

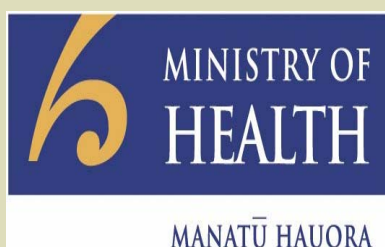
Interdisciplinary Trauma Research Unit

Hospital Responsiveness To Family Violence: Enablers, Barriers and Sustainability



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Te wairere au noa



Hospital Responsiveness to Family Violence: Enablers, Barriers and Sustainability

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Contracted Organisation

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Executive Summary

In June 2005, the Taskforce for Action on Violence within Families was established to advise the Family Violence Ministerial Team on how to make improvements to the way family violence is addressed, and how to eliminate family violence in New Zealand¹. The Ministerial Team and Taskforce are part of a 'whole of government' response to family violence in Aotearoa New Zealand. The health sector has a significant part to play in that response.

Within the health sector, family violence is recognised as a priority issue that requires an effective and sustainable system-wide response². Recent audits of New Zealand hospitals documented significant programme development over the period 2003-2006, but highlighted that it was still 'early days'^{3, 4}.

This is a critical time for learning. As noted by The Taskforce, "A sound understanding of the motivators, influencers and barriers to change is needed".¹ In this qualitative evaluation project, we gathered information from those in the health care system closest to where change is occurring, the family violence intervention coordinators.

During 2005 we conducted in-depth interviews with 9 family violence intervention coordinators (6 responsible for partner abuse intervention programmes, 2 for child abuse and neglect programmes and 1 paediatrician). We also conducted focus groups with family violence intervention programme members at three hospitals that were at different stages of development. Interview and focus group participants included representatives from secondary and tertiary hospitals in the North and South Islands. Actions that will enable family violence intervention programme development, implementation and sustainability were identified (Table 1).

An effective, sustainable health sector response to family violence requires the will and effort of many, both within and outside of the health sector. This report gathered information from experts in health sector family violence intervention programme development at the coalface; it behoves us to listen carefully.

Table 1. Health Family Violence Intervention Programme Enablers

<i>Internal organisational factors</i>	Actions	Responsibility
a) Human & financial resources	<ul style="list-style-type: none"> • Ensure funding is allocated to FV programme • Make permanent appointments to FV coordinator positions • Foster good relationships within the hospital and across DHB • Ensure FVICs are supported internally and have jurisdiction across services • Provide mandatory FV training and enable release of staff 	MOH/DHB management/DHB Funding & Planning FVIC DHB management DHB management
b) Structures	<ul style="list-style-type: none"> • Implement FV Committees/working groups (across DHB/hospital) to support programme development • Ensure FVIC reports to senior person within DHB structure • Enhance pre-existing systems to support the FV programme (eg. Alert systems) 	DHB management/FVICs DHB management Quality & Risk; IT
c) Processes	<ul style="list-style-type: none"> • Implement FV hospital and DHB-wide policies and procedures • Coordinate across departments • Work with 'friendly' units and services initially • Roll out programme gradually • Include 'refresher' and advanced training, along with accessible staff supervision • Monitor for quality and self- evaluate to ensure continuous FV programme improvement 	DHB management/service level managers/FVIC FVIC DHB management FVIC Quality and Risk
d) Leadership	<ul style="list-style-type: none"> • Engage senior management (including CEO) • Involve influential staff, gain senior management sponsorship, enrol/identify FV 'champions' 	MOH/ DHB CEO & management/Funding & Planning DHB Management DHB Quality and Risk/ FVIC
<i>External system factors</i>		
a) Partnerships	<ul style="list-style-type: none"> • Make FV high priority in central government and local community • Involve/collaborate with community FV agencies, government agencies & other health providers 	MOH DHB/FVIC
b) Support from resource systems	<ul style="list-style-type: none"> • Utilise services/resources of outside agencies; network with local contacts to assist in FV response • Continue/enhance MOH support for family violence intervention programmes (including coordinators' meeting, provision of resources) • Conduct regular external audits (e.g. AUT audits) 	FVIC MOH External evaluation agency
c) Contextual factors	<ul style="list-style-type: none"> • Engage with local community to ensure FV programme responsive to nature of community eg. ethnicity/ size/location/geographical access 	DHB management FVIC

MOH = Ministry of Health; DHB = District Health Board; FVIC = family violence intervention coordinator

Background

The Health Sector Role in Family Violence Intervention and Prevention

Family violence (FV) is a serious issue - both internationally and in Aotearoa NZ - and eliminating FV is a significant priority within the NZ Government's 'Families-young and old' theme.¹ In recognition of this, the Taskforce for Action on Violence within Families (referred to here as The Taskforce) was established in June 2005 to: "advise the Family Violence Ministerial Team on how to make improvements to the way family violence is addressed, and to eliminate family violence in New Zealand." ¹ p.32. Figure 1 presents a diagram of the relationships and compositions of both The Taskforce and the Ministerial Team.

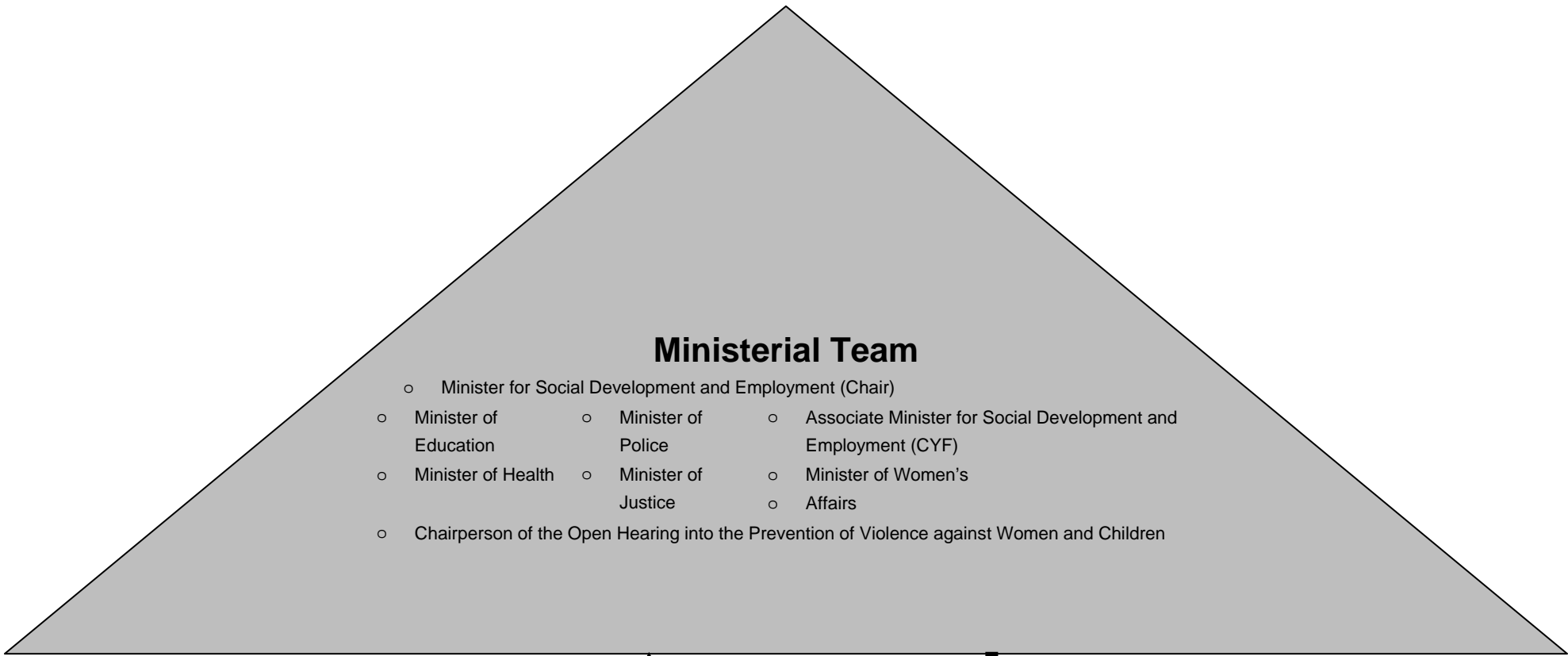
The Taskforce has been charged with building on work carried out under *Te Rito, New Zealand Family Violence Prevention Strategy* (2002) and has developed a programme of action, initially focusing on the years 2006-07, for four key areas¹ p.2:

- leadership
- changing attitudes and behaviour
- safety and accountability and
- effective support services.

