Born Homeless

Channel Four Dispatches & Royal College of Midwives Survey Results

THE ROYAL COLLEGE OF MIDWIVES

Dispatches

UK Pregnancy & Homelessness Survey Results

- **Maternity staff from all over the UK, who collectively care for over 15,000 women per month, responded to our survey**
- **On average, the midwives who responded to our survey see a pregnant woman who is at risk of homelessness every working day**
- **Two-thirds (67%) said they had seen an increase in the number of their clients experiencing housing issues over the past year**
- **99.7% reported that they had seen at least one client who was homeless in the past 6 months**
- **95% of midwives who responded believe that homelessness puts the health of pregnant mothers and their unborn babies at risk**

Introduction

The housing crisis in the UK is deepening. Reports from frontline maternity staff suggest that cuts to benefits, changes in the welfare system, and widespread issues with suitable housing in many areas of the UK are disproportionately affecting pregnant women. However, there is currently little systematic data to give full insight into the real impacts on women who are pregnant and homeless, or at high risk of homelessness, across the UK.

The aims of this cross-sectional enquiry are three-fold:

(i) To understand what, if any, additional needs maternity staff are currently identifying in their client base.

(ii) To understand the impacts of housing difficulties on clients, as observed by maternity staff.

(iii) To understand how maternity staff are currently responding to housing needs expressed by their clients.

We aim to provide a representative snapshot of the experiences of maternity staff in UK, targeted respectively to these key aims. The fully anonymised and collated key findings are available in this report.

> *"In London, housing boroughs will deny their duty of care if women do not have any links to the area. Women are routinely pushed from pillar to post around different LA housing departments. The borough system makes the level of bureaucracy even higher. Housing departments will usually not move a pregnant woman until she's 34 weeks, which results in higher levels of mental stress, inability to get prepared due to lack of space, and fear. The housing crisis and associated lack of suitable council housing combined with the bedroom tax causes immense hours of work for us."*
>
> *"There is not a single woman in my caseload of vulnerable women who doesn't have some sort of housing issue"*
>
> *"Often our women are very vulnerable and end up in private rental agreements in squalid living condition. This is a silent problem in the UK."*

Survey Methods and Analyses

We used an online survey to gather information from maternity staff (primarily midwives, but also other roles within maternity services working with clients) across the UK. The survey was composed of 20 basic questions, from which more detailed answers branch. It was intended to be simple and quick to complete. We ran the survey for three weeks in Autumn 2019. Results are presented as totals and percentages.

Detailed sampling methodology, survey questions, and analytic strategy are available in the appendices.

In total survey respondents estimate that they see 15,000 pregnant women per month.

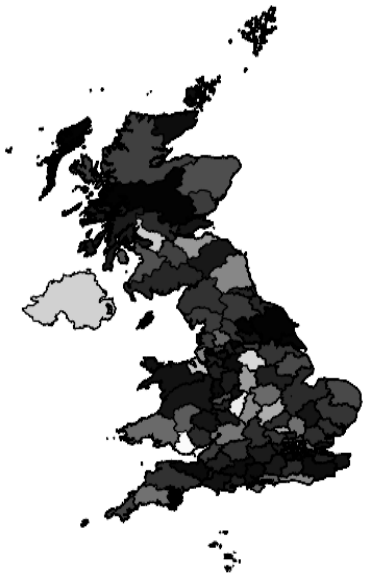
> *"A big issue for us at a busy unit is having to keep women and their new babies in hospital unnecessarily whilst they wait for appropriate housing. Unfortunately we do not have the space or flexibility to act like a hotel"*
>
> *"As a midwife working with vulnerable families we struggle with the local authorities to have a voice in our concerns for women who are pregnant and homeless. It's as though our opinion doesn't matter."*

Results

The Sample

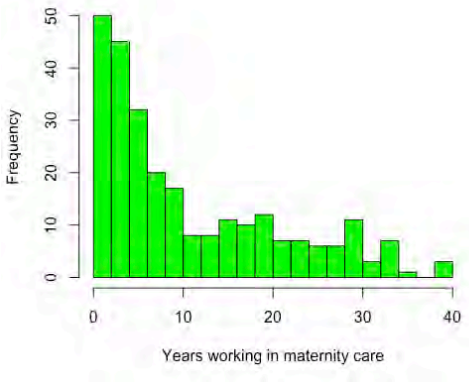
In total, 301 eligible responses to the survey were received.

