## CULTURAL RESPONSIVENESS

VIP recognises culturally responsive health systems contribute to reducing health inequalities. However, despite advances in some DHBs, further development is needed. For example, 40% (n=8) of DHBS have a quality framework used to evaluate whether services are effective for Māori in the CAN Programme.

Partner Abuse Programme DHB cultural responsiveness scores ranged from 80 to 100 with 93 as the median score.

Child Abuse and Neglect Programme DHB cultural responsiveness scores ranged from 71 to 100 with 91 as the median score.

## PROGRAMME MONITORING

The national VIP Snapshot clinical audits will include Alcohol & Drug and Community Mental Health Services in 2016. Refinement of definitions and processes to ensure standardisation and data reliability continues as new DHB services join the Snapshot clinical audit system.

DHBs continue to self audit programme system indicators in 2016. In addition to submitting audit tools, DHBs will analyse audit results to inform local quality improvement action plans.

Quality improvement activities need to be increased to improve VIP service delivery reliability and quality.

**Infrastructure Monitoring 2016:**

- All DHBs will submit a self audit with data collated by external evaluators. External evaluators will also provide comment on self audit documents. External audits may be conducted in 2016. This spot-check will assess programme progress and quality of self auditing.

**Quality Monitoring of Programme Delivery:**

- Standardised 'snapshot' data will be collated nationally in 2016 for all MoH DHB targeted services.
- All DHBs will submit two Model for Improvement PDSA (Plan, Do, Study, Act) plans focused on improving their services to children, women and families/whanau experiencing violence in their lives.

## PRIORITIES FOR 2016 -2018

- **Conduct a Delphi study** to update the current VIP Delphi Partner Abuse and Child Abuse and Neglect audit tools. The aim is to identify best practice elements of a health response to family violence informed by current literature, the refreshed Family Violence Assessment and Intervention Guideline: IPV and Child Abuse 2016, the New Zealand health context, and programme innovations (e.g. Elder Abuse, Shaken Baby Programmes).
- DHBs to focus on improving the identification, assessment and responses to vulnerable children, women and their families/whānau to achieve MoH targets of 80% for CAN and IPV assessment rates and CP concern/IPV disclosure rates of 5%.
- Implementation of standardised national IT solutions to enable electronic monitoring of VIP by DHB and services.
- VIP will continue to contribute to and support all government initiatives and interventions to reduce child abuse and neglect and family violence.

**For further information about the Violence Intervention Programme (VIP): www.moh.govt.nz/familyviolence**
**The full series of evaluation reports is available from: www.aut.ac.nz/vipevaluation**
**This evaluation work was commissioned by the Ministry of Health to the Auckland University of Technology.**
**Citation: Jane Koziol-McLain, Christine McLean & Nick Garrett. (November 2016) Health Response to Family Violence: 2015 Follow-Up Evaluation Summary. Centre for Interdisciplinary Trauma Research, Auckland University of Technology, Auckland, New Zealand.**

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# HEALTH RESPONSIVENESS TO FAMILY VIOLENCE

## 2015 FOLLOW-UP EVALUATION SUMMARY

The Ministry of Health (MOH) **Violence Intervention Programme (VIP)** seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to designated District Health Board (DHB) services.

Ministry-funded national resources support a comprehensive, systems approach (Figure 1).

This evaluation summary documents the results of the 2015 **VIP Snapshot Audits** in five services at 20 DHBs providing information on VIP implementation and the results of applying an audit tool to measure **system indicators**.

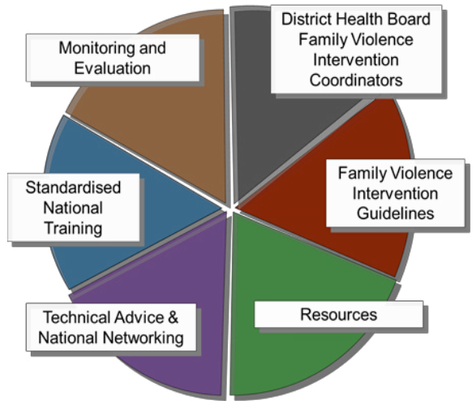


***Figure 1.*** *VIP Systems Support Model*

## VIP Service Delivery Monitoring: Snapshot Audits

***Intimate Partner Violence Snapshots***

**VIP Snapshot audits** use a nationally standardised reporting process to monitor service delivery and inform performance improvements. Each DHB submitted 25 randomly selected cases from among all eligible women and children seen during the 3 month audit period 1 April to 30 June 2015. Snapshot audits provide estimates of: (1) VIP outputs – women and children assessed for violence and abuse, and (2) VIP outcomes – women and children with a violence concern who received specialist assistance.

***Snapshot Benchmarking***

- System reliability is achieved when a standard action occurs at least 80% of the time. Therefore, the VIP aims to achieve intimate partner violence (IPV) and child abuse and neglect (CAN) assessment rates ≥ 80%. The quality of IPV screening (routine inquiry) influences women's decision whether or not to disclose IPV to a health worker.
- The estimated New Zealand population past year IPV prevalence rate among women is ≈ 5%. Therefore, it is expected that with quality service delivery, IPV disclosure rates among women seeking health care are at least 5%.
- Based on the prevalence of CAN indicators (e.g. CAN alert), it is also expected that the identification of Child Protection Concerns is at least 5% of those assessed.

***Child Abuse and Neglect Snapshot***

The 2015 national weighted mean for CAN assessment of children under two years presenting to an emergency department for any reason was 26%; similar to the weighted mean in 2014 (27%). A child protection concern was identified in 9% of the children who had been assessed, a decrease from 13% in 2014. All audited cases in 2015 where a child protection concern was identified, involved specialist consultation.

**Table 1.** Emergency department population estimates of children under two years of age who received CAN assessment and service (April-June 2014 & 2015).

| | Children assessed for CAN indicators | | CP Concern (one or more positive indicators) | | Specialist Consultation | |
|---|---|---|---|---|---|---|
| | **2014** | **2015** | **2014** | **2015** | **2014** | **2015** |
| Population estimate | 4163 | 4242 | 549 | 374 | 489 | 374 |
| Weighted mean | 27% | 26% | 13% | 9% | 89% | 100% |
| 95% CI | 20%, 34% | 21%, 32% | 8%, 18% | 6%, 12% | * | * |

Notes: Proportion of child protection (CP) concerns is among those who received an assessment; proportion of specialist consultation is among those with an identified CP concern; confidence intervals not calculated for specialist consultation due to small numbers within individual DHBs.

VIP snapshot IPV clinical audit findings are presented Figure 2 and Table 2. Sexual Health and Postnatal Maternity services evidenced equal IPV screening rates (48%), but despite more women being seen in Postnatal Maternity services, fewer women received specialist IPV services due to the lower disclosure rate (5% versus 20%). In Emergency Departments, despite lower rates of screening (23%) and disclosure (6%), many more women are served due to the volume of women seen. In the 2015 Snapshot, disclosure rates, as a proxy for screening quality, in Child Health and Postnatal Maternity services dropped below the national prevalence rate of 5%.

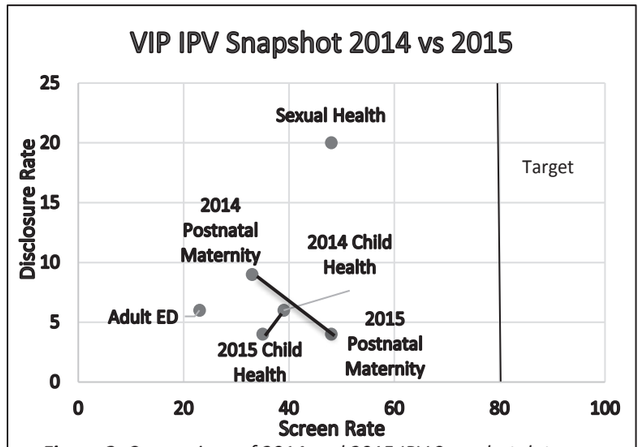


***Figure 2**: Comparison of 2014 and 2015 IPV Snapshot data*

***Table 2**: IPV Population estimates of admissions who received an IPV assessment and service - April-June 2015*

| | Women screened | | Disclosures | | Referrals | |
|---|---|---|---|---|---|---|
| | **2014** | **2015** | **2014** | **2015** | **2014** | **2015** |
| **Postnatal Maternity Inpatients** | | | | | | |
| Population estimate | 2935 | 4,637 | 257 | 197 | 193 | 197 |
| Weighted Mean | 33% | 48% | 9% | 4% | 75% | 100% |
| 95% CI | 26%, 39% | 42%, 55% | 3%,14% | 2%,6% | * | * |
| **Child Health Inpatients** | | | | | | |
| Population estimate | 4869 | 4,513 | 259 | 160 | 181 | 160 |
| Weighted Mean | 39% | 35% | 6% | 4% | 70% | 100% |
| 95% CI | 31%, 48% | 33%, 38% | 4%, 9% | 2%,5% | * | * |
| **Sexual Health Services** | | | | | | |
| Population estimate | na | 2703 | na | 537 | na | 446 |
| Weighted Mean | na | 48% | na | 20% | na | 83% |
| 95% CI | na | 42%, 55% | na | 13%, 27% | na | * |
| **Emergency Department (adult)** | | | | | | |
| Population estimate | na | 21,924 | na | 1310 | na | 982 |
| Weighted Mean | na | (23%) | na | (6%) | na | (75%) |
| 95% CI | na | 20%,26% | na | 4%,8% | na | * |

Notes: na=not audited; Proportion of intimate partner (IPV) disclosures is among those who received an IPV screen; proportion of IPV referrals is among those who disclosed; confidence intervals not calculated for referrals due to small numbers within individual DHBs.

## VIP Infrastructure Monitoring: DELPHI self-audits

All (20) DHBs completed self audits providing system indicator data.

The Ministry of Health target for Delphi overall and domain scores is 80 and over.

All DHBs achieved the MoH target for CAN system indicators; 19 DHBs achieved the MoH target for PA indicators. Median scores over time are shown in Figure 3.

- 2015 Delphi DHB CAN scores ranged from 82 to 100
- 2015 Delphi DHB PA scores ranged from 76 to 99.
- The domain with the widest variation across DHBs for both CAN and PA was 'Evaluation Activities' (SD=23 and 22 respectively).

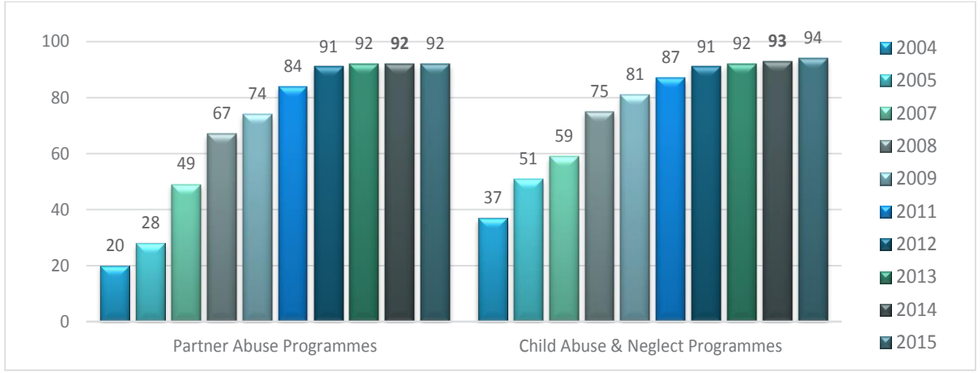


***Figure 3**. National Median Hospital VIP Programme Scores (2004-2015)*

## VIP Implementation

VIP service implementation increased in all targeted services from 2014 to 2015. (See Figure 4).

Note: There are a total of 17 Alcohol & Drug Services and 15 Sexual Health Services nationally.