As shown in Figure 1, the health sector is included in both the Ministerial Team and Taskforce through Ministerial and Ministry representation. After providing definitions to be used in this report, Health's recent contribution to FV intervention and prevention, through the Family Violence Project will be presented.

Definition of Family Violence

Family violence is a term that encompasses all forms of violence, including child abuse and neglect, intimate partner violence and elder abuse and neglect. In this report, the term is limited to partner abuse (PA) (or intimate partner violence - IPV) and child abuse and neglect (CAN). These are the two aspects of family violence addressed in the MOH *Family Violence Guidelines*⁵ and the primary focus of most DHB Family Violence Intervention (FVI) programmes. Where possible, the area of FV that is being discussed is made explicit in this report.



The Family Violence Project

In recognition of the role of health in addressing the issue of FV, the Aotearoa New Zealand Ministry of Health (MOH) began the Family Violence Project (FVP) to improve the health sector's response to victims of family violence. During the period 2001-2004, three project objectives were achieved:

1. Practice procedures were established (MOH *Family Violence Guidelines* published, referred to here as *The Guidelines*)⁵
2. Fund health professional training (Train the Trainers programme)
3. Pilot *The Guidelines* implementation in four District Health Boards (DHBs).

The MOH funded an evaluation project to coincide with implementation of the Family Violence Project. In this evaluation the institutional culture of hospitals towards improving the safety of women and children at risk for family violence was monitored. An evaluation framework and health services research paradigm informed the multi-method, longitudinal evaluation.

This report on the qualitative findings of the FVP evaluation is one in a series evaluating health care responsiveness to FV. The first report, published in November 2004, presented baseline hospital family violence intervention programme (FVIC) audit findings for the New Zealand acute care (secondary and tertiary) public hospitals (n=25)⁴. A second report, published in February 2006, presented the 12 month follow-up audit findings^{3a}. A brief summary of the audit results is provided in the next section.

Audit Results

Results of the hospital FVIP audits indicate that significant progress had been made in programme development for responding to both partner abuse and child abuse and neglect within a 12 month period (Figure 2)³. The 12 month follow-up median score for partner abuse intervention programmes was 28, an increase of 41% over baseline. The median score for child abuse and neglect intervention programmes was 51, with a similar increase of 40% over baseline. The higher child

^a The reader is referred to this report for full details of the FVP and evaluation project background. The report can be found at:

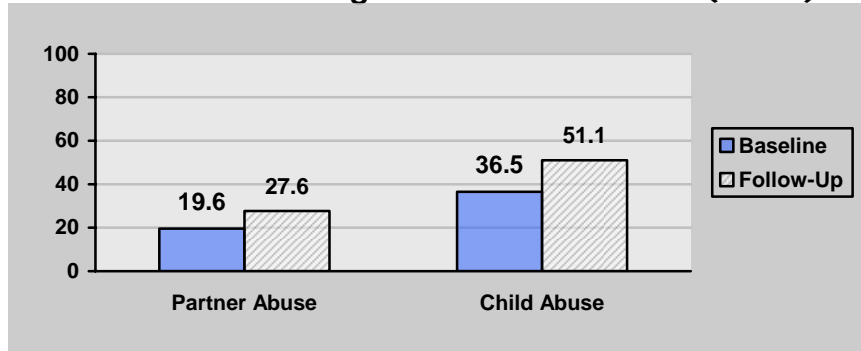
http://www.trauma-research.info/fv_evaluation.htm

In this evaluation the institutional culture of hospitals towards improving the safety of women and children at risk for family was monitored.

Results of the hospital FVIP audits indicate that significant progress had been made in programme development for responding to both partner abuse and child abuse and neglect within a 12 month period.

abuse and neglect intervention scores are indicative of programme longevity compared to partner abuse intervention. At the time of the 12 month follow up audit, 80% of the child abuse programmes had been in existence for longer than 2 years, compared to only 16% of partner abuse programmes.

Figure 2. Baseline and Follow-up Median Hospital Family Violence Intervention Programme Audit Scores (n=25)



Despite the progress made in programmes overall, most remain in an early stage of development.

Despite progress made in programmes overall, most remain in an early stage of development. Table 2 highlights some ongoing concerns.

Table 2: Concerns Evident at the 12 Month Follow-up Audit

- 9 (36%) hospitals did not have a family violence coordinator.
- 16 (64%) hospitals did not have written, endorsed policies and procedures regarding assessment and treatment for responding to partner violence.
- 16 hospitals did not have a formal staff family violence training plan in place.
- 19 hospitals have not instituted partner violence screening in any inpatient or outpatient unit.
- 17 hospitals had no internal family violence programme monitoring process in place.
- 10 (40%) hospitals did not have a child protection coordinator.
- 6 (24%) hospitals did not have written policies addressing child protection reporting requirements.
- 6 hospitals did not have a child abuse and neglect working group.
- 9 (36%) hospitals did not have a mechanism for regular feedback from Child Youth and Family.
- 15 hospitals did not have a formal staff child abuse and neglect training plan in place.
- 8 hospitals had no internal child abuse and neglect programme monitoring process in place.

The hospital audit data provides important information about health system development; it does not however, inform us about the 'how' and 'why' of FVIP development. Given that programme development is in its early days, with significant challenges ahead (see Table 2), this is a critical time for learning. As noted by The Taskforce, "A sound understanding of the motivators, influencers and barriers to change is needed".¹ Included in the evaluation project plan were activities to gather information from those in the health care system closest to where change is occurring, the family violence coordinators.

Given that programme development is in its early days, with significant challenges ahead, this is a critical time for learning.

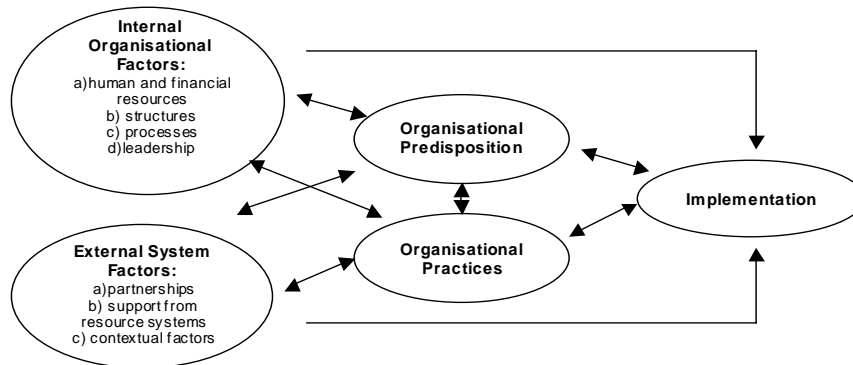
Hospital family violence intervention (FVI) programme focus groups and individual in-depth interviews with FV coordinators were included in the evaluation design to provide qualitative information on programme enablers, barriers, and factors that promote organisational change. Data were examined within an organisational change framework.

Organisational Change Framework

In understanding FV programme implementation we have selected to use the organisational change framework of Riley et al⁶. The framework was developed to explain differences in levels of health promotion programme implementation in Ontario (Figure 3). Our aim in applying this framework is to examine variability in the implementation of FV intervention programmes in New Zealand hospitals. The framework identifies two broad classes of variables known to influence programme implementation by organisations: 1) change in organisational predisposition and 2) change in organisational practices. Changes in organisational predisposition and practices are influenced by a variety of factors related to internal organisation (notably, human and financial resources, structures, processes, leadership) as well as the external system (notably, partnerships, support from the resource system and contextual factors)⁶.

Our aim in applying this framework is to examine variability in the implementation of FV intervention programmes in New Zealand hospitals.

Figure 3: Theoretical Framework to Explain Variation in FVIP Implementation (Riley, Taylor & Elliot, 2003, p.757)



Qualitative Evaluation Purpose

This report responds to the third evaluation question, "What may need to be done to enhance sustainability over time for professionals and organisations?"

The primary evaluation goal was to measure healthcare system responsiveness to the Ministry of Health's (MOH) Family Violence Project (FVP). The questions set by the MOH for the project (as specified at a MOH Family Violence Evaluation Management Committee Meeting, 18 September 2002) and the methods used to address them are included in Table 3. This report responds to the third evaluation question, "What may need to be done to enhance sustainability over time for professionals and organisations?"

Table 3. Family Violence Project Evaluation Question and Data Collection Methods

Evaluation Question	Data Collection Methods	Reporting
How are New Zealand District Health Boards (DHBs) performing in terms of institutional support for family violence prevention?	Hospital Audits: Secondary and tertiary acute care public hospitals were audited during site visits using a modification of the Delphi Instrument for Hospital-Based Domestic Violence Programmes ⁷ (referred to as The Delphi).	Findings reported to the MOH in November 2004: <i>Hospital Responsiveness to Family Violence: Baseline Audit Findings</i> ⁴
Is institutional change sustained over time?	Hospital Audits: Audits were repeated 12 months following the baseline audit (see above) and again at 30 months post baseline.	Findings reported to the MOH in February 2006: <i>Hospital Responsiveness to Family Violence: 12 Month Follow-Up Evaluation</i> ³ .
What may need to be done to enhance sustainability over time for professionals and organisations?	Key Stakeholder Interviews: Nine semi-structured key stakeholder interviews were conducted to identify enablers and barriers to institutional change in the area of family violence. Focus Groups: Three semi-structured focus groups were conducted following the 12 month follow up audit to contextualise the audit results and address sustainability.	Findings reported in this document.
How are healthcare referral patterns changing?	Health Referrals to Women's Refuge: Women's Refuge provided frequencies of referrals from health over time.	Findings included in 12 Month Follow-Up report ³ .
How do women who screen positive for intimate partner violence feel about screening and intervention?	Interviews: Semi-structured interviews were conducted with 36 women who had participated in a study of healthcare site-based partner violence screening and brief intervention.	Findings reported in the document: <i>Women's perceptions of partner violence screening in two Aotearoa New Zealand healthcare settings: "What took you so long?"</i> ⁸

Methods

In focus groups and individual interviews we asked participants to share their experiences and beliefs about FVIP development.

Two qualitative methods were selected for this evaluation project: focus groups and individual interviews. Both were conducted to gather information to answer the question, "What may need to be done to enhance sustainability over time for professionals and organisations?" In focus groups and individual interviews we asked participants to share their experiences and beliefs about FVIP development. Interview schedules included the following domains:

1. Description of programme (context)
2. Enablers
3. Barriers
4. Sustainability
5. The Future

Focus Groups

Focus groups were conducted following the 12 month follow up audits. The focus group interview guide is provided in Appendix A.

Questions included, for example:

- ◆ What are the barriers to implementing and sustaining a family violence programme in your setting?
- ◆ What are the enablers of organizational change?
- ◆ To what extent does your setting integrate services with other agencies in the community?

Participants

Purposeful sampling of hospital programmes was based on the maturity of the programme (high or low) and their degree of improvement (high or low) between the baseline and 12 month follow up audits. Four hospitals were initially selected, however one site was not able to take part due to staff turn over (departure of family violence coordinator). For each focus group, 7-12 individuals involved in the hospital response to family violence were invited to participate in the focus group.

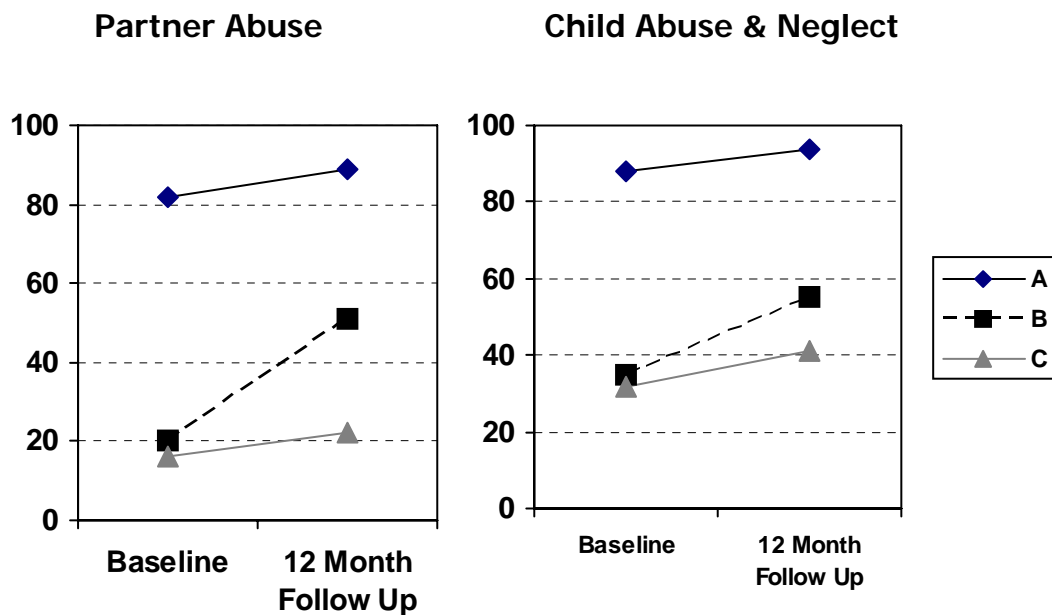
Among the three participating hospital programmes, one was from the South Island and two were from the North Island. Focus group attendees (n= 6, 9 and 8) included representatives from the hospital programme such as social workers, physicians, nurses, family violence coordinators, managers, child protection workers and community women's advocates.

Purposeful sampling of hospital programmes was based on the maturity of the programme (high or low) and their degree of improvement (high or low) between the baseline and 12 month follow up audits.

The characteristics of each site are outlined below (see Figure 4):

- ◆ **Site A:** A mature (4 years) family violence intervention programme; sustained high audit scores over time, ranking in the highest (4th) quartile at both baseline and 12 month follow up audits for both partner abuse and child abuse and neglect programmes; 0.6FTE family violence intervention coordinator (FVIC)
- ◆ **Site B:** Medium level of programme maturity (22 months); large improvement in scores over time, moving from the 3rd to 4th quartile for partner abuse and child abuse and neglect programmes; 0.7FTE FVIC.
- ◆ **Site C:** No formal programme or FVIC; ranking in the 2nd quartile at both baseline and 12 month follow up audits for both partner abuse and child abuse and neglect programmes.

Figure 4: Audit scores for selected focus group sites



Procedure

Family violence coordinators in the selected hospitals suggested focus group participants. Following an informed consent process, focus groups were held at the hospital site with a research team moderator and assistant moderator. Standard focus group methods were followed⁹. Focus groups lasted one and one half to two hours and were audiotape recorded. A summary of each focus group was prepared and provided to focus group participants to check for accuracy of interpretation and for general comment.

Data Management and Analysis

A trained transcriptionist created a written version of the audio-taped focus groups which was audited by research team members for accuracy. Data were analysed using content analysis^{10, 11}. Analysis was descriptive; categories of analysis were developed related to the interview purposes and interview guide questions. Analysis was informed by organisational change and development theory^{6, 12-14}. The software program QRS NVivo (Thousand Oaks, CA: SCOLARI) was used to assist with data management.

Key Stakeholder Interviews

Semi-structured interviews, of one to one and a half hours duration were conducted face-to-face, following an interview guide (see Appendix B).

Participants

Family violence intervention coordinators were purposefully selected so as to gather information from a wide variety of hospital contexts.

Family violence intervention coordinators (FVICs) (including for both partner abuse and child abuse and neglect, or for one aspect only) were purposefully selected so as to gather information from a wide variety of hospital contexts such as rural and urban, and naïve and mature programmes. Participants included FVICs from the four Ministry of Health funded pilot sites. A total of nine interviews were completed with 6 family violence intervention coordinators, 2 child abuse programme coordinators and one paediatrician.