Figure 1 shows the distribution of sampling across the UK, demonstrating that the 301 respondents included in the analytic sample represent 118/121 postcode areas of the UK.



← Map of UK. White areas: 0-5 respondents, Black areas 25+ respondents. The minimum respondents from any area was 0 and the maximum 72.

Respondents experience in maternity care ranging from 1 to 48 years. The median time working in school was 15 years. Most (79%) had been in their current role for 5 or more years →



The median number of clients seen every month by midwives who completed our survey was 51 (mean 45; interquartile range 28-73). The distribution of client numbers per month is shown in Figure 5. Using the median value of 51, the midwives we surveyed had personal experience of caring for a total of over 15,000 clients every month.

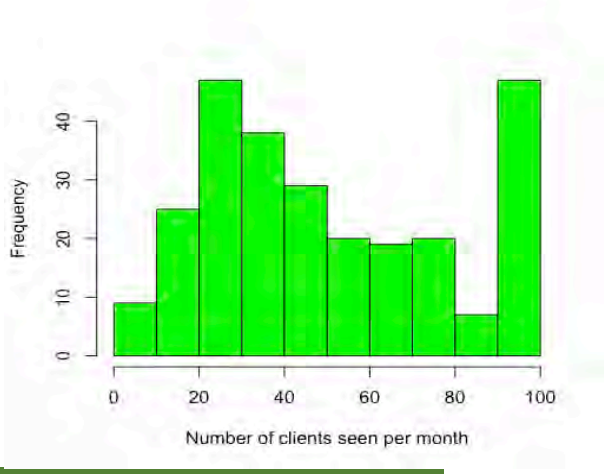


Figure 5: Frequency histogram showing the average number of clients seen per month by midwives responding to our survey. Median; 51 (mean 45; interquartile range 28-73). Total range 3-100.

"Caring for homeless women is the most stressful aspect of my work. I do everything in my power to keep her safe. They are so high risk, it's terrifying."

"I have seen a number of refugees refused asylum here and who have them also been kicked out of the country and ended up heavily pregnant in camps in France."

Changing experience of clients with housing issues

Midwives were asked how, in their experience, the prevalence of housing issues among their client base had changed over the past year. Two-thirds (67%, 202/301) responded that they had seen an increase (either a large increase or some increase) in the number of clients they see with housing issues over the past year.

If midwives reported that they had been in their current role for more than 5 years, they were also asked how the prevalence of housing issues among their client base had changed over the time they had worked in their current role. 71 midwives (24% of respondents) had been in post for long enough to answer this question. 87% (62/71) midwives reported that since they commenced their current role they had seen an increase (either a large increase or some increase) in the number of clients with housing issues.

"My experience of providing caseloading care for a homeless pregnant woman involved me attending and often waiting around at a city centre shelter. This client had no means to attend a clinic or hospital for scans or appointments and her lifestyle choices meant that antenatal care was often not her priority. It was important to adapt care in a way that made it accessible to her and to go above and beyond to remain in contact with her."

"Housing issues can occur to anyone, more support is required for those that are vulnerable but also to those that find themselves in situations where they are at risk of losing their tenancy through no fault of their own. Such as domestic abuse, losing their job, illness. "

Types of client homelessness and numbers seen by midwives

99.7% (300/301) of the midwives who responded to the survey reported that they had seen clients who were homeless over the past 6 months. 96.7% (291/301) reported that they had seen clients whom they believed to be at risk of homelessness over the past 6 months.

