Royal Commission into Family Violence

WITNESS STATEMENT OF ASSOCIATE PROFESSOR STEPHANIE JANNE BROWN

I, Stephanie Janne Brown, Associate Professor and Head of Healthy Mothers Healthy Families research group, Murdoch Childrens Research Institute, Parkville, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

2. I am a Senior Principal Research Fellow and Group Leader at the Murdoch Childrens Research Institute in Parkville. The research group that I lead is known as Healthy Mothers Healthy Families and it focuses on what can be done in pregnancy and the early postnatal period to improve maternal, newborn and child health outcomes.

3. I am the principal investigator for three National Health and Medical Research Council-funded studies focusing on maternal and child health and resilience in vulnerable populations, including:

   3.1. Aboriginal families;

   3.2. families of refugee background; and

   3.3. women and children exposed to family violence.

Background and qualifications

4. I hold an Australian Research Council Future Fellowship and I am on the editorial boards of three international journals.

5. My research on matters related to the extent and impact of common maternal physical and mental health problems after childbirth, and health consequences of intimate partner violence has been published widely. Attached to this statement and marked "**SB 1**" is a copy of my curriculum vitae, which includes my publication record.

Relevant research findings

6. Some of my research relating to women and children exposed to family violence is detailed in a confidential summary attached to this statement and marked "**SB 2**". In this research first-time mothers were asked to complete a validated 18-item measure of

intimate partner abuse developed by Professor Kelsey Hegarty, called the Composite Abuse Scale (CAS). The CAS assesses both emotional and physical abuse by an intimate partner over a 12-month period. In addition, we asked women in the baseline questionnaire in early pregnancy whether they had ever felt afraid of an intimate partner, and whether they currently felt afraid of an intimate partner. These two questions have been found to identify women likely to be experiencing severe combined physical, emotional and sexual abuse. For safety reasons, we did not include the 18-item version of the CAS in the first study questionnaire. We also assessed maternal mental health from pregnancy to 4 years postpartum using the Edinburgh Postnatal Depression Scale (EPDS), and the children's emotional wellbeing at 4 years using the Strengths and Difficulties Questionnaire (SDQ). The Strengths and Difficulties Questionnaire is a well validated measure for assessing emotional or behavioural difficulties.

7. Key findings from a study referred to in the confidential attachment, include that:

7.1. Children exposed to family violence during the first and fourth year of life were twice as likely as children not exposed to family violence to experience emotional and behavioural difficulties at age four.

7.2. 20 percent of women experienced emotional or physical abuse by an intimate partner in the first 12 months postpartum.

7.3. 21 percent of women experienced emotional or physical abuse by an intimate partner in the year that their first child turned four.

7.4. 29 percent of women experienced emotional or physical abuse by an intimate partner at some stage in the first four years after the birth of their first child.

7.5. Whilst impacts are most severe when a woman is currently experiencing family violence, women who are no longer in an abusive relationship, but have experienced abuse in the past, often continue to experience physical and psychological health consequences of abuse. I think it is very important to consider what kind of longer term support women may need if they are left with psychological or physical health issues as a legacy of their experience.

7.6. Often the lasting impacts are mental health issues such as anxiety and depression, which I address further below but there are also physical impacts. For example, a woman who has been in a violent relationship is more likely to have urinary and/or faecal incontinence after childbirth. The reasons for this are not entirely clear, but are likely to include the effects of heightened anxiety, and in some cases, sexual abuse. These are the kinds of issues that, in my experience, women do not tend to talk about, or even necessarily link up in their mind as consequences of abuse.

7.7. The study findings also show that compared to women who have never been afraid of an intimate partner, women who were afraid of a partner during pregnancy are four times more likely to report depressive symptoms, ten times more likely to report anxiety and three times more likely to report vaginal bleeding in pregnancy.

7.8. The health outcomes of the group of women that had been afraid in the past (although not afraid currently), were worse than those of women who had never been afraid of an intimate partner.

