Family adversity and health indicators of IPV in parents and children presenting to healthcare during the first 1000 days

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Dr Shabeer Syed, Prof Ruth Gilbert, Prof Gene Feder, Dr Claire Powell, Dr Emma Howarth, Prof Jess Deighton, Dr Rebecca Lacey
1 in 3
WHO (2002): “Intimate partner violence (IPV) refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.”

The Domestic Abuse Act (2021): children exposed to IPV, or its effects are victims of IPV in their own right if under parental responsibility of the abuser or the survivor of IPV.
Background

- GPs, emergency departments, CAMHS & other services see a lot of families (children/parents) affected by intimate partner violence.

- 1 in 5 of all police recorded incidents (2020-21) in Eng/Wales were IPV-related\(^1\)

- IPV damages the mental and physical health of women, men, young people and children, and is a leading contributor to disease burden for women of childbearing age.

- Most families are not identified by healthcare.
First study: birth cohort with repeated surveys

- ASLPAC Birth cohort of 4490 children and parents (South–West England) followed from birth to 18y\(^2\)
- IPV self-reported via questionnaires by mothers and their partner on six occasions between ages 2-10y
- 1 in 5 (19.6%) mothers (or their partner) met criteria for IPV at least once between 2 and 10 years after birth\(^2\)
- IPV in childhood was associated with more depressive symptoms at age 18.
- Caveats: high attrition ~ 70% of sample dropped out by time children were 18y

Second study: Rationale

Various signs in children or parents may guide practitioners to suspect and ask about IPV and respond appropriately. BUT...

Research gaps

- Limited evidence on clinically relevant indicators of IPV in families
- Limited “think-family” data, with few studies involving both parents and children
- Limited evidence from different healthcare settings
- Indicators like ACEs not well defined, lack relevance to services
- Limited clinical guidelines

= Limited clinical recognition
= Limited supportive opportunities
= More family adversity
NICE Domestic violence and abuse multi-agency working: Public health guideline [PH50]

Recommendation 6: Ensure trained staff ask people about domestic violence and abuse

Health and social care service managers and professionals should:

• Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.

• Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children’s and vulnerable adults’ services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

NICE do not recommend frontline clinicians in general practice, A&E, or other non-specialist settings asking about IPV during routine clinical contacts of children and parents.

So, what is the “threshold” for asking about IPV in the family? When should you ask?
Aims

**Identifying IPV**
1. Examine family adversity related indicators of IPV using electronic health records of families presenting to healthcare to inform clinical guidelines.

**Responding (to needs) of IPV**
2. Describing the prevalence of physical and mental health problems among families with and without IPV to inform coordinated responses to family's health needs.
Methods

Study period: 2008-2020

1yr before

2yr after

Antenatal period

1y before birth
Registered with a GP

delivery

Mothers & fathers
records

Linked

birth

Child’s record

Registered
Child’s record
Methods
Birth cohort study of 129,948 children and mothers, and 73.3% had an identified father followed across primary and secondary care records in England.

Primary care data source:
• 400 general practices - Clinical Practice Research Database GOLD (CPRD)

Linked to hospitals:
• Hospitals episode statistics - A&E, outpatient visits, admissions, and death records – ONS
Methods

Clinical indicators (exposures):
4 domains of family adversities or ACEs

Outcome:
IPV in any family record
*Parental physical and mental health problems*

Analyses:
Cross-sectional analysis, logistic regression models
(adjusted + inverse probability weights)

For more info: [https://ACEsinEHRs.com](https://ACEsinEHRs.com)
Results

Prevalence

Of the 129,948 children and parents:

• 2 in 5 had any family adversity (41.2%)
• 1 in 48 had IPV (2.1%)

41.2% with any family adversity
### Results

<table>
<thead>
<tr>
<th>Family adversity indicators</th>
<th>Probability of IPV in children and parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>No adversity</td>
<td>1 in 175</td>
</tr>
<tr>
<td>Any adversity</td>
<td>1 in 22</td>
</tr>
</tbody>
</table>

Proportion of parents & children with any IPV and co-occurring adversities:

- IPV 20% only (no other recorded ACE) - 6.7%
- Parental mental health and substance misuse - 71.5%
- High-risk presentations of CM - 6.7%

Hidden beneath the surface

**NIHR Policy Research Unit Children and Families**
Results

Mother, father & child

<table>
<thead>
<tr>
<th>Family member with adversity</th>
<th>Probability of IPV in children and parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any parent</td>
<td>1 in 29</td>
</tr>
<tr>
<td>One parent &amp; child</td>
<td>1 in 11</td>
</tr>
<tr>
<td>Both parents &amp; child</td>
<td>1 in 6</td>
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All adversities increased risk IPV

More family members with adversities or more adversities risk IPV

Family adversities

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<tr>
<td>Parental mental health</td>
<td>1 in 19</td>
</tr>
<tr>
<td>Parental substance misuse</td>
<td>1 in 16</td>
</tr>
<tr>
<td>High-risk presentations of CM</td>
<td>1 in 15</td>
</tr>
<tr>
<td>Adverse family environments</td>
<td>1 in 12</td>
</tr>
<tr>
<td>Three or more adversities</td>
<td>1 in 6</td>
</tr>
</tbody>
</table>
Results

- Distribution of all recorded adversity and IPV during the first 1000 days
- Keeping only the first recording per child or parent
Prevalence of health needs in families with and without parental IPV

Mental health problems 2x higher among families with IPV

Chronic pain ~ 40% among families with IPV
Limitations

• Findings should be considered with caution. Not everyone are affected in the same way. Family adversities are complex and heterogeneous. Families can be incredibly resilient and adapt to trauma as they move along the family life cycle.

• Family adversity and the probability of IPV are influenced by wider contextual systemic factors such as deprivation.

• Underreporting/underrecording of IPV. Not everyone report to healthcare and not everything is recorded in a consistent way.

• Limited follow-up. The focus is on first 1000 days.
Take home messages

• Be aware of increased risk of IPV in the presences of ACEs/family adversity in parents and young children

• Trauma informed: Be aware that even before the child is born, families have recorded adversity indicators of IPV, especially parental mental health problems and a history of adverse family environments.

• Importance of “think-family” approaches. Review both parent and child records. Ask about children in the household. THINK FAMILY!

• Safely ask about IPV if there are family adversities present in the child or parent and respond appropriately. See the WHO’s “LIVES” principle for supportive first responses to IPV.
Acknowledgements

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Main presentation:


- Gondek D, Howe LD, Gilbert R, Feder G, Howarth E, Deighton J, Lacey RE. Association of interparental violence and maternal depression with depression among adolescents at the population and individual level. JAMA network open. 2023 Mar 1;6(3):e231175-


Development work of ACES in EHRs (www.ACEsinEHRs.com):


Definition, statistics and prevalence of IPV:


Home Office UK. Domestic Abuse Statutory Guidance July 2022

ONS. Domestic abuse prevalence and trends, England and Wales: year ending March 2021


Q&A references provided at seminar: