



POLICY BRIEF 2 | Health consequences of family violence

Translating evidence from the Maternal Health Study to inform policy and practice

This policy brief summarises findings from the Maternal Health Study: an Australian longitudinal study of over 1500 first time mothers and their firstborn children. One in five mothers experienced emotional and/or physical abuse by an intimate partner in the year after having a baby. This translates to 14,000 Victorian families a year affected by family violence in the course of a child's first year of life. Family violence is at least as common as maternal depression and in many cases more devastating, with potentially grave consequences for maternal and child health.

The first 1000 days – the period from conception to age 2 – is recognised as the time when foundations are laid for health across the life span. If we don't get it right in this period, there are life long costs to individuals, families and communities.

There is now strong evidence to show that early life stress, family violence and trauma have a profound impact on the developing architecture of children's brains and immune systems.¹ Intimate partner violence is the most common type of family violence and is the focus of this policy brief. The good news is that there is a 'window of opportunity' in the first 1000 days to do things to support women and families that can have long-term effects on the health and wellbeing of future generations of Australian children.

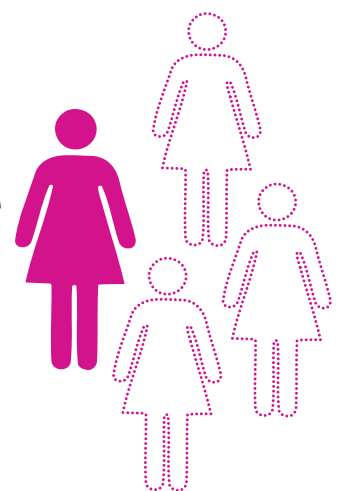
The Maternal Health Study

The Maternal Health Study is a multi-wave prospective cohort study investigating the health and well-being of over 1500 first-time mothers and their firstborn children. Women participating in the study completed questionnaires in early pregnancy, and at 3, 6, 12, and 18 months postpartum, and were followed up again when their first child was four years of age.

How common is family violence?

One in five women (20%) experienced emotional and/or physical abuse by an intimate partner in the first 12 months postpartum, and 21% experienced abuse by an intimate partner in the year that their first child turned four. A similar proportion of women (19%) had been afraid of an intimate partner before becoming pregnant with their first child.

More than **one in four** mothers experience family violence in the first four years after having their first child



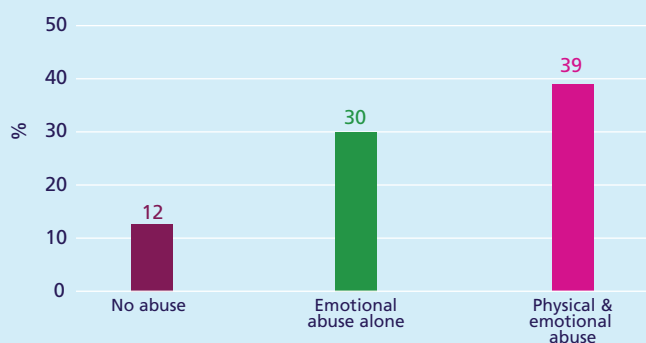
Health consequences for women

Women who were afraid of an intimate partner during pregnancy were more likely to experience physical and psychological health problems, such as:

- vaginal bleeding during pregnancy
- urinary and faecal incontinence
- depressive symptoms
- anxiety symptoms.

As shown in Figure 1, women who experienced abuse by an intimate partner in the first 12 months postpartum were more likely to report depressive symptoms in the first year after having their baby. Almost 40% of women who experienced physical and emotional abuse in the first 12 months reported depressive symptoms in the year after childbirth, compared with 12% of women who did not experience abuse by an intimate partner.²

Figure 1 Proportion of women experiencing family violence who reported depressive symptoms



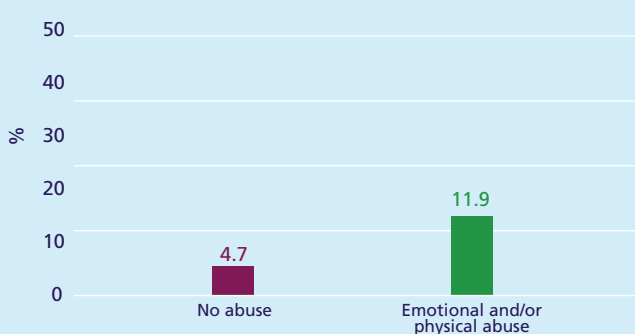
While the impact of family violence was most severe for women currently experiencing abuse, women who were no longer in an abusive relationship often continued to experience physical and psychological health problems.³

Health consequences for babies

Women experiencing family violence are twice as likely to give birth to a baby with a low birthweight (<2,500 grams).

Babies born with a low birthweight and/or small for gestational age are at higher risk of developing a range of chronic conditions such as diabetes and hypertension earlier in their life span than babies born in the normal weight range.