7.9. There is now much better public awareness that women may experience depression during and after pregnancy, and services are leaning in to the challenge of enquiring about women's mental health, and how best to support and manage maternal depression. However, there is not yet an equivalent capacity to enquire about family violence, nor is there sufficient evidence regarding how services can best respond to support mothers and children exposed to family violence.

7.10. Women who experienced emotional and/or physical abuse in the first 12 months postpartum are also more likely to report depressive symptoms and anxiety in the year after childbirth.

7.11. Women who experienced intimate partner abuse in the first 12 months postpartum and at four years were four times more likely to report depressive symptoms.

7.12. Among women who experienced abuse in the year their first child turned four, 31.7 percent of women reported depressive symptoms.

7.13. Among women who experienced abuse in the first 12 months postpartum and at four years, the prevalence of depression was even higher (35.7 percent).

7.14. In relation to the health consequences of family violence for children, we found that at age four, children of mothers experiencing abuse are more likely to experience emotional and behavioural difficulties than children of mothers not experiencing abuse (even after taking into account the impact of maternal depressive symptoms, relationship transitions and other social characteristics such as maternal age and income).

8. These findings have very important implications for antenatal care, and for ongoing primary care of women and children. I firmly believe that it is imperative that partner violence is considered as one of the factors that commonly influences women's health. Hence, health professionals providing care to women during and after pregnancy need to be enquiring about family violence and women's mental health, because they really do go hand in hand.

Aboriginal Families Study

9. I have worked for 10 years now in Aboriginal health, mainly in South Australia. We are currently analysing findings of the Aboriginal Families Study which is a population-based study of 344 Aboriginal women who gave birth in South Australia between July 2011 and June 2013. The study was conducted in collaboration with the Aboriginal Health Council of South Australia. Attached to this statement and marked '**SB 3**' is a Policy Brief, published in November 2013, which summarises preliminary findings from the Aboriginal Families Study.

10. State-wide consultations with Aboriginal communities in South Australia were conducted to inform the design of the Aboriginal Families Study. The consultations

identified that if we were wanting to learn about women's experiences of care during pregnancy, it would also be important for us to enquire about "things happening in women's lives likely to affect their health is pregnancy". In particular, we were encouraged to ask about family violence, housing problems, family members passing away, and other stressful events and social health issues. At the time we were designing the study, members of the Aboriginal Advisory Group and Aboriginal staff working on the study were reluctant about the use of a standardised scale, such as the Composite Abuse Scale, to assess family violence. Instead, we worked with the Aboriginal Advisory Group to design a series of questions that asked about stressful events and social health issues that included items referring to different types of violence. We pre-tested these questions to ensure that women in urban, regional and remote communities were comfortable to answer the questions, and assess whether women would be open about their experiences. The pilot study demonstrated that women were comfortable to answer the questions, and saw them as important. The questions were well completed in the main study, with very few women opting not to answer this section of the questionnaire.

11. It was striking when we first presented the results to the Aboriginal Advisory Group, that even the members of the Aboriginal Advisory Group who worked in health services were shocked by the extent and nature of the issues women were dealing with. During the period of their pregnancy:

    11.1. 55 percent of women in the Aboriginal Families Study reported that they had been upset by family arguments;

    11.2. 31 percent said they had been scared by other people's behaviour;

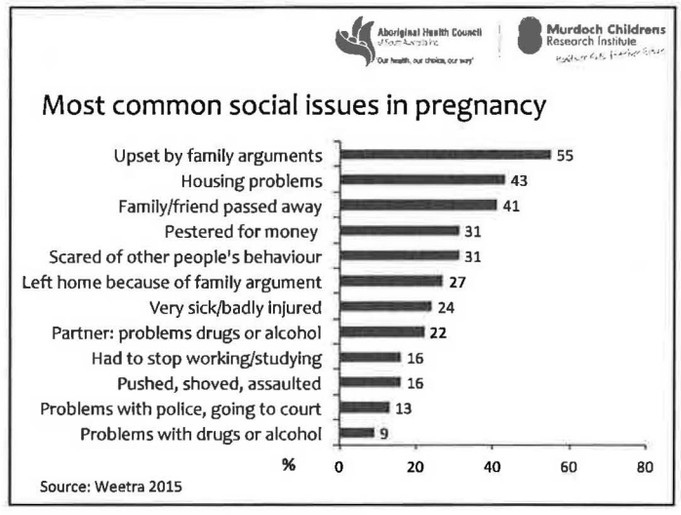
    11.3. 27 percent had left home because of a family fight or argument; and

    11.4. 16 percent said that they had been pushed, shoved or assaulted.

