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You're in the Right Spot.

Responding to Pregnancy and Homelessness: Evaluation of the Cornelia Program

July 2024

LA TROBE UNIVERSITY AUSTRALIA

the Cornelia program

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Report by:
RMIT University
GPO Box 2476
Melbourne VIC 3001
Australia
Tel: +61 3 9925 2000
ABN: 49 781 030 034
CRICOS Provider No: 00122A

Contact:

Juliet Watson, RMIT University
juliet.watson@rmit.edu.au

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Acknowledgement of Country

In the spirit of reconciliation, the Cornelia Program acknowledges that their operations are situated on the land of the Boonwurrung people of the Kulin Nation. We also acknowledge the Traditional Custodians of Country throughout Australia and their connections to land, sea, and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Report Authors

- Associate Professor Juliet Watson
  juliet.watson@rmit.edu.au
- Dr Jacqui Theobald
  J.Theobald@latrobe.edu.au
- Dr Freda Haylett
  freda.haylett@rmit.edu.au
- Professor Leesa Hooker
  L.Hooker@latrobe.edu.au
- Professor Suellen Murray
  suellen.murray@rmit.edu.au

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Glossary

AMES	Adult Multicultural Education Services.
Anglicare	Children, young people, and families support service provider.
APGAR score	The clinical indicator of a baby's condition shortly after birth.
Botanical Apartments	The Cornelia Program's supported accommodation studio units in St Kilda.
Bridgehaven	Salvation Army provided alcohol and other drugs residential rehabilitation program for women and women with accompanying children.
Chronic disorder	A long-lasting condition with persistent effects. The social and economic consequences can impact on people's quality of life.
Dame Phyllis Frost Centre	Deer Park Metropolitan Women's Correctional Centre.
Evolve Housing	Community housing provider.
External service providers	Agencies involved in providing support to Cornelia service users representing health, alcohol and other drugs, family violence, Aboriginal services, parenting, and child welfare services.
Fusion Australia	Youth and community-based charity and housing provider.
Gestation	Period of time between conception and birth.
Horn of Africa	The North-Eastern region of the African continent.
Income Support	Payments and benefits administered by the Commonwealth agency Centrelink.
Juno	Homelessness and family violence service provider.
Koori Maternity Services	Department of Health auspiced maternity care for Aboriginal women, or women having Aboriginal babies, and their families.
MiCare	Community service provider for people from multicultural backgrounds.
Ngwala Willumbong	State-wide community controlled organisation for Aboriginal and Torres Strait Islander communities.
Operational staff	Staff employed during business hours by partner organisations providing care coordination, social work, midwifery care, family support, and tenancy support to Cornelia service users.
Orange Door	Family violence support service.
Parity	The number of births (including live births and stillbirths) where pregnancies reached viable gestational age.
Safe Steps	Victoria's 24/7 family violence crisis service.

Salvation Army	Homelessness, community housing, and social services provider.
Senior management	Senior managers representing the Cornelia Program partner organisations Royal Women's Hospital, Launch Housing, and HousingFirst.
Service users	Women clients of the Cornelia Program.
Unison Housing	Homelessness and community housing service provider.
Vincent Care	Homelessness, housing, and social services provider.
WAYSS	Housing and family violence service provider.
Windana	Alcohol and other drugs service provider.
Wombat Housing and Support Services	Community housing provider.

Abbreviations

AOD	Alcohol and Other Drugs
BMI	Body Mass Index
DFFH	Department of Families, Fairness and Housing
EAG	Evaluation Advisory Group
MCHN	Maternal and Child Health Nursing
NFA	No Fixed Address
NICU	Neonatal Intensive Care Unit
PTSD	Post-Traumatic Stress Disorder
RWH	Royal Women's Hospital
WADS	Women's Alcohol and Drug Service (at the Royal Women's Hospital)

Executive summary and recommendations

Background

Researchers from RMIT University and La Trobe University were contracted to undertake an impact evaluation of the Cornelia Program, a partnership between the Royal Women's Hospital, Launch Housing, and HousingFirst. This report is designed to provide an evidence base to assist stakeholders to communicate the evaluation findings to key audiences (including government and the housing and health sectors) of the value of the Cornelia Program.

The Cornelia Program works with women experiencing pregnancy and new mothers and their babies who are homeless, providing temporary accommodation at the Botanical Apartments and holistic supports for up to 12 months. The program was established in response to a need identified by health and homelessness practitioners, service providers, and researchers that women experiencing pregnancy and homelessness require more urgent, specialised, and longer-term supports than are currently available.

Method

Using a longitudinal, mixed-methods approach, the evaluation aimed to understand whether the work of the Cornelia Program has helped the women and their babies using the service, and how effective the program has been to this end. In total, the research team engaged 35 stakeholders comprising 15 service users, seven Cornelia operational staff, five senior managers from partnership organisations, and eight participants from seven external service providers. Alongside this qualitative data, administrative data from the Cornelia Program and routine perinatal data from the Royal Women's Hospital were collected and analysed to help inform the findings of this report.

Aims

Working with the Evaluation Advisory Group, researchers developed a set of four aims to guide the evaluation process. These aims centred on:

1. The effectiveness of the Cornelia Program's implementation.
2. The experience of women and their babies of the program.
3. Long-term secure housing outcomes of women and babies supported by the Cornelia Program.
4. The extent that the Cornelia Program improved the health and quality of life of women and their babies.

These aims were developed to address both the program's processes and outcomes.

The evaluation aims have been achieved as outlined in the findings, which demonstrate that the program:

1. Has been implemented successfully.
2. Is experienced by service users as supportive and provides life-changing outcomes.
3. Delivers long-term, safe, and secure housing.
4. Provides support that improves the health and quality of life for women and babies across a range of domains

Summary of characteristics of Cornelia Program service users

89
service users have entered Cornelia since it first opened

41%
of service users were born overseas

14%
were Aboriginal women

27%
of Cornelia newborns required Neonatal Intensive Care admission

92%
of Cornelia service users reported a past or current history of mental illness

84%
had experienced or were currently experiencing family violence

70%
of Cornelia service users moved to long-term housing after exiting the program

As of February 2024, a total of 89 women had entered the Cornelia Program. Seventy-nine babies had been born, of which 27 per cent required admission to the Neonatal Intensive Care Unit. Forty-one per cent of women were born overseas and 14 per cent were Aboriginal women. Ninety-two per cent of women reported a past or current history of mental ill health, and 84 per cent had experienced or were experiencing family violence on entering the program. On exiting the program, 70 per cent of women and their babies moved into long-term housing.

Furthermore, women in the Cornelia evaluation cohort (n=65) compared with RWH controls (n=13,351) were significantly:

- Younger
- Having their first baby
- Single
- Aboriginal or Torres Strait Islander
- Receiving income support and in receipt of a health care card

Findings

The Cornelia Program is a critical intervention for women experiencing pregnancy and homelessness who would otherwise have few specialised housing and support options. The perinatal and antenatal periods are crucial for establishing stability, security, good health, and assured parenting practices that have long-term impacts on the lives of mothers and their children. This report provides evidence that the Cornelia Program is delivering an essential service that is achieving outstanding longer-term results, particularly in the areas of housing sustainment, service engagement, mother-baby bonding, and parenting skills. Without the high-quality service provided by the Cornelia Program, women experiencing pregnancy and homelessness would not have access to equivalent support and would be at far greater risk of ongoing homelessness and being unable to care for their babies.

The outcomes of the evaluation are presented in accordance with the research aims and are as follows:

Evaluation Aim 1: The Effectiveness of the Cornelia Program's Implementation

Governance

- Cooperation between partnering organisations, the involvement of external expertise, and careful consideration of staff recruitment in the lead-up to the opening of the Cornelia Program contributed to successful implementation.
- The governance structure of the program was not fully defined at the inception of the program. Uncertainties relating to governance, risk, and responsibility created some

confusion at the service delivery level.

- More equal representation and engagement across organisations in governance matters such as risk management and meeting attendance is recommended.
- The Cornelia Program partnership provides strong human and financial resources, as well as substantial institutional and community knowledge, which have been beneficial to the program's implementation.

Referrals

- 89 women entered Cornelia as of February 2024 and 79 babies were born.
- Most (51 per cent) referrals to the program occurred through the Royal Women's Hospital, with others coming through external support services (32 per cent), self-referrals (10 per cent), and other health referrals (7 per cent).
- External referrals were made from a wide range of housing and support services, with most coming from Safe Steps/Orange Door (n=7) and Launch Housing (n=6).
- At the time of the stakeholder interviews it was noted that the referral processes and procedures at the Cornelia Program had been established well and reflected a high quality of service.

Staffing

- Senior management, operational staff, and service users agreed that staff levels were low for the level of complexity involved in the work.
- External service providers did not perceive low staff levels as having a detrimental effect on the quality of supports provided to women.
- Operational staff with the right skillset and expertise have been successfully recruited and retained in the workforce.

External partnerships

- The program has built strong relationships with external partner organisations that enable the provision of wraparound care for women and babies.

Evaluation Aim 2: The experience of women and their babies of the program

Accommodation

- Security of tenure at the Botanical Apartments provides the foundation for housing stability and significantly reduces stress felt by women, thereby enabling them to engage with services, prepare for motherhood, and develop closer bonds with their babies.
- The small size of the units at the Botanical Apartments presents challenges for women, particularly once their babies become mobile. The benefits of the program overrode these concerns, and the women did not indicate that unit size prompted them to leave prematurely.

Safety

- Varied experiences of a sense of safety at the Botanical Apartments were noted. Some felt the building was adequately secure, while others expressed concerns about trespassers, and operational staff only being available during business hours.
- Onsite security improved during the period of the evaluation.
- The independent housing provides women with protection from perpetrators and creates conditions that can facilitate leaving violent relationships. This enables better service user engagement with alcohol and other drug services, and improved bonding with babies.

Wraparound support

- The Cornelia Program is unique in its capacity to offer continuity of care via onsite multidisciplinary and wraparound support through care coordination, social work, family support, tenancy support, and midwifery.
- The Cornelia operational staff work collaboratively with external services across a range of domains including alcohol and other drug use, family violence, legal issues, maternal and child health, Child Protection, mental health, and cultural support.
- Relationships with external service providers offer great value through specialist services and enable the program to deliver high quality care to women and babies. This is especially valuable given funding and resource constraints that limit what the Cornelia Program can provide in-house.
- The material support provided by the Cornelia Program removes some of the financial burden, and associated stress, for women on low incomes.

Accessibility

- 41 per cent of service users were born overseas.
- 14 per cent of service users were Aboriginal women.
- The Cornelia Program is highly accessible to women from multicultural backgrounds.
- Operational staff are client-centred in their supports, exhibiting a welcoming, inclusive, and non-judgmental approach.
- The quality of care provided is of a level that many of the women had not experienced previously.
- Cultural aptitude is demonstrated consistently by the operational staff.

Peer support

- Peer support relationships are important in building independence as well as offering support networks.
- Building relationships between women generates opportunities for sharing experiences and providing emotional support, which fosters healing.

Evaluation Aim 3: Long-term secure housing outcomes of women and babies supported by the Cornelia Program

Housing

- Some women had long histories of homelessness prior to entering the program, which included multiple forms of insecure housing with some periods of relative stability.
- The Cornelia Program has proven to be highly successful in facilitating women's access to support and advocacy in relation to post-exit accommodation with 70 per cent of all service users moving into permanent/long-term housing.
- HousingFirst is an important supplier of properties, indicating the value of this partnership.
- Operational staff take careful consideration of location, condition, and community connections when arranging long-term housing to improve sustainability.
- The women were mostly satisfied with their post-Cornelia housing arrangements.
- The housing sourced by the Cornelia Program is suitable for women who do not have babies in their care to work towards reunification.

Transitions

- The Cornelia Program builds women's independence though equipping them with the skills to manage day-to-day living on their own after they exit the program.
- The women were mostly satisfied with the level of support they received as they transitioned into their post-Cornelia housing.

Community connections

- Location is important for housing sustainability for reasons stemming from ease of access to amenities and services to community engagement and social connection.
- The women reported satisfaction with the locations to which they had moved, indicated by engagement with local services and amenities, religious institutions, and proximity to family and friends.

Evaluation Aim 4: The extent that the Cornelia Program improved the health and quality of life of women and their babies

Health and wellbeing

- Women in the Cornelia Program (n=65), compared to other women attending the Royal Women's Hospital birthing services (n=13,351), during the period August 2021 to July 2023, were significantly more disadvantaged, with greater health needs and social issues.
- The Cornelia Program infants required more resuscitation, more neonatal support, and were less likely to be breastfed.
- 40 per cent of women in the Cornelia Program disclosed alcohol and other drug use.
- 92 per cent of Cornelia service users reported a past or current history of mental illness.

- The partnership with the Royal Women's Hospital, including onsite midwifery support, is vital to the continuity of care model offered by the Cornelia Program. It increases women's access to antenatal care and, by extension, the likelihood of positive clinical outcomes.
- The Cornelia Program facilitates relationships with external health providers such as Maternal and Child Health Nursing, GPs, and mental health support, which women access after exiting the program.

Family violence

- 84 per cent of women had experienced or were currently experiencing family violence on entering the Cornelia Program.
- The women reported significantly increased levels of self-confidence and independence following their exit from the Cornelia Program. This played an important role in preventing them from returning to violent ex-partners.
- The Cornelia Program's educative role to explain and identify perpetrator responsibility is an essential part of supporting women to continue to live free from violence after they leave the program.

Parenting

- 43 per cent of women had previous involvement with Child Protection.
- The Cornelia Program produces positive outcomes for women and babies including keeping families together and reducing the likelihood of women being subject to repeat Child Protection notifications and/or ongoing involvement post-birth.
- The women reported increased confidence in working with Child Protection.
- The women had improved relationships with their babies while in the Cornelia Program and this bond continued to strengthen after exiting the program.
- Parenting programs offer onsite assistance to women to develop, and build confidence in, their parenting skills.
- The support provided by the Cornelia Program makes it possible for women to reconnect with children not in their care.

Education and employment

- Some women entered paid employment or education after leaving the program.

Recommendations

The findings of this evaluation led to the formation of five recommendations.

Funding and service model

1. Secure ongoing funding to ensure the continuation and consolidation of the Cornelia Program.

Safety and use of space

2. Conduct an audit of the Botanical Apartments building to investigate both the ongoing safety of the premises, including the viability of after-hours security measures, and to maximise the most effective use of space, including access to communal areas.

Governance

3. Ensure consistency of input, responsibility, and risk across all partnering organisations and consider implementing a new partnership agreement to promote good governance and sustainability of the program.

Staffing

4. Continue to employ staff with specialist knowledge, to build and consolidate external partnerships, and to consider increasing the size of the team dependent on need.

Evaluation

5. Invest in further evaluation to capture: 1) the Cornelia Program's economic value, 2) the sustained benefits to women and children, and 3) the development of the program.

Chapter 1 | Introduction

1.1 About the Cornelia Program

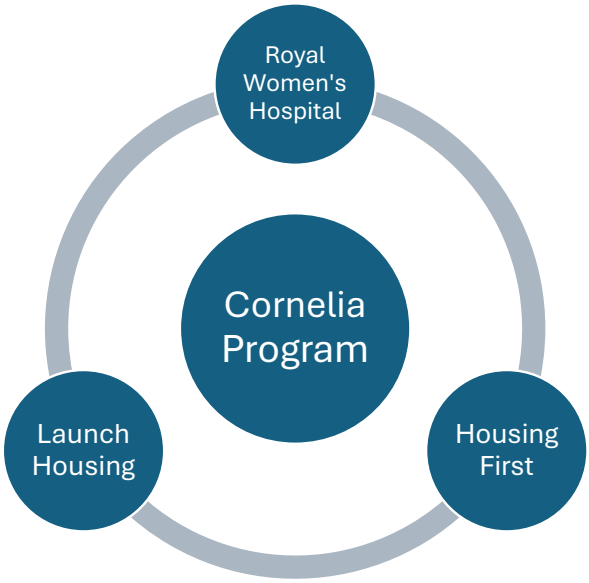
The Cornelia Program commenced in July 2021 as a partnership between the Royal Women's Hospital, Launch Housing, and HousingFirst. Funded by the Department of Health, Homes Victoria, and philanthropic funding from the Royal Women's Hospital, the Cornelia Program is the first of its kind in Australia using a multidisciplinary model of care that provides women experiencing pregnancy and homelessness and their babies with a range of supports.

The Royal Women's Hospital is Australia's first and largest specialist hospital dedicated to improving the health of all women and newborns. Each year, it provides more than 250,000 episodes of care for women from 189 countries, who speak 90 different languages and follow 69 separate religious faiths. For more than 160 years, the Royal Women's Hospital has led the advocacy and advancement of women's health and wellbeing across Victoria and beyond. It is committed to a holistic philosophy of health and provides comprehensive services ranging from health promotion to clinical expertise and leadership in maternity, gynaecology, women's cancer services, termination services, and in the specialist care of newborns.

Launch Housing is a Melbourne-based, secular, and independent community agency with the mission to end homelessness. Launch Housing provides high-quality housing, support, education, and employment services to thousands of people across 14 sites in metropolitan Melbourne. Launch Housing also drives social policy change, advocacy, research, and innovation.

HousingFirst is a not-for-profit community housing organisation providing social housing across Melbourne. Its mission is to build affordable homes and local communities. HousingFirst achieves this by increasing the supply of secure, high-quality, affordable housing; providing exceptional property and tenancy management; supporting residents to achieve personal well-being; building cohesive communities in collaboration with residents; and partnering to achieve these outcomes.

Figure 1: Cornelia Program partnering organisations



The Cornelia Program is named after Cornelia Africana, a Roman woman who was celebrated for her dedication to her children, and was suggested by Professor John McBain and Dr Penelope Foster, who are private donors to the program. Cornelia is often cited as the Roman symbol of motherhood and is renowned for valuing her children over wealth.

Women entering the Cornelia Program are provided with support from a multidisciplinary workforce, which includes a program manager, two care coordinators, one social worker, and one midwife employed by The Royal Women's Hospital; two senior family support workers employed by Launch Housing; and one tenancy support worker employed by HousingFirst. Each organisation involved in delivering the Cornelia Program has designated roles and responsibilities. The Royal Women's Hospital provides clinical services including antenatal and postnatal care for up to six weeks. Women are provided with continuity of midwifery care onsite at the Botanical Apartments. Social work services and care coordination are also provided for a period of up to 12 months to support women and their babies with needs related to matters such as alcohol and other drug use, family violence, mental health, and Child Protection. The Royal Women's Hospital also resources the Cornelia program manager role and facilitates referral of women into the program. Housing support is provided to women by staff employed from Launch Housing. This involves preparing women for tenancy readiness through parenting support and building capacity with daily living skills to assist women

and their babies to transition from the Cornelia Program to live independently in long-term, affordable, and stable accommodation. They also broker access to key social resources and material aids for women—particularly in relation to preparing for, and managing, the arrival of their babies. Tenancy management and administration is provided by HousingFirst involving activities such as managing residential tenancy agreements, property maintenance, financial management, and employment support. They also provide long-term housing to women exiting the program.

Figure 2: Supports provided by the Cornelia Program

	Supported accommodation in studio units at the Botanical Apartments in St Kilda for a period of up to 12 months.
	Access to maternity, neonatal, sexual, reproductive and specialist women's health services.
	Care coordination services to support women to access other health and psychosocial services they may require.
	Housing support to access long-term, stable and affordable housing.

To be eligible for the program, women must not have other children in their care, be willing to engage with support services, and be willing to reside alone with their baby. The program gives priority access to:

- Women experiencing pregnancy and homelessness
- Aboriginal and Torres Strait Islander women
- Women impacted by alcohol and other drugs who are willing to engage in treatment

1.2 Purpose of the report

This report evaluates whether the work of the Cornelia Program helped the women and babies using the service, and how effective the program has been to this end. Researchers worked alongside members of the Evaluation Advisory Group to develop a set of four evaluation aims from which to assess the success of the program.

Figure 3: Aims of the evaluation

1	The effectiveness of the Cornelia Program's implementation.
2	The experience of women and their babies of the program.
3	Long-term, secure housing outcomes for women who are pregnant within a 12-month period.
4	The extent that the Cornelia Program improves the health and quality of life of women and their babies.

The report provides an evidence base to assist stakeholders with understanding how the Cornelia Program supports and advocates for women and their babies, and to communicate these findings to key audiences, including to government and the housing and health sectors, with the aim of securing ongoing funding. It makes recommendations designed to guide and support the ambitions of the Cornelia Program to enhance the health and wellbeing outcomes of women experiencing pregnancy and homelessness, and their babies, positively shifting their life trajectories.

1.3 Reviewing the existing research on pregnancy and homelessness

The Cornelia Program was established to address a need identified by health and homelessness practitioners, service providers, and researchers of women experiencing pregnancy presenting to homelessness services requiring urgent, specialised, and longer-term supports but too often being met with service responses that are fragmented, siloed,

insufficient, and confusing to service users (Murray, Theobald & Watson 2018; Murray et al. 2020).