Procedure

Following informed consent, interviews were conducted in a private space within participant's workplace and audiotape recorded.

Data Management and Analysis

A trained transcriptionist created a written version of the audio-taped interviews that was audited by research team members for accuracy. Data were analysed in the first instance using content analysis^{10, 11}, in which categories were developed related to the interview purposes and interview guide questions. The software program QRS NVivo (Thousand Oaks, CA: SCOLARI) was used to assist with data management. Further interpretive analysis was conducted using Giddings⁸ model of social consciousness.

Findings

Descriptive Findings

The focus group data are presented below, supplemented by the descriptive findings from the individual interviews, where appropriate. Following a description of site and individual participants' characteristics, the descriptive content analysis is presented, where the findings are categorised in terms of the focus group guide under the following headings:

1. Description of programme (context)
2. Enablers
3. Barriers
4. Sustainability
5. The Future.

Programme Description

Participants were asked about aspects of the FVI programme in their institution including where the programme was located, who initiated it, why and how, and how it was funded. Key points raised by focus group participants included:

- ◆ 2 programmes had a FVIC (0.6-0.7 FTE); 1 did not
- ◆ Programmes were initially driven by responding to child abuse and neglect (including Children's Commissioner Report (2000))
- ◆ Programmes resided in child and women's health

Participants reported that attention in the health sector had been drawn to the area of family violence as a result of a high profile case of child abuse which resulted in the child's death. As one participant stated, "*It was on the front page of the newspaper continually. It was in magazines, it was very high profile and obviously high profile within the [emergency] department. The DHB had been identified in the review as certainly having some systems changes that we needed to address.*"

In the two hospitals where there were identifiable programmes and family violence intervention coordinators (FVIC) in place, they were situated in women's and children's health units.

Several FVI coordinators reported that the FVI programme began as a collaborative exercise between the DHB and the community, including NGOs and statutory agencies: "*We'd had the liaison with Women's Refuge, CYFS, the police from the very beginning ... Its essential to do this from the very beginning.*" This was not consistent across DHBs however

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another coordinator stated that the [MOH FVI] pilot project was tendered for "*in isolation*" from the community.

FV coordinators shared that they struggled to get programmes started. One coordinator indicated a lack of engagement within the hospital for the programme, reporting a "*huge delay*" in getting staff involved. That was echoed by another coordinator, "*I assumed the Steering Group nominations would have a bit of understanding, but it didn't follow ... Basically I spent the first year trying to warm up the place to this idea which was incredibly wasteful.*"

Enablers

Enablers are defined here as factors that participants reported as assisting their FVI programme development. Enablers identified by participants are listed below with supporting reflections following.

- ◆ Senior management support
- ◆ Support of senior and influential clinical staff, including 'programme champions'
- ◆ Dedicated Family Violence Intervention Coordinators (FVICs) for both partner abuse and child abuse and neglect
- ◆ Building on existing systems and structures
- ◆ Working with family violence 'friendly' units
- ◆ Good internal relationships within the hospital and building a collaborative team
- ◆ Clear policies and procedures
- ◆ Gradual programme roll out (including piloting)
- ◆ Close networking with NGOs (eg. Women's Refuge) and other agencies in the community (police, CYFS)
- ◆ Family Violence Project Evaluation Audit
- ◆ Identifying and addressing attitudinal barriers first.

It is very difficult to move a culture from the bottom up, it has to have buy-in from the top.

Initial senior management support for the programme was crucial in getting resources and funding for the programme: "*We need a lot of persistence but what is needed is managerial power, managerial weight to make the cultural shifts and changes ... it is very difficult to move a culture from the bottom up, it has to have buy-in from the top...*" Senior and general managers advocated for the funding to appoint a family violence coordinator and acted as programme champions or sponsors. "*[The senior manager] makes sure that [the FVI programme] stays in place. It's in the district annual plan, and it stays on the strategic plan for the Children and Youth Service, its in all of our strategic planning documents which means that now its reported against and we're constantly keeping it visible.*". One strategy identified for involving senior managers was to include them in the FVI programme steering group.

Programme champions: Several felt strongly that champions (staff in different services who supported the FVI programme and modelled behaviours such as screening) were important in strengthening the programme: *"amazing ... she just made it happen ... has been contagious ... done some training ... amazing response from staff ... she said 'just b**##r all the issues and get going and try it' . She is a bit of a risk taker."*

Family violence coordinator: Leading on from that, the fact that there was a person dedicated to the driving of the programme was also strongly identified as an important factor in programmes success. That person was able to work closely within the hospital structure and build on relationships internally and externally (other enabling factors frequently mentioned).

Building on systems and structures already in place: Systems and structures include policies and procedures, documentation and monitoring procedures, and internal or external working groups (e.g. internal case review groups; involvement in CYF Care & Protection panel). Both hospitals already had some policies and procedures in place for child abuse and neglect and could build on those as a framework for more comprehensive family violence intervention programmes (e.g. procedures for notification of NAI- non-accidental injury). Even in the hospital with no programme, there were clear elements that people identified of what could be called 'programme readiness' including child abuse and neglect policies and mandatory child abuse and neglect training; where participants said things like 'all the structures are in place, all we need is someone to coordinate it'

Working with FV 'friendly' services: Where systems, policies and procedures were already in place to some extent, focus group participants reported that they were occurring in the more receptive or 'friendly' services to work with initially. In the two hospitals with programmes, both identified child health services as being a starting point for programme development. In addition, one mentioned that mental health services were particularly receptive; in the other, the ED unit staff themselves identified the need for a more proactive strategy regarding the management of abused women and initiated a pilot project.

In the two hospitals with programmes, both identified child health services as being a starting point for programme development.

Fostering good internal relationships: Focus group and interview participants from hospitals where there was a programme in place believed the FVIC was also able to establish and maintain good working relationships within the hospital and via the steering group build up a group of resource people and internal 'champions' to advocate,

educate and act as mentors for staff. FVI coordinators also reported that achieving 'buy in' from staff was important: "We just link in to heaps, and heaps of different places – IT, Training Unit, legal system, mental health, all staff ..." and including a cross-section of representatives on the steering group was helpful: *"Its much easier I think in some ways for managers to talk to managers, or doctors to talk to doctors, to get that buy in it's really useful to have that level [of involvement]"*.

Establishing clear policies and procedures was also a crucial part of embedding the programmes in systems.

Developing clear policies and procedures: Once the FVIC and steering groups were in place, establishing clear policies and procedures was also a crucial part of embedding the programmes in systems. In conjunction with this was communicating the policies and procedures to staff through comprehensive and mandatory education and training. In addition, when it came to implementing the programme, both hospitals emphasised it was important to do it gradually. One person from a region with a strong farming sector mentioned that it was important not to 'top dress' the programme. Others used the concept of 'piloting' as a way of introducing the programme in a manageable fashion; this 'trial' led to an ongoing commitment:

"I suggested 'what about a 3 month trial with monthly reviews to see how it's going' which we've done. ... it was about giving them a bite size chunk, you know lets try this out. And they did... they did say though that no matter how much we look at it as a trial we can't start and stop so we have to commit. I mean they all did, they committed to keeping going".

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Outside community and other agencies were involved in a genuinely collaborative way very early in the process: *"I think the absolute thing that has helped and worked are the networks and the relationships ... the community collaboration"*.

Developing good collaborative external networks: Also given emphasis by participants was the importance of close networking with NGOs and other agencies. This 'networking' occurred at different levels, from the development of prevention strategies and activities, to information and resource sharing, to case management (through mechanisms such as the local CYF Care and Protection Resource Panel). Tangible demonstrations of collaboration included developing a memorandum of understanding with agencies such as CYFs; involving them and other agencies such as the local women's refuge and police in training, and in fact involving them in the development of the training programmes. Thus, outside community and other agencies were involved in a genuinely collaborative way very early in the process: *"I think the absolute thing that has helped and worked are the networks and the relationships ... the community collaboration"*. Involvement of NGO and agency

representatives from the community from the beginning also ensured that the programme was responsive to the community's needs: *"we drafted the guidelines. Police, Refuge, DOVE, E.D., me and our legal person from the DHB ... we had all the key players around the table,*

sitting down, talked it through. We drafted the guidelines [document], sent it back out to them for review".