97% had seen at least one client sharing over-crowded or otherwise unsuitable accommodation
99% had seen at least one client living in hostels, shelters or temporary accommodation
97% had seen at least one client sofa-surfing
81% had seen at least one client who was street homeless

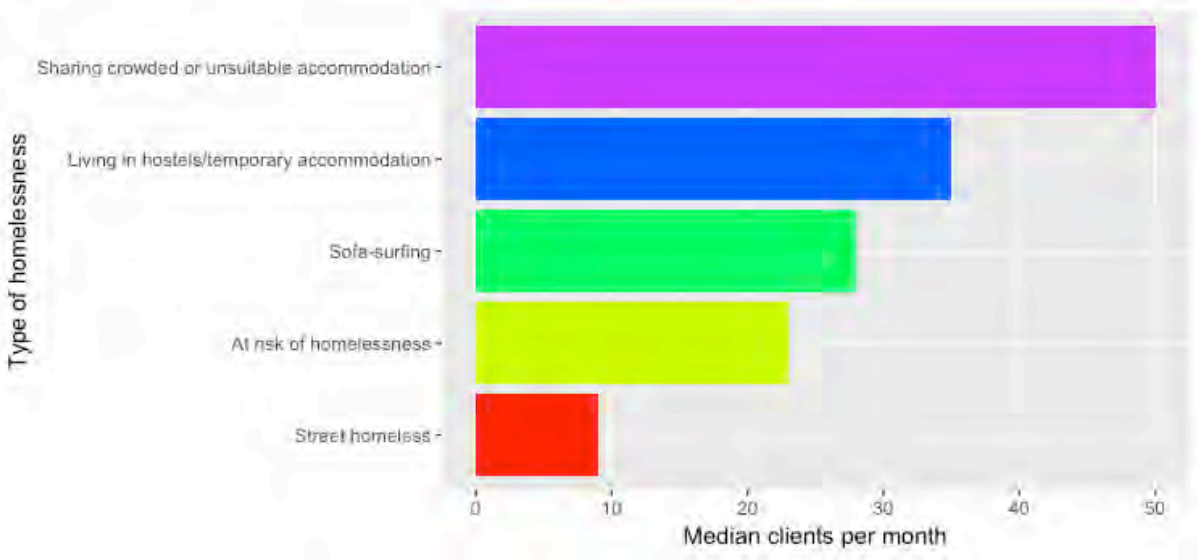


Figure 5: Median numbers of each type of homelessness reported per midwife per month.

> *"Midwives are not listened to when it comes to housing. Sometimes clients believe that if they have babies they are more likely to get improved housing that doesn't exist. Those in need are rarely helped."*
>
> *"Many mother told they cannot receive help until baby born and to present to local authorities with baby and belongings, very traumatic and can impact maternal/newborn relationship, breastfeeding etc. as mothers are stressed."*

Issues associated with homelessness

We asked midwives to rate a series of factors for their association with homeless amongst their clients. Midwives were asked to identified how likely their homeless clients were to experience each factor compared to their general client base. Midwives strongly identified an increased risk of homelessness among clients with substance misuse issues (95% of midwives identified as much more or a bit more likely), clients who grew up in care (87.5%), clients who are refugees (84.7%) and clients with mental health issues (83.9%).