1.3.1 Pregnancy and homelessness

Women can have a range of routes into homelessness; however, research has shown there are reasons specific to pregnancy and motherhood that can be a trigger for homelessness. For example, mothers will leave their home to protect themselves and their children from physical and sexual abuse (Mayock & Sheridan, 2012; Reeve, Casey & Goudie, 2006; Smith et al. 2001). While the number of women experiencing pregnancy and homelessness in Australia is not precisely known, there have been recent research endeavours to try and uncover the extent of the problem. Two snapshot surveys undertaken in 2017 at Launch Housing and the Salvation Army Crisis Services Network found that women experiencing homelessness were slightly more likely to be pregnant than the wider population of Australian women (Murray, Theobald & Watson 2018). It is likely that these data do not reflect the full extent of the problem, as they only included women who sought support from services and subsequently disclosed their pregnancies. Therefore, it is probable that there is a population of women experiencing pregnancy and homelessness who remain invisible to services. Reasons for this vary, but may include women not disclosing a pregnancy out of concern that it would make them less likely to be housed; that they could be excluded from access to short-term crisis accommodation because they would need to move when their baby is born; and that some women fear that making services aware of their pregnancy could lead to their baby's removal by Child Protection (Murray et al. 2020; Smid, Bourgois & Auerswald, 2010; Stringer et al. 2012)

1.3.2 A time for change

The insecure, unpredictable, and disruptive nature of homelessness interferes with the ability of mothers to implement regular routines for their children, or to create a familiar environment in which they can learn and develop (Hogg et al., 2015). Nonetheless, pregnancy is a time when women experiencing homelessness report a willingness to make changes and re-engage with support services (Theobald et al., 2023). In Watson's (2018) research on young women experiencing homelessness, becoming a mother became the impetus for one participant to leave an abusive relationship and find a safe environment, and another decided to begin a methadone program knowing her baby would be born soon. In a study involving interviews with 24 young women experiencing homelessness, Keys (2007) found that pregnancy prompted many of the women to make positive changes, but this was often a difficult process due to barriers such as unstable accommodation, substance use, poor mental health, and volatile relationships. Smid, Bourgois & Auerswald's (2010) research on homeless youth also found that despite significant obstacles, almost all the young women experiencing pregnancy in their study were convinced of their personal capacity to change their lives.

1.3.3 Health and welfare systems

The inability to properly look after their health during pregnancy or to prepare adequately for motherhood denies women experiencing pregnancy and homelessness control over their lives. Lavender (2021) argues that women experiencing homelessness face 'overlapping and mutually reinforcing constraints' while attempting to comply with welfare measures ostensibly designed to protect their babies (p. 1609). Because pregnancy requires more involvement with public hospitals and the health care system, women's exposure to surveillance by welfare agencies increases while homeless, making them vulnerable to Child Protection intervention and the removal of their baby. Parr (2024) explored the harms associated with housing and child protection policy for mothers experiencing homelessness in the UK—characterising their lived experience of child removal as a sustained 'harrowing absent-presence' (p. 14). Indeed, women's treatment within the health system while homeless can be variable and hard to predict, as Nickasch and Marnocha's study (2009) found. Participants in their study felt that 'fate' and 'luck' played a significant role in how they were treated by service providers, with one participant explaining that she felt like a victim of her circumstances and that she lacked any free will.

1.3.4 Homelessness, pregnancy, and gender-based violence

Homelessness exposes women to increased risk of gender-based violence (Murray, 2011; Watson, 2018). Exposure to domestic or family violence can have devastating consequences for maternal and foetal outcomes, for example a physical assault to the abdomen or sexual trauma during pregnancy 'can increase the risk of preterm birth, low birthweight, placental abruption, spontaneous abortion, and neonatal death' (Orr et al., 2022, p. 2). In Australia, 47 per cent of women who reported violence in a relationship had experienced violence during pregnancy (Australian Institute of Health and Welfare, 2018), and when gender-based violence co-occurs with factors such as homelessness, poor access to nutritious food, AOD use, and mental health issues this further contributes to poor maternal and neonatal outcomes (Brownridge et al., 2011). The indications that housing interventions benefit women experiencing homelessness while pregnant or parenting young children are promising (Brew et al., 2024), and given there are many co-occurring disadvantages, which can have negative maternal and neonatal health consequences, collaborative responses between health and housing sectors can help facilitate the best possible outcomes for a woman and her baby.

1.4 Report structure

This report evaluates the effectiveness of the Cornelia Program at meeting its aims with input from its service users, senior management, operational staff, and external stakeholders. This qualitative material is presented in Chapters 4, 5, and 6 of the report and is accompanied by quantitative routine and administrative data from the Cornelia Program and the Royal

Women's Hospital birthing services, which are displayed in tables in Chapter 3.

Chapter 2 details the evaluation design and methodology, explaining the research approach, how participants were recruited, and the process involved in collecting data. **Chapter 3** provides a summary of the socio-demographic characteristics of the Cornelia Program's service users and a comparison between their maternal and neonatal outcomes with that of a wider Royal Women's Hospital cohort. The qualitative findings of the evaluation begin in **Chapter 4** with an analysis of 'Establishing and entering Cornelia'. This chapter describes how the program was set up and chronicles the women's experiences leading up to their entry to the Cornelia Program. Drawing on the baseline interviews, the chapter looks at how the women found out about the program and their referral pathways into it. This chapter addresses evaluation aim 1 by examining how the program was first developed and implemented from the perspective of the professionals involved at this early stage. **Chapter 5** charts the experiences and practice learnings of 'Being at Cornelia'. Evaluation aims 2 and 4 are addressed here, with a particular focus on the experiences of women and their babies and how the program improved their quality of life. This chapter examines how the women navigated the living environment at the Botanical Apartments alongside opportunities produced for freedom from violence, security, peer support, and preparation for motherhood. The approachability of staff, their collaborative and culturally aware practice, and continuity of care are also documented. The last chapter of the findings, **Chapter 6**, depicts life 'After Cornelia' drawn primarily from exit and follow-up interviews with the women, and the other qualitative data. This chapter attends to evaluation aim 3 and whether long-term housing outcomes have been achieved. It outlines the key findings such as security of tenure, quality and location of long-term housing, transition supports, bond with baby, self-confidence and independence, and education and employment after leaving Cornelia. Finally, the report concludes with a set of recommendations in **Chapter 7** to take the program forward.

Chapter 2 | Evaluation Design and Methods

This chapter describes how the evaluation was conducted, including how participants were recruited, the research ethics considerations, and the collection of qualitative and quantitative data.

The research team was led by Associate Professor Juliet Watson (RMIT University) and comprised Professor Suellen Murray and Dr Freda Haylett (RMIT University), and Dr Jacqui Theobald and Professor Leesa Hooker (La Trobe University). Dr Clair Bennett (La Trobe University) was also involved in the early stages of the evaluation. Kate McCredie (La Trobe University) assisted with quantitative data analysis. Team members Watson, Murray, Haylett, and Theobald have extensive experience using qualitative research methods and in undertaking research with people from diverse backgrounds including women experiencing homelessness and with non-government organisations. Professor Hooker has extensive experience using quantitative research methods and is a registered nurse, midwife/maternal and child health nurse with expertise in program evaluation across women's health and parenting.

2.1 Evaluation Advisory Group (EAG)

The evaluation was overseen by an advisory group convened and chaired by the Royal Women's Hospital, which reported to the Cornelia Program steering committee. Membership of the EAG included representatives from Launch Housing, HousingFirst, the Victorian Department of Health, and two members with lived expertise of homelessness and pregnancy. The EAG approved the evaluation design and met quarterly between October 2021 and July 2024, advising on, and supporting, the evaluation activities.

2.2 Research approach

To accommodate the flexible entry and exit points for service users, and their complex and varied circumstances, the evaluation involved a longitudinal, mixed-methods approach to provide quantitative and qualitative evidence on program processes and efficacy.

The evaluation focused on the lived experiences of the Cornelia Program's service users, with findings drawn from multiple, in-depth interviews capturing women's experiences, including how their circumstances changed during and after their service engagement. The evaluation was designed to give voice to women. Critical interpretation of the lived experience accounts, combined with the expertise of operational staff, senior management, and external service providers, were used to evaluate the effectiveness of the Cornelia Program in meeting its objectives.

The qualitative data, collected from interviews and a focus group, are supplemented by quantitative data including administrative data of Cornelia service users and Royal Women's Hospital routine clinical perinatal data.

2.3 Data collection and analysis

2.3.1 Recruitment of participants

The research team worked with the Cornelia program manager and operational staff to identify suitable service users during the first weeks of their stay. A script was used by a trusted worker to invite them to participate in an interview. The invitation explained that participation in the research was voluntary and made clear that declining involvement in the research would not in any way jeopardise their access to services. If the service user gave initial consent to the worker, the contact details were passed to the researchers to gain full consent to participate and to arrange the interview. At the first interview, the researcher sought consent to contact the service user in the future to conduct the second and third interviews.

In advance of the evaluation commencing, operational staff were made aware that the evaluation was going to take place. With contact details provided by the Cornelia Program manager, the research team invited operational staff to participate in a focus group. It was

made clear that participation was voluntary and that their involvement would not affect their relationship with the Cornelia Program. A similar process to that of the operational staff was used to recruit senior managers to be interviewed.

Cornelia senior managers and the EAG provided guidance on which external service providers to contact to participate. The research team then reached out to the service providers directly via email to invite them to participate in an interview.

2.3.2 Ethical considerations

The evaluators acknowledge the sensitive nature of the research undertaken for this evaluation and the potential for discussions raised in the interviews to cause upset to participants. Being mindful of this, evaluators informed participants they could have a support person attend the interview with them, their welfare was attended to over the course of the interview, and they were offered breaks. It was again made clear that if they chose not to participate in the evaluation this would have no effect on their access to the Cornelia Program.

The evaluation was approved by the RMIT University and the La Trobe University Human Research Ethics Committees. Detailed advice was sought from the Royal Women's Hospital Human Research Ethics Committee and the approvals granted are consistent with this advice. All participants were advised that their involvement in the evaluation was voluntary and were given in advance a participant information and consent form that explained the research. Before commencing, the purpose of the research was reiterated, the opportunity was provided to ask questions of the researchers, and consent to participate was confirmed. Participants were provided with the researchers' contact information in case they wanted to follow up after the interview or focus group.

The interviews and focus group were digitally recorded and professionally transcribed. Copies of the transcript were offered to interview participants, who were given the opportunity to comment and make changes. No participants requested changes. Service users were provided a $50 voucher for each interview as acknowledgement of their expertise.

The names and identifying information of participants have been anonymised in this report to ensure confidentiality. Service user participants have been provided with pseudonyms or, in certain circumstances, not named at all. Composite case studies have been used in the findings chapters to further protect confidentiality. The external service providers are referred to by their general profession (e.g., family support worker, health worker). One external service provider gave permission to be referred to as an *Aboriginal child and family worker* to highlight the work being undertaken with Indigenous service users.

2.3.3 Qualitative data collection

Qualitative data collection was undertaken through a series of one-on-one interviews and a focus group. Interviews with Cornelia service users occurred in three stages. In this report, these interviews are referred to as the baseline, exit, and follow-up interviews. Baseline

interviews with 15 women were conducted between May 2022 and January 2023 and were undertaken up to three months after women entered the program onsite at the Botanical Apartments. Following consultation with the EAG, the original target of 10 interviews was increased to 15 in an endeavour to offset the low take-up of a survey that had been developed for all eligible Cornelia Program service users (discussed below).

There were 10 exit interviews conducted with service users when they left or were about to leave the Botanical Apartments. Two service users chose to withdraw their participation at either the exit or follow-up interviews due to personal circumstances. Four other service users participated in a baseline interview but not an exit interview due to difficulties being contacted for their involvement in subsequent interviews. The exit interviews were conducted between January 2023 and April 2024. These interviews took place either onsite at the Botanical Apartments, at the women's new place of residence, or over the phone. A further five follow-up interviews were conducted with service users between February and April 2024.

In all, the research team engaged 35 stakeholders comprising 15 service users, seven Cornelia operational staff members, five senior managers from collaborating agencies, and eight participants from seven external service providers. Interviews with service users ranged from 25 minutes to one hour in length, while the interviews with senior managers and external service providers and the focus group were each approximately an hour in length.

The focus group with operational staff was conducted in October 2022 onsite at the Botanical Apartments with seven participants including two care coordinators, a social worker, and a midwife employed by the Royal Women's Hospital, two senior family support workers employed by Launch Housing, and a tenancy support worker employed by HousingFirst. Opportunities were provided for staff to share their views on the program and interact with other participants, thus generating a reflective and collective discussion about the opportunities, challenges, and issues facing service users and staff in the Cornelia Program.

Interviews were conducted with five senior managers representing the Cornelia Program partner organisations between September and December 2022. Participants were provided with the opportunity to discuss their views on the establishment of the Cornelia service model and its effectiveness in meeting its aims.

Interviews were conducted between April and May 2023 with eight participants from seven external agencies providing support to Cornelia service users. These included agencies representing health, alcohol and other drugs, family violence, Aboriginal services, parenting, and child welfare services. The participants provided views on the effectiveness of the Cornelia Program and their experiences in supporting women engaged with the program.

Given that interviews with each senior manager and external provider, and the focus group with operational staff, occurred once, it is acknowledged that the findings from these data represent the perspectives of the program at that time. The three sequential interviews with

service users give a fuller picture of how the program evolved across the evaluation period, as well as ongoing communications with Cornelia senior management who conveyed changes within the program to evaluators to help inform the findings.

Analysis of the data involved an open coding approach, allowing themes to emerge from the interviews and focus group. These themes were compared across the interviews and focus group to refine and confirm the findings.

Figure 4: Summary of qualitative data collection

Participants	Activity	Timing	Number planned and completed
Service users	Interview 1: Baseline	Conducted up to 3 months after entering Cornelia Program between May 2022 and January 2023	Planned 10 Completed 15
Service users	Interview 2: Exit	Upon exiting Cornelia Program and accessing long-term accommodation between January 2023 and April 2024	Planned 15 Completed 10, 1 withdrawn, 4 not contactable
Service users	Interview 3: Follow-up	6 months post-exit from Cornelia Program between February and April 2024	Planned 15, Completed five, 2 withdrawn, 8 not contactable
Operational staff	Focus group	September 2022	Planned 1 Completed 1
Senior management	Interview	September-December 2022	Planned 4 Completed 5
External service providers	Interview	April-May 2023	Planned 6 Completed 7

2.3.4 Quantitative data collection

Comparative quantitative data were collected from the Cornelia Program and the Royal Women's Hospital (RWH). This secondary data analysis of hospital data includes demographic and routine perinatal information as well as health and wellbeing outcomes for all women and their babies attending the RWH over the two-year period to coincide with the commencement of the Cornelia Program.

The sample includes all births between August 2021 and July 2023. For multiple births, only the details of twin one were included.

- RWH cohort (n=13,351)
- Cornelia program (n=65)

The total Cornelia participant number was n=80 women; however, 15 women did not present for care to the RWH or birth during the evaluation time frame (August 2021 and July 2023) so they were not identified in the RWH data set. Cornelia Program administrative data (July 2021-February 2024) were also used to capture service user demographics, characteristics, and outcomes.

2.3.5 Missing data

There were low levels of missing data for pregnancy, birth, and infant outcome measures in the RWH data set. In this instance, missing observations have been excluded from analysis on a variable-by-variable basis, with the final sample included for analysis listed in the table for each variable. Inferential statistical analysis was conducted and based on two-sample t-test for continuous variables and two-sample test of proportions for categorical variables. The level of statistical significance was set at $p < 0.05$ and all data were analysed using STATA software (version 18) (StataCorp., 2023).

2.3.6 Limitations of the evaluation

Methodological limitations are expected in secondary data analysis for several reasons, including the desired analysis being limited to the variables collected and researchers being reliant on the quality of clinician data entry. While the large numbers in the RWH cohort gives strength to the study, the relatively small sample of women (n=65) in the Cornelia group is a limitation, restricting generalisability of our findings.

Qualitative data were collected at different points in time over the course of this evaluation. Longitudinal data were collected on the service users' experience on three separate occasions from May 2022 to April 2024, and the interviews with external service providers were conducted from April to May 2023. However, other qualitative data collection occurred in the earlier period of the evaluation with the focus group with operational staff members conducted in October 2022, and the interviews with senior management conducted from September to December 2022. Data analysis, therefore, needs to be considered within the context of these timeframes, and issues that may have emerged subsequently are not captured in the report.

The evaluation methods initially included the collection of survey data from all eligible service users to supplement the service user interview data including demographic characteristics as well as health, wellbeing, and social outcomes. The intention was to collect surveys at baseline, exit from the Cornelia Program, and six months post-exit (in alignment with the three stages of interviews); however, only10 baseline surveys were completed by the end of

the data collection period. There were multiple reasons for this low take-up including lack of resources to support this method, the long length of the survey, the women's busy schedules caring for their new babies, difficulty sending the survey to the women once they had exited Cornelia, and some women needing assistance to complete the survey, which was offered by researchers but could not always be achieved. Due to low take-up of the survey, the EAG agreed to cancel this component and instead to increase the service user interview target from 10 to 15 participants, which was achieved.

The evaluation interviewed one Aboriginal woman. To ensure confidentiality, her Aboriginality has not been identified in this report. This reduced the capacity of the evaluation to capture the work being undertaken by the Cornelia Program with Indigenous women. The evaluation team, however, did interview one service provider who agreed to be identified in the report as an *Aboriginal child and family worker* in order to represent this area of practice.

Eight women interviewed were born in the Horn of Africa region or were from a Horn of African background. We have chosen not to specify their countries of birth or their pathways to Australia to protect their confidentiality. This places limits on the degree of detail we are able to provide on these women's circumstances prior to entering the Cornelia Program.

Several women entered the Cornelia Program while restrictions imposed by the Covid-19 pandemic were in place. This meant that they were unable to participate in, and therefore comment on, some of the onsite activities facilitated by external service providers.

An economic evaluation is beyond the scope of this report, so we are unable to analyse the economic value of the Cornelia Program beyond the overall benefits of secure housing and improved health for women and babies.

Chapter 3

Key quantitative findings

- A total of 89 women entered the Cornelia Program and 79 babies were born since the program commenced in July 2021 to February 2024.
- Most (51 per cent) referrals to the program occurred through the Royal Women's Hospital, with others coming through external support services (32 per cent), self-referrals (10 per cent), and other health referrals (7 per cent).
- Women in the Cornelia Program (n=65), compared to other women attending the Royal Women's Hospital birthing services (n=13,351), during the period August 2021 to July 2023, were significantly more disadvantaged, with greater health needs and social issues.
- The Cornelia Program infants required more resuscitation, more neonatal support, and were less likely to be breastfed.
- 70 per cent of women moved to permanent/long-term housing after exiting the program.

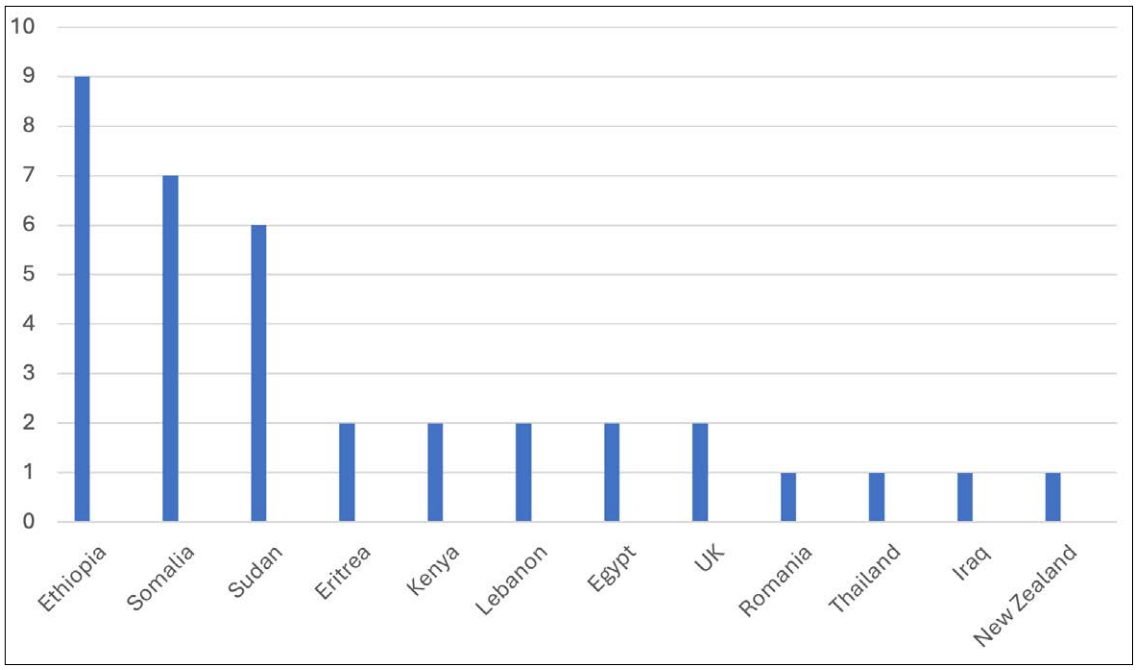
This chapter presents administrative data from the Cornelia Program and RWH routine clinical perinatal data. First, the socio-demographic characteristics of all Cornelia Program service users (n=89) are outlined, followed by specific data of the women (n=15) interviewed for the evaluation. Then, a comparative analysis of routine clinical perinatal data outlines the maternal and neonatal outcomes over the evaluation period between the Cornelia Program service users (n=65) and the RWH control group (n=13,351).

3.1 Summary of Cornelia service users' socio-demographic characteristics

Administrative data collected by the Cornelia Program provides an overview of all service users who have been supported by the program since it opened in July 2021 to February 2024. As of February 2024, a total of 89 women have entered the Cornelia Program and 79 babies have been born. One third (33 per cent) of women were under 25 years of age when referred to the program. Some 41 per cent were born overseas, and 14 per cent were Aboriginal women. Of those born overseas, most came from Ethiopia (n=9), Somalia (n=7), and Sudan (n=6). Other countries included Eritrea (n=2), Kenya (n=2), Lebanon (n=2), Egypt (n=2), UK (n=2), Romania (n=1), Thailand (n=1), Iraq (n=1), and New Zealand (n=1).

89
women have entered Cornelia

Figure 5: Country of birth (outside of Australia) - all Cornelia service users



3.1.1 Health and wellbeing characteristics

43%
had prior involvement with Child Protection

Most women reported a past or current history of mental illness (92 per cent) and 84 per cent had experienced or were currently experiencing family violence. Up to 40 per cent reported alcohol or other drug use and 43 per cent had previous involvement with Child Protection Services.

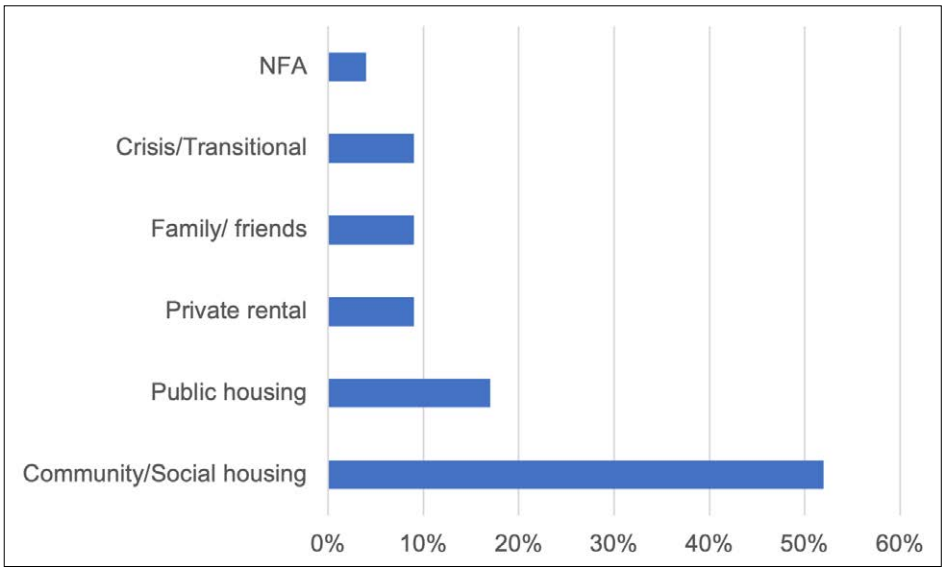
3.1.2 Birthing Outcomes

Three quarters of women attending the Cornelia Program were first time mothers (76 per cent), with most having a normal vaginal birth (65 per cent). More than one quarter of all Cornelia newborns (27 per cent) required NICU admission for ongoing support.

3.1.3 Tenancy

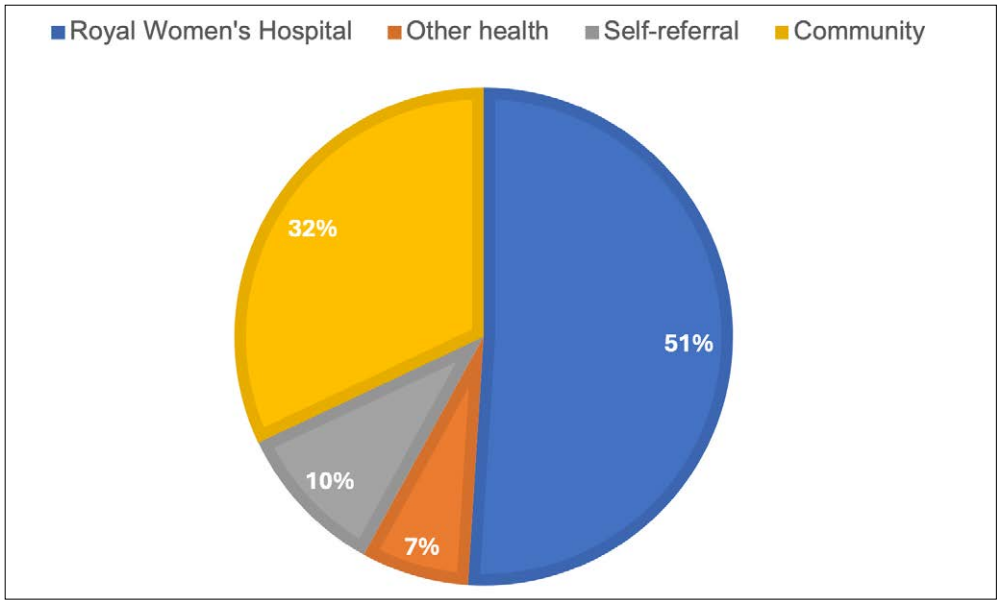
For the first 12 months of the evaluation period, the average stay at the Botanical Apartments was around 7.5 months. Of those who exited in the last 12-month period of 2023-24, the average extended to 12 months. **Of the 62 women overall who exited Cornelia, 70 per cent moved to permanent/long-term housing.**

Figure 6: Housing outcomes - all Cornelia service users



All referrals to the Cornelia Program come through the Royal Women's Hospital. In addition to direct referrals for existing service users, referrals to the Royal Women's Hospital to access the Cornelia Program specifically included: (1) self-referral, (2) referral by a regional public hospital, and (3) referral by a support service. External referrals for all Cornelia service users were made from a wide range of housing and support services, with most coming from Safe Steps/Orange Door (n=7) and Launch Housing (n=6). Other referral sources included AMES, Bridgehaven, WAYSS, Windana, Juno, Vincent Care, Anglicare, Fusion Australia, Ngwala Willumbong, Koori Maternity Services, The Salvation Army, Unison Housing, Wombat Housing and Support Services, MiCare, Dame Phyllis Frost Centre, and the Department of Families, Fairness and Housing.

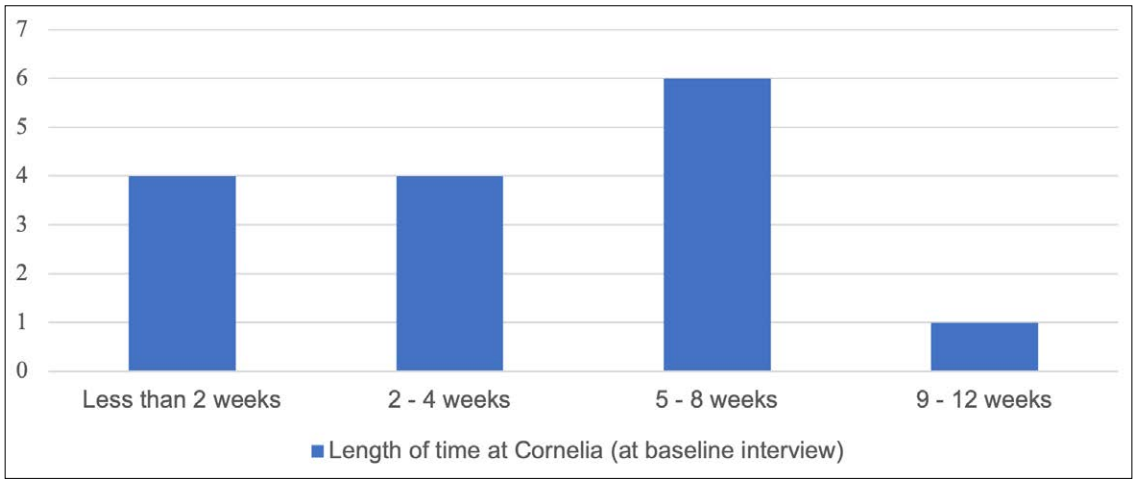
Figure 7: Referral sources – all Cornelia service users



3.2 Interview participants

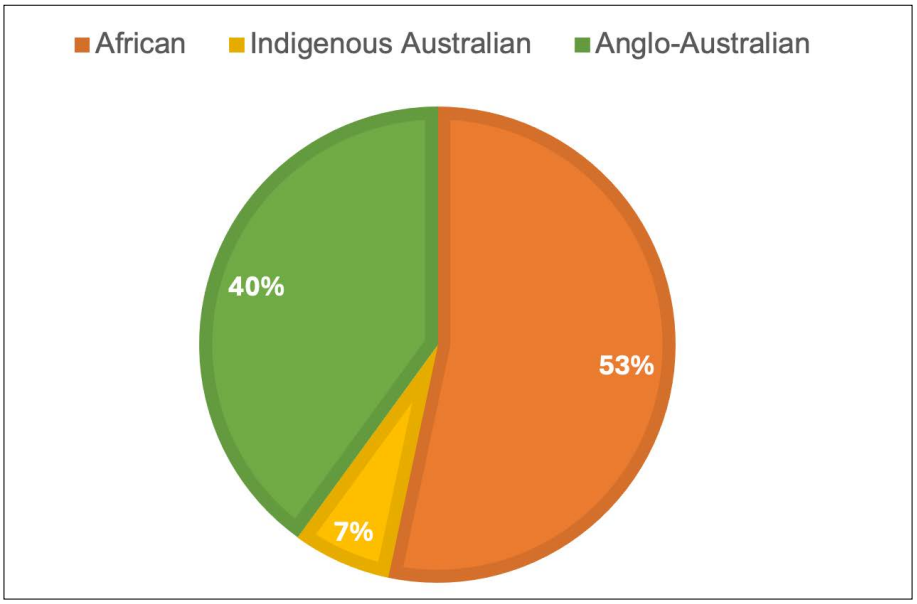
Baseline interviews were conducted with 15 women between May 2022 and January 2023 at the Botanical Apartments. The women were aged between 19 and 43 at the time they were interviewed, with an average age of 29 years. The majority of women were aged under 30 years. Their length of stay at the Botanical Apartments at the time they were interviewed ranged from one day to three months, with a slight majority having stayed between one to two months.

Figure 8: Length of time in the Cornelia Program - interview participants at baseline interview



The group of 15 women interviewed included eight women of multicultural backgrounds. Of these women, six were born in countries in the Horn of Africa, with the remaining two women also from a Horn of African background but having been born in Europe or elsewhere in Africa. Six were white Australian-born women of English-speaking background, and one was Indigenous.

Figure 9: Participant demographics by ethnicity – interview participants

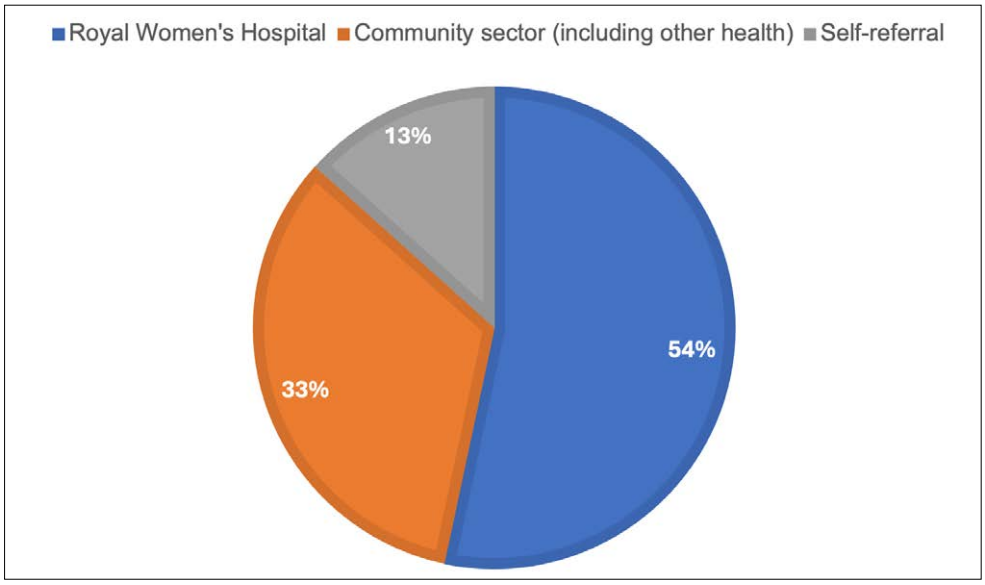


Seven of the women disclosed mental ill health including depression, anxiety, and PTSD. Four of the women had medical conditions requiring ongoing management. Seven of the women disclosed a history of problematic alcohol and/or other drug use. Five of the women disclosed Child Protection involvement during their pregnancies or after giving birth. Six of the women disclosed experiences of being subjected to family violence in the past, including during pregnancy.

Prior to entering the Cornelia Program, the women interviewed had experienced a breadth of living arrangements, sometimes moving between different forms of accommodation within short periods of time while they were pregnant. These included couch-surfing, emergency accommodation, caravan, sleeping in cars, private rental, hotels, motels, share houses, refuges, and community housing.

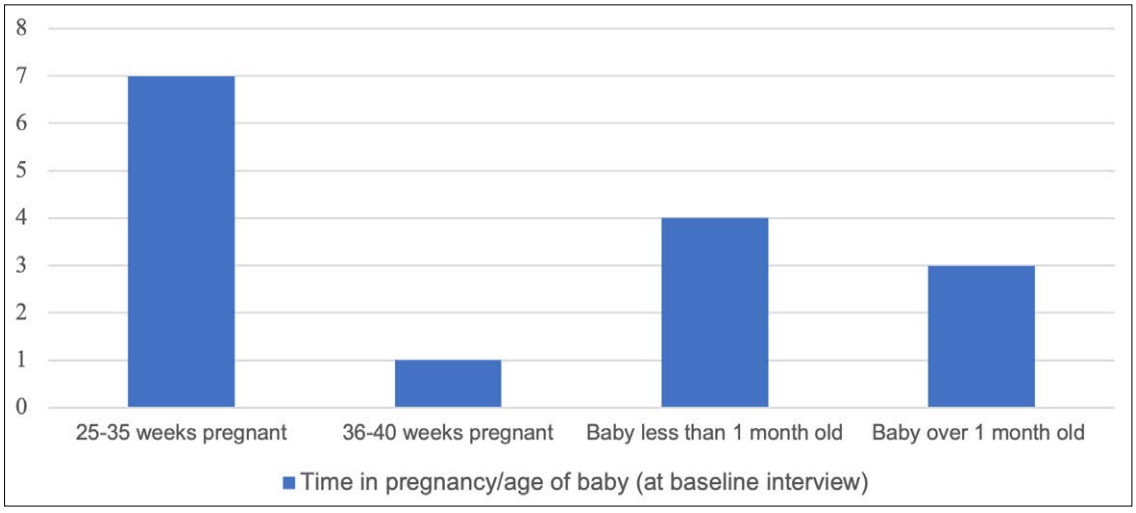
Of the 15 women who were interviewed for the evaluation, referrals came from RWH including two from the Women's Alcohol and Drug Service (WADS) (n=8); the community sector including Launch Housing, Unison Housing, WAYSS, and Safe Steps; community health (n=5); and self-referral (n=2).

Figure 10: Referral sources – interview participants



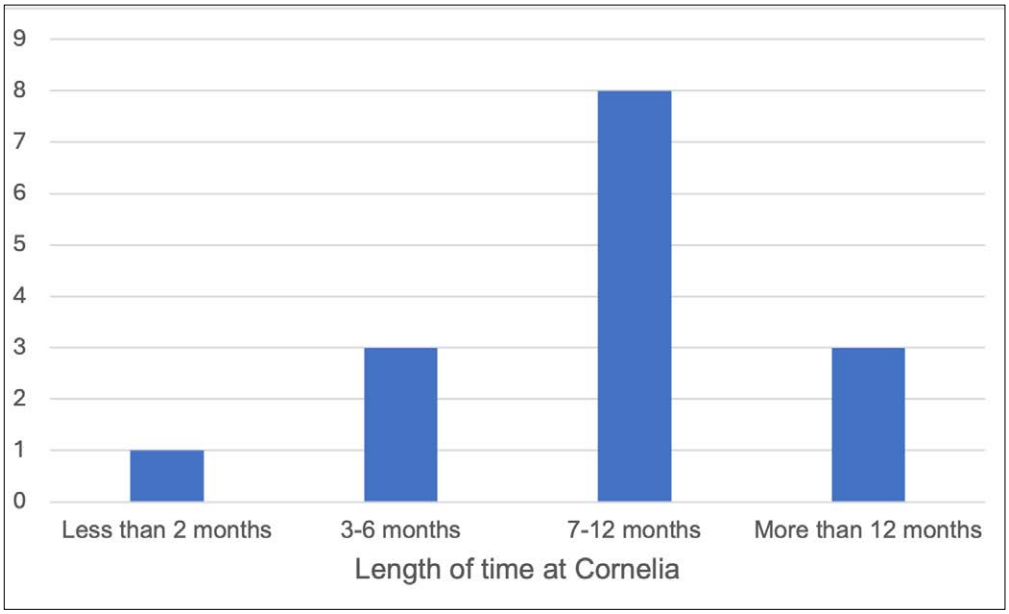
Thirteen of the 15 women were first-time mothers and, of those, five had recently given birth and eight were late-term in their pregnancy at the time of the baseline interview, ranging from 25-weeks pregnant to full-term. The remaining two women had older children; of these women, one was pregnant, and one had recently given birth.

Figure 11: Time in pregnancy/age of baby - interview participants at baseline interview



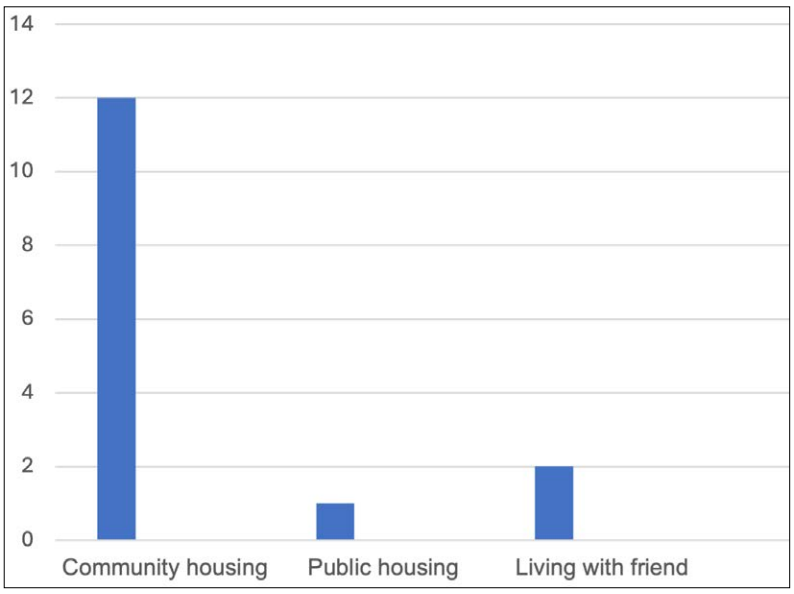
Service users stayed at the Botanical Apartments for an average of 9.8 months, ranging from 1.5 to 21 months. Fifty-three per cent stayed between seven and 12 months.

Figure 12: Total length of time in the Cornelia Program - interview participants



Of the 15 women interviewed, 14 moved into long-term housing, with the final woman about to move. Thirteen women (86 per cent) were living in (or about to move into) social housing (including 12 in community housing and one in public housing), and two women were sharing with friends in private rental properties. Seven of the women in community housing were living in HousingFirst properties, demonstrating the importance of the partnership.

Figure 13: Dwelling type - interview participants



3.3 Comparison of maternal and neonatal outcomes between the Cornelia Program and Royal Women's Hospital birthing services

Findings from the comparison of outcomes between the Cornelia Program and RWH women (controls) using routine RWH birthing services data between August 2021 and July 2023 show that there were statistically significant differences in sociodemographic factors across the two groups, indicating substantial disadvantage in the Cornelia group (Table 1). Women in the Cornelia group (n=65) compared to controls (n=13,351) were more likely to be:

- Younger
- Having their first baby
- Single
- Aboriginal or Torres Strait Islander
- Receiving income support and in receipt of a health care card

Health Factors

Cornelia women (versus RWH controls) were more likely to have a history of poor health, including:

- Significant mental illness
- Chronic health condition
- History of substance misuse

This included findings that Cornelia women drank alcohol and smoked tobacco more during their pregnancy and were less likely to quit smoking before 20 weeks' gestation.

Pregnancy Outcomes

On average, Cornelia women presented later to hospital (15.5 weeks) compared with the RWH control group (12.7 weeks) for the first visit and had more antenatal visits.

Birth Outcomes

Women in the Cornelia Program were more likely to have an induction of labour, although there were no differences in birth type (e.g., vaginal, forceps, caesarean section) or blood loss.

