freely available in public libraries. **It is therefore recommended that the use of communications technology be exploited by service providers wherever feasible in order to advertise services and communicate with young pregnant women and mothers.**

7. **Findings for literacy problems prompt us to recommend a review of the written information, including information available on the internet, that is currently available from government and non-government services.** While many of the forms and information pamphlets have been improved over the
past decade, it appears that the complexity of rules and regulations surrounding support benefits and housing are still confusing for people with literacy problems. Literacy problems were overcome when staff were able to assist young women and provide information verbally.

8. The providers of government services where young women had positive experiences with prompt, respectful and informative service are to be complimented on their professionalism and courtesy. However, some individual government services were criticised. **It is therefore recommended that a set of best practice principles for working with young pregnant women and mothers be developed and implemented.** These principles should reflect the findings of the current report, including praise for young women’s parenting ability, respect, a non-judgemental attitude, appropriate referrals and use of appropriate models (e.g. one stop shops, peer support, home visits, supported education programs, specific support for women from the vulnerable subgroups).

9. The complexity of some government support benefits were criticised by both service providers and young women. Indeed, we also experienced difficulties when trying to assess the various benefits to which young pregnant women and mothers might be entitled. With the introduction of the New Tax System some benefits were streamlined, such as the Family Tax Benefit. However, the various means tests, sliding scales of entitlements and the interactions between these remain confusing for service providers and young women. A bulletin received by some service providers was found to help with this, although not all services received such a bulletin. **Therefore, we firstly recommend that any information bulletins be advertised more widely, so that providers are aware of their existence and can access them. Secondly, we recommend that a method of simplifying the system be explored. Thirdly, we recommend that information delivery about entitlements be simplified.**

10. Young women with family support were found to make the transition to parenthood more easily and were also more able to access services. However, we noted that young women did not always have family support available, particularly those young women who had experienced abuse, had disabilities, had been state wards, had substance use/abuse problems, had moved areas, or who had moved to Australia from another country. We understand that many hospital exits involve a checklist of the degree of support that is available on returning home. As part of this service, **we recommend a universal provision of follow-up care that includes home visits, telephone calls and SMS which**
would be useful for young women who have little or no family support. Furthermore, it is even more important that women without family support be introduced to services that will provide them with the opportunity to meet other young mothers. Peer support programs might also be useful.

11. Peer support programs were found to help young pregnant women and mothers to develop social networks, reduce isolation, improve confidence and learn of other services. Although some informal peer support programs were in place, formal peer support programs were not common. **It is recommended that existing service providers, particularly those who facilitate support groups, be encouraged to introduce formal peer support programs**, for example, the *Talking Realities Program*. Peer support programs would also help those young pregnant women and mothers who were ‘too old’ for young parenting groups.

12. Transport and child care were major barriers to service delivery. **It is therefore recommended that services be funded to include the provision of transport and child care to young pregnant women and mothers, without the need for assets or income tests.**

13. Secondary education was best achieved through the provision of a specialised in-school service, such as the Plumpton High School *Young Mothers in Education Program*. It is not feasible or necessary for all high schools to offer such a service. However, schools that provide for young pregnant women and mothers are uncommon and are, therefore, not always located close to where young women live. **It is therefore recommended that the feasibility of introducing specialised in-school programs for young pregnant women and mothers into more schools be examined.** Particular attention should be paid to establishing schools in locations that would be of most benefit, such as those areas with high teen birth rates, and consideration should also be paid to the distance between the schools. **It is further recommended that child care and support workers be made more readily available to alternative education providers who offer services that are of potential benefit to young pregnant women and mothers.**

14. Findings for women from culturally and linguistically diverse backgrounds indicated that these young women are at risk of being socially isolated and are unaware of available services. **We therefore recommend that cultural sensitivity training be introduced to services where this is not currently conducted.** In addition, **we recommend that multicultural services be made known to women from culturally and linguistically diverse backgrounds during their antenatal and birthing care, where this is not already routinely**
done. Further, we recommend that services endeavour to supply written material in languages that are common to their areas.

15. We would like to acknowledge that some Indigenous communities might consider that sufficient research has been carried out within their community. Therefore, the following recommendation is made with the caveat that further research should only occur in communities where the research is assessed by the community as being of potential benefit to the community concerned. With this caution, it is recommended that future research be conducted both by and within individual Indigenous communities. The results that pertain to Indigenous women included in this report are of a limited nature, and more research in this area is required, given the poor outcomes for young pregnant women and mothers who are of Indigenous descent. Indigenous communities are diverse and research needs to be designed by the people concerned in a manner that is suitable for the individual community culture. It was further noted that there were differences between urban and rural areas in the types of services needed among Indigenous young women. The failure of the current project to devise such a research strategy was largely due to the lack of perceived need for such research in the communities that were approached. It is highly likely that we did not fully appreciate the research needs as perceived by the communities concerned, despite making every effort to do so. It is therefore recommended that research funds be made available at a community level to those communities who see a need for such research to enable community members to ascertain the level and types of need that are present within their individual communities among young pregnant women and mothers. Service workers highlighted the success of programs where communities were actively involved in program design, development and implementation.

16. It is highly recommended that further research be conducted into the situations of young pregnant women and mothers who have mental health problems, substance use problems and/or intellectual disabilities. These young women appeared to be particularly prone to service exclusion, and to the removal of their children. Furthermore, intellectual and mental disabilities and substance use problems appeared to be linked with the possibility of becoming homeless and disconnected from society. However, the extent and scope of this problem in the community is largely unknown and warrants investigation. The value of effective service provision for these young women should not be underestimated.
17. Service providers supplied a number of suggestions for methods that might enable service delivery to young pregnant women and mothers who belonged to one or more of the vulnerable subgroups. In particular they were referring to young women who had disabilities, had been in state care, experienced abuse, and/or who had used or were using alcohol and illicit substances. The overriding recommendation was for young women to have a single point of entry into a care based system that would then cater for their individual needs. Important in this system was the provision of a single caseworker who would oversee the care of the woman, coordinate services, and where appropriate, facilitate a positive, supportive relationship between the young woman and her family. In addition to recommendations 10 and 16, we recommend that a program that includes these elements is pilot tested for efficacy.
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APPENDICES

A. Services
B. Service Provider Study Materials
C. Young Pregnant Women and Mothers Study Materials
D. Centrelink Benefits
Services

The following services were sent invitations to attend focus groups:

- Local hospital maternity and clinic services;
- TAFE managers, counsellors, support workers, educators;
- Outreach education programs;
- University and college counsellors, educators, equity officers;
- Secondary school principals (public and private);
- Early Childhood Health Centres;
- Family Planning Clinics;
- NGOs (e.g. Centacare, Anglicare, Red Cross, YMCA, Unifam);
- Department of Community Service centres;
- Women’s Centres;
- Playgroups, mother’s groups;
- Family daycare, preschools, child care centres;
- Family Support Services;
- Community Service Centres, community centres;
- Community Health Centres;
- Youth Centres, Youth Support Services, PCYC;
- Multicultural centres, diversity services;
- English language education centres;
- Homestart, Families First and similar programs;
- Government services (e.g. Centrelink, Department of Community Services, Department of Housing);
- Housing services (e.g. refuges, shelters, supported accommodation); and
- Disability support services.

Specific services are not named by area for reasons of confidentiality of participation or non-participation status.
APPENDIX B

Service provider study materials

Focus group schedule for service providers

Ethical requirements

- Indicate the section in the Information Sheet that concerns the reporting of illegal acts;
- Ask everyone to respect the confidentiality of the group, and not to divulge the specific content of the discussion to people outside of the group;
- Point out that participants have the right not to respond to any questions that they do not wish to respond to;
- Ask participants to complete the surveys; and
- Ask participants if they have any questions.

Schedule
The tape recorder is now switched on. I’d like to start by asking what motivated you to come along to the group today?

What have your experiences with young mothers and young pregnant women been like?

What do you think are some of the reasons that young pregnant women and mothers might find it difficult to access services?

Why do you think that young pregnant women and mothers don’t use services as often as they might?

What do you think helps young pregnant women and mothers to access services?

What sort of things do you think might help young pregnant women and mothers to access services more often?

What role does the family of a young woman play in her ability to access services?

Do any of you share office space, or pool other resources? Do any services act as ‘one stop shop’ for referrals? [elaborate]

Is there anything you would like to add?

Thank participants for their time.
Written response questions for service providers

You have the right not to respond to any questions you may not wish to answer.

Your responses can be as detailed or as brief as you wish. If there is not enough space for your answer, please feel free to continue on the back of the page. There is no need to put your name on this survey.

1. Please tell us what motivated you to respond to this questionnaire.

2. What have your experiences with young mothers and young pregnant women been like?

3. What do you think are some of the reasons that young pregnant women and mothers might find it difficult to access services?

4. Why do you think that young pregnant women and mothers don’t use services as often as they might?

5. What do you think helps young pregnant women and mothers to access services?

6. What sort of things do you think might help young pregnant women and mothers to access services more often?

7. What role does the family of a young woman play in her ability to access services?

8. Is there anything you would like to add?
Demographic survey for service providers

This survey will be used to make sure that we have spoken with a range of service providers from a variety of different organisations. Please try and answer every question. There is no need to put your name on this survey.

If you have any questions about the survey, please ask.

1. What is your occupation, or the position that you hold, that brings you into contact with young pregnant women and mothers?

____________________________________________________________________

2. How long have you held this position? ______________________________

3. What type of organisation do you belong to?
   - Volunteer organisation (e.g. Salvation Army, Benevolent Society, Playgroup co-ordinator)
   - State Government department (e.g. Department of Community Services)
   - Department of Education
   - Area health service
   - Commonwealth government department (e.g. Centrelink)
   - Family, multicultural, or youth support service
   - Non-government organisation
   - Other (please specify) ___________________________

Thank you for your participation.
APPENDIX C

Young pregnant women and mothers study materials

Phase 1: Telephone interviews

The interview schedule was changed during the project to include a verbal consent statement. Originally, participants were asked to mail a signed consent form. However, young women found this task difficult to accomplish. Ethics committee approval to include a verbal consent rather than a written consent was obtained. Only the schedule that includes the verbal consent has been included here.

Interview schedule

After introductions, the participant will be invited to ask any questions they have. After these have been asked and answered, the participant will be told that the first set of questions will be verbal consent questions, they will then be told that the tape recorder is being switched on.

[tape recorder on]

Verbal consent

Do you agree to participate in this research project and give your consent freely?

Do you understand that the project will be conducted as described in the Information Statement, that you have a copy of?

Do you understand that you can withdraw from the project at any time and do not have to give any reason for withdrawing?

Do you consent to participate in a telephone interview about your experiences as a young pregnant woman and/or mother?

Do you understand that your personal information will remain confidential to the researchers?

Have you had the opportunity to have questions answered?

For those aged 14-17 and who live with parent/guardian

Have you discussed the research with your parent/guardian?

Do they agree that you can take part in the project?
For those aged 14-15 who do not have a parent/guardian that they can talk to

Have you discussed the research with a responsible adult?

Do you agree to take part in the research considering what this person has said to you about the project?

[16-17 year olds who live independently, and 14-15 year olds who are unable to find a responsible adult to talk to will be giving their own consent, as was previously approved]

Do you have any questions before we begin the interview?

Interview

[Ask Verbal Demographic Survey questions]

Would you mind telling me a little about the birth of your child? [Was the birth natural? Were there complications? Were forceps or vacuum extraction used? Did you have a caesarian? Where did you give birth?]

Thank you for answering those questions. I was wondering what motivated you to do this interview today?

What have your experiences with [service providers] been like?

- Prenatal health services, hospital stays, postnatal care
- Early childhood nurses, home nurse visits
- Doctors
- Education providers
- Child care
- Volunteer organizations
- Government organizations (e.g. Centrelink, DOCS)

Could you tell me about any problems that you have had with using any of these services? [What happened then, were you able to use the service/solve the problem, how do you think the problem could be solved?]

Could you tell me about times when using services has been easy? [What happened then? What was it about using this service that made it easy? How does it compare to those times when using a service has been difficult?]

What do you think about service providers?

How often have you used different services? Was that enough? [Why/why not?]
What sort of things have put you off using a service so that you don’t use it as often as you might like to?

Has your family been able to offer you any sort of help in accessing services? [What sort of help did they offer? What sort of help would you like them to offer? Is there anything your family could do that would help you to access services?]