12. Also of particular concern was that 57 percent of women in the Aboriginal Families Study reported three or more stressful events and social health issues during pregnancy, and one in four women reported 5-12 issues.

13. Despite the high prevalence of family violence experienced by women during pregnancy, very few women recalled midwives, doctors or health workers asking them about this or offering any support to deal with this issue.

14. Below is a table which depicts the most common social issues experienced by participants in the Aboriginal Families Study during pregnancy:



Aboriginal Maternity Service programs

15. I am aware of the Bumps to Babes and Beyond initiative that was established by Mallee District Aboriginal Services in Mildura. I had involvement in the evaluation of the Women's Business Service at the Mildura Aboriginal Cooperation. The evaluation was conducted by Dr Sandra Campbell, who was as at that time undertaking a Masters degree at Australian National University, and on placement with my research group. Attached to this statement and marked '**SB 4**' is an article called: *Maternity care with the Women's Business Service at the Mildura Aboriginal Health Service*.

16. The Koori Maternity Services program provides culturally appropriate maternity care and support for Aboriginal and Torres Strait Islander women via services located across Victoria. The Mildura Women's Business Service was established in May 2000 to provide more personalised, holistic care to women during pregnancy. The program was provided by a midwife and an Aboriginal health worker, working very closely together to provide culturally appropriate care and encourage Aboriginal women to engage with the service. There is good evidence that without efforts to overcome barriers to access, such as lack of transport, poor health literacy, and past experiences of racist attitudes in health services, Aboriginal women are less likely to attend antenatal check-ups, and more likely to have their first visit later in pregnancy. There is also evidence that women experiencing family violence are more likely to attend their first pregnancy visit later in pregnancy. This may be because their partner is controlling their behaviour, and does not want them to access services, or because of other factors, such as lack of transport, transient housing, or other issues that women may be dealing with such as drug and alcohol problems, or going to court.

17. The Women's Business Service was not specifically designed to address family violence, but it would have been amongst the social health issues affecting women

using the service. The evaluation showed that Aboriginal women valued the service, and were particularly positive about the care provided to them during pregnancy.

18. I have also recently completed a state-government commissioned evaluation of the Aboriginal Family Birthing Program (**AFBP**) in South Australia, which works on a somewhat different model to the Koori Maternity Services program here in Victoria The South Australian program builds on a highly successful program developed in Port Augusta, called the Anangu Bibi Family Birthing Program. The key features of the program are: community consultation and engagement in the establishment of the program, creation of a new Aboriginal Maternal and Infant Care (**AMIC**) worker position in a leadership role within maternity services; partnerships and skill exchange between AMIC workers and midwives; education and training for AMIC workers in antenatal, intrapartum and postnatal care; and a commitment to providing high quality primary health care and continuity of care for families. In the Aboriginal Families Study, we found that women who attended the AFBP services were 2-3 times more likely to report positive experiences of antenatal care, and twice as likely to say that midwives provided support to them with "things happening in their lives." Attached to this statement and marked '**SB 5**' is a an article called: *Improving Aboriginal women's experiences of antenatal care: findings from the Aboriginal Families Study in South Australia, published March 2015,* which summarises findings from the Aboriginal Families Study.

19. While we do not have conclusive data on whether these services are able to reduce the impact of family violence on women and children, I would expect that where there is more engagement with such programs, families are likely to benefit in ways that, logically, might lead to less stress on families, potentially lowering the likelihood of family violence and other pressures contributing to Aboriginal children being placed in out of home care.