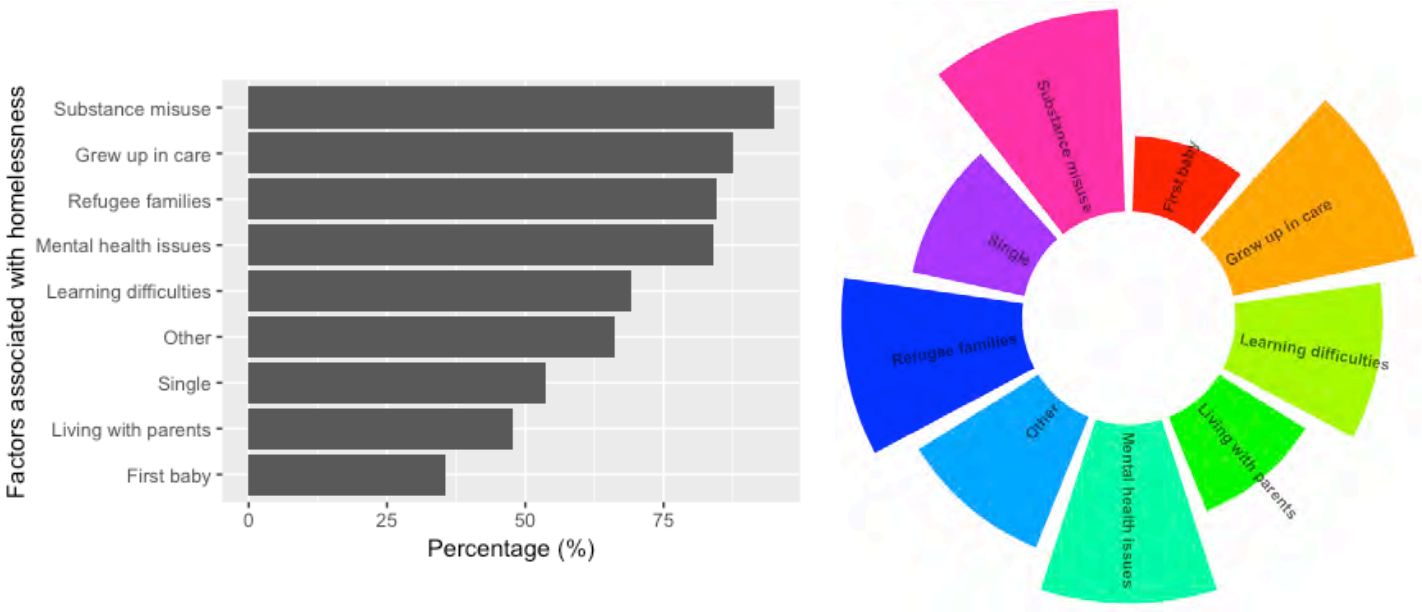


Figure 6: Percentage of midwives who reported that each factor was much more or a bit more likely among their homeless clients than their total client population.

> *"It's really frustrating trying to get some agencies to invest in some women when they are pregnant to help them make changes that would be better for them and their unborn baby and if we don't make a difference when they are pregnant they often end up back on the streets as no one is bothered once they have the baby and it's been accommodated by the local authority."*
>
> *"I feel it is sometimes a vicious circle for these women. Many homeless pregnant women in my experience come from backgrounds where they have grown up in care and/or been victim to abuse as a child. They receive good care and support during pregnancy. After birth their babies are removed and they spiral back to where they started, and often end up back on the streets. It is really sad."*

Other challenges faced by clients who are homeless

The midwives who completed our survey were asked what additional challenges their clients who are homeless face. We asked whether each of the following challenges was more common in the homeless clients than in the general maternity population seen by each midwife. A high percentage of midwives reported domestic abuse (87.7% of midwives identified as 'really common' or 'quite common' among their homeless clients), child-safeguarding concerns (84.7%), and debt/financial difficulties (81.9%) as factors commonly associated with homelessness in their experience.