Participating in external audit: Participants in both the focus groups and individual interviews emphasised that the AUT audit process had been an important enabler in programme development: *"helps in terms of buy-in – 'Oh, my god, they are coming back!" "It's a bomb under people here ... nothing quite like the 'A' word to get people moving." "Provides pressure from above". "We bleat from the sidelines while you come in with your stick".*

Of note, the focus group held at the site with no programme mentioned that the audit played a role in developing programme readiness for several reasons. The audit played a part in raising awareness of FV within the hospital; it prompted them to develop an Action Plan to be more proactive in the area of FV; it was a tool for encouraging more consistency across DHBs; and it was a resource for lobbying for more resources, particularly in the area of child protection.

Addressing institutional and attitudinal barriers: identifying and addressing barriers to FVI programmes first was identified by FVICs in particular as being a key strategy in assisting programme implementation: *"deal first with all the reasons why screening is impossible"; "You know they would just be brewing in the background". "I put to them 'these are all the blocks, these are all the hassles, here are some solutions".* In the course of programme implementation, one FVIC explicitly asked management and staff to voice their concerns:

"Oh internally there were people concerned about whether the community groups were skilled and were they good enough, all that kind of institutional arrogance really ... there were lots of concerns about who carries the responsibility and the risk ... But there was lots of concern about ... who does the patient belong to, for want of a better word, once that partnership [with community agency] gets going."

Oh internally there were people concerned about whether the community groups were skilled and were they good enough, all that kind of institutional arrogance really.

Barriers

Barriers to programme development are factors that are perceived to hinder or prevent programme implementation and development. Participants in the focus group from the hospital where there was no programme in place identified over a dozen barriers to implementing a programme compared to those where there was a programme (which identified only three or four). However, FVICs identified more barriers, many of them relating to the resistance to attitude and institutional culture change.

Key barriers identified by focus group and individual interview participants are listed below.

- ◆ Pre-existing attitudes
- ◆ Resistance to institutional culture change
- ◆ Lack of institutional support
- ◆ Lack of long term commitment
- ◆ Relying on individuals (rather than embedded in systems)
- ◆ Competing demands.

Pre-existing attitudes: As highlighted in the section above, in those places where programmes were in place, participants identified lack of awareness and education as a strong initial barrier that was largely addressed through ongoing education and mentoring. In the hospital focus group where no programme was in place, participants themselves expressed opinions that reflected they were not supportive of initiatives such as screening. In that group, through the course of the discussions, participants also began to acknowledge that lack of awareness could mean that cases both of partner abuse and child abuse were not being identified or addressed.

Other concerns raised included the issues of staff and referral agency overload: *"there was a huge concern about overload, you know if you are going to screen ... and some of those want referral, you know is this going to bombard the community agencies."* – *"[the issue is] huge internally and externally", "People to pick up the work generated by the screening programme". "Overload on existing workers."*

In addition, gender issues were also mentioned: *"My experience has been the [staff] that ask me the most challenging or slightly aggressive defensive questions have normally been men."* *"The first male clinician said 'what about men aren't you going to screen men'. ... The whole process stopped there and it came back to the table."*, *"[Men have] challenged me more than the women in [staff training] groups ...sometimes huge defensiveness, sometimes outright kind of aggression- 'are you trying to tell us this is all our problem, all our fault' attitude".*

Institutional culture: Several of the FVIC participants believed that FVI was not supported by the institutional culture or part of the health care service delivery paradigm: *"Getting medical and nursing staff to broaden their scope even fractionally, to incorporate family violence is just not in question – 'Just let me fix the bones or whatever'."* , *"FV not seen as a health issue", "there's a resistance to risk-assessment, suicide and homicide", "it's not an organisational issue yet. They don't see themselves organisationally accountable for addressing family violence as part of a health care service".*

Lack of institutional and senior management support: Further, attitudes of management were also reported to be barriers to programme implementation and development, and were reflected in institutional barriers including lack of institutional support (reflected by lack of senior management support and corresponding lack of allocated resources): *"I think we are fast becoming a luxury item ... I think that is how we are perceived." "When I raise the issue of funding people kind of shift around in their seats and I do sense they are uncomfortable ... they just hope it will go away actually." , "We took it to (two managers) who neither understood the issues of family violence so in terms of barriers that is a huge one." [FVIC] being a SW affected the buy-in. People still see FV as a social work issue". "[Service providers say] 'We are not funded to do this. The MOH puts out these Guidelines and they ask us to do more and more but no resources'".*

We are not funded to do this. The MOH puts out these Guidelines and they ask us to do more and more but no resources.

In the focus group site where there was no programme or coordinator, the DHB senior management did not support allocating any dedicated resource to the programme and this was seen by group participants as the primary reason why there was no proactive programme in place. This lack of support meant that there were no DHB wide policies and procedures. The lack of FV policies and procedures was seen as a large barrier to implementing a programme at that hospital.

The absence of institutional support was reflected in the perceptions of FVICs that their position in the hospital was unclear, and they felt unsupported and isolated in their role: *"There are always issues because we are isolated within the hospital and within the wider DHB network...". "Not being accepted as knowing about health – get isolated off ..."if you were from health that would be better; ...", "there is no structural accountability, I don't report to any manager ... I could have done nothing and no one would know".* Several FVICs reported that there was a lack of immediate collegial and administrative support, and they were expected to have a wide range of skills and knowledge that they did not necessarily have: *"Oh it is tricky. I think it's about marketing, change-management, it's about awareness raising ... a really good understanding of the systems in this place ... I have had to learn some of these.*

Lack of long term commitment: Even in those sites where there was both an established programme and coordinator, a lack of long term commitment was perceived as being a threat to the programme. Several FVICs noted that the nature of FVI programme implementation was long term: *"No matter how many presentations I do [to staff], no matter how much research I put to them ... use their language ... it's a long slow process."* And that resource allocation needed to reflect that.

Our institutional supporters are amazing people but not people with a lot of pull in this joint.

Reliance on individuals: The majority of participants expressed a concern that the programme was reliant on individuals rather than being embedded in systems, and that if one or two key people left, initiatives could be jeopardised. This concern perhaps reflects that programmes, and the policies and procedures that go with them, are still very new and recognised as 'fragile': "*The problem is when that one person goes the whole lot gets lost so there is no institutional knowledge ... knowing your way around the health system, the Fv systems, database systems, office systems ...*". There was also concern that programme supporters were not influential enough to effect system change: "*[our institutional supporters are] amazing people but not people with a lot of pull in this joint*". "*we talk ad-nauseum about programme champions, we didn't have any ... it's tricky to rely on one person*".

Competing demands: Across all hospitals where the focus groups and interviews were held, participants acknowledged the wider context of competing demands for health resources. This was especially expressed amongst participants where there was no programme in place. However, even where there was a programme, there was an acknowledgement that at times it was difficult to implement in some services or release staff for training (for example in winter where staff were often ill and admission levels in services such as children's wards were higher).

Sustainability

Sustainability factors include those that participants identified as contributing to the programme's survivability. Many of the barriers mentioned in the section above were also included as factors hindering the sustainability of the programme, including lack of long term commitment and lack of institutional and management support. Issues identified across the three groups as enhancing programme sustainability are listed below.

- ◆ Gradual roll out
- ◆ Doing things well
- ◆ Embedding before expanding
- ◆ Providing ongoing support and refresher training
- ◆ Network of resource people
- ◆ Secure, ongoing funding.

Gradual roll out: Closely linked to programme barriers and enablers are the issues that people identified as necessary to keep FV initiatives going. In the hospitals where programmes were in place, participants emphasised the importance of doing things gradually and well, so that policies and procedures were well established in some units or services before expanding into others.

Ongoing training: was identified as being key to this embedding process, because of factors such as staff turnover and need for 'refreshers' and support for those staff who were having difficulty with aspects of the programme (such as asking screening questions). In addition to this training, a network of resource people both within and outside the hospital was regarded as being important in supporting staff in consistently carrying out procedures such as screening, identification and documentation. Ongoing support also included encouragement: “[what keeps the programme going is] the ongoing support from [the paediatrician], from the clinical charge nurses, the celebrating small successes. You get to 22% [screening rate] and you make a huge fuss of everybody. You look at small incremental changes”. In the site with no programme, internal networking across the DHB was regarded as an important way of building on the initiatives that were already in place, particularly in the area of child abuse and neglect.

You get to 22% screening rate and you make a huge fuss of everybody. You look at small incremental changes.

Secure, ongoing funding: A need stated by all participants was for ongoing, secure funding for the programme. In the case where there were programmes, participants expressed concern about the uncertainty of funding for the programme in the future; where there was no programme, people said that some kind of support with dedicated funding was necessary before any kind of formal programme could be implemented.

The Future

Focus group participants identified several factors necessary for moving FV programmes into the future.

- ◆ Need for ongoing commitment and funding
- ◆ Communicating the programme to the community and developing stronger links
- ◆ Expanding programme (services, abuses)
- ◆ Location of FVIC within the hospital structure (related to the need for authority across services)
- ◆ More support from MOH
- ◆ Coordination of effort across health services, and sectors.

Need for ongoing commitment and funding: This featured most strongly in discussions with participants about the future of their FVI programmes, whether from the DHB or from the Ministry of Health. All the coordinators were on short term contracts, which participants reported as adding to the air of uncertainty. Where there was no programme, the lack of dedicated funding from the DHB meant, in participant's eyes, no formal programme was possible.

Communicating programme to community and creating stronger links:

Where there was a programme in place, the groups had many positive ideas about the future of their programme. These included developing stronger links with the community, communicating what the DHB was doing to the community, and perhaps having the equivalent of a health appointed FVIC in the community.

Expanding the programme to other services and health professionals:

Other ideas included expanding the programme into other services that until that time had been less receptive, including medical and surgical services; providing more in-depth education and training for health professionals eg. Lead Maternity Carers and general practitioners; and also expanding the type of abuses addressed, in particular elder abuse. These approaches would be consistent with, as one participant put it: *"Ensuring a whole DHB wide coordinated response – not a crisis response"* which coordinated both partner abuse and child abuse and neglect intervention: *"[Partner abuse] and child protection need to work together closely – need experience at the same level"*.

Location of FVIC in institutional structure: Participants from the hospitals with programmes also expressed a need for FVIC to have authority across services. Participants noted that their current location in either children's or women and children's health impeded their authority and credibility beyond those services.

More MOH assistance: For example within the MOH Guidelines a 'how to use' 'tool kit for coordinators' section and training for FVIC – change management, marketing.

We just keep reinventing the wheel in our own little areas when there is no need to do that.

Intersectoral responsibility and coordination of effort: *"All the Ministries are responsible ... to work together ...", "We need to stop re-inventing the wheel ... we just keep reinventing the wheel in our own little areas when there is no need to do that."*

Programme Variation

The quotes below provide an illustration of the themes from each of the focus groups and suggests the different challenges according to stage of programme development.

Greater programme maturity, high audit scores:

- *I think the programme remains fragile. Even within the services with high screen rates, it would take only a few key staff to leave, and I think that it would be at risk of falling over...So we need to put time and effort into supporting the key practice leaders in those services who are asking the questions... I think it would be a mistake to assume that everybody is doing well, take the pressure off.*

I think it would be a mistake to assume that everybody is doing well, take the pressure off.

Medium programme maturity, large increase in audit scores:

- *But I find I've grown through this process and I've learned a lot more about the real value of what we're trying to do and how important it is...just about every family in the region has somebody contact[ing] our services through the year...the screening function, I think we've just got this amazing capacity.*
- *I was told at this training about two social workers who did excellent work, and the emergency department staff wanted me, they were very explicit, they clearly wanted me to go back to social work and tell them what they did and how much they appreciated and respected their involvement ...and I think that then kind of creates a culture of goodwill and good interpersonal...and professional relationships.*

No programme, low audit scores with no change:

- *The implementation of the family violence guidelines was very much influenced by funding and resources to be able to do that. For example [we would need a] family violence coordinator so...we are very much awaiting the...lead from the DHB.*
- *We're still struggling obviously with the partner abuse side because there's no one ...it needs a DHB approach and they need to employ someone in the ...partner abuse area, ... there [are] initiatives everywhere but ... they don't have enough support for the initiatives*

It needs a DHB approach and they need to employ someone in the ...partner abuse area.

Application of Organisational Change Framework

Barriers and enablers were organised according to concepts included in the organisational change framework of Riley et al⁶ (Table 4). According to Riley et al⁶ changes in organisational predisposition and practices are key in predicting programme implementation. Predisposition and practices are in turn influenced by a variety of factors related to internal organisation (notably, human and financial

resources, structures, processes, leadership) as well as the external system (notably, partnerships, support from the resource system and contextual factors). Across all groups and individual interviews, institutional and management support was mentioned as an important factor influencing FVI programme implementation and development. Where this existed, it was evidenced by senior management participation including sponsorship of the programme, participation in the steering groups, and the provision of resources including financial support and FV programme staff. In addition, attention to processes such as networking and relationship building both internally and externally was regarded as being important.

One significant threat to the programmes' that participants perceived was a lack of ongoing commitment to the programme, which was reflected in the short term nature of the FVIC contracts, and an overall feeling that FV was still not a priority within the health sector. As a result, many of the FVICs interviewed reported feeling isolated and unsupported in their role, because the change in the way of working and corresponding cultural shift was not supported by the institution. As one FVIC summarised:

The foundation [work is the] collaboration with community agencies and all those sorts of things which is really important and it takes time developing you know, years.

"I would say this is one of the biggest changes that we've, that I've, experienced [as a health professional], but then I can remember the response when we first asked about asking about ethnicity and smoking and all those sorts of things, and they were pretty scary, but I think that there's a lot of other issues in relation to this around socialization and all of those things that make [screening] quite difficult so, I think that the sustainability is about making sure that you can have a coordinator who's got dedicated time. You've got management support so that funding is not [short term]; this is a five to 10 year plan...the foundation [work is the] collaboration with community agencies and all those sorts of things which is really important and it takes time developing you know, years".

Table 4: Barriers and Enablers for Organisational Change

Factors	Examples of Enablers	Examples of Barriers
Organisational predisposition	High levels of awareness of FV as a health issue and corresponding recognition of overall importance of FV to individual practitioner, hospital and DHB; proactive & sustained response to high profile child abuse cases;	Lack of education and awareness about FV; FV not acknowledged as priority (e.g. not part of strategic plan, annual plan); no sustained response to child abuse;
Organisational practices	High compatibility of existing processes/ positive perceptions of capacity to address FV and effectiveness of FV activities;	Lack of existing processes/negative perceptions about capacity to address FV and effectiveness of interventions;
<i>Internal organisational factors</i>		
a) Human & financial resources	Long term funding for FVI including permanent contract for dedicated FVIC and >0.5FTE, DHB wide support for training; (eg. across the board support of training vs 'project' only for limited time); workload levels/responsibilities ; FV included in senior staff responsibilities; diversity of staff backgrounds involved in FV; training provided and supported by release of staff;	Limited funding for restricted time periods (e.g. 'project only'); FVIC included in other responsibilities with heavy workload; no senior staff responsibilities; staff involvement limited to small no. of services/departments; ad-hoc response to training;
b) Structures	FV Committee hospital & DHB-wide DHB/ where FVIC reports to senior level in DHB; pre-existing identification/recording systems (eg. Alert systems);	FV committee with representatives from limited number of services/departments; FVIC jurisdiction limited to one service/department; no systems;
c) Processes	Comprehensive hospital and DHB-wide policies and procedures that are implemented; Coordination across departments; frequent internal	No/unclear policies and procedures (or not followed); poor coordination across departments; little internal collaboration/communication; No mechanisms for quality

	collaboration/communication; internal self-evaluation;	assurance/evaluation;
d) Leadership	Active commitment by senior management (including CEO); Involvement of influential staff, Senior level(s) of FV programme sponsorship; identifiable FV 'champions' throughout hospital/DHB;	Senior management not committed to FV or engaged in FVI programme; lack of sponsorship at senior levels; profile of FVI programme limited to small no. of services;
External system factors		
a) Partnerships	FV high priority in local community (reflected by active working groups); involvement/collaboration with community FV agencies, government agencies & other health providers;	Few/no FV collaborative working groups in local community; no DHB involvement with local FVI NGOs of statutory agencies;
b) Support from resource systems	Close linkages with, and use of, services/resources of outside agencies; using local contacts to assist in FV response; Accessing MOH FVP support (including coordinators' meeting); actively engaging with external audit (AUT evaluation);	Few/no links with external agencies; not accessing MOH or other DHB supports; non-participation in audit;
c) Contextual factors	Mobilised & engaged community (proxy indicators- accessibility and representativeness of local community networks) Nature of community eg. ethnicity/ SES indicators/size/location/geographical access;	Disenfranchised/mobile community; disbursed over wide geographical area

Interpretive Findings

The stories told by the FVIC about their work paradoxically evoked militaristic metaphors such as 'working at the frontline', 'working under fire', 'caught in the cross fire', 'holding the line', 'spear-heading operations', and 'getting a foothold'. The images reflect the 'battleground phenomenon' often associated with the introduction of new ideas or policies that challenge the status quo and make visible marginalised issues. Family violence is such an issue.