Afghan Families Study

20. My research group is also collaborating with the Victorian Foundation for Survivors of Torture (**Foundation House**) to undertake research with families of refugee background. In 2010, the Department of Treasury and Finance commissioned me to provide a report based on data collected in a population-based survey of women giving birth in Victoria conducted by my team in 2008. We were specifically asked to comment on evidence regarding the extent to which Victorian maternity services are addressing modifiable risk factors for poor maternal and child outcomes in vulnerable population groups, including refugees. We were unable to comment on the extent to which services were addressing the needs of refugee families, because the survey had not been designed with this specific goal in mind.

21. Together with Foundation House, we decided to do some work with Afghan communities to address this gap in the literature. We designed a study involving consultation and interviews with around 100 Afghan women and men residing in Melbourne's south-east who had recently had a baby, and then held interviews with health professionals providing care to families with refugee backgrounds in this region of Melbourne.

22. We worked with two bicultural workers to facilitate the involvement of Afghan women and men in this study. It was just a small study but we learnt an enormous amount. Attached to this statement and marked '**SB 6**' is a copy of our final report of November 2013, titled *Having a baby in a new country, The views and experiences of Afghan Families and Stakeholders.*

23. In summary, Afghan women and men who shared their experience of recently having a baby:

    23.1. reported significant social hardship during and after pregnancy including the absence of extended family, limited English proficiency, unemployment and housing issues;

    23.2. reflected on the impact of changing gender roles, and stresses associated with men assuming care of their wife and baby, care that traditionally has been undertaken by female relatives; and

    23.3. commented that health professionals very rarely asked about their personal family circumstances.

24. We found that health professionals had a very limited understanding of the context of migration and how to identify and respond to the social circumstances of Afghan and other refugee families. It was clear from the findings that family violence was an issue that health professionals were aware of, but something they were not routinely seeking to address as part of antenatal care.

25. A particular issue that we learnt about was the way that settlement experiences affect interaction with health services. For many men, there was a trade-off between the importance of getting employment (which they needed to survive) and resulting priority placed on men learning English, and the fact that when their wives need to interact with health services, they felt they needed to take time off work to accompany their wives to health services, in order to interpret. Another issue that concerned both men and women, was that maternity services are not necessarily able to guarantee female caregivers or interpreters. The men that we interviewed expressed to us that they needed to accompany their wives to antenatal appointments for these reasons, and that they were forgoing employment in order to do this. There is less opportunity for health

professionals to enquire about family violence, and/or provide support to women experiencing violence at home with their partners present.

26. Improving access to professional interpreting support and providing choice with regard to gender of both the attending health professionals and interpreters are fundamental steps that need to be taken, to equip maternity services to be able to support women of refugee backgrounds experiencing family violence. By not providing choice with regard to the gender of the doctor or midwife, we are actually compounding this problem (as with the lack of suitable interpreters). Hospitals currently cannot guarantee choice with regard to the gender of interpreters, and the other difficulty is that there may not be an onsite interpreter available that speaks the right dialect. In the Afghan community for example, there are at least four different languages in common use, making it more complicated for services to provide access to onsite interpreters.

27. The Afghan Families Study was a catalyst for another study we are conducting, called Bridging the Gap. In this study, 11 agencies in Melbourne's south east and western suburbs, including four maternity hospitals, two maternal and child health teams, two primary care networks, and two state government departments, are working together to improve maternal and child health outcomes for refugee families. At one of the hospitals, a project is being implemented to increase the use of professional interpreting services, including the use of telephone interpreters.

28. This is a really important initiative. More concerted efforts to facilitate access to professional interpreters, and wider adoption of the use of telephone interpreters, may reduce the need for men to accompany their wives to antenatal care. This would create more opportunities for caregivers to identify and support women with refugee backgrounds experiencing family violence.

29. As outlined above, in talking to health professionals involved in providing care to refugee families, we also learnt that they were very aware of the impact of changing gender roles and stresses on families contributing to the likelihood of family violence, but they were uncomfortable asking women about any stresses they were experiencing. We were told that this reluctance was because:

    29.1. both men and women were present in the consultation; and

    29.2. they did not know what to do upon uncovering issues such as family violence.