Is there anything you would like to add about your experiences with different services?

How are you feeling after talking about these issues? [ascertain that participant is feeling well.]

I was wondering if you know of anyone else who is a young mother or who is pregnant who might like to take part in an interview? [If yes, ask them to pass along researcher’s contact details]. Thank you for your time today.

**Verbal Demographic Survey Questions**
(to be asked at the start of interview)

I’d like to start by asking you a few questions about your circumstances, if that would be okay?

1. What are the ages of your children?
2. How old were you when you had your first child?
3. How old are you now?
4. Who lives in your household? (partner?)
5. What is your postcode?
6. What country were you born in?
7. What are the sources of your income?
   a. Wage or salary
   b. Own business/farm/partnership
   c. Superannuation or other private income
   d. Child support (maintenance)
   e. Government pension or allowance
   f. Austudy/Abstudy
   g. Other (Please specify) ______________
8. How do you manage on the income you have available?
   a. It is impossible
   b. It is difficult all the time
   c. It is difficult some of the time
   d. It is not too bad
   e. It is easy

9. Are you in paid employment?
   a. No
   b. Yes

   If yes, is your paid employment:
   i. Full time
   ii. Part time
   iii. Casual

10. What is the highest educational qualification you have completed?
    □ Year 10 (or equivalent)   □ Certificate or diploma
    □ Year 12 (or equivalent)   □ Degree
    □ Trade qualification       □ Higher degree

11. Are you currently a student?
    a. No
    b. Yes

12. At the place you live now, are you:
    a. An owner
    b. A purchaser
    c. A renter
    d. Living rent free
    e. A border
    f. Other (Please specify) ___________________
**Phase 2: Face to face interviews**

**Face to face interview schedule**

Have you used any of the following services?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>If no, any reason?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal or birthing classes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital prenatal clinic visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital stays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood health nurse home visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood health centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family support services</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mother's groups/playgroups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinics within Chemists shops</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education (school, TAFE, uni)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government services (Centrelink)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from family and friends</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Is there anything else that stopped you from using services?
2. How did you find out about services that you did use? Eg. Did your family tell you, brochures, friends, family doctor etc?
3. Do you mind if I ask how old you are?
4. How old are your children?
5. That’s the end of the survey is there anything else you would like to ask about the survey?
APPENDIX D

Centrelink Benefits

Various financial benefits are payable to eligible individuals through Centrelink. These benefits cover a range of areas including: age pensions, student payments, employment related payments, carer allowances, disability support pensions, family tax benefits, maternity payments, and widow allowances and pensions. Payments are generally subject to income tests and/or assets tests. The Centrelink web site provides information on eligibility and income and assets tests.

Many of the young pregnant women and mothers targeted in this research may be eligible for Centrelink benefits, primarily in relation to parenting, and also in many cases, in relation to education. Some women with specialized needs (e.g. Indigenous, disabilities) may also be eligible for other targeted benefits. Information on all Centrelink benefits is provided via www.centrelink.gov.au.

The following outlines the basic steps followed in retrieving information from the Centrelink website, specifically on family payments and benefits.

Accessing Information

Access to information about any Centrelink benefits and payments is via the Individuals link on the Centrelink homepage. The Individuals page includes a link with the question: are you a parent or a guardian? When this link is activated it opens a new page with further links to information about child and family related payments. The links that refer to payments are:

- Payments to help you raise children;
- Payments if you are having a baby;
- Payments to help with the education of your child; and
- Payments while your child is ill, injured or has a disability.

In addition there are a further nine links to information pages such as: services for parents and guardians, publication forms for parents and guardians, claim forms for parents and guardians, child care information and more choices for families. The process of accessing information and forms from the Centrelink website to make an application for a Benefit involves downloading numerous Portable Document Format (PDF) documents and other pages. The time taken to do this is 30 to 60 minutes. Once this information is retrieved and printed, it is necessary to devote further time to interpretation of the numerous pages.
It is not obvious, from the Centrelink website, whether the information on parenting is age specific, although in email correspondence with Centrelink we were told that there are no customer related age conditions for either the Family Tax Benefit, Parts A or B or the Parenting Payment.