FV coordinators are charged with the task of implementing new policies, practices and protocols that address the needs of victims of violence, who are more likely to experience negative health consequences. Thus, their task is one of affecting a shift in the current culture. The status quo is a culture where FV is not perceived as a health issue, and therefore intervention is not the role of the health professional. The 'awakened' and 'expanded' culture is where FV is a significant health issue, and intervention by not only health professionals, but the health care system in total, is an expected and routine part of quality health care provision.

In keeping with the militaristic language used by interview participants, the metaphor of being 'at war' has been used to further describe the interpretation of the findings. FV coordinators were at the forefront in the implementation of FV prevention strategies, they become the 'face' of the programme. Their mandate, to assist in changing institutional culture, placed them everyday in the position of challenging personal and societal attitudes and institutional systems that maintain the status quo of tolerance of abuse. FV coordinators were faced with dilemmas and paradoxes related to their positioning. As stated by Giddings, "it is instituting the changes that will disrupt the constructed ideal that is the challenge"⁸. The paradoxes that emerged in analysing the FV coordinator data are included in Table 5.

Table 5. Paradoxes for Family Violence Intervention Coordinators (FVIC) in Challenging the Health Care System to be Responsive to Family Violence

<i>On the one hand</i>	<i>On the other</i>
<ul style="list-style-type: none"> • FVIC is an institutional position • FVIC positions are on short-term contracts and limited FTE • Resourced for a picnic • Lack of clear job descriptions, collegial support and role delineation • 'Burrowing-in' and 'lying low' • Getting rhetorical support • Negotiating shifting terrain • Assumptions about FV 'community' sharing common values, goals and visions 	<ul style="list-style-type: none"> • FVIC is not on the organisational chart • FVICs have high levels of passion and commitment • Faced with a war • Expected to know and do 'it all' • Need to 'stand tall' and be seen • Receiving constant critique • Juggling demands • Not matched by experience

Discussion

This family violence project evaluation indicates there are vast differences in levels of FV intervention programme service delivery, ranging from no programme to programmes that are beginning to be well supported by systems and processes. Organisational predisposition and attitudinal change at senior management/decision making levels appears key in initiating the introduction of a family violence programme (including the funding and support of a coordinator position), and is important in mitigating the at times stressful position of FV coordinator as change agent.

As FV programme development is still in its infancy across Aotearoa NZ, it is appropriate that efforts are concentrated on actions directed at enabling programme implementation. However, in those small number of DHBs where programmes have been in place for at least four years, it is appropriate that attention be re-directed at factors that may impact on sustainability. Table 6 below identifies actions that could be taken to influence internal organisational and contextual factors and who could take those actions.

Table 6: Suggested actions to positively influence factors related to FV programme implementation

Factors	Examples of suggested actions	Responsibility
<i>Internal organisational factors</i>		
a) Human & financial resources	<ul style="list-style-type: none"> ○ Ensure funding is allocated to FV programme; ○ Appoint permanent staff to FV coordinator positions; ○ Foster good relationships within the hospital and across DHB; ○ Ensure FVICs are supported internally and have jurisdiction across services; ○ Provide mandatory FV training and enable release of staff; 	MOH/DHB management/DHB Funding & Planning FVIC DHB management DHB management
b) Structures	<ul style="list-style-type: none"> ○ Implement FV Committees/working groups (across DHB/hospital) to support programme development; ○ Ensure FVIC/CPC reports to senior person within DHB structure; ○ Enhance pre-existing systems to support the FV programme (eg. Alert systems); 	DHB management/FVICs DHB management Quality & Risk; IT
c) Processes	<ul style="list-style-type: none"> ○ Implement FV hospital and 	DHB

	<p>DHB-wide policies and procedures;</p> <ul style="list-style-type: none"> o Coordinate across departments; o Work with 'friendly' units and services initially; o Roll out programme gradually; o Include 'refresher' and advanced training, along with accessible staff supervision; o Monitor for quality and self-evaluate to ensure continuous FV programme improvement; 	<p>management/service level managers/ FVIC</p> <p>FVIC</p> <p>DHB management FVIC Quality and Risk</p>
d) Leadership	<ul style="list-style-type: none"> o Engage senior management (including CEO); o Involve influential staff, gain senior management sponsorship; enrol/identify FV 'champions'; 	<p>MOH/ DHB CEO & management/Funding & Planning DHB Management DHB Quality and Risk/ FVIC</p>
External system factors		
a) Partnerships	<ul style="list-style-type: none"> o Make FV high priority in central government and local community; o Involve/collaborate with community FV agencies, government agencies & other health providers; 	<p>MOH</p> <p>FVIC</p>
b) Support from resource systems	<ul style="list-style-type: none"> o Utilise services/resources of outside agencies; network with local contacts to assist in FV response; o Continue/enhance MOH FVP support (including coordinators' meeting, provision of resources); o Conduct regular external audits (e.g. AUT evaluation); 	<p>FVIC</p> <p>MOH</p> <p>External evaluation agency</p>
c) Contextual factors	<ul style="list-style-type: none"> o Engage with local community to ensure FV programme responsive to nature of community eg. ethnicity/size/location/geographical access; 	<p>DHB management FVIC</p>

Implications for Health Services

In a review of partner abuse intervention evaluations, Ramsay et al¹⁵ make several recommendations for health policy in the United Kingdom, including:

- Improve links between community-based FV advocacy programmes and local health services, for example by implementing a formal relationship between advocates and health services
- Make advocates available in health settings in response to routine questioning in antenatal and emergency departments as a matter of priority;
- Health care services need to integrate responses to FV with clinical activity, with a designated person responsible
- Training on FV identification, support and referral need to be integrated into health care professional education at graduate and post-graduate levels
- Training should include close collaboration with community-based services.

Many of these recommendations are supported by our findings and it is encouraging that they are currently being implemented in FVIP across the DHBs.

As highlighted in this report, it is essential that the health sector does not work in isolation in its efforts. Collaboration with other agencies such as police and CYFs, and NGOs such as Women's Refuge, is a major contributing factor to the success in programme implementation (and arguably, ultimately to outcomes). The inclusion of Health in the Ministerial Team and Taskforce recognises that the health sector has a key role to play in an integrated, 'whole of government' cross-sector response to violence.

It is essential that the health sector does not work in isolation in its efforts.

In their *First Report*, The Taskforce state:

"Eliminating family violence requires co-ordinated, multi-level action over a number of years – no intervention will work for everyone, and no government department, court or community organisation can prevent family violence in isolation. We need a long-term integrated suite of actions at national and local levels. We also need to keep people well-informed about what works, and put people in touch with others working in their field."^{1p. 32}

A number of the action plans included in the Taskforce's *First Report*

are directly relevant to this report, including “learning from people on the frontline about what we need to change policies and practices” and “train all the people who come into contact with families that experience violence so that they can better screen, help and refer” (2006:p.10). From the findings reported above, many lessons are apparent: FVI programmes need dedicated, ongoing resource (in the form of FVICs and long-term contracts for those positions) to ensure sustainability of programme development.