30. These health professionals were not trained to identify or respond to family violence, and did not feel that they had service systems on which they could rely for referral or additional support. This meant that many felt unable to respond to support a family experiencing violence.

Bridging the Gap Partnership

31. In terms of our current work, I think that the best example of a model for services working together to tackle complex issues such as family violence, is the Bridging the Gap Partnership. The study is funded by a National Health and Medical Research Council Partnership Grant and is using an interrupted time series design and process evaluation to assess the impact and outcomes of co-designed quality improvement initiatives.

32. The Bridging the Gap Partnership is:

    32.1. building workforce capacity to identify and respond to the social circumstances of families of refugee background including mental health issues and family violence;

    32.2. finding new ways for maternity and early childhood services to work together to ensure families with complex social needs receive coordinated and seamless care; and

    32.3. testing new ways to ensure families can access care that best meets their needs including care close to home, bicultural workers being an integral part of the health care team and engaging accredited interpreters in care.

33. In my view, Bridging the Gap has enormous potential to address a range of issues. The Bridging the Gap program has been underway for almost two years and there is now strong 'buy-in' from the 11 agencies taking part. I think it is a very important initiative, not only for its focus on a very vulnerable population group, but also as an approach to organisational change in maternity and early childhood services. Attached to this statement and marked '**SB 7**' is a paper, recently published in Implementation Science, entitled: *Bridging the Gap: using an interrupted time series design to evaluate systems reform addressing refugee maternal and child health inequalities*. This paper outlines the approach we have taken to co-design and evaluation of strategies to improve the way that maternity services and early childhood services approach meeting the needs of refugee families.

34. 'Happy Healthy Beginnings' is a demonstration project situated within the broader Bridging the Gap initiative, designed for Karen (Burmese) women and their families during pregnancy, childbirth and the months after. The program is facilitated by a multidisciplinary team including midwives, a maternal and child health nurse, an interpreter and a bicultural worker, and offers antenatal education in a group setting, with antenatal check-ups happening either just before or just after the group activity. I think the Healthy Happy Beginnings model (providing care and education to groups of women of the same cultural background) has a lot of potential to improve support for

women experiencing family violence by providing a safe place for women to meet, and access to a range of resources, support and referral to other agencies, in conjunction with clinical or medical components of antenatal care.

35. There are parallels with the findings from the Aboriginal Families Study and evaluation of the Aboriginal Family Birthing Program in South Australia. The AFBP evaluation clearly showed that the role of the Aboriginal Maternal Infant Care Worker and quality of the partnerships between AMIC workers and midwives is critical to the success of the program. Similarly, the role of the bicultural workers and ability to develop models that integrate and utilise the skills of interpreters and bicultural workers will be critical to the successful development of more effective ways to address social health issues associated with poor maternal and child health outcomes in refugee communities.

Re-design antenatal care

36. Given the high prevalence of family violence during and after pregnancy, and the implications for maternal and child health, there is a compelling case for redesigning antenatal care to combine high quality clinical care with a much stronger focus on addressing family violence and other social health issues contributing to poor maternal and child health outcomes.

Key elements for re-designing antenatal care

37. Antenatal care provides a window of opportunity where there is high contact with a range of primary and specialist health services. Women have, on average, 8 to10 visits to such services with their first child. The focus of these visits is largely on routine screening and clinical care, in particular, screening for rare, but serious conditions that may affect the health of the mother and her unborn child. There is an urgent need to integrate high quality clinical care with a stronger primary care approach to addressing social risk factors for poor maternal and child health outcomes, of which family violence is one.

38. Redesigning antenatal care to have a much broader public health approach embedded in routine care would require rethinking a range of factors, including the make-up of the maternity care workforce, and how teams work together to deliver a more highly integrated, and seamless approach to combining clinical and primary care addressing broader social determinants of health such as family violence.

39. Over the course of more than 25 years working as a perinatal and maternal epidemiologist and health services researcher in the perinatal field, it has become increasingly clear that attempts to enhance maternity and early childhood services only succeed when there is good 'buy-in' from the agencies, managers and staff working 'on the ground'. There is good evidence that organisational change in health services only

works if people are 'on board' with the reasons for making changes, and actively want to try out new approaches and develop new ways of doing things.