Infant Outcomes

Despite no difference between infant birth weights and Apgar scores across the groups, more Cornelia Program infants needed resuscitation and NICU support.

Infant Feeding

There were significant differences noted in breastfeeding outcomes. Fewer Cornelia women attempted to breastfeed or were exclusively breastfeeding on discharge from hospital. Consequently, more Cornelia infants received formula during hospital.

Table 1. Socio-demographic characteristics and outcomes by Cornelia or control (RWH) group

Characteristic	Cornelia women (N=65)	RWH control group (N=13,351)	
	N (%) or Mean (SD)	N (%) or Mean (SD)	*P*-value
Age at admission			
Mean (SD)	27.9 (6.2)	32.6 (4.9)	**0.000**
< 20	5 (7.7)	8 (1.6)	**0.000**
20-34	51 (78.5)	8,451 (63.3)	**0.011**
>= 35	9 (13.9)	4,819 (36.1)	**0.000**
Parity			
Mean (SD)	0.8 (1.8)	0.7 (1.7)	0.889
0	44 (67.7)	7,126 (53.4)	**0.021**
1 or more	21 (32.3)	6,225 (46.6)	**0.021**
Marital status – single	53 (81.5)	1,36 (12.2)	**0.000**
Born in Australia (*n* = 65/13,309)	41 (63.1)	6,933 (52.1)	0.077
Aboriginal or Torres Strait Islander mother	9 (13.9)	218 (1.6)	**0.000**
Spoken language – English	58 (92.1)	12,025 (91.8)	0.949
Level of health cover (*n* = 63/13,039)			
Health care card	21 (33.3)	1,37 (13.5)	**0.000**
Medicare card	36 (57.1)	8,648 (66.1)	0.137
Private insurance	6 (9.5)	3,072 (23.5)	**0.009**
Income support (*n* = 63/13,039)	24 (38.1)	1,490 (11.4)	**0.000**
BMI (-*n* = 43/11,791)			
Mean (SD)	26.2 (6.1)	25.5 (6.2)	0.497
< 25	21 (48.8)	6,673 (56.6)	0.306
Overweight (25-29.9)	14 (32.6)	3,084 (26.2)	0.340
Obese (>= 30)	8 (18.6)	2,034 (17.3)	0.815
Mental illness (*n* = 63/13,039)	28 (44.4)	739 (5.6)	**0.000**
Chronic disorder (*n* = 63/13,039)	3 (68.3)	4,770 (36.4)	**0.000**
History of substance use (*n* = 63/13,039)	15 (23.8)	10 (9.8)	**0.000**
Smoking status <20 weeks (-*n* = 65/13,347)			
No smoking at all before 20 weeks of gestation	32 (49.2)	12,726 (95.4)	**0.000**
Continued smoking before 20 weeks of pregnancy	27 (41.5)	465 (3.5)	**0.000**

Quit smoking during pregnancy (before 20 weeks)	6 (9.2)	156 (1.2)	**0.000**
Alcohol use < 20 weeks (*-n* = 65/ 13,290)			
Never	54 (83.1)	12,876 (96.9)	**0.012**
Multiple times a week to Monthly or less	8 (12.3)	346 (2.6)	**0.000**
Not stated / inadequately described	3 (4.6)	6 (8.5)	**0.000**
Alcohol use > 20 weeks (*-n* = 65/ 13,289)			
Never	61 (93.9)	13,016 (98.0)	**0.000**
Multiple times a week to Monthly or less	3 (4.6)	211 (1.6)	0.061
Not stated / inadequately described	1 (1.5)	62 (0.5)	0.208

Pregnancy outcomes

Outcome	Cornelia program (N=65)	RWH cohort (N=13,351)	*P*-value
	N (%) or Mean (SD)	N (%) or Mean (SD)	
Gestation at first booking in visit (*-n* = 65/13,348)			
Mean (SD)	15.5 (8.5)	12.7 (9.3)	**0.016**
>= 12 weeks	39 (60.0)	6,849 (51.3)	0.162
Number of antenatal visits (*-n* = 65/13,287)			
Mean (SD)	12.3 (6.4)	10.5 (4.4)	**0.001**
>= 10	41 (63.1)	7,624 (57.4)	0.354

Birth outcomes

Outcome	Cornelia program (N=65)	RWH cohort (N=13,351)	*P*-value
	N (%) or Mean (SD)	N (%) or Mean (SD)	
Onset of labour			
Spontaneous	21 (32.3)	5,523 (41.4)	0.139
Induction	34 (52.3)	4,437 (33.2)	**0.001**
No labour	10 (15.4)	3,391 (25.4)	0.064

Birth type			
Spontaneous vaginal	33 (50.8)	6,029 (45.2)	0.365
Instrumental - forceps or vacuum	12 (18.5)	2,267 (17.0)	0.751
Caesarean section	20 (30.8)	5,053 (37.9)	0.240
Other operative birth	0 (0.0)	2 (0.01)	0.921
Blood loss (-*n* = 65/13,350)			
Mean (SD)	459.3 (45.2)	519.6 (3.7)	0.262
>= 500mL	22 (33.9)	5,233 (39.2)	0.378
Estimated gestation at birth (n= 65/13,335) >=37 weeks	59 (90.8)	12,002 (90.00)	0.837

Infant outcomes

Outcome	Cornelia program (N=65)	RWH cohort (N=13,351)	*P*-value
	N (%) or Mean (SD)	N (%) or Mean (SD)	
Liveborn (-*n* = 65/13,349)	65 (100.0)	13,128 (98.3)	0.296
Birth weight (-*n* = 65/13,350)			
Mean	3,224 (545.4)	3,261 (688.8)	0.668
<2500g	4 (6.2)	1,223 (9.2)	0.401
APGAR score at 5 mins (-*n* = 65/ 13,312)			
Mean	8.7 (0.1)	8.7 (0.0)	0.971
<7	3 (4.6)	531 (4.0)	0.797
Resuscitation (-*n* = 65/13,291)	50 (76.9)	7,127 (53.6)	**0.000**
NICU (-*n* = 65/13,128)	21 (32.3)	2,907 (22.1)	**0.049**

Infant feeding

Outcome	Cornelia program (N=65)	RWH cohort (N=13,351)	*P*-value
	N (%) or Mean (SD)	N (%) or Mean (SD)	
Breastfeeding attempted (-*n* = 65/ 13068)	58 (89.2)	12,378 (94.7)	**0.049**
Formula given in hospital (-*n* = 65/13,068)	30 (46.2)	4,227 (32.4)	**0.018**
Feed before discharge exclusively from breast (-*n* = 65/13,010)	29 (44.6)	8,307 (63.9)	**0.001**

3.3.1 Comparison of select demographic characteristics between interview participants and Royal Women's Hospital birthing services

Focusing on the 15 women interviewed for this evaluation, there were significant differences between the Cornelia Program interview participants and the RWH control group on a select set of demographic characteristics. For example, the Cornelia Program interview participants were from more multicultural backgrounds than the control group, and reported significantly higher levels of mental illness.

Table 2. Demographic characteristics by Cornelia interview participants or control (RWH) group

Characteristic	Cornelia participants (N=15)	RWH control group (N=13,315)
Age (mean)	29	32.6
Aboriginal or Torres Strait Islander mother	6.6%	1.6%
Born in Australia	40%	52.1%
Mental illness	53.3%	5.6%

3.3.2 Summary

As expected, **women in the Cornelia group (cf RWH controls) were more disadvantaged, having experienced high rates of substance use, chronic disorder, and mental illness**, consistent with other research (Australian Institute of Health and Welfare, 2024; Oram et al., 2022; Wendt, Natalier & Goudie, 2024). However, **pregnancy, birth, and neonatal outcomes did not differ greatly**. The exceptions were in relation to induction of pregnancy, neonatal resuscitation, NICU admission, and breastfeeding outcomes.

Higher rates of induction in the Cornelia group may reflect their primiparity, with first-time mothers more often needing inducement of labour for post term (Middleton, et al., 2020). Despite no differences in gestation at birth and infant Apgar scores, neonates in the Cornelia group required more resuscitation and NICU admission, compared with the wider RWH controls. This contradictory result may reflect the higher rates of maternal substance use in the Cornelia group and the delayed presentation of neonatal abstinence syndrome needing support a day or two after birth (Lazić Mitrović et al., 2015). In addition, induction of labour can result in greater neonatal birth trauma, resuscitation, and respiratory disorders requiring medical support (Dahlen et al., 2021).

More research with this population, using larger samples, is needed to obtain consistent and accurate results that can inform the future of housing interventions for perinatal women.

Chapter 4 | Establishing and Entering Cornelia

Evaluation Aim 1: The Effectiveness of the Cornelia Program's Implementation

It's really good, really helpful and everyone just checks in on you and sees how you're going like with Launch and HousingFirst and Cornelia so it's quite good. I think some of the ladies I see when I go to my appointments at the Women's are Cornelia as well so they're all linked. (Millie)

My experience with implementation is that all the partners, HousingFirst, Launch Housing, and then Royal Women's Hospital have been highly involved with the project [...] and they have been involved at all levels of the program.
(Senior manager)

Key findings

Governance

- Cooperation between partnering organisations, the involvement of external expertise, and careful consideration of staff recruitment in the lead-up to the opening of the Cornelia Program contributed to successful implementation.
- The governance structure of the program was not fully defined at the inception of the program. Uncertainties relating to governance, risk, and responsibility created some confusion at the service delivery level.
- More equal representation and engagement across organisations in governance matters such as risk management and meeting attendance is recommended.
- The Cornelia Program partnership provides strong human and financial resources, as well as substantial institutional and community knowledge, which have been beneficial to the program's implementation.

Referrals

- The top three referral sources for the participants were a hospital, a support service, or self-referred.
- At the time of data collection it was noted that the referral processes and procedures at the Cornelia Program had been established well and reflected a high quality of service.

Staffing

- Senior management, operational staff, and service users agreed that staff levels were low for the level of complexity involved in the work.
- External service providers did not perceive low staff levels as having a detrimental effect on the quality of supports provided to women.
- Operational staff with the right skillset and expertise have been successfully recruited and retained in the workforce.

External partnerships

- The program has built strong relationships with external partner organisations that enable the provision of wraparound care for women and babies.

CASE STUDY: Veronica

Veronica moved to Melbourne from a regional area after experiencing family violence, which escalated upon finding out she was pregnant. She was unable to stay with family because of her father's past use of violence towards her combined with her mother's drug use.

Veronica moved between friends' places and slept in her car for several weeks in the early stages of her pregnancy recalling how 'it was just stressful moving around so much'. These arrangements became increasingly difficult to maintain when Veronica became unwell with preeclampsia. She first accessed pregnancy care through the Royal Women's Hospital while staying at a friend's place nearby who suggested she go there. She explained to the hospital social worker that she was 'at risk of being on the street' and was informed about the Cornelia Program.

Veronica arranged to meet a Cornelia worker who assessed her as eligible for the program. She was at first reluctant to enter the program because she had hoped to move to a suburb closer to some extended family located an hour away from the Botanical Apartments. She was encouraged to recontact the program if her circumstances changed. Veronica was unable to obtain accommodation in her preferred area due to her lack of rental history, the high cost of housing, and her low income.

She soon got back in touch with Cornelia staff and was assisted to move in within three weeks. Upon entering the program, Veronica explained that she felt 'safe and it's good here'.

4.1 Setting up and implementing the Cornelia Program

There was broad agreement among senior management that the implementation of the Cornelia Program was handled well owing to cooperation between the partnering organisations and the involvement of external expertise:

> *So we're talking right from the executive level to the staff from the ground, they have been able to participate in that implementation in I guess setting up the program, setting up expectations, the KPIs and I guess supporting all that program development.* (Senior manager)

At the outset, an external consultancy firm was hired to assist with developing the program model. The firm held a series of workshops with the partnering organisations, which one senior manager described as having the effect of elevating the *'structure, process, [and] risk'* in part by *'scenario planning around worst case'.* Another senior manager highlighted the benefits of the workplan developed by the consultancy firm: *'[It] helped me to then know what the priorities were in terms of implementation.'*

An external service provider recognised that the strong human and financial resources the partnering organisations brought to the program, as well as substantial institutional and community knowledge, were beneficial during the program's implementation:

> *It helped that the Royal Women's Hospital, Launch Housing, and HousingFirst came together as a partnership because I think you brought together the resources, human resources and financial resources, of three different organisations. So I think that really helped and I think the fact that Launch Housing particularly already had local networks, they already existed in St Kilda and had relationships with services and relationships with clients and an understanding of community needs and all of those sorts of things.*
> (Health worker)

4.1.1 Workforce capacity and retention

An unexpected five-month delay in the opening of the Cornelia Program in 2021 due to ongoing building construction enabled management to take their time hiring appropriate staff: *'We were doing a lot of formulation of policies and procedures and referral processes and really developing that from scratch'* (Senior manager). However, both senior management and operational staff recognised inadequacies in the number of staff employed at the Cornelia Program: *'It will be great to have more staff on the ground to provide a more manageable caseload,'* said one senior manager, a sentiment echoed by an operational staff member: *'It doesn't feel like we're adequately staffed.'* The senior manager added that 12 months into the running of the program, it had become apparent that more staff were needed given the complexity of the service user cohort and the high level of skill required. This would also ensure *'more safety for the staff, clients, and the babies as well'*. The women had noticed this too, *'they have a lot of people to cater to,'* said Eleanor. Despite the resource constraints noted by operational staff and senior management, this did not impact the experience of external service providers who reported that the **Cornelia operational staff were consistently responsive, helpful, accessible, and available**, and that it *'hasn't seemed from the outside like a shortage of staff'* (Family support worker). Similarly, one health worker observed that, *'Time was committed, and resources committed to [establishing the program] well rather than necessarily racing to something without thinking things through.'* **The strong retention of staff, including the program manager, is a significant feature of the program,** and is an important achievement given the high turnover rates characteristic

of similar workforces. This suggests that the **Cornelia Program has been successful in recruiting an appropriate and suitably skilled team:** *'Since we've started they've [Cornelia] had almost no staff turnover, which is really impressive in that field 'cause other high-risk areas in case management you just see so much staff turnover and we haven't seen any there virtually'* (Health worker).

4.1.2 Partnering with external providers

From the Cornelia Program's outset, emphasis was placed on developing strong relationships with external service providers. **These external relationships are crucial given that funding and resource constraints limit what the Cornelia Program can provide in-house to women. These partnerships enable and enhance the program to deliver high quality, wraparound care to the women and babies.** It was apparent in interviews with external service providers that extensive effort had been invested in promoting the Cornelia Program, which produced *'strong working relationships':*

> *[A] lot of effort was put into really letting people know who Cornelia was and really developing strong working relationships to become part of the service sector in the area*. (Health worker)

These relationships were aided in part by the allocation of case managers for each woman in the Cornelia Program, according to external providers. This was helpful because it provided a consistent contact person on staff, which enabled effective and efficient information sharing in relation to their support needs and risk.

It was apparent in interviews with senior management and external providers that the development of cross-agency collaboration with organisations who sit outside the formal partnership had been a high priority for the Cornelia Program. One external service provider stated that:

> *In terms of our working relationship there's a few things that we've tried to implement with the Cornelia Program to obviously enhance information-sharing and our working relationship so we've got liaison meetings with the Cornelia Program, which we find to be really effective and beneficial.* (Child and family worker)

4.1.3 Governance arrangements

Oversight of the Cornelia Program and governance responsibilities are complex due to the involvement of three partner organisations. The feedback from senior managers and operational staff suggests that **during the implementation stage of the program the governance structure was not clearly established.** *'We didn't tease that out very well initially,'* stated one senior manager. An operational staff member noted that the complex governance structure created some confusion at the service delivery level, and at times worked against creating a unified purpose between the partner organisations: *'We were*

coming from three different orgs, going well this is how I do my job over there so this is how we do the job—instead of bringing [us] together […] to establish our own culture.' This led to earlier confusion about lines of management.

Among the senior managers, there were some differing perspectives on responsibilities and accountability. One senior manager noted:

> *We do all the minutes, we do all the coordination, we do all the follow-up of actions and so from that perspective it is not a partnership as far as governance.*

This perception may have been exacerbated by irregular attendance at scheduled program meetings—it was noted by one senior manager that: *'Attendance is spasmodic so I think moving forward we have to get clearer about attendance at meetings.'* Other comments relating to governance included one senior manager stating: *'we're a tad top-heavy with the whole governance structure,'* and another querying if the number of meetings at every level was necessary:

> *There's a lot of meetings and then what is the worth of all of those meetings? In fact I think it's four levels so one, two, three—yeah, four levels if you include the weekly operational. I just think that's a bit much personally.*

A need for more equal representation and engagement across organisations was emphasised, so that one party does not feel it is left carrying disproportionate risk, accountability, and responsibility. Additionally, it was perceived that there were different organisational approaches to, and value placed on, risk management. One senior manager pointed out how considerations of risk were handled during planning and implementation, and how in hindsight more attention could have been given to the development of risk management policies and procedures:

> *It was all a little bit too friendly, I think, it was all a little bit too 'we're all going to work together, this is going to be great'. There'd be the occasional voice of 'oh gosh, what if? We're a little bit worried about risk and what if someone dies? What if something happens to a baby?' But really didn't get into that kind of operational level detail, policies, and procedures, who's really going to do what? Some of the issues I think that come up now is that lack of real understanding about each agency's role, responsibility.*

Referring to an element of the program's risk management procedure, one external service provider suggested the policy of communicating breaches of tenancies could be modified to ensure service users were fully informed of their rights and responsibilities. For example, rather than sending an email or letter—that may run the risk of not being received—it was recommended that a formal meeting be conducted with all key support people involved to ensure clear communication and requirements.

The senior managers agreed that they did not want the program to be driven by the agenda

of one partner organisation, and *'there was hope that that would be more of a shared process'* (Senior manager). One senior manager talked about the need to carefully clarify the governance model with the partnering organisations in the lead-up to the program opening: *'You're working at your own organisational system structures and then you've got three different organisations having to come together and work that out together.'* There was, however, acknowledgement from senior management that, **despite the challenges involved in deploying the governance structure, on the ground, operational staff across multiple disciplines and organisations were functioning well:**

> *It's very difficult for agencies that have different ways of working and I guess with one purpose but different ways to achieve that purpose. So I think that it's really good that they work really well together, especially staff on the ground.*
> (Senior manager)

Operational staff described the effects of a lack of clarity regarding governance and accountability when they tried to relay concerns to those senior to them. As one staff member stated:

> *I think that's something that all three organisations haven't sat down probably at a level above us and taken into account all the issues that we've been reporting back.*

Contributing to this was uncertainty about lines of management; the focus group agreed that the structure of program management was *'very confusing',* with one operational staff member asking: *'who's responsible for me?'* Another added:

> *There's no group just above us that really takes that risk from us and accepts that and deals with it so we can go okay, we can do our job, trusting that you guys are backing us.*

Despite these concerns, as Chapter 4 shows, the women had overwhelmingly positive experiences of the Cornelia Program. In an effort to better understand these experiences, this chapter now turns to the circumstances of the women's lives prior to their entry to the Cornelia Program.

4.2 The women's experiences prior to the Cornelia Program

The women were asked during the first interviews to discuss their recent circumstances leading up to entering the Cornelia Program. For some, there had been a long history of homelessness, which included multiple forms of insecure housing with some periods of relative stability. Family violence, alcohol and other drug use, and migration also underpinned their homeless circumstances.

4.2.1 Family violence

A number of women discussed their histories of family violence that had contributed to their homelessness: *'I'd been in a really bad family violence situation,'* Millie stated, whose ex-partner had *'tried to kill me a couple of times. He's actually still in jail for that so it was really, really brutal like strangled to the point of nearly dying so it was quite bad violence'*. Millie became pregnant by choice, and hoped she would be able to raise her baby with her partner; however, *'as soon as we did he went off the rails, becoming really full-on, really possessive verging on violent'.*

Ann was evicted from her private rental property after her ex-partner, in her words, *'destroyed my home.'* Farida also became homeless following an assault by her ex-partner: *'He came home drunk one day and assaulted me really badly and that ended up in me not being able to go back to where I lived before.'* Victoria had experienced a range of homeless circumstances including rough sleeping and couch surfing. She first became homeless because *'I was the typical 18-year-old wanting to party and everything like that and left home early'*. Prior to entering the Cornelia Program with her newborn, she *'was living in a caravan at my mum's house, practically homeless'* following family violence and the breakdown of a relationship.

4.2.2 Alcohol and other drug use

Millie's homelessness first manifested when she was *'about 16'* due to drug use and exposure to family violence. She explained that she had *'a bit of a tumultuous family life, left school when I was 15 and that sort of thing and there was lots of drugs and lots of stuff like that for a long time'*. Millie added that her mother was *'quite violent'* and her stepfather *'ended up being creepy to me when I was about 20'*, which made remaining at home untenable. Millie described *'years of battles'* after this with trying to stop her drug use and *'getting out of this pattern of family violence'*. Mary experienced homelessness for the first time when, falling behind on her home loan repayments, the bank foreclosed on her mortgage. Contending with a history of family violence and substance misuse, before entering the Cornelia Program, Mary was:

> *By that stage literally just bouncing from—I can't even say friend but they are friends we'll call it but just the circle I was into just—gosh, now I feel silly telling you but the drug scene was full-on and that's how I survived, that's how I bounced around. I didn't even know where I was going that night, I'd just wait for the next phone call.*

Anita explained that she had applied for housing, but *'we didn't have money for bond'* and the pressures kept mounting as she got further into her pregnancy, *'I was just closer and closer to giving birth'*, and there were co-occurring issues including substance use and family violence. With her due date approaching, Anita was referred by Unison Housing to the Cornelia Program.

4.2.3 Migration

Traumatic experiences associated with migration also contributed to homelessness. Uba, for example, because homeless upon arriving in Australia because: *'I don't have any family at all in Australia. I just came myself so there's not any help. That's why I have so much stress.'*

4.3 Finding out about the Cornelia Program

As noted in Chapter 3, there were three main referral pathways for the service users who were interviewed: 1) referred by a hospital, 2) referred by a support service, 3) self-referred. No women reported any concerns with the referral process. A limitation of the criteria for referral noted by a senior manager is that women must have a source of income to pay their rent: *'so we can't take refugees and asylum-seekers, for example.'*

4.3.1 Referring to Cornelia

Mary learned how far along she was in her pregnancy during an ultrasound at 24 weeks: *'not only did I not have the funds for the ultrasound but of course I'd looked into having an abortion and I didn't have the funds for that either.'* A later ultrasound detected a possible genetic abnormality and Mary was referred to the Women's Alcohol and Drug Service (WADS) at the Royal Women's Hospital, which organised her referral to the Cornelia Program. Mary explained that the referral process was straightforward, which left her feeling positive about the experience:

> *WADS, and I don't even know how to explain it, [are] a blessing, and I don't use that word, so [the social worker] was quite dedicated to getting it sorted and trying to look for housing and such and it came up about the Cornelia Program. So it was as simple—well simple—well it did seem as simple as putting a referral through and then meeting the [operational staff].*

The women who discussed referring services made mentions of Launch Housing, Safe Steps, Unison Housing, and the Salvation Army. A support service Ann was engaged with made the referral for her: *'I was living out of my car and then in emergency accommodation and hotels and things like that and then eventually a support service referred me to here and I took it up.'* Similarly, Millie explained that, through her involvement with the Salvation Army, it was suggested *'Cornelia would be appropriate for you, so that's how I ended up here'.* A family violence service referred Charlotte: *'I didn't know about the program, my GP was trying to help me with housing, she didn't know about the program. Safe Steps knew about it and linked me in.'*

4.3.2 A responsive referral process

Until entering the Cornelia Program, Charlotte had been staying in crisis accommodation organised by Safe Steps and was moving around a lot. Once the service made the referral, it was only three weeks before she was able to move into the Botanical Apartments. The

women who self-referred to the Cornelia Program described a process that was prompt and straightforward: *'I just Googled "homeless for woman" and Cornelia came up and I emailed the case manager and she called me back the next day saying to come in,'* Jamilah explained. Uba's first contact with the program was similarly casual, and she found the Cornelia Program to be responsive:

> *I contacted the Cornelia Program; I had a self-referral. I just emailed them my situation kind of and one of the social workers got in contact with me then I made my way to Melbourne.*

Conclusion

This chapter has addressed Aim 1 of the evaluation through an examination of the effectiveness of the Cornelia Program's implementation. **A cooperative approach and active engagement by the partnering organisations—Royal Women's Hospital, Launch Housing, and HousingFirst—were found to provide a strong foundation for the implementation of the program.** Together, they developed high quality referral mechanisms and undertook careful consideration regarding personnel recruitment, which ensured the appropriateness of staff hired. That **operational staff were suitably appointed** is evidenced by strong retention rates in the Cornelia Program. **Effective working relationships were developed with external service providers through collaborative methods,** which produced efficient information sharing in relation to support needs and risk. While partnering organisations undoubtedly provided complementary resources and capital, during implementation the governance structure was not clearly established. **A need for equal representation and engagement across organisations was identified to ensure shared responsibility for risk and accountability**. Despite challenges involved in deploying the governance structure, **operational staff across multiple disciplines and organisations were functioning well**—a view reinforced by external service providers.

This chapter also chronicled the women's histories of homelessness prior to entering the Cornelia Program, which included multiple forms of insecure and unsafe housing. Their homeless circumstances were commonly underpinned by family violence, alcohol and other drug use, and migration. Despite their complex situations, **entry to the Cornelia Program was effectively facilitated through a referral process that reduced barriers and advanced access**—further demonstrating its effective implementation.

Chapter 5 | Being at Cornelia

Evaluation Aim 2: The experience of women and their babies of the program

Evaluation Aim 4: The extent that the Cornelia Program improved the health and quality of life of women and their babies

With the Cornelia Program, it's given me the opportunity to have that time to enjoy what's inside me and what's happening and to look forward.
(Ann)

I think Cornelia is a fantastic program and I think a really valuable addition to […] the community services sector. I think it would be such a shame if it did lose funding along the way because I think it's such valuable work that's being provided to a group that tends to be underserviced. […] I think also in terms of all the great relationships that Cornelia staff have built up with external service providers it would be such a shame to lose all of those 'cause it takes time to build relationships and gain traction as a service and so it would be such a shame if the service was ever unfunded and all of that great work just disappeared.
(Health worker)

Key findings

Accommodation

- Security of tenure at the Botanical Apartments provides the foundation for housing stability and significantly reduces stress felt by women, thereby enabling them to engage with services, prepare for motherhood, and develop closer bonds with their babies.
- The small size of the units at the Botanical Apartments presents challenges for women, particularly once their babies become mobile. The benefits of the program overrode these concerns, and the women did not indicate unit size prompted them to leave prematurely.

Safety

- Varied experiences of a sense of safety at the Botanical Apartments were noted. Some felt the building was adequately secure, while others expressed concerns about trespassers, and operational staff only being available during business hours.
- Onsite security improved during the period of the evaluation.
- The independent housing provides women with protection from perpetrators and creates conditions that facilitate leaving violent relationships. This enables better service user engagement with alcohol and other drug services, and improved bonding with babies.

Wraparound support

- The Cornelia Program is unique in its capacity to offer continuity of care via onsite multidisciplinary and wraparound support through care coordination, social work, family support, tenancy support, and midwifery.
- The Cornelia operational staff work collaboratively with external services across a range of domains including alcohol and other drug use, family violence, legal issues, maternal and child health, Child Protection, mental health, and cultural support.
- Relationships with external service providers offer great value through specialist services and enable the program to deliver high quality care to women and babies. This is especially valuable given funding and resource constraints that limit what the Cornelia Program can provide in-house.
- The material support provided by the Cornelia Program removes some of the financial burden, and associated stress, for women on low incomes.

Accessibility

- The Cornelia Program is highly accessible to women experiencing pregnancy from multicultural backgrounds.
- Operational staff are client-centred in their supports, exhibiting a welcoming, inclusive, and non-judgmental approach.
- The quality of care provided is of a level that many of the women had not experienced previously.
- Cultural aptitude is demonstrated consistently by the operational staff.
- The partnership with the Royal Women's Hospital is vital to the continuity of care model offered by the Cornelia Program. It increases women's access to antenatal care and, by extension, the likelihood of positive clinical outcomes.

Peer support

- Peer support relationships are important in building independence as well as offering support networks.
- Building relationships between women generates opportunities for sharing experiences and providing emotional support, which fosters healing.

CASE STUDY: Connie

Connie entered the Cornelia Program at 34-weeks pregnant as a first-time mother-to-be.
She had previously been living with her mother in squalid circumstances where she felt physically and psychologically unsafe, which exacerbated her drug use. Prior to that, she had been in a violent relationship with the father of her baby, which resulted in Child Protection's involvement due to safety concerns about her pregnancy.

Through the Cornelia Program, Connie accessed essential supports including midwifery care alongside baby items including a breast pump, which would otherwise have been unaffordable. Connie said staff showed 'compassion' so she did not feel 'scared to ask for help' including for her drug use, which she was fearful would negatively impact her baby.

With support from the Cornelia operational staff, Connie entered an in-patient withdrawal management program accompanied by her baby, which she experienced as 'helpful'. The operational staff also supported Connie to improve her relationship with Child Protection, which eventually led to them 'closing the case'. She felt sure that 'if it wasn't for Cornelia they wouldn't have'.

Being around other women going through similar circumstances meant Connie did not 'feel lonely', and though things continued to feel 'up and down', her mental health stabilised and bonding with her baby was 'starting to happen'. Without the support and stability afforded by the Cornelia Program, Connie felt that she and her baby 'wouldn't have survived'.

5.1 Accommodation at the Botanical Apartments

5.1.1 A foundation of stable housing and support

Women and babies are accommodated in self-contained units at the Botanical Apartments that include a single bed, bathroom, kitchenette, and laundry facilities. Having come from circumstances where there was often a poor sense of control over space, minimal privacy, and ongoing uncertainty, the **importance of security of tenure offered by the Cornelia Program cannot be overstated**. Prior to the Cornelia Program, a woman experiencing pregnancy would be seen by homelessness and housing organisations as a childless person and would be unlikely to receive the same access to services as someone with children (Murray et al., 2018; Murray et al., 2020). **The Cornelia Program fills a critical gap in this service system**, a view supported by the external service providers:

> *One of the outcomes that I think is most significant and most successful about Cornelia is that it gives women the basic need of having a safe place to live and a roof over their head. […] The issue in the housing sector was that people were pregnant, they were asking for support. […] Housing services were saying we don't have anywhere that's appropriate for you to stay or we don't have enough housing and basically you have to be more pregnant to be eligible for housing.* (Health worker)

The provision of accommodation to the women was therefore the foundation that enabled them to stabilise their housing and to access support. Farida explained: *'I feel safe now like I just feel me and my baby have nothing to worry about like we're going to be fine.'* The self-contained units allow women who want more privacy to retreat into their own space and choose the degree to which they want to interact with other residents. Jamilah liked this aspect and the solitude it offered her and her baby: *'It's just me and her so we have one-on-one time to ourselves.'*

5.1.2 The built environment

An issue raised by several of the women was the small size of the units, a concern that increased the longer they stayed and as their babies became more active. Ann noted: *'There's not much room, it's a single bed and stuff but obviously it's better than a car so I'm very happy with it.'* For Farida, the lack of space not only meant there were physical limitations, but it affected her emotional wellbeing to the point that she needed her mother to provide respite:

> *It was getting way too small and unbearable to a point where I had to let him go stay with my mum for a bit. […] Sometimes it kind of plays with your emotional and mental health like you're just in a small room, no space.*

The external health workers agreed with the women's concerns about the size of the units, adding that they did not meet the needs of the mothers, particularly when the babies became mobile.

> *The physical space, it's just too small. They're just tiny apartments, they're not set up for mothers. They're not set up to do laundry and have a cot so it's just extremely cramped. As soon as that baby's mobile there's no floor space for it to move around*. (Health worker)

Space for operational staff to undertake their work was also raised as an issue by senior managers and the focus group. This created difficulties in arranging team meetings, case conferences, and communal activities: *'There's a small communal lounge but it doesn't lend itself to large numbers so it would have been nicer to have bigger space available'* (Senior manager). Ad hoc measures were made, such as using one of the empty units for operational activities and holding communal activities outdoors; however, these were not viewed as ideal arrangements.

5.1.3 Housing costs

Another issue raised by some of the women was the cost to live at the Botanical Apartments. Millie explained:

> *The only thing that I and a lot of other people struggled here with is the financial aspect […] like it's actually expensive. I mean I know we're getting a lot out of here like it's an amazing service and I definitely plan to stick it out like there's more in the positives than there is in the negatives for me but financially it's a massive struggle.*

The women who disclosed their source of income were on either JobSeeker or Disability Support Pension. Ladan, for example, described her apprehension about managing the rent while on income support payments: *'For people like me that has just one source of income it could be a bit difficult, the rent could be a bit high, to be honest.'* The Cornelia Program sets rent at the HousingFirst rate of 30 per cent of household income (plus service fee), which aligns with the current social housing rent level of 25-30 per cent. It is therefore unlikely that cheaper rental accommodation could be found to house this cohort, and it would certainly not offer the same level of support. Furthermore, the concerns raised about the space and the rent did not override the benefits the women outlined through being in the Cornelia Program, and they did not indicate that it would prompt them to leave prematurely.

5.2 Freedom from violence

5.2.1 Independent and safe housing

Homelessness carries significant physical and psychological threats, and for women there are increased risks of gender-based violence (Watson, 2018). Providing a living environment that is free from violence is therefore critical to supporting women and their babies, not only for reasons of safety, but also for women to heal from trauma. **The Cornelia Program gives women access to independent and safe housing, which has important implications**

for those experiencing family violence. Notably, women are not forced to rely on, or negotiate with, violent ex-/partners to obtain accommodation, which *'mitigate[s] the family violence risk now that she's got her own safe space'* (Family support worker).

The provision of independent accommodation to women—that is unavailable to their violent partner—creates conditions that can facilitate them to leave violent relationships. As one external service provider commented:

> *So that would be another factor that we see [as a] tremendous benefit. If Cornelia House is affording a client independent housing […] [a perpetrator] can't attend and he can't corrupt. […] [There are] really positive results from that that might not be quantifiable but in terms of women just having the opportunities to leave relationships that they otherwise wouldn't have.*
> (Health worker)

For the women who had previously experienced family violence, this **security was especially important in offering ongoing protection from abusive ex-partners.** Victoria described how it was essential that her ex-partner did not know where she was living, and how the staff ensured the secrecy of her location:

> *They made sure nobody would tell anybody really where we were living. […] They made sure even the hospital didn't really have my address. They worked it all out in case [my baby's] father came then I was safe and they made sure to tell me every time that I needed to go to the hospital or something like that, they made sure that we were safe.*

5.2.2 Reimagined relationships

Providing safety from men's violence was also critical to improving the women's mental health, and further enabling them the opportunity to focus instead on developing a relationship with their baby, and imagining their future:

> *Being in a safe space, you're alleviating a lot of stresses from them like […] being away from the perpetrators, away from the dealers and all that stuff and given that chance to grow and love their babies and see that there is life after all the other stuff.* (Aboriginal child and family worker)

There were also benefits reported for women experiencing family violence in the Cornelia Program seeking treatment for alcohol and other drug use. External service providers observed that space and safety from an abusive partner enabled women greater opportunity, while in an in-patient withdrawal management program, to focus on their own needs and relationship with their baby and *'form an identity and a sense of independence away from drugs and alcohol, which the partner is typically using to control them'* (Health worker).

5.3 Feeling safe

Offering a safe physical environment is essential for women and their babies as well as for workers and visitors. There were a range of experiences reported over the course of this evaluation about the security of the Botanical Apartments. **Several women reflected on having a new sense of safety**. Farida explained: *'I feel safe now like I just feel me and my baby don't have nothing to worry about like we're going to be fine.'* Uba reported feeling *'very safe'* at the Botanical Apartments, and Anita felt assured that the building was secure: *'It's just the building itself, I feel safe like the fact that no-one can just get in, it feels very safe.'* For some, it was also the sense of community among the residents that meant the women kept each other informed if a safety matter occurred: *'Safety's pretty good here like we all look out for each other and if something happens we're all in the loop, we text each other'* (Farida).

5.3.1 Security concerns

However, a sense of safety at the Botanical Apartments was not shared by all. **Security concerns centred on incidents occurring outside staffed hours, and unwanted people having access to the building**. The focus group cited past incidents of men with a record of family violence that were *'high risk'* (Operational staff member) accessing the main gate to the premises outside of staffed hours. One reported: *'the courtyards at the front are easy […] to jump over,'* stating that because the gate is low, *'men open it from the outside.'* The lack of safety due to the building design was also raised by some external service providers, with certain health workers attending the site in pairs at times due to security breaches they had observed:

> *Certainly on the ground floor I've been in consultations with women in their apartments and men have just hopped over that low brick fence, walked right in and they're definitely not residents.*

For the women who raised the issue of safety, they also expressed concern about the property not being staffed after business hours. Currently, the accommodation is staffed between 9am to 5pm Monday to Friday, leading to periods of time when the site is not overseen by a staff member. Millie stated: *'I've always thought it is a bit strange that no-one's here on the weekends. […] A lot of girls here have family violence problems.'*

5.3.2 Improving security measures

A measure to improve building security proposed by operational staff and senior management is to modify the building to reduce the likelihood that residents will be impacted by trespassers. One senior manager suggested:

> *We need to consider safety because I know some of the women on the ground floor [for] example get harassment from family or partners or whatever and then if you've got balconies and people can climb up to them, so I think we just need to be considerate of design moving forward.*

Specifically, the construction of a taller fence designed to prevent trespassers gaining access to the ground floor apartments was endorsed by operational staff: *'Adding a few metres to a fence like it could be something really simple that would have a big effect'* (Operational staff member).

Another recommendation from some women was to provide after-hours security for the building for incidents that occur outside the Cornelia Program's working hours. This could be managed by giving women an after-hours number to call, as suggested by Eleanor:

> *If there's something really going on at the apartments like if somebody's got people in there [and] you don't feel safe or something's going on, someone that you can call just to let them know there's someone here, a man, a strange man at the apartments wandering around and no-one seems to know who he is or just security reasons.*

One senior manager raised the issue of after-hours security in the context of overall greater support for women and babies on site. An adjustment of the model was suggested whereby:

> *[Cornelia] need[s] to have […] more staff to have a different model around I guess providing more safety for the staff, clients and the babies as well. […] Sometimes incidents can occur or support may be required by mums especially after hours and we don't have that model as part of the program. So it will be interesting to see if it's necessary to have an after-hours model that can provide that support, especially when we talk about having onsite [women] that have experienced family violence in the past.*

Following the implementation of extra security measures, **safety on the site was reported to have improved.** Farida noted: *'Recently they've changed, you can't come up the elevator without a fob.'* CCTV has also been added to the front of the building to monitor building access. An external service provider noted that security issues had decreased, making visiting workers feel much safer:

> *We've had periods where we've only gone in in pairs […] maybe a year or so ago. That seems to have settled down. […] A lot of that still goes on but it's not to the same extent and we feel a lot more safe going in at this stage, which is good.* (Health worker)

Nonetheless, due to the concerns about the accessibility of the ground floor units and incidents occurring outside of business hours, **it would be worthwhile for the ongoing safety of residents, workers, and visitors for a security audit of the building to be conducted.**

5.4 Material support

Women experiencing pregnancy and homelessness endure substantial financial hardship making it difficult to acquire the necessary supplies for their babies. For those reliant on Centrelink for income, access to the parenting payment only occurs following birth; items such as nappies, maternity and baby clothes, furniture, and even food can be unattainable. **The Cornelia Program delivers much-needed material support to women.** This commences when women arrive at the Botanical Apartments at which time they receive a donated welcome pack containing toiletries and baby products. The Royal Women's Hospital also provides a range of items that are customised as the baby's needs change. These include: pepi pods, baby bed linen, bottles, wraps, baby carriers, feeding pillows, change mats/tables, and prams. Charlotte stated that the range of material supports she received through the program covered her needs:

> *Things to do with furniture, everyday things, getting vouchers to go to the hospital when I need to. If we need help bringing things up or getting things delivered or any sort of random everyday things. They can assist with pretty much anything.*

The material support provided by the Cornelia Program not only removed some of the financial burden, and associated stress, faced by women, it also assisted them to feel at home. Sophia shared the relief and comfort she felt when finding that everything had already been set up when she arrived at the Botanical Apartments:

> *It took a whole bunch of weight off my shoulders because I was thinking I got to wait 'til I'm paid, pay first with the rent then I get left with a little bit of money then to go buy this and that. […] It was driving me crazy but as soon as I opened the door there was a bed ready, blankets, pillows, everything brand new, baby cot so it kind of gave me a head start where I don't need to really stress.*

5.5 Approachability and accessibility of operational staff

The Cornelia Program offers a respectful and healing space. The women who enter come with many vulnerabilities and have often experienced past and ongoing trauma, including family violence. Emotional safety in the program is therefore essential to their immediate and ongoing wellbeing. Central to this is the welcoming, supportive, and non-judgmental environment created by the operational staff and the care they provide daily. There was a widespread view among the women that **the operational staff are approachable, accessible, and helpful**, which allowed women to be vulnerable in a way that was not possible while homeless. **The quality of care provided is of a level that many of the women had not experienced previously.** Ladan expressed surprise at the support she received, having only expected to be given accommodation through the Botanical Apartments: *'At the beginning all I was thinking of was this accommodation, [to]*

have somewhere to stay, but I received more than I was expecting.' Mary emphasised the accessibility of, and proximity to, the operational staff, and how this reduced her anxiety about asking for assistance:

> *Having access to the women downstairs, and in all honesty, I can't explain the relief and just almost the satisfaction of knowing that I can knock on that door and it doesn't matter who answers […] I hope that the [Cornelia staff have] got half a clue of the assistance that they provide just from knowing that they're there because I haven't had that support before.*

The Cornelia Program is staffed by women, which Farida credited with making communication easier: *'The staff are actually nice and it helps that they're women too like it's just so easy to talk to them and they listen.'* Moreover, some women expressed relief that staff did not judge their circumstances, which contrasted with experiences they had been through in other areas of their lives. As Ladan put it: *'It's okay to ask [Cornelia staff] any type of question'.* Millie felt relieved that she was *'able to let people know where I'm at and not fear this massive judgement'.* Yasmin also explained: *'The way they treat me, how quick they were to accept me and they don't judge me when I was telling them everything.'* The operational staff support women in a client-centered manner, whereby relationships are forged through *'sitting alongside that mother'* to *'really try and engage her'* (Family support worker).

5.6 Culturally-aware practice

5.6.1 Fostering cultural safety

Due to the diversity of the women in the Cornelia Program, providing a culturally safe environment and service is imperative to the work being undertaken. The Cornelia Program provides the sanctuary needed by women who have likely experienced multiple discriminations associated with their race, ethnicity, Indigeneity, and/or culture. An indicator of the isolation that can be faced by multicultural women experiencing pregnancy and homelessness was noted by Farida who had not expected there to be other women from multicultural backgrounds in the program:

> *It's so multicultural [at Cornelia] like I thought I would be the only African in here. I've met a whole bunch of different people and even though we're so different we're so alike.*

Promoting cultural safety enhances the accessibility of the Cornelia Program to women of diverse backgrounds and is a significant strength, especially considering the increased risk of homelessness faced by both migrants and Indigenous people. The women from diverse backgrounds, including those who were born overseas and Indigenous, were asked about cultural safety within the Cornelia Program and none expressed any concerns; instead, they offered assurance that the program was welcoming and inclusive

and that racism was not accepted. As noted by Anita: *'It's been very good, no racism at all. Everyone gets along pretty well.'* Uba noted that while the location of the Cornelia Program in St Kilda placed her at some distance from her cultural community in outer Melbourne, the support provided made it worthwhile: *'It's very stressful because there's not also [my African] community in St Kilda, it's too far for me but I'm happy to stay here, it's safe for me and for [my daughter].'* Reflecting on the welcoming atmosphere of the Cornelia Program, an Aboriginal child and family worker observed her service user *'build[ing] community connections'* after being separated from her own due to family violence: *'There are so many different cultures in [Cornelia] but she embraced and they would call each other sisters and that which was nice.'*

Cultural safety was critical for women who had experienced cultural shame due to their pregnancies. Yasmin and Farida spoke about having been dishonoured by their families because they had babies outside of marriage, highlighting the importance of the acceptance shown by operational staff at Cornelia:

> *I believe in my culture, I love my culture 110% but it's just some things that I want to break away and having programs like this just gives you the opportunity and space to know you're not doing anything wrong, like this is okay.*
> (Farida)

5.6.2 Adopting a cultural lens

The Cornelia Program also supports the work of Aboriginal family support services by demonstrating a willingness to recognise Indigenous expertise regarding culturally appropriate support:

> *They're [Cornelia] really good, they were open to what I was bringing on board around parenting and that and linking them to culture and family and […] started letting us be the main one that was taking the lead, […] make sure things would happen for the families in a safe cultural way.*
> (Aboriginal child and family worker)

Operational staff adopt a cultural lens in their work as evidenced by interventions designed to link Indigenous service users to culturally appropriate supports such as local gathering places. An Aboriginal child and family worker reflected on an Aboriginal service user entering Cornelia *'without a voice and when she left she had a voice'.* This was fostered through the provision of culturally appropriate support that was part of a safe, stable, and non-judgmental environment. As observed below, the service user felt empowered as she learnt skills to protect and prioritise herself and her baby, and assess dangerous relationships in new ways:

> *She became more empowered around relationships and that 'cause she'd been in a very volatile, dangerous relationship with the father of her child and she was able to work through seeing it for what it was and put herself and her child first in*

her life. […] So having that stable living environment, having the supports there when she needed them, feeling safe to express herself and parent her child without being judged and all that, it just made her grow within herself. Like I say she had a voice towards the end.
(Aboriginal child and family worker)

Cultural aptitude was demonstrated consistently by the operational staff. This was expressed through openness, respect, acceptance, curiosity, and a willingness to learn. All the women interviewed spoke positively of how cultural matters were considered and incorporated into the support they received. The operational staff were credited with taking the time to learn about cultural traditions and supporting cultural events. Cooking classes organised by the operational staff, for example, were noted as a successful illustration of cultural inclusivity. Farida said: *'They had Somali food then they had Aboriginal food and Middle East [food], and so everyone was asked.'* Uba explained how an operational staff member took the time and initiative to educate herself on a particular cultural tradition, and she was thereby able to prepare, and provide the materials, for a celebratory event. This signified to Uba that Cornelia was a place of acceptance where her culture was valued:

She knows something about our ceremony […] I just say wow because she accepts my culture and my tradition. […] Every time I just say thank you so much because she accepts my culture.

More generally, Cornelia fosters an environment where women *'feel safe and also that they are part of the decision-making'* (Aboriginal child and family worker). This enables opportunities for the development of cross-cultural connections and mutual support between residents that produce *'lasting relationships'* (Aboriginal child and family worker) and reciprocal support networks.

5.7 Continuity of care

Continuity of care is the preferred model of support for women experiencing pregnancy and homelessness (Murray, Theobald & Watson, 2018). This group has typically experienced disrupted service provision or even complete disengagement due to homelessness and the associated privation (Murray et al., 2020). The pressure of everyday survival, as noted by one external service provider, can therefore see women experiencing pregnancy and homelessness being labelled as recalcitrant:

You're totally in the stress of day-to-day survival when you're bouncing between—that constant worry about where you're going to stay. So I think then these mums get labelled as well, they're not engaging with antenatal care, they're not attending hospital appointments. Yeah 'cause they're trying to find a place for them and the baby to sleep tonight like has to be the number one priority.
(Family support worker)

5.7.1 A unique model of practice

Sustained connections with the same service providers are vital for better outcomes for mothers and babies. **The Cornelia Program is unique in its capacity to offer continuity of care via onsite multidisciplinary operational staff providing wraparound support through care coordination, social work, family support, tenancy support, and midwifery. The support offered to women and their babies is client-centred and specifically targeted to individual needs.**

This model of practice accords with trauma-informed practice through ensuring women build relationships with key workers and not be required to repeat social and medical histories each time they receive a service. Seeing the same workers throughout their care period means women build up familiarity and rapport:

> *I've got my own regular midwife now that works both here and the Royal so it's better seeing just the one person. Normally I would just go to the hospital and see every time a different person […] we have some sort of bond.* (Ladan)

Uba discussed how helpful it was having a consistent worker to assist with navigating a new and unfamiliar location, and establishing health care services for herself and her baby:

> *I don't know St Kilda so she'll just show me, and last time [my baby] had an appointment with the doctor […] so she goes with me and she makes appointment with the GP doctor for us.*

The partnership with the Royal Women's Hospital is vital to the continuity of care model offered by the Cornelia Program. It increases women's access to antenatal care and, by extension, the likelihood of positive clinical outcomes: *'Issues may be picked up earlier than they may otherwise have been, all of those clinical outcomes for the pregnancy and for the baby at birth I think will be successful'* (Health worker). This is exemplified in the case of Uba who received continuous, targeted, and intensive support from the midwife through the Cornelia Program after developing anaemia following a complicated delivery. The support Uba received enabled her to rest and recover. Several women cited the ease of access the program provided to clinical supports through the Royal Women's Hospital in the lead up to their birth and in the weeks afterwards as highly beneficial to their wellbeing. For example, Mary explained that:

> *I had the [midwife] so that was my strong connection that never stopped because she came from the Royal Women's and was of course available here so that was my backbone for a long time.*

The value of this partnership was also noted by Charlotte: *'The linking in part that Cornelia did took away all the stress of me having to research and find someone and also they know who's good.'* Notably, the capacity to build positive regard and trusting relationships with women during their time in the program was seen as valuable even when engagement was short lived

and longer-term outcomes were not achieved. Reflecting on an experience of supporting a service user who exited the program following a tenancy breach, one external service provider expressed that:

> *The safety that the Cornelia Program has given these women is just amazing and even [for] the women that don't engage. […] I was working with [one] that had to be moved out […] but I've probably met her about 10 times. […]*
> *[W]e didn't really get anywhere in typical case management goals but I saw her and the staff there saw her. I think she would have not been visible at all if she wasn't in Cornelia. (*Family support worker)

The Cornelia Program provides support to women who may otherwise remain invisible and without a service response. As discussed above, even short support periods of positive engagement produce productive outcomes that can be considered a resource for service users in so much as they can build trust and increase the likelihood of future engagement.

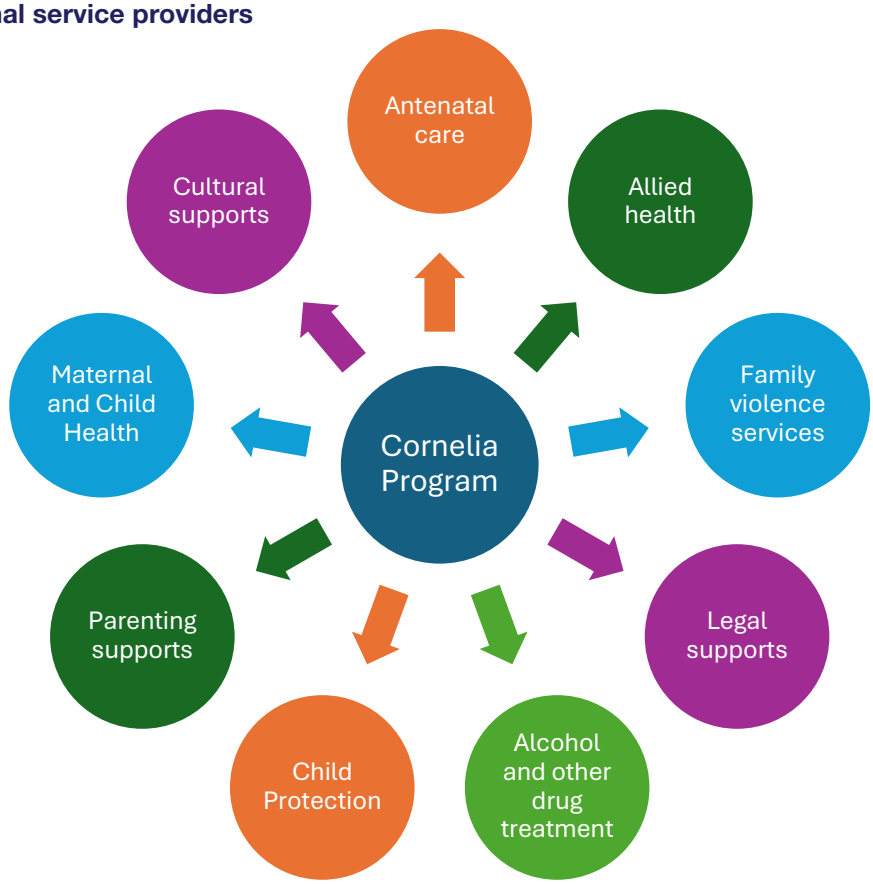
The provision of stable housing through the Cornelia Program is also critical to the capacity of external service providers—as discussed further below—to build relationships with women and to offer continuity of care to achieve positive outcomes:

> *The value of having [housing] continuity can't be understated. We build relationships and if these mothers were in transient accommodation for a week here or a week there they would have a different [staff member] every time, there'd be delays between services picking it up and you wouldn't have the same relationship and you wouldn't get the same outcomes. (Health worker)*

5.8 Collaborative practice with external services

The Cornelia Program provides a comprehensive wraparound service to women and their babies. A key component is the relationships built with external service providers. The Cornelia Program works collaboratively to support women across a range of domains including antenatal care, allied health, family violence, legal issues, mental health, alcohol and other drugs, parenting support, Child Protection, maternal and child health care, and cultural support.

Figure 14: External service providers



5.8.1 Working together and overcoming barriers

Operational staff play a critical role in facilitating the work of external service providers. External service providers reported how helpful it was being able to *'check in with the staff'* and to undertake *'collaborative catching up'* (Health worker) when visiting women and babies onsite. They also valued invitations to participate in joint meetings, and assistance with accessing clients:

> *[T]he Cornelia Program has been brilliant in terms of my engagement because of the staff that are onsite […] [they] give me information about […] when [clients are] at the accommodation for me to try and catch them […] [and] call me along to meet women jointly with them. So a lot of that joined-up work to engage women has been really good.* (Family support worker)

Millie noted that relationships between operational staff and external service providers were handled in a cooperative, client-centred manner, which indicated to her that the Cornelia Program was meeting her support needs:

> *They [Salvation Army] liaise with these guys at Cornelia as well and they've all had a meeting and done a care plan and stuff for me so it's quite amazing […] It's like wow, you just know you're in the right spot when everyone's working together.*

In this way, the **operational staff work as navigators in an often-complex service system, which can be impenetrable for women on their own.** One external service

provider reported: *'The relational nature of the program […] and presence of the staff onsite […] helps my work because of my focus being trying to engage women who struggle with working with services'* (Family support worker).

While residing at the Botanical Apartments, women are actively supported through these partnerships to access a range of services thereby reducing barriers that would otherwise exist. One example, provided by an external service provider, demonstrates how the Cornelia Program assists women to access multiple forms of allied health care:

> *They can access a whole lot of health services that if they were transient it's much more difficult to access. […] Being able to see a dentist and get dental work done is really significant for women. […] They may be having back pain or hip pain or pelvic pain related to the pregnancy or they may have pre-occurring health issues that haven't been addressed as a result of being homeless and transient or a whole range of different issues so they can link in with the physio or the podiatrist or other allied health as needed.*
> (Health worker)

5.8.2 Enhancing access to withdrawal services

The Cornelia Program's collaboration with alcohol and other drug services was also identified as an area that produced positive outcomes, specifically through the provision of timely and effective withdrawal treatment to women. It was because of *'the complex trauma [Cornelia] clients have often experienced'* that withdrawal services needed to be approached with *'a significant degree of nuance'* (Health worker). Central to this is ensuring treatment occurs when women are in stable accommodation, at a time that best suits their circumstances, and when support is bookended around their entry to, and exit from, inpatient withdrawal services. One external service provider reported how such support arrangements were conducive to enabling *'clients to enter detox in a manner that they wouldn't usually, and I think that's one of the chief benefits of the program so far'* (Health worker). These arrangements were also identified as important for enabling withdrawal services to be provided in a flexible and timely manner, as one external service provider commented: *'I think that the partnership with Cornelia has worked really well because we can do that rapid intake, we can be super-flexible because they have that support structure already in place'* (Health worker).

5.8.3 Facilitating legal and policing support

Women can enter the Cornelia Program with impending legal matters and operational staff can connect them to essential legal support. Some women reported that the confusion and uncertainty about the legal system, as well as the prohibitively high cost of obtaining legal representation, had caused significant harms. In some cases, the women required legal support to resolve issues that had dragged on for years and had been a barrier to housing stability. This was Mary's experience:

> *It was through [Cornelia] resourcing and getting me involved with legal counsel through [a community legal service] I think it is, yeah, through that. So without that I probably wouldn't have progressed through the court proceedings with legal representation.*

Where there were legal issues, these were largely connected to the women's experiences of family violence. An extension of the work done by the operational staff to connect women with legal assistance is advocating with police for women's safety. **A culture of collaboration produced opportunities for engaging women in positive relationships with police** who were invited onsite to join support meetings. The aim was to enhance the safety of women experiencing family violence by reducing barriers to reporting violence and accessing police support. As explained by a family support worker: *'Being able to take [police] to the Cornelia Program, meet them there in the communal space […] has been really helpful'.*

5.9 Keeping mothers and babies together

Another notable area in which the relationships built by the Cornelia Program produced particularly good outcomes was supporting and advocating for women to have their babies remain in their care. This involved intensive support across multiple service domains that often began before birth. **Cornelia operational staff actively facilitate women's engagement with services like maternal and child health care, which was identified as reducing the likelihood of women being subject to repeat Child Protection notifications and/or ongoing involvement post-birth:**

> *Say mum misses three consecutive maternal child health nurse appointments, [Cornelia] might set up a joint visit with the nurse […] and that might be the opportunity that mum actually engages with the nurse. We've had that sighting of the child, we've had the health and developmental check and mum's agreeable to a further appointment. So it prevents that report back into Child Protection.* (Child and family worker)

Collaborative pre-birth planning meetings with external services provide a critical source of information that underpins the support provided to women and their babies. As noted by one external service provider: *'The sooner that we can engage with a mother to address the concerns […] the better the potential early intervention and outcomes can be for that mother and her baby'* (Child and family worker).

5.9.1 Navigation of systems

The complexity of women's lives often means that **the Cornelia Program manages relationships with, and makes referrals to, numerous external service providers to assist women to retain care of their babies.** Charlotte, for example, in addition to being homeless and having past Child Protection involvement, had an extensive history of family

violence, current chronic health issues, and multiple mental health conditions. She explained: *'There was a lot of family violence […] so I lost custody of [my other] children. […] I lost them through not understanding the legal system.'* In addition to working successfully with Child Protection for Charlotte to retain care of her baby, the Cornelia Program referred her to legal support, which assisted with past Child Protection matters, resulting in a child reunification order being put in place for her other children. Legal support also assisted with filing an application to the Victims of Crime Assistance Tribunal, which provided for ongoing trauma counselling. Charlotte was especially appreciative of the additional advocacy and expertise offered by the operational staff in relation to Child Protection matters:

> *Child Protection will walk all over you if you don't have someone standing up in your corner so Cornelia were really good at dealing with them because they've done it a lot.*

In sum, Charlotte said of Cornelia that: *'They handled all those really difficult outside matters, whether it was legal or whatever. They took a big chunk of stress away.'*

Opportunities for engagement produced through collaboration with external services enable positive long-term outcomes for women. **The high level of support offered through these relationships is carried out alongside building the women's self-sufficiency and the confidence to navigate the service systems themselves and to maintain their relationships independently.** The women noted the educative role played by the program in developing their self-determination: *'One thing this program does do, it helps, pushes you to be more independent and learn things and learn what type of help is actually available out there'* (Victoria).

5.10 Preparing for motherhood and bonding with baby

5.10.1 Homelessness is detrimental to motherhood

Through housing stability and wraparound support, the Cornelia Program offers a unique opportunity, that would otherwise be unavailable, for mothers and babies to bond. Mother-baby bonding usually begins well before birth, but this can be interrupted and delayed due to homelessness (Murray et al., 2020). The consistent message from the women was that being homeless did not allow them to focus on their pregnancies because their immediate concern was finding accommodation. The hardship of homelessness, which for some was compounded by difficulties such as family violence, mental ill health, and/or alcohol and other drug misuse, meant that, in many cases, they had not been able to rest or even think about and plan their futures as mothers until they entered the Cornelia Program. As Anita explained: *'It's hard to bond with a child when you're suicidal.'* Charlotte's struggle with severe anxiety, which was exacerbated by not knowing where she was going to be living next, had led her to push the pregnancy to the back of her mind. *'I didn't acknowledge it for*

so long, I didn't feel pregnant for so long,' she said, but since arriving at Cornelia her anxiety levels had *'come down a lot'.* Ladan spoke similarly about her experience with homelessness prior to entering the Cornelia Program, and how the stress of it all meant that she sometimes forgot that she was pregnant.

The external service providers also observed how detrimental homelessness was for preparing for motherhood. One explained that entering the Cornelia Program was 'the first time' that some women were able to focus on their pregnancies and impending motherhood:

> *Women that I've worked with, when they've been pregnant then moved in there, it's the first time they've been able to actually think about their pregnancy and prepare for being a mum 'cause prior to that they've been figuring out where they could stay, traipsing on buses and trains and trams going here, there, everywhere, trying to hustle for a friend to stay with.*
> (Family support worker)

5.10.2 Housing stability supports mother-baby bonding

The accommodation provided at the Botanical Apartments to women prior to, and after, giving birth is crucial in removing housing stress and thereby enables women to build stronger bonds with their babies. Having a home meant Sophia could start preparing for motherhood through 'nesting' in anticipation of her baby's arrival:

> *I'm at that stage of nesting so just to make sure everything is prepared because from 35 weeks onwards, even earlier, you just don't know when the baby's going to arrive and it's so important to have access to baby items and getting it all prepared. I'm still preparing my hospital bag but I've got most of the stuff now thanks to the Cornelia program.*

This view was supported by the external service providers:

> *It creates a space where they can […] engag[e] with the idea that they're going to be a parent and focusing on that relationship with their baby and the attachment with their baby. That of course continues once the baby's born and mum and bub have […] a safe space to really strengthen that relationship in the early days so I think that's a hugely significant outcome for women.*
> (Health worker)

5.10.3 Fostering the relationship between mother and baby

In addition to housing stability, **the service provision from the operational staff and the connections they have been built with external service providers are essential elements in fostering mother-baby bonds**. Yasmin explained that it was ***'crazy'*** stepping into motherhood but that the Cornelia Program *'just made it not as scary'.* The overriding sentiment expressed by the women was that once the stress of trying to secure a place to

live was alleviated, and support services had been engaged, it enabled room for a relationship with their baby to flourish. Mary also reflected on how the support offered to her through the Cornelia Program had helped shape her as a new mother:

> *I don't know if magical's an appropriate word like it's everything I could have hoped it would be and more. […] It's let me be me and this is exactly how I would want to be when it comes to being a mum and being available to her in the best capacity.*

Charlotte explained how the wraparound support provided by the Cornelia Program allowed her to focus on her baby in a way that had not been possible with her previous children due to ongoing homelessness and family violence.