Implementing a FVIP is part of a process of affecting a shift from the dominant culture in the DHB

Strategies for Culture Change

Family violence intervention coordinators are at the forefront of a cultural change within DHBs becoming more responsive to family violence. Implementing a FVIP is part of a process of affecting a shift from the dominant culture in the DHB environment. A shift from a system unable to adequately respond to FV, to one where FV response is integrated into the organisation, becoming part of the everyday health care service delivery. The focus group and interview findings presented above highlight factors that help and hinder that change process, and that contribute to, or detract from, the hospital’s predisposition to adopting and implementing a FVIP.

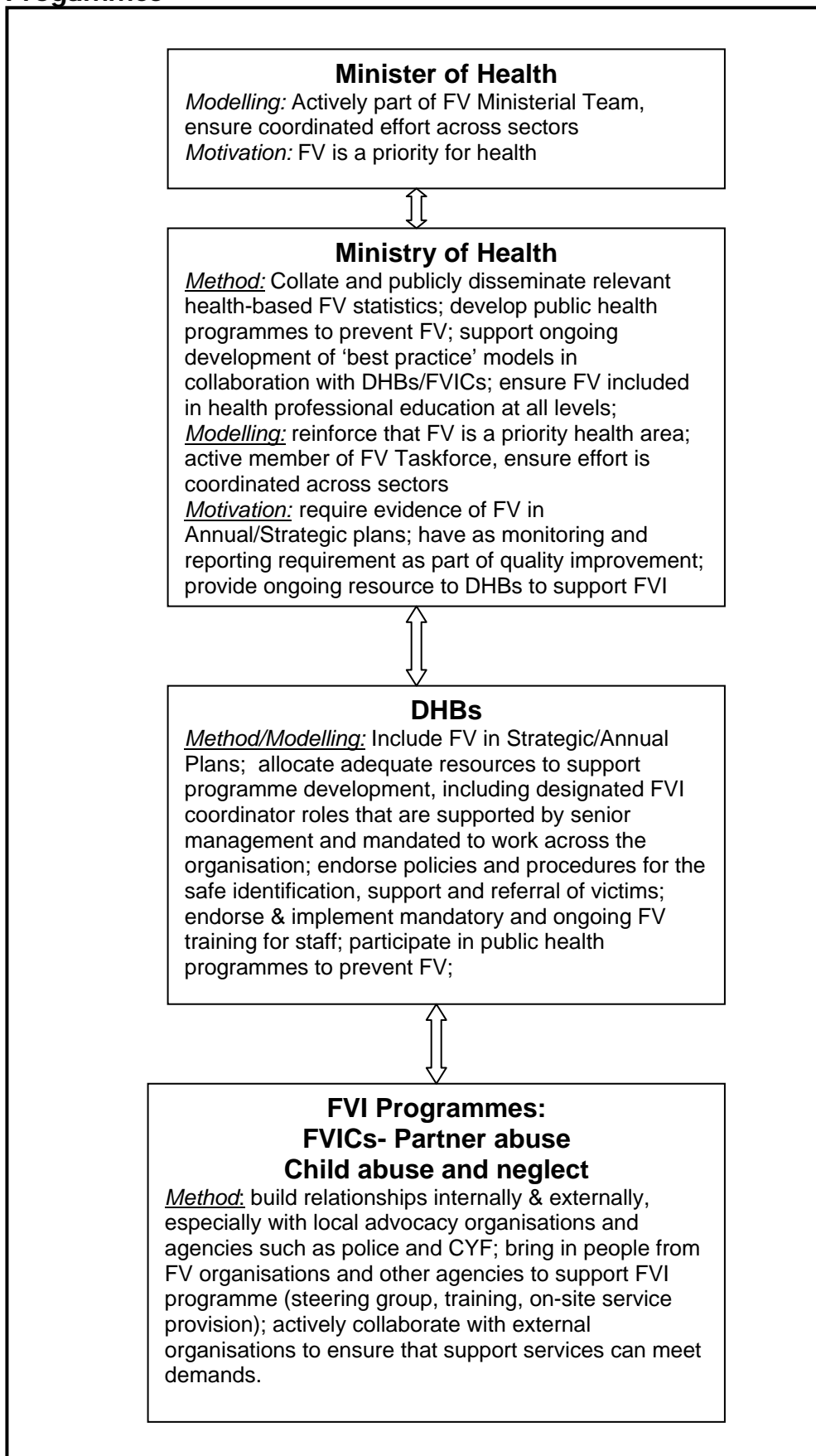
To implement change in the area of family violence within the health care institution, a number of principles apply to both individual and organisational change^a

1. **Method:** (skills, knowledge, competencies and resources to implement the change)
2. **Model** for change (What does the new behaviour/practice actually look like? How will we know if we’re doing it right?)
3. **Motivation** (intrinsic – understanding that it’s a good idea; plus extrinsic – carrots and sticks)

Attention to each of these areas builds the capacity of the health sector to respond to family violence. Based on these general principles and the findings of the qualitative data collection, recommendations to support the development of FV programmes within DHBs across Aotearoa NZ are made below (Figure 5).

^a Adapted from Davidson (2006).

Figure 5: Recommendations to support development of FV Programmes



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Appendix A: Focus Group Interview Guide

Opening:

- Tell us who you are, what organisation you're from, and your role there.
 - What is your role in the area of family violence?
-

Introduction: Background to the FV programme in the hospital

- How did the Family Violence Programme come about at the hospital?
 - Describe the family violence intervention programme in your hospital: Where is it situated in the organisation? Which groups are involved?
 - To what extent does the hospital integrate services with other agencies in the community?
-

Key: Implementing an Effective Family Violence Intervention Programme

- How would you describe an effective family violence intervention programme?
 - What does it take for a Family Violence programme to be successful?
 - Structures, processes, outcomes, community collaboration
-

Key: description of the FVP at the hospital

- Thinking about the elements of a successful programme, to what extent has such a programme been achieved in your setting?
 - What things about your organisation help it change?
 - What things get in the way of it changing?
 - Thinking about the programme here, what has helped to get things going?
 - What has got in the way?
 - Financial, social, cultural, structural, policy, processes
 - What has helped things continue to improve?
 - Financial, social, cultural, structural, policy, processes
 - Once things have got underway, to what extent do they keep going? Why? Why not?
-

Where To From Here?

- If you were in charge, what would you do with regards to family violence?
 - How would you make sure that things kept going?
 - What would you need to do to make sure that what was done was effective?
-

Closing

- We recognise that there are other perspectives on family violence programme that haven't been represented here today- would anyone like to bring anything to the table to acknowledge those perspectives?
 - Have we missed anything?
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Appendix B: Individual Interview Guide

1. Interviewee history

- a) *Can you tell me about how you came to be involved in Family Violence work?*
 - *How did your role evolve?*
 - *What is the title of/clarify your current position?*
 - *Who do you report to? (for an idea of where fits in structure)*
 - *If appropriate: How do you link with the FV Programme? (especially if in CP role)*
- b) *Tell me about the family violence programme locally and in your organisation.*
 - *How/when did it start?*
 - *What individuals/agencies are involved?*
 - *Where does the funding come from?*

2. Experience of barriers/enablers

- a) *Every intervention programme has aspects which help and others which hinder the programme to work. Thinking about a family violence programme:*
 - i. *What kind of things do you think make a successful programme?*
 - ii. *What about things that are barriers to a good family violence programme?*
- b) *Thinking about the organisation where you work,:*
 - i. *What kind of things have helped the programme?*
 - ii. *What kind of things have not helped or have stopped the programme working as well as it could?*

3. Sustainability of the programme

- a) *How do you see the future of the programme at your organisation?*
- b) *Which parts of the programme are more likely to last?*
- c) *Why do think that is?*

4. Policy environment

- a) *How have you found the MOH Family Violence Intervention Guidelines?*
Possible probes/prompts: Which aspects have been helpful? Which parts have not been so useful? What ways could they be improved?
- b) *In your view, what role should the MOH take in FVP?*
- c) *What about other agencies?*

5. The future of the FVP

- a) *What other strategies would help organisations deal more effectively with FV in the long term?*