Figure 2 Proportion of infants with a low birthweight (<2,500 grams)

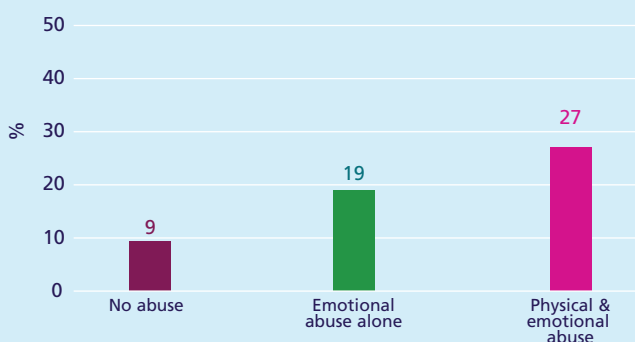


Health consequences for children

Children whose mothers experienced family violence in the first 12 months postpartum were more likely to have emotional and/or behavioural difficulties at age four (see Figure 3).⁴

If the abuse continued over the first four years of the child's life, there was a greater likelihood that the child would experience emotional and behavioural difficulties.⁴

Figure 3 Proportion of children with emotional and behavioural difficulties at age 4



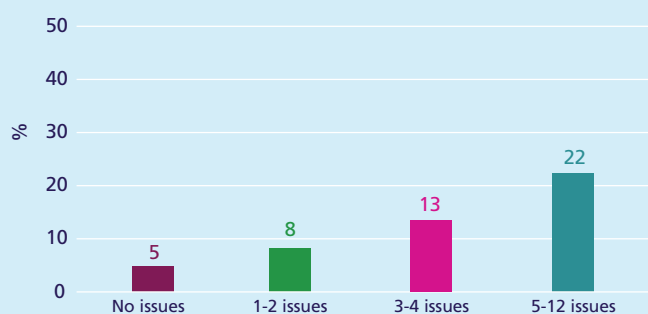
Other predictors of children's outcomes at age 4 years

A range of factors influenced children's health and behavioural outcomes at age four. The strongest predictors (in addition to family violence and maternal mental health) were social factors, including:

- mothers being under 25 at the time of a first birth
- managing on a very low income
- relationship transitions, such as separation and divorce.^{4,5}

There is clear evidence that women and men who experience trauma and abuse in early life are at greater risk of family violence, and that social risks often cluster in families. Put simply, more bad things happen to people that bad things are already happening to. For example, children in families that experienced three or more stressful events or social health issues were three times more likely to be experiencing emotional and/or behavioural difficulties at age four (see Figure 4).

Figure 4 Proportion of children with emotional and behavioural difficulties by number of stressful life events and social health issues



About the Maternal Health Study

1507 women were recruited from six metropolitan public maternity hospitals in Melbourne, between 2003 and 2005. All women in the study were pregnant with their first child when they joined the study.

The study provides a comprehensive picture of women's health during pregnancy, and after a first birth. Data were collected on common maternal physical and psychological health problems, including urinary and faecal incontinence, sexual health problems, depression, anxiety and intimate partner abuse. In addition, the study is collecting information about a range of child health and developmental health outcomes at age 4 and age 10. This has resulted in a rich data set with unique data on trajectories of mothers and first born children.

The mean age of women in the study when their first baby was born was 31 years (range 19-50).

The women in the study are largely representative in relation to obstetric characteristics, including the method of birth for their first baby. As is common in cohort studies, younger women (under 25 years) and women born overseas of non-English speaking background are under-represented.

Participation in follow-up was excellent, ranging from 95% at 3 months postpartum to 90% at 18 months postpartum. 83% of women consenting to follow-up at 4 years took part in this stage of the study.

By the time that their first child turned 4 years of age, 62% of women in the study had two children, and 10% had 3 or more children.

Considerations for policy and practice are discussed over the page.

For a list of publications from the study, please visit the study website: <https://www.mcri.edu.au/research-projects/maternalhealthstudy>

Considerations for policy and practice

Case for re-designing antenatal care

- The Australian health care system invests heavily in providing maternal health surveillance and screening to identify relatively rare medical complications of pregnancy that pose risks to mothers and babies.
- Currently, publicly funded maternity services are not investing to a similar extent in public health measures and systems to address the significant risks to maternal and child health posed by family violence.
- There is a compelling case for health services to complement the current focus on high quality clinical care with equivalent attention to social factors, such as family violence, that also place the health of the mother and child at risk.

What types of changes are needed?

- All maternity and early childhood services must be equipped to identify, manage and support women experiencing family violence and other social health issues, such as housing problems and financial difficulties that potentially compromise women's physical and psychological health and safety during pregnancy.
- The types of changes that are needed are far reaching, and require systems changes to enable health professionals to be better placed to identify women experiencing family violence and to offer appropriate support.

Some of the changes urgently required to address the health consequences of family violence are:

- longer antenatal and primary care consultations for women experiencing family violence and social adversity
- stronger links between health services and community, housing and legal services to facilitate appropriate, timely referral
- training for health professionals at all levels within public hospitals and primary care services to facilitate a co-ordinated and sensitive response to family violence matched to the needs of individual families
- expansion of multi-disciplinary teams to include allied health professionals, bi-cultural workers and Aboriginal health workers in order to tailor care appropriately in different cultural and community contexts.

Key challenges

- Given the higher prevalence of family violence in socially disadvantaged populations, service responses and care pathways need to be developed giving consideration to the constellation of risk and vulnerability that often surrounds women's experience of family violence.
- A universal or 'one size fits all' approach is unlikely to work for younger women, Aboriginal families, and families of refugee background. Engagement with these communities will be essential for development of successful programs.

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References

References for the policy brief, and a link to peer-reviewed publications from the Maternal Health Study can be accessed at the study website: <https://www.mcri.edu.au/research/research-projects/maternalhealthstudy/>

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