> *I guess it allowed me the time and space to bond with the baby, whether it was through pregnancy or once he was born or whatever, to focus on myself and the baby and the pregnancy and my own health and the things that I needed to do for myself.*

The Cornelia Program plays an important role in assisting women to develop the skills to communicate and play with their babies, which further promotes mother-baby bonding. Uba described how the program built her confidence in being able to parent her baby: *'How I communicate with her, how I play with her, I'm learning there because [of the Cornelia] program.'*

5.10.4 Providing parenting programs and building caregiving skills

The Cornelia Program has a small communal space onsite, which external service providers use to run programs to assist women to bond with their babies and to develop their parenting skills. These include the Playsteps group run every school term by the Queen Elizabeth Centre, and Koala Babies—a group program focused on attachment and parenting for women who have experienced family violence run by specialist family violence workers from the Salvation Army. The Cornelia Program works closely with external service providers to assist with the setting up of groups including establishing programs, recruiting participants, and providing pre-and post-program support:

> *They spent time identifying the women and the infants that they felt would engage best and would get the most out of the program. […] They did all the pre-program work and then one of the Cornelia House staff actually sat in on the program so it was a really important thing […] that the staff at Cornelia House knew what we'd been talking about and so they were able to be aware if anything came up in the program that might have needed following up. […] They were there to support the mum and their bub in any way that was needed.*
> (Parenting service provider)

The collaborative work undertaken by the Cornelia Program is crucial to the success of these parenting programs, which produces positive outcomes through the bonds between mothers and babies growing over the program's duration. A parenting service provider reported how *'women were keen to engage, keen to learn and explore, and really blossomed in their engagement with their babies'.* The only challenge identified in relation to the successful delivery of the programs was the onsite communal space that was not designed for purpose:

> *From my point of view and from an organisation that is offering a group program, [it's] really not an amazing setup for groupwork. The little communal area there is a very small area, it's a funny-shaped area but it was really the only space in the whole place that we could even contemplate running a group program from.* (Parenting service provider)

Many of the women interviewed entered the Cornelia Program during the lockdown periods over 2021-2022 mandated by the Victorian Government due to the Covid-19 pandemic. This meant that onsite activities were postponed due to the imposed restrictions. Nonetheless, for the women who participated, they appreciated being given the choice to engage or not. **They valued the activities and credited them with assisting in building skills to care for their babies.**

Uba regarded highly the range of activities available and that through these she was able to develop new competencies to care for her baby:

> *Yeah, it's good because there are so many programs, for example how to give massage, I don't know before because I don't have a kid. How I communicate with her, how I play with her, I'm learning there because we have some programs. [The worker] prepares some programs for newborn baby and new mothers. So it's good.*

5.10.5 The impact of child removal

A concern raised by an external service provider was the impact on women whose babies were removed from their care while in the Cornelia Program, thereby interrupting the bonding process. These women were observed to experience the Cornelia Program as challenging, particularly because they were surrounded by reminders of their absent babies. It was suggested that they were less likely to continue engaging:

> *Where women were living there without children in their care, their presence at the program was massively reduced so not even being there and staying elsewhere. […] I imagine it was difficult to stay there at a place that was for you and your baby, potentially baby stuff in your room and babies around.* (Family support worker)

It was proposed that additional supports be provided for women whose babies had been

removed from their care because of the emotional and psychological difficulties associated with living in that environment:

> *I wonder whether some kind of therapeutic role or counselling or wellbeing or psychologist stuff for women could be another part of that holistic care, especially for like I said the difficulties that come with women having kids removed from their care and then residing in a building full of pregnant women and women with newborn babies and babies crying when your baby's not with you.*
> (Family support worker)

Despite the difficulties raised with continuing to engage these women, the Cornelia operational staff, wherever possible, worked with women to adapt to their circumstances and to deliver good outcomes. As discussed in the following chapter, for example, the staff collaborated with external agencies, including Child Protection, to work towards family reunification, and to seek housing that would accommodate a family even if the woman moved in on her own.

5.11 Peer support

The opportunities provided by the Cornelia Program for women to interact and socialise with each other encourage peer support and the building of relationships; this is especially pertinent for women who are often isolated from, or without, family and friends. The cultivation of an environment where women with similar experiences can live together was a powerful acknowledgment that gave the women a sense that *'you belong there'* (Ladan). Victoria described how *'the workers also encouraged me to be social'* and how after coming *'from a very abusive relationship and nearly being homeless, […] being encouraged to just open up a bit more, […] it made a world of difference'.* Building relationships between women generates opportunities for sharing experiences and providing emotional support, which fosters healing. An Aboriginal child and family worker observed how an Aboriginal service user *'share[d] her story with others and talk[ed] about her recovery',* which she identified as individually empowering because it *'made her voice powerful'* while simultaneously *'help[ing] other ones who were still trying to do that journey'.*

For Anita, mixing with other residents enhanced her stay at Cornelia by getting her out and about and giving her company: *'It makes it less boring and we can go for walks at the park and we've been doing that, going to the shops so it's pretty nice.'* Several women spoke of making friendships, some of which lasted beyond the time spent at the Botanical Apartments, that were emotionally supportive as well as offering practical assistance. For example, Farida stated:

> *I've made two really great friends and we are supporting each other so always helping each other, if I've got to run down to the shop and it's too cold they'll watch my kid while I run down.*

Farida further noted the peer support aspects of these friendships that assisted the women to build independence: *'Now we're more dependent on each other than we are the workers.'* The housing stability and social support offered by the program were credited by the women in creating the circumstances for them to reflect on their relationships and thereby improved them. Ladan described how prior to entering the Cornelia Program she had been somewhat of a loner, but the community atmosphere fostered by the workers had prompted her to become more social, which improved her quality of life:

> *Most of my time I would like to spend on my own but the Cornelia Program showed me the other side of myself, actually I enjoy community and having people that are similar.*

A barrier to making social ties noted by Victoria was the perceived alcohol and drug use by some residents. Victoria explained that this caused her to avoid certain areas and people: *'That made it a bit harder for me because I am a recovering addict, […] I can't go down there but I want to.'* Nonetheless, the overall sentiment was that being able to live close to, socialise with, and have mutually supportive relationships with, other women in similar circumstances was a highly valuable aspect of the Cornelia Program. As Millie noted:

> *'Cause the best thing about Cornelia for me was the social aspect of the other girls, the other mums with kids as well. Really loved having that experience of growing up with other kids. That's massive.*

Conclusion

This chapter has addressed Aims 2 and 4 of the evaluation. Through an exploration of the experience of women and their babies of the program and the extent that the Cornelia Program improved their health and quality of life it was found that **the provision of accommodation to women experiencing pregnancy and homelessness is a foundation that enables them to stabilise their housing and access support and safety.** While the size of the units did not always meet women's needs—particularly when their babies became more active—**providing a living environment free from violence is critical to supporting women and their babies for reasons of safety and to enable healing from trauma**. Security concerns were raised about the accessibility of the ground floor units and incidents occurring outside of business hours. However, there was a sense that following the implementation of extra security measures the site was becoming safer. Nonetheless, **it is recommended that a security audit of the building be conducted.**

The Cornelia Program delivers much-needed material and emotional support to women. **Emotional safety is facilitated by operational staff that are approachable, accessible, and helpful.** Another significant strength of the program is its accessibility to multicultural and Indigenous women. **Cultural aptitude was demonstrated consistently through**

openness, respect, acceptance, curiosity, and a willingness to learn. The Cornelia Program provides continuity of care via the provision of stable housing alongside onsite multidisciplinary and wraparound support. **Ease of access to clinical supports through the Royal Women's Hospital enhances women's access to antenatal care.**

The Cornelia Program manages relationships with, and makes referrals to, numerous external service providers to assist women to retain care of their babies. **Supportive relationships between Cornelia operational staff and women, alongside the provision of stable housing, provide important groundwork for external service providers' positive engagement across a range of domains** including: antenatal care, allied health, family violence, legal issues, mental health, alcohol and other drugs, parenting support, Child Protection, maternal and child health care, and cultural support.

Taken together, **the work of the Cornelia program in collaboration with external services produces positive and life-changing outcomes for women** including: living free from violence; fostering healing; developing a new sense of physical safety; building self-sufficiency and confidence; reducing stigma and stress; building bonds with babies; enhancing mutual support and building relationships; developing cross-cultural connections; and skills to communicate and play with their babies.

Chapter 6 | After Cornelia

Evaluation Aim 3: Long-term secure housing outcomes of women and babies supported by the Cornelia Program

I've come a long way, I'm proud of myself. I'm doing a lot better than when I was maybe a year ago. […] I'm always going to be grateful and thankful to Cornelia that they gave me a placement there and then they also gave me the opportunity to thrive in a new environment all by myself. So, so happy.
(Sophia)

I know it sounds corny but it gives me goosebumps to think that there's 36 women that could potentially have a really negative outcome—and we know the importance of those first early years to children and their life—so if Cornelia House has that opportunity for these women to have a safe space to build their relationship with their children it's invaluable from my point of view.
(Parenting service provider)

Key findings

Housing

- The Cornelia Program has proven to be highly successful in facilitating women's access to support and advocacy in relation to long-term housing.
- The program has had great success with all women interviewed exiting into ongoing accommodation. This consisted of 13 women moving into, or about to move into, social housing (including 12 women in community housing and one woman in public housing).
- HousingFirst is an important supplier of properties (n=7), indicating the value of this partnership.
- Operational staff takes careful consideration of location, condition, and community connections when arranging long-term housing to improve sustainability.
- The women were mostly satisfied with their post-Cornelia housing arrangements.

Transitions

- The Cornelia Program builds women's independence through equipping them with the skills to manage day-to-day living on their own after they exit the program.
- The women were mostly satisfied with the level of support they received as they transitioned into their post-Cornelia conditions.
- Relationships built with external service providers during their time with the Cornelia Program continue to be valuable for women after they exit.
- The Cornelia Program's educative role to explain and identify perpetrator responsibility is an essential part of supporting women to continue to live free from violence after they leave the program.

Community connections

- Location is important for housing sustainability for reasons stemming from ease of access to amenities and services to community engagement and social connection.
- The women reported satisfaction with the locations to which they had moved, indicated by engagement with local services and amenities, religious institutions, and proximity to family and friends.

Parenting

- The women reported improved relationships with their babies and this bond continued to strengthen after exiting the program as demonstrated by independent parenting and reduced or no involvement with Child Protection.
- The support provided by the Cornelia Program makes it possible for women to reconnect with other children not in their care.
- The support offered by the Cornelia Program increases women's confidence in working with Child Protection.

Health and wellbeing

- The women reported significantly increased levels of self-confidence and independence following the Cornelia Program. This played an important role in preventing them from returning to violent ex-partners after exiting the program.

- The Cornelia Program facilitates relationships with external health providers such as Maternal and Child Health Nursing, GPs, and mental health support, which women access after exiting the program.

Employment and Education

- Some women entered paid employment or education after leaving the program.

CASE STUDY: Sara

After residing at the Botanical Apartments for a period six months— during which time she gave birth to her baby— Sara moved into a social housing property in an area she had lived previously and where she felt comfortable and had family and cultural connections. Location was especially important to assist with settling into her new home and she felt 'safe and secure'.

The Cornelia operational staff assisted with connecting utilities, furnishing the house, and linking Sara into a range of services including a GP and MCHN. Sara was grateful for the support she received from the operational staff when moving into and setting up her 'beautiful new apartment'; however, transitioning to independent living with her baby was challenging because she went from having 'a lot of hands of help' while in the program to 'doing it all on your own'. Despite this, Sara reflected that being in the program had assisted her to develop the ability to 'live independently without feeling scared'. It also helped knowing that she had the backing of the operational staff who insisted they be contacted when needed to seek advice and support.

Sara felt she now had 'all the connections I need' and was looking forward to a future where she could 'thrive in a new environment all by myself'.

6.1 Housing transitions

A central tenet of the Cornelia Program is transitioning women and their babies into long-term housing. The Botanical Apartment accommodation is generally limited to twelve months, so there is a need during the tenancy to plan for housing when the lease ends or when women are ready to leave. Accessing long-term, affordable properties for Cornelia service users occurs within the broader context of a housing sector that does not have the resources to accommodate the enormous number of people on low incomes requiring housing. Private rental properties are largely unaffordable for Cornelia service users and social housing has long waiting lists, even for families eligible for priority access. The Cornelia housing workers are therefore operating within a severely restricted system with extremely limited options when trying to source properties. Unsurprisingly, the uncertainty of the housing sector induced anxiety for some women:

> *They've been telling me you've got a property, then you don't, then you do, then you don't. […] Not having exact information that can at least calm my mind, it's a bit frustrating. […] A lot of us are actually going through the same thing.*
> (Farida)

6.1.1 Facilitating access to long-term housing

Despite the challenges involved, the Cornelia Program has proven to be highly successful in facilitating women's access to support and advocacy in relation to long-term housing, which was otherwise seen as *'impossible to get […] if they're just in the community or sofa-surfing'* (Family support worker). Long-term housing support was highly valued by external service providers:

> *[Having] a housing worker allocated to you to make sure that you have somewhere to go at the end of the 12 months I imagine would be a significant relief.*
> (Health worker)

The housing workers kept women informed about the status of their post-Cornelia housing applications, which as noted by Anita, was appreciated: *'[The housing worker] updated me every step of the way.'* The housing workers made it clear to the women that the Botanical Apartments accommodation was time limited and that they would be assisted to find ongoing accommodation, as well as receive the necessary preparatory support to maintain a successful tenancy:

> *It's almost like it's a plan forward as well because it's temporary, the end of this we start looking for permanent housing, so it gives you stepping stones of where you're going, you know what I mean? It gives you something to work towards.*
> (Millie)

In the main, the women understood the challenges facing the housing workers in finding long-term tenancies. The exception was Eleanor who was quite critical of having to remain in the Botanical Apartments for a month after the end of her lease:

> *They didn't give me housing until a month over my lease and there were people here with only three- or four-month-old babies moving and I'm like oh that's nice. So, I'm here with a nearly one-year-old. Cool, like I could have got housing a lot earlier, but they just dragged it out.*

Despite the limitations imposed by the housing sector, **the Cornelia Program has had great success with all women interviewed exiting into ongoing accommodation.** During the period of the evaluation, 62 women exited Cornelia and, of these, 70 per cent moved into permanent, long-term housing. Of the women interviewed for this evaluation, 13 (86 per cent) moved, or were about to move, into social housing (including 12 women in community housing and one woman in public housing). Here, the partnership with HousingFirst played an essential role with seven of these women exiting into HousingFirst properties. **The Cornelia housing workers also undertook indispensable networking and advocacy work with other social housing providers,** which was demonstrated through five women moving into properties managed by organisations such as Unison Housing and Evolve Housing. **There was an overall sense among the women who moved into social housing that this would have been inaccessible if they had been required to navigate the housing system on their own:**

> *Cornelia has provided me with a lot of opportunities, especially with the help to find a government house. I wouldn't have been able to do that otherwise. I would have still been struggling to get private rental with friends.*
> (Anita)

The remaining two women made their own arrangements to move in with long-term friends who were renting privately. These can also be considered successful outcomes as both were very satisfied with their housing circumstances and were still living in these properties 12 months after leaving the Cornelia Program.

The external service providers recognised the invaluable work done by the Cornelia Program to produce positive housing outcomes for women and babies. One external service provider noted that she had observed first-hand the *'really great housing options'* that would not have occurred without the support and advocacy of the Cornelia Program:

> *I know that certainly some of the people I've worked with have been supported into some really great housing outcomes like public housing, private rental, and longer-term transitional housing. So, I think those outcomes wouldn't have happened or would have been much more difficult to access had they not been in a safe, stable place with allocated pregnancy workers and housing workers.*
> (Community health worker)

6.1.2 Secure housing affords stability

Overall, **the women expressed satisfaction with their post-Cornelia housing arrangements.** Overwhelmingly, they valued the stability that security of tenure in comfortable and appropriate housing had given them. Sophia stated that accessing stable housing allowed her to feel safe and focus on matters other than looking for accommodation:

> *I think it's fantastic because now I don't have to focus on being homeless, I can actually worry about the things I need to get done, I can get things done now because I can feel safe in a place that's called my home. I don't have to put up with anyone's drama or mess.*

Security of tenure offers women much-needed stability for raising their babies. Charlotte acknowledged the contribution of the stability offered through the Cornelia Program that had assisted her to transition to ongoing accommodation after many years of transience. For Charlotte, staying at the Botanical Apartments was the first time in 15 years that she had resided in one place for more than a few months. This allowed her to experience the value of a more settled living environment.

> *Even before I went there, before I was homeless, I moved all the time, every few months, I moved close to 30 times in the last 15 years […] and this is the most stable I've been. I think it's been since I've been [in the Cornelia Program] everything's calmed down and I got on a more stable path, […] wanting to stay here 'cause I also want the kids to have stability, […] one daycare, kinder, and school.*

6.1.3 Housing design

For long-term housing post-Cornelia to be viable, it must meet the needs of families. This includes the condition, size, and security of the property. This requires the housing workers to source appropriate properties that meet the specific needs of women with a growing family. **For the women who had moved into social housing, they were generally highly appreciative of the quality of properties the workers had negotiated for them**, which consisted of apartment living—the predominant type of accommodation available. Two women indicated that their housing did not meet their expectations. Eleanor said this was because: *'I was just hoping that it was going to be a unit or a townhouse or something like that, […] detached from people like a little backyard or a courtyard or something.'* And Millie, who also expressed preference for a house, spoke about being angry about the lack of housing options on offer:

> *When I got there I had no idea what I was waiting for. I might not have stayed if I knew. […] 'Cause it was a real big letdown. Just made me so angry like I was so angry, I can't tell you the anger […] but they just kept saying to me there's nowhere else.*

The other women interviewed were satisfied with the design of their homes, including the size. As noted by Anita: *'It's very spacious, it's big enough for me and my son.'* In some cases, the Cornelia housing workers sourced brand new builds for women and their babies. Sophia described how her home far exceeded where she imagined she'd be living when she first entered the Cornelia Program:

> *I just remember the first day I came to look at the apartment, I was so excited and [my worker] says, 'this could be your brand new apartment,' and she goes, 'how do you feel about it?' I said, 'I feel like a brand new woman,' like I can't believe this might be mine. Then when it was confirmed I was over the moon, I was like, wow, my very own first apartment. […] When I first got accepted to Cornelia I didn't think my life would be where I'm at now and I will always thank Cornelia for giving me such helping hands to give me a beautiful freshly built apartment for me and my children.*

6.1.4 Housing women to enable child reunification

One woman's situation was particularly noteworthy because the Cornelia Program was able to find her a family property even though her baby was not in her care. She had visitation with her baby and was on a family reunification order. Typically, women who do not have children in their care are not entitled to access family properties in social housing making it very difficult to have children returned to their care (Murray et al., 2020). **The effort taken here by the Cornelia Program to put housing measures in place so that this mother had the best opportunity to live with her child cannot be overemphasised.**

For women to live with their babies free from violence, procuring properties that are safe is necessary. Security measures such as intercom systems, cameras, and fob keys were included in the social housing properties and were highly valued by the women. Sophia noted: *'This is a safe place because we have an intercom that we use so we actually see who presses the bell […] and we've got our own fob key.'*

Living in social housing had, however, presented challenges for some of the women. They described observing or hearing about violent incidents such as assaults, and crimes such as theft and drug dealing, occurring on the social housing sites. Sophia explained:

> *I think it's just because it's community housing and there's a mix of people and obviously they've got their own issues but sometimes at night you can hear some horrible screaming and stuff.*

All but one of the women interviewed indicated that the positive features of social housing such as security of tenure, location, and community connections outweighed the negative aspects. Eleanor was the exception. Although she acknowledged the value of security of tenure: *'The only thing is obviously having a house over your head, knowing that you've got a home, that you've got somewhere to go and you can't get kicked out,'* she was highly critical

of the social housing environment. Specifically, she expressed concerns about the quality of the housing, citing safety, other tenants, and the cost.

> *You hear yelling nearly every night from a different junkie having a fight with somebody. [...] I get its public housing galore around here, absolutely disgusting. I just didn't realise I guess when you're that desperate for a home you didn't realise what you're actually getting yourself into. […] They put the rent up every bloody six months. Paying so much for something so small.*

Overall, despite the challenges posed by social housing, **the women were content with their post-Cornelia housing**, and they understood the pressures involved in securing long-term accommodation in a housing market that is under enormous strain and where available properties for people on low incomes are scarce.

6.2 Community connections

6.2.1 The importance of location

Location is important for housing sustainability for reasons stemming from ease of access to amenities and services to community engagement and social connection. These were factors that the housing workers kept in mind when matching the women with potential properties and, according to the women, they were successful in this mission. Ladan stated: *'It's a great place in terms of the house, the neighbourhood, everything, I wouldn't want to move out. […] So it's great and I love where I live, to be honest.'* Some were able to move to suburbs where they already had social ties. Anita said: *'It's really good 'cause my cousins just live about four minutes from here so we help each other out a lot'*; she had also made a friend that lived in the same building. Charlotte, who had arranged her own housing, was glad to be living in an area that was already familiar, and although she described herself as *'not very social'*, she was building connections that were making her feel at ease in the area to the point that she wanted to stay:

> *I've got my things that I do around here so I've got my hairdresser who I like and I'm comfortable with and I like seeing her. […] I go to the gym all the time and things so I mean I feel like I wouldn't want to leave this area, I feel like I've got everything I need here and I'm comfortable here so in that way I'm connected but not to actual people.*

Those who had moved to unfamiliar areas were also happy with their locations due to the ties that they had subsequently made there. Sophia had high regard for the local community centre, which offered a range of services and activities:

> *At [the community centre] they can help you with food packages. They also have childcare there. They've got lots of things happening and it's all community based*

so they always give us handouts to tell us what's going on in the community. Sometimes that have days for the kids, which is fantastic.

6.2.2 Accommodating cultural and religious requirements

There are cultural considerations that need attention if women are to settle permanently in a location. Where possible, **care was taken by the housing workers to accommodate cultural and religious factors when sourcing the location of housing**. This indicates the ongoing commitment of the Cornelia Program to demonstrate culturally-aware practice that underpins the support given to women so that they will thrive after they leave the program. Uba, for example, who had felt culturally safe in the Cornelia Program, yet also quite isolated from her ethnic and religious community due its location, and was concerned about how she would educate her child about her culture, was delighted to discover that her new home was located in a suburb that had a denomination of the church to which she belonged:

When I lived [at Cornelia] I [was] thinking most of the time [about] housing and how I get to be [with] community, how I [can] meet new people and how I [can] develop my culture and how I [can] show my baby our culture so [living here] it's changed everything.

Religion and culture were also important factors for Ladan in where she wanted to live; however, this was considered in the context of also feeling part of the broader community in her new area. She noted that the location offered cultural and religious options, but that being able to *'get along'* generally in the community was also important:

There is a lot of things around that's in my culture or religion-wise. I basically get along with everyone, to be honest, it's not like I'm specifically looking for what I know and what I believe in. So I do feel I belong here and I love where I live like I said. I get along with the community, all the shopping centres that I need are around me.

6.3 Support transitions

6.3.1 Promoting independence

Given the high level of support available to the women while they were in the Cornelia Program, it is to be expected that they would experience challenges as they transitioned to fully independent living. The operational staff were mindful of suitably equipping the women with the skills to manage day-to-day living on their own. Despite the challenges involved, **the women spoke about having been well-prepared by the program to manage the reduction in the level of support**, as noted by Anita: *'They set me up to basically be able to manage on my own. […] I'm doing pretty good.'* There was also a sense among the women that they were ready to leave when the time came to exit the program. Charlotte noted that it was *'perfect timing':*

> *I feel like I left right at the right time. Just 'cause I found somewhere else stable to go it was probably a good time to go and I had got all the help I needed in the meantime so it was perfect timing.*

The process was made easier by the operational staff remaining in contact and checking in with the women for the first few weeks after they exited the Botanical Apartments. Ladan spoke of how this post-exit communication assisted with the transition:

> *I was ready to do it 'cause it was time for me to move on and take this on my own. So it was a bit challenging but like I said I did have the family support. The social worker from there and the caseworker, they still contacted me, checked up on me.*

With the exception of Eleanor, who was unhappy with the level of material support she received when she moved into her social housing property *('I got absolutely left pretty much bone dry')*, **the women were satisfied with the level of support they received as they transitioned into their post-Cornelia conditions.** They particularly valued the practical support that was offered by the staff such as attending inspections, the organisation of new items to furnish the properties, and the management of utilities. Nala appreciated that: *'They buy furniture for me. Also, they give me all the information I need to contact for electricity, they give me all the information.'*

6.3.2 Sustained relationships with service providers

For some, **the relationships built with external service providers during their time with the Cornelia Program continued to be valuable after they exited.** As discussed below, Anita was connected with a family violence support service by the Cornelia Program, and she had the confidence to re-engage when she needed support after leaving the program. Likewise, Charlotte was still receiving counselling from the psychologist to whom she was referred while in the Cornelia Program:

> *I still see my psychologist. […] She's a trauma specialist and deals with family violence clients a lot. […] I just saw her today and it's a video chat we do every three weeks. […] I've had her since I've been at Cornelia so it's good to have the same person who knows my whole story and I don't have to tell it over and over again.*

6.3.3 Embedding women in community and building confidence

The Cornelia Program helped in the transition to independent living through assisting with embedding the women in their new communities and local systems of support. As discussed previously, women experiencing homelessness can struggle to engage with health and support services. Engagement with local services, therefore, is an indicator that women are adjusting to new environments. The continuity of care and wraparound support offered through the Cornelia Program, as well as the work undertaken by the operational staff

to establish the women in their communities, set them up to form and maintain relationships with services. Examples of services the women were using included: GPs, mental health support, family violence support, and sexual assault counselling. Specialist support for their babies included: maternal and child health nurses (MCHN), childcare, paediatricians, and speech therapy. Time was also taken by the operational staff to ensure that the women were connected with the services that were most suitable for their specific needs. Victoria, for example, spoke of being assisted by the Cornelia Program to switch to the enhanced MCHN program after a bad experience with a universal MCHN program: *'It wasn't too great, there was a bit of mum-shaming […] but now I'm actually going to an advanced maternal health nurse and she's brilliant.'*

Having had positive experiences of service provision through the Cornelia Program, the women were able to build their confidence in their ongoing interactions with services. For Victoria, this was particularly pertinent in relation to her interactions with Child Protection. She noted that it was the support provided by the Cornelia operational staff that gave her the confidence to not only speak up for herself in matters relating to her baby, but also to have trust that services could provide valuable assistance:

> *I've kept their knowledge and everything about being able to speak up and speak about what's going on with my child and actually accessing services. I'm more capable and aware what services are around me.*

That the women discussed a range of local services they received is indicative that they were now much better positioned to care for their own and their baby's health and welfare than they were prior to entering the Cornelia Program.

6.4 Ongoing relationships with children

6.4.1 Sustained bonding with babies

As previously discussed, the Cornelia Program creates the conditions in which women can bond with their babies. These **bonds continued to strengthen after the women exited the Cornelia Program**. Victoria noted that her living circumstances prior to entering the program were such that she did not imagine at that time that she would later be in the position to care for her baby:

> *Before I moved to Cornelia I was living in a caravan and I was just so scared about what was going on and everything and now I'm in a stable home, I'm able to actually care for my child in the way that I never thought I would be able to.*

Even Eleanor, who was the only participant to be overly critical of the Cornelia Program and her current housing, acknowledged that having her own long-term property enhanced her relationship with her baby and allowed her to make modifications to the space to accommodate the baby's growth:

Obviously it's been great because she has a home and she has her room, which we're going to change soon to a toddler room. She has her house. […] She lays in my bed for half the day and we just play in bed and chill out.

Charlotte reflected on how her experience of the support offered during her time with the Cornelia Program had allowed her to bond with her baby in a way that meant she was experiencing this relationship in a manner not previously possible with her other children due to ongoing homelessness and family violence:

It's had a big effect because we had that bond together initially, which I didn't have with my other children. I think that was because I had a partner at the time and when you've got a partner, especially in bad relationships, you don't have time to just focus on yourself and the baby and I really had that with him. So I think we've had a really good bond from the beginning and I feel very close to him and I feel like he's had the best start to life he could have had. He's always been a happy, really content baby and I think that's because I got to stay at Cornelia.

6.4.2 Reconnecting with children

The support offered by the Cornelia Program was instrumental in Charlotte being able to reconnect with some of her children with whom she had not been in contact when she entered the program. At the final interview, Child Protection had closed her case, and Charlotte had one of her other children living with her. Another two children had been living with her but had moved in with their father to be closer to a school that offered better support for the children's special needs. Reuniting with her children required legal support due to previous family violence with the children's father, which Charlotte indicated she would not have followed up if she had not been in the Cornelia Program:

That was a big difference 'cause I think I wouldn't have even gone ahead with any of it if I didn't have [the legal service] doing it for me, helping me, it was too stressful and I didn't want to deal with him.

Even the woman whose baby was not in her care and who had ongoing involvement with Child Protection was optimistic about continuing to build the relationship with her baby. She had regular visitation and was undertaking the requirements set by Child Protection with the hope of one day bringing her baby home:

I just hope I get given the chance to not only live independently, which has been awesome, but to be an independent mother, and what would it be like when he comes back home? I think it's going to be challenging. I must be honest, I think that being a parent is never easy but with all these programs that I've had put in place and all these experiences that I've had so far I feel like I've grown as a person, not just as a mother but just me, myself and I'm just looking forward to a new beginning with my son.

The housing stability and the bonds the women were building with their babies as a result of being in the Cornelia Program meant that they were future focused and were not only imagining what their lives would be like as families, they were also making plans. Charlotte explained: *'I've now got put on that stable path and everything and I know what I want for [my children] and for their future and for mine so it's helped.'*

6.5 Ongoing freedom from violence and improvements in self-confidence

There is a strong association between family violence and homelessness and, as previously noted, this was a common experience among the women. Some were still in contact with their abusive ex-partners. **Detaching was complicated further when the ex-partner was involved in the baby's life**. Anita, for example, had spent some time staying with her ex-partner when she first moved into her home to help adjust to living alone: *'I was able to settle in fine and when I didn't settle in I stayed at [his] house most of the time until I ended up being comfortable being alone.'* An incident occurred when she needed to call the police. This led to her subsequently re-engaging with a family violence support service. Anita was satisfied with the support she received, and her case was closed. She was continuing to see her ex-partner when he visited the baby and reported that she currently felt safe. Anita had been linked in with the family violence support service during her time with the Cornelia Program, and her situation demonstrates how important these external service relationships are for the ongoing safety of women and their babies.

Anita's experience also indicates that relationships with ex-partners, and particularly loneliness, can complicate the transition to independent living. Another woman described how allowing her ex-partner to be present during contact visits with her baby had compromised her efforts to gain custody:

> *I kind of ruined it by letting baby daddy in during contacts when he wasn't supposed to be here. It was a really hard time for me because I felt really lonely but then I was also having issues with him so now it's just me, and me trying to fight for my son.*

The Cornelia operational staff play an essential educative role in explaining and identifying perpetrator responsibility and supporting women to continue to live free from violence after they leave the program. Unlike the above two women, Charlotte had no contact with her baby's father, but she had previously experienced multiple violent relationships over an extended period of time. Charlotte was especially grateful for the time and support offered to her by the Cornelia Program that had allowed her to focus on her own needs and not that of a partner. She credited this experience with building her confidence and independence:

> *I think because of my previous relationship and things, having that time on my own at Cornelia with all the support, it made me more confident within myself and*

> *I was able to decide where I wanted to go, have more goals for myself and it's put me on a more stable path. […] I think I'm just doing things more for myself. I realise that I could never do things on my own, I always followed my partner around, I did what they said, I basically was told what to do. Now I get to do what I want to do, do things for myself, focus on myself, so I think that's a big thing. Still makes me feel uncomfortable but I'm working through it.*

As noted by Charlotte, when someone has been subjected to family violence, building confidence and independence can take time and be an ongoing process. Eleanor, for instance, was still in contact with her ex-partner; however, she described changes she had made in how she interacted with him. She stated that she no longer tolerated his abuse and felt confident to ask him to leave her home if she did not like his behaviour:

> *Even though [my baby's father has] got a key to the place, I'm like, get out, you don't talk to me like that in my house. Especially in front of my daughter. Are you okay for some guy to treat your daughter like that? That's what she's seeing, that's what you're showing her, that it's okay for a guy to call her fat. I'm showing her it's not okay. I'm trying to say you got to stick up for yourself.*

Despite the challenges for some of being in contact with their ex-partners, the women overall were working at building their independence and maintaining their boundaries. **The women's involvement in the Cornelia Program had improved their sense of self-worth and increased their confidence in managing their personal relationships.**

6.6 Education and employment

A measure of independence is the capacity to work and study. As all but one of the women who were interviewed after exiting the Cornelia Program were single mothers parenting their babies, it is unrealistic and unreasonable to expect them to be engaged in the workforce or educational activities. Nonetheless, **some were managing to juggle motherhood alongside study or work.** Two women, Anita and Uba, had returned to education. For Uba, studying was not only important for getting an education and future employment opportunities, but she also wanted to be a role model for her baby: *'I'm not lazy, I want to show my baby how I am strong […] so when she grows up, she [can] look at me […] because I'm [a] teacher for her.'*

Two women had also engaged in paid work since exiting the Cornelia Program. The woman who did not have her child in her care had gained employment in hospitality and noted it *'helps with the bills a little bit'.* Ladan had been employed from home by a call centre; however, she explained that it had been necessary to leave because the demands of the job were too high alongside caring for her baby: *'I couldn't continue 'cause it was online at home and I had a baby, she wasn't in care at the time and it was tough so I had to stop. 'Cause it*

was fulltime—morning until the afternoon.' Ladan was now looking for a casual job that would give her the flexibility to return to education. She noted:

> *I'm looking for a casual job now 'cause I want to go back to studies. So I've been doing great, sorting out my life. […] I was studying before […] but I decided not to go back to that. I also had a passion for counselling so soon I'm planning to start a counselling course.*

Conclusion

This chapter has addressed Aim 3 of the evaluation through examining the long-term secure housing outcomes of women and babies. **The Cornelia Program has been highly successful in exiting women into ongoing accommodation, and its support and advocacy role has been essential for obtaining housing** otherwise inaccessible to women navigating the housing system independently. The security of tenure was valued by the women and afforded them stability for raising their babies. They were appreciative of the quality of properties they moved into, though two women reported being upset that their housing did not match their expectations. This suggests there may be value in further clarifying expectations about the type and style of housing women are likely to be offered. **Efforts taken by the Cornelia Program to arrange appropriate housing for women without children in their care—so that it might enable reunification—overcomes an enormous obstacle otherwise facing these women. Its significance should be stressed, and its value recognised.**

The overwhelming majority of women interviewed indicated that they valued positive features of social housing such as security of tenure, location, and community connections. This was enhanced through the care taken by the Cornelia housing workers to accommodate cultural and religious factors when sourcing the location of housing. **Women were also suitably equipped by the Cornelia program with skills to manage day-to-day independent living and to become established in their communities.** For some, this was enhanced by relationships built with external service providers, which continued to be valuable after they exited in managing their safety from violence and mental wellbeing. **Bonds between women and their children continued to strengthen after women exited the Cornelia Program.** The Cornelia operational staff play an essential educative role in explaining and identifying perpetrator responsibility and supporting women to continue to live free from violence after leaving the program. The women's involvement in the Cornelia Program had improved their sense of self-worth and increased their confidence in managing their personal relationships.

Chapter 7 | Conclusion and recommendations

The purpose of this evaluation was to assess:

1. The effectiveness of the Cornelia Program's implementation.
2. The experience of women and their babies of the program.
3. Long-term secure housing outcomes of women and babies supported by the Cornelia Program.
4. The extent that the Cornelia Program improved the health and quality of life of women and their babies.

The evaluation found that the Cornelia Program is an important and valuable program meeting a gap in service delivery to a vulnerable population. Despite some challenges in the governance structure, the effectiveness of the program is indicated by the cooperation between the partnering organisations, the employment of efficient referral processes, and the high quality of service offered to women and their babies (Aim 1).

Women in the Cornelia Program, compared with all women from the RWH cohort, were more disadvantaged, with fewer resources and had significant mental health and social issues. Their infants also needed greater support, having poorer health outcomes than their peers. The findings of the report indicate that a highly-skilled team of multidisciplinary workers and an emphasis on strong, collaborative relationships with external service providers underpin the success of the Cornelia Program through holistic and wraparound support (Aim 2).

The Cornelia Program is delivering remarkable housing outcomes for women and their babies, with all women interviewed for the evaluation exiting into long-term, secure housing. This is particularly noteworthy in the current housing climate in which mainstream homelessness and housing services typically are unable to secure long-term housing for women experiencing pregnancy. (Aim 3).

Women's health and quality of life, and that of their babies, are greatly improved through engagement with the Cornelia Program. These include a range of domains such as: antenatal care, allied health, family violence, legal issues, mental health, alcohol and other drugs, parenting support, Child Protection, maternal and child health care, and cultural support. In the longer term, this is producing positive outcomes for women such as greater independence, living free from violence, mother-baby bonding, and healing from trauma (Aim 4).

These findings demonstrate the greater needs of women experiencing pregnancy and homelessness and the requirement of sustained funding for the Cornelia Program to support women who are pregnant and postpartum and their babies. Based on the findings of this report, we have developed the following recommendations for the program to take forward.

7.1 Recommendation 1 – Funding and service model

The Cornelia Program model is the first of its kind in Australia. It offers women and babies security of tenure for 12 months, continuity of care, integration of antenatal care, multidisciplinary and wraparound supports for co-occurring issues, pathways into long-term housing, and collaborative and flexible practice with external services. Our analysis reveals that the Cornelia Program is providing an essential service to women experiencing pregnancy and homelessness, a service user group that experiences significant disadvantage, poorer maternal and infant health outcomes, and that has few housing and support options. This critical intervention during the perinatal and antenatal periods is achieving outstanding longer-term outcomes, particularly in the areas of housing sustainment, mother-baby bonding, service engagement, and parenting skills. Without the Cornelia Program, women experiencing pregnancy and homelessness would be unable to access comparable support and would be at far greater risk of ongoing homelessness, and the associated privation, and thus be unable to care for their babies. **We recommend that ongoing funding is secured to ensure the continuation and consolidation of the Cornelia Program.**

7.2 Recommendation 2 – Safety and use of space

The Botanical Apartments building provides onsite housing and support for women and babies; however, it has limitations in terms of safety and utility for service users, operational staff, and external service providers. Measures have been put in place to improve building

security such as fob key access and security cameras, and operational staff have made ad-hoc arrangements to manage the workspace constraints; however, there is scope for further improvement to ensure the safety of women, babies, workers, and visitors, and to meet the needs of the program. **We recommend that an audit of the Botanical Apartments building be conducted to investigate both the ongoing safety of the premises, including the viability of after-hours security measures, and to maximise the most effective use of space, including access to communal areas.**

7.3 Recommendation 3 – Governance

Considerable attention was given to the establishment of the Cornelia Program, with protocols put in place to delineate roles and responsibilities. The governance structure is somewhat complex and, as with most new programs, there have been some challenges as intra-organisational relationships developed and as the new model was put in place. The evaluation found that the partnership of the Royal Women's Hospital, Launch Housing, and HousingFirst is complementary and works well to deliver positive outcomes for women and their babies. As the partnership is critical for resourcing the Cornelia Program, **we recommend that senior management continues to give careful deliberation to upholding equal participation, and consider implementing a new agreement to ensure consistency of input, responsibility, and risk across all partnering organisations to promote good governance and sustainability of the program.**

7.4 Recommendation 4 – Staffing

A key asset of the Cornelia Program is the operational staff. The multi-disciplinary team and program manager demonstrate specialist knowledge and skills and are particularly adept in culturally-aware practice. The Cornelia Program has also built strong relationships with external service providers that ensure women and their babies are well-positioned to transition to independent living after they exit the program. Concerns were raised, however, about there being enough staff to manage the level of support required by women. **We recommend that the Cornelia Program continues to employ staff with specialist knowledge, to build and consolidate external relationships, and to consider increasing the size of the team dependent on need.**

7.5 Recommendation 5 – Evaluation

This evaluation provides evidence that the Cornelia Program delivers a service that is achieving outstanding outcomes for women and babies during and after exiting the program. Investment in further evaluation, however, would allow for capturing: 1) the Cornelia Program's economic value, 2) the sustained benefits to women and children, and 3) the development of

the program.

First, it would be useful to capture the economic benefits of the Cornelia Program, including cost savings to government and the sector, to assess its wider impact on homelessness and maternal and child health, as well as to provide direction for future funding. **We recommend that an Economic Impact Assessment of the Cornelia Program is conducted in consultation with key stakeholders to examine the impacts of the program and its economic costs and benefits.**

Second, this evaluation did not have the resources to collect survey data at multiple stages from all eligible Cornelia service users. This measurement of sustained benefits of the program would be useful for evaluating long-term outcomes for women and babies, and could also provide richer data to inform the economic benefits of the program. **We recommend that a comprehensive quantitative longitudinal evaluation of women's and children's health, wellbeing, and social needs be conducted that assesses outcomes as women enter the program, at point of exit, and at multiple stages for up to five years post-exit.** This could be enhanced by further qualitative data collection particularly during the post-exit stages.

Finally, the findings in this report reflect the analysis of data that were collected at specific points in time in the development of the Cornelia Program. Issues that may have emerged subsequently have not been included. It is also likely that the program will continue to evolve. Therefore, **we recommend the resourcing of an embedded Developmental Evaluation to capture changes to the service model, contemporary challenges, and emerging outcomes.**

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Contact us

330 Swanston Street
(cnr La Trobe Street)
Melbourne VIC 3000
Tel. +61 3 9925 2260
rmit.edu.au/contact-us

RMIT University

GPO Box 2476
Melbourne VIC 3001
rmit.edu.au

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