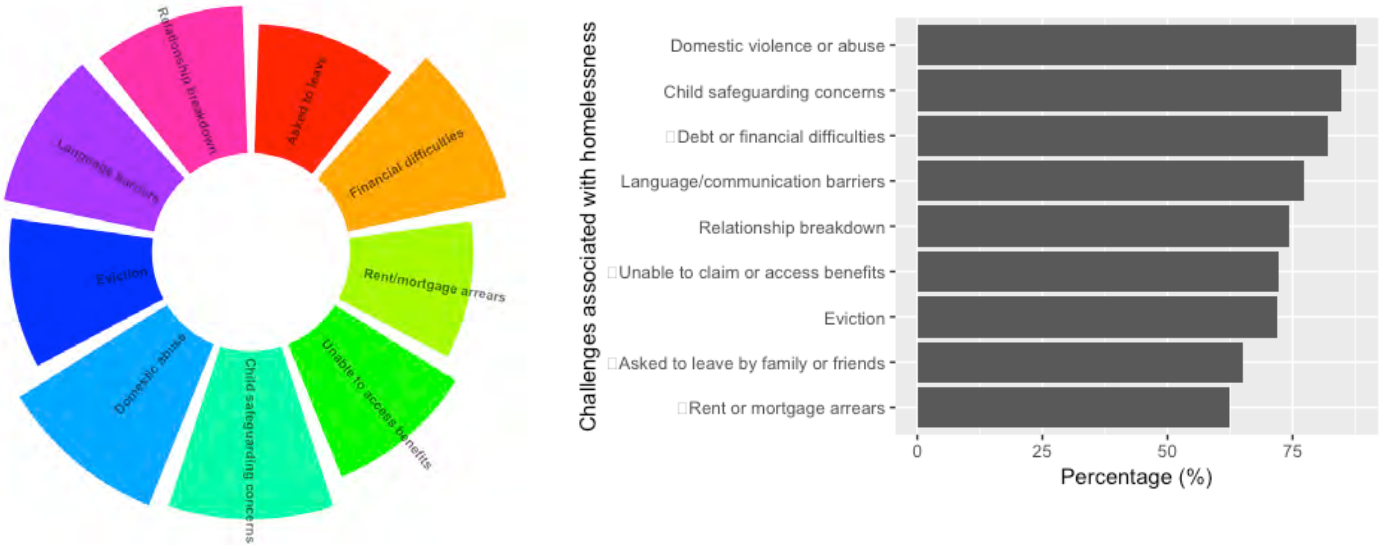


Figure 7: Percentage of midwives who reported that each issue was either 'Really common' or 'More common' among their homeless clients than in their total client population.

> *"Homelessness is not always considered a reason for social services to become involved. I am aware of a case in our Trust when a young homeless mother was to be discharged from hospital to a street doorway with her young baby, and much effort was required for any extra help or support to get her temporary accommodation."*
>
> *"One of the biggest factors that impacts on women is the suitability (for pregnant women) of the temporary accommodation they are housed in. This accommodation can be of a poor standard and women and families who stay there are even more vulnerable to further exploitation, violence and increasing access to illegal substances."*

The health implications of homelessness during pregnancy

Midwives were asked their opinion on the statement 'Homelessness puts the health of pregnant mothers and their unborn babies at risk'. Of 206 midwives who responded, 95% agreed with this statement (196). Peer-reviewed academic research supports this, several studies suggest that stress in pregnancy adversely affects both the baby's growth[i] and future development[ii].

Midwives were also given the option to specify the major health challenges that they perceived were faced by their homeless clients. They cited a variety of other issues, commonly;

- Exacerbation of mental health issues
- Drug and alcohol misuse
- Poor nutrition/self-neglect
- Difficulty maintain good hygiene and subsequent infection risk
- Respiratory difficulties, including asthma
- Fetal growth restriction
- Physical safety issues, particularly for those living on streets

Response of midwives and midwifery services to client homelessness

Approximately two-thirds (64%, 131/204) midwives who responded had not heard of the midwives' duty to refer under the Homelessness Reduction Act (HRA). Of those who had heard of this, the number of local authority referrals made varied greatly, between 0 and 100 referrals over the past 6 months (median referrals 14; interquartile range 2 – 48). For those who did refer homeless women under the HRA, we asked to which agency or agencies they commonly referred. Two-thirds (66%) of midwives who answered this questions made referrals for housing support to the local authority.

3 in 5 midwives (60%; 123/06) reported that they did not know or were unsure of their local referral pathways to provide appropriate support for clients experiencing housing difficulties during pregnancy.