40. Initiatives such as Bridging the Gap that bring researchers, health services, and policy makers together to co-design quality improvement initiatives, represent the best, and in my view, the only model for achieving sustainable improvements to tackle complex issues, such as family violence. It is also important that quality improvement initiatives draw on the best available research evidence, which is where researchers have an important role to play in making research accessible.

41. All maternity services must be equipped to identify, manage and support women experiencing family violence and other related social health issues, such as drug and alcohol problems. Currently, many women experiencing family violence in pregnancy are not identified by services, including women experiencing physical, as well as emotional abuse. There are some examples of projects and initiatives that have been undertaken by Victorian public hospitals, which may provide a model for further initiatives. However, we lack adequate evidence about what works and what does not work in different contexts. It is therefore imperative that concurrent evaluation is built into any new initiatives.

42. Antenatal care happens in public hospitals and community settings, so strategies to improve identification, management and support of women experiencing family violence must encompass both community and hospital-based practitioners and services.

43. A universal or 'one size fits all' approach is unlikely to work for vulnerable population groups, such as Aboriginal families, and families with refugee or migrant backgrounds. Engagement with these communities in the process of designing strategies to improve access and responsiveness of services to specific populations will be essential for development of successful programs.

44. In order to address the needs of Aboriginal people, the involvement of Aboriginal workforce, and strategies to address barriers to access, such as lack of transport, will also be essential to improve the likelihood of successful program delivery and improved outcomes for Aboriginal women and children.

Issues for consideration in relation to maternal and child health services

45. We have some highly skilled maternal and child health teams in Victoria, doing great work. However, where their programs are working really effectively, it is largely because of individuals that have vision and a capacity to inspire their teams. While there have been some important steps taken in Victoria to improve the training of maternal and child health nurses to identify and respond to family violence, the current schedule of

visits at 'key ages and stages' from birth to age three only focusses on family violence at one visit, 4 weeks after childbirth.

46. Given that women are often reluctant to disclose family violence, I think it is important that strategies to promote identification and support of women experiencing family violence are better articulated in the program logic for the maternal and child health service, and that specific protocols for maternal health surveillance (incorporating a focus on family violence) are included in more than one 'key ages and stages visit', and preferably on at least three occasions in the first 12 months postpartum, and other contacts during the early years before children start school.

47. The handover from maternity services to maternal and child health is also a critical time point for maternity services to flag concerns regarding family violence. Currently, there are very limited systems in place to facilitate appropriate handover of information and/or referral to maternal and child health and other agencies that may be able to provide support to women and children.

48. Ongoing professional development for maternal and child health nurses and development of a service response protocol is required to enhance service responses and care pathways for women and children exposed to family violence.

49. Given the higher prevalence of family violence in socially disadvantaged and vulnerable 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. The maternal and child health service has not historically been funded or supported to work from a social model of health. The current universal platform lacks flexibility to respond to women and families with more complex social needs, such as younger mothers, families of refugee background and Aboriginal families.

50. There are also challenges for maternal and child health services in finding ways to support mothers, children and fathers. At the moment, there are very few services targeting the needs of fathers, either during pregnancy or the early years of parenting. Even the name of the maternal and child health service, and female composition of the workforce, are potential barriers. I do not believe services will be successful in engaging with many men, especially in Aboriginal communities and some refugee communities, unless there are male workers involved.

51. I am aware that some other states are considering the introduction of a tiered level of service delivery in early childhood services, providing a basic level of support for all families, and more intensive support to families with more complex needs. This kind of approach provides scope to enhance multidisciplinary and allied health involvement in

early childhood services, including the potential to involve male and female bicultural workers and Aboriginal health workers.

52. At a local, regional and state level, there is also a need for better information sharing between agencies to facilitate integrated approaches to care and support during and after pregnancy. This is also important to ensure that women and children don't fall between the 'gaps' in the handover between universal services.

Stephanie Brown

Stephanie Janne Brown
Dated: 9 July, 2015