Young pregnant women and mothers under 25 are a diverse group with varying social and economic circumstances. It is also not apparent from the Centrelink website whether young pregnant women and mothers who are financially and/or legally dependent on their own parents (e.g. aged under 18 years) are eligible for the same benefits as other women living independently. As many of the benefits are subject to income and/or asset tests, it is likely that eligibility for some young dependent women may be restricted (due to their own parents’ income and asset levels).

The pathways on the Centrelink website are designed to answer a pre-determined set of questions that conform to the circumstances of the majority of the population. These pathways do not always address the special needs and circumstances of marginalized sub-groups, such as pregnant and parenting adolescents. Questions referring to less common circumstances (e.g. those of our target group of younger mothers) are not generally addressed through Centrelink website.

**Parenting Benefits**

Some of the benefits that may be payable to a young mothers include:

- The Family Tax Benefit A;
- The Family Tax Benefit B;
- The Parenting Payment;
- The Child Care Payment; and
- The Maternity Payment.

The Family Tax Benefit Part A is an annual tax benefit paid to help families with the cost of raising children. The Family Tax Benefit Part B gives extra assistance to families with one income, including sole parents and also gives extra assistance to families who have a child under the age of five. The Family Tax Benefit Part B includes a supplement which is only available at the end of the financial year after clients’ tax returns have been lodged. Both Parts A and B are subject to an income test. Neither is subject to an assets test. The Parenting Payment is for parents, grandparents or foster carers who have one child under 16 who is wholly or substantially in their care. The payment is subject to an income and an assets test. The Child Care Benefit helps to meet costs associated with registered child care and to receive it, parents must be working or studying. It is subject
to an income test but not an assets test. The Maternity Payment is a one off payment made upon the birth of a child and has neither income nor assets tests.

**Other Benefits**

The Youth Allowance assists young people who are studying, undertaking training or a New Apprenticeship, looking for work, or sick. The Allowance is subject to an assets and an income test. The Special Benefit is a discretionary payment made in special circumstances and is subject to an income and an assets test. This may be applicable to some young pregnant girls and mothers although in order to qualify, a case for severe financial hardship must be put to Centrelink. The Newstart Allowance is designed to help people (aged over 21 years) find work and allow them to participate in activities while looking for work. The Newstart Allowance is subject to an income and an assets test. Indigenous students may receive benefits through ABSTUDY. This consists of a fortnightly living allowance as well as additional components to help with the costs associated with attending school.

**Barriers**

The Centrelink website is a major vehicle for information dissemination regarding benefits payable across many sub-groups in Australia. Navigation of the website requires a considerable level of concentration and computer literacy. There are numerous inter-related links and pathways and it is very easy to ‘get lost’ in the maze of pathways. This is also a very time consuming exercise. While technically precise, the website is not generally user-friendly.

Clients are encouraged to submit applications for benefits electronically. In order to do this they would need access to a working computer and printer, internet connection, (preferably broadband), and appropriate software to browse and download documents. In addition to the site itself, some of the barriers that the young women in our target group may face in relation to accessing information electronically include:

- Costs of accessing computer hardware and software;
- Low computer literacy and general education;
- Low concentration/attention span;
- Insufficient experience with internet searches;
- Lack of access to IT support;
- Lack of exposure to computers;
- Low confidence levels; and
- Time constraints.
Clients are also advised that they may obtain further information and documents by telephoning Centrelink or visiting a local office. This approach may also be difficult for some young women in our target group. The Centrelink telephone enquiry line is automated and a degree of time and patience is required when seeking answers to specific questions by phone. Many matters related to benefits are generally not dealt with by phone and clients are invited to make appointments for interviews. Young pregnant women and mothers may experience difficulties in arranging time and transport to attend meetings with Centrelink officers. Negative experiences and judgmental attitudes previously encountered in service delivery may also inhibit young women from attending Centrelink appointments.

Finally in order to ascertain their eligibility for Centrelink benefits, and make relevant applications, clients need to be sufficiently informed to be able to articulate their needs and circumstances, either electronically or person to person. As already reported here, studies of young pregnant women, mothers and their infants describe multiple levels of disadvantage, with lower income, education, social support and confidence, compared with other young women. It is likely that the sub-group of young pregnant women and mothers, with often complex social circumstances, will face numerous barriers in accessing information and resources regarding Centrelink benefits.