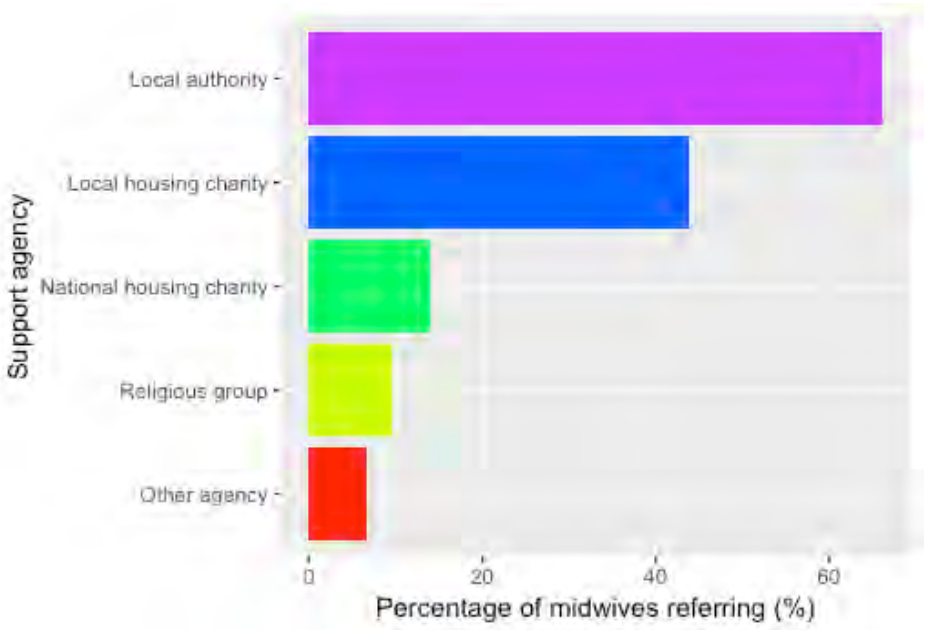


Figure 10: Agencies that midwives report referring clients to for housing support

> *"There are many pregnant women in hotels, bed and breakfasts and temporary accommodation. In my area there are only 2 specific mother and baby accommodations and they are for 16-25 year olds. Many women I see are older than this, or in a family where they have been evicted or family support has ceased. In my role, I find it very difficult as I know the current housing situation is at crisis level but I have so many women asking for help and it is difficult to be honest as the situation is so bleak. It feels quite hopeless at times but I have learnt that even the smallest gesture as a midwife, from being there to listen, write a letter or make a phone call helps take stress off that woman and helps her feel supported."*

Training and knowledge of midwives on supporting homeless clients

Over half (54%) of midwives who responded to the survey question reported that they did not feel well prepared to help clients who are homeless or at risk of homelessness. We further asked whether midwives felt they needed more training around helping clients who are homeless. Of the midwives who answered this question, 87% (180/206) responded that they would like to have additional training in this area.

> *"Cuts in hospital budgets and have led to a more conservative and mean mindset by hospital personnel. I have been frequently told that the hospital "is not a hotel" and it is not the responsibility of the hospital to host women who have nowhere to go. But managers lack the resources and knowledge about appropriate care pathways once women leave primary care facilities."*

Prevalence of particular words in response to free-text survey responses (n=301 responses)

Appendix

Methodology

i. Overview of survey methods

The cross-sectional survey was intended to be completed by maternity staff (primarily midwives, but also other roles within maternity services working with clients) within the UK (see Results section). It was answered online, via distribution on social media accounts run by the Royal College of Midwives. The survey was formatted to be suitable for a range of electronic devices. The survey was composed of 20 basic questions, from which more detailed answers branch. It was intended to be simple and quick to complete, without undue respondent burden. Initial beta testing (20 respondents not working in maternity services and 5 respondents working in maternity services) suggested that the average response time was 12 minutes.

ii. Sampling frame

The Royal College of Midwives (RCM) estimate that their current membership includes 48,000 midwives, midwifery students, and maternity support workers (https://www.rcm.org.uk/member-benefits/). In 2019, Nursing and Midwifery Council figures show 44,204 people registered and eligible to work as midwives within the UK (https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/). Our sampling frame is therefore likely to include a significant proportion of midwives currently working in the UK.

Royal College membership is virtually ubiquitous in the midwifery profession among midwives practising in a variety of settings. The high proportion who belong to the RCM are a result of the professional development opportunities offered, legal support, and trades union services. Sampling midwives via the RCM is therefore a legitimate means of obtaining a large and representative sampling frame without introducing substantial risk of bias.

It is unknown what total percentage of student midwives or maternity support workers nationally are members of the RCM. For these membership categories, estimating the percentage coverage of the surveyed population is more difficult.

iii. Sample population

The survey was electronically distributed via established RCM social media accounts. A survey link was posted on all platforms commonly used to promote RCM issues (Facebook, Twitter, Instagram).

The survey link was available continuously on these platforms for the duration of the survey. The initial questions enabled us to filter responses from anyone not currently working in a client-facing role in maternity services in the UK to derive the analytical sample.

Other respondents who completed the survey provided important background information and context, but their responses were not included in the analytic sample in order to ensure that the analytic group represented the views of a clear sector of maternity staff.

iv. Exclusions from the survey population

Maternity staff who are retired, working elsewhere, or currently not working are likely to provide an important source of background and context that will be of interest to professionals working in this field. However due to the lower percentage of other staff that responded to the survey, and the increased likely heterogeneity of their roles, experiences, and definitions, we have limited the analytic sample to those currently employed in client-facing maternity services roles only. Other respondents may have experienced homelessness among clients in a systematically different way to the defined analytic group.

Sample methods

i. Sampling error

Respondents were asked for their geographical location. These have been used to determine whether the survey responses should be weighted to produce a snapshot that is as representative as possible of views of maternity staff across in the UK. In total 117 out of 121 postcode areas in the UK were represented. Those with no respondents included: Llandrindod Wells (sparsely populated) and commercial districts in large city centres (e.g. Piccadilly Circus/Oxford Street). We also gathered data regarding each respondent's experience of working in maternity care, by asking how long they had been a midwife, estimated to the nearest number of whole years. The results showed experience levels approximating a normal distribution. No weighting was therefore implemented with respect to the characteristics of the responding population.

No other demographic characteristics of the respondents (age, gender, etc.) were collected during the survey, and no weighting was applied with respect to any other characteristics.

ii. Coverage error

Previous research indicates that while there are some seasonal trends in maternity service utilisation in the UK, there are no clear annual differences during the period of survey distribution (Oct/Nov). There is therefore no rationale to believe that exacerbations in workload would influence survey completion rates in our population. Our survey period (17/10/19 – 04/11/19) overlapped with the autumn half-term period in a number of UK schools. It is unclear whether this may have influenced the response rates in either direction, and there is a lack of previous data on which to base conclusions.

iii. Response rates

The pre-specified response rate for the survey was 1±0.5%. This relatively low pre-specified rate reflects the large expected sample size, the survey methodolody, and the resulting smaller non-response error. It also reflects the likely behaviour of this population (maternity staff in UK) in response to previously conducted surveys, and based on previous investigations of maternity staff surveyed online. The relevant calculation for response rates will be based on the total number of respondents (including those who complete up to 5 questions), regardless of the number of respondents eligible for inclusion in the final analytical sample. This ensures that the reported response rate accurately reflects the sector of the entire surveyed population that engaged with the survey.

Data collection

The survey is based on the secure, encrypted, subscription-based data collection platform RedCap[4] which is used to collect and collate secure clinical trials data. The survey results were downloaded from RedCap and analysed using 'R' software for statistical analysis[5].

The summarized survey results only will be in the public domain. The raw data are held securely by True Vision Productions within the UK.

Data and data security

True Vision Productions have no access to contact details of individual respondents.

No personal information regarding individuals was collected during the survey. No respondent was asked for information that could identify any individual client or specific client group at any stage of the survey. The postcode area of the respondent's practice was requested to assess the coverage and national response rate of the survey. We attributed each response to the postcode area of the nearest hospital Trust offering maternity care.

Survey data in the public domain will consist of aggregated responses only. The answers of any particular respondent to the online survey will not be identifiable from information in the public domain. Published data may be aggregated at national or regional level.

Contact details for True Vision Productions were available throughout the survey, so that any respondent with questions or concerns about the survey could contact the production team directly. No individuals contacted the team with any concerns about the instrument or content during the survey period.

Instrument design

i. Content

The survey questions were designed to gain maximum useful information, while limiting the burden of survey completion. The survey questions were developed by the True Vision team based on the following preparatory phases

- In depth interviews with midwives currently working in the NHS, particularly those with safeguarding responsibilities
- Consultation with RCM communications team
- Other issues of public interest in the domain of the key objectives (see introduction)

The pdf version of the code book is available as Appendix 1. The data dictionary for the survey is available as Appendix 2. The link to the online beta version survey is: https://redcap.vanderbilt.edu/surveys/?s=FD3XDNC437

ii Inclusivity

The framing of the questions is designed to be user-friendly. The survey has not been translated into other languages. True Vision Productions would have provided a paper-based copy of the survey in other languages if requested, however no such requests were forth-coming. The use of RedCap version 9.0 improves survey accessibility for visually-impaired users utilizing screen-readers.

The survey design recognizes that different maternity services will have different levels of need in their catchment areas, and that different staff will have differing experience and exposure to clients who are homeless. Therefore, branching logic is written into the system to minimize inconvenience to respondents for whom a particular domain is not of relevance. Using this strategy, we aimed to maximize response rates and to reduce as far as possible the number of incomplete responses.

The only field that was mandatory for the survey response to be included is the first, which identified the current role of the respondent.

iii Incentivizing survey completion

No material incentive was provided to respondents completing the survey. However, the survey was framed to help respondents feel that it will contribute to bringing issues likely to matter to the midwifery profession and pregnant women into public discourse. The endorsement of survey completion by a trusted source (RCM) was also likely to improve the survey completion rates.

(i) Piloting the survey

The survey was designed by the True Vision Production team with an external consultant contracted from the University of Cambridge, and then cascaded through various editing and piloting steps.

(i) The survey questions were reviewed and advice given by relevant experts:
   a. Representatives of the RCM who assisted with checking for appropriate language and phrasing, and that the questions covered of key elements of concern to their members.
   b. A sample of 5 current NHS maternity staff involved specifically with safe-guarding who gave detailed feedback on content and phrasing.

(ii) A further edit was performed by key stakeholders including True Vision's executive producer

(iii) A technical pilot was carried out among True Vision's staff (n=20) using demonstration data to check the information flow through the survey and to remove any technical glitches, phrasing errors, or branching logic errors.

(iv) A final pilot was performed with 5 other maternity staff using their own data. Feedback was received and acted upon to ensure that all aspects of the survey were optimized prior to going live at scale.

Dissemination strategy

The dissemination strategy was designed to reach as broad a section of the population of current midwives in the UK as possible.

No mail version of the survey was sent to any respondent, although this would have been provided if requested. The potential to bias the survey results towards younger midwives by using an electronic-only strategy does exist, but the intention to weight the results by experience in midwifery practice if required would mitigate this potential bias as far as possible.

i. Non-responders strategy

After an initial period, the RCM re-posted the survey links on all social media channels to improve response rates. Our response strategy was designed to maximize the chances of receiving the relevant information while minimizing the number of posts required.

No direct participant contact was made at any stage during the survey. As participants are not obliged to provide a contact email or to identify themselves, it was not possible to send reminders or prompts to those who did not complete the survey.

The survey remained open for a total period of 19 days

ii Analysis

Data analyses were performed by an external consultant (University of Cambridge).

The final survey data set was downloaded as a .csv file and analysis performed using R (https://www.r-project.org/). After an initial interpretation phase, further analysis, for example breaking down into sub-groups, was performed. A data-driven discovery approach to the final analytic data set was taken. A full analytic summary was made available to RCM and to True Vision Productions. The raw data are held securely by True Vision and will not be available publically.

iii Data analysis and report presentation

Exclusions from the analytic data set were made according to pre-specified criteria.
Inclusion criteria (ALL must be met):

(i) Individual identifies as currently working in maternity care in the UK
(ii) Inidividual specifies a role within maternity care consistent with client-facing practice (e.g. midwife, midwifery student, maternity support worker)

Small number suppression has been applied to unweighted data tables where appropriate.

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[i] **In-utero stress and mode of conception: impact on regulation of imprinted genes, fetal development and future health.**
https://www.ncbi.nlm.nih.gov/pubmed/?term=31633761

[ii] **Antenatal determinants of early childhood talking delay and behavioural difficulties**
https://www.ncbi.nlm.nih.gov/pubmed/?term=31634704
In-utero stress and mode of conception: impact on regulation of imprinted genes, fetal development and future health.
https://www.ncbi.nlm.nih.gov/pubmed/?term=31633761%5Buid%5D
; Maternal Pregnancy-Related Anxiety Is Associated With Sexually Dimorphic Alterations in Amygdala Volume in 4-Year-Old Children
https://www.ncbi.nlm.nih.gov/pubmed/?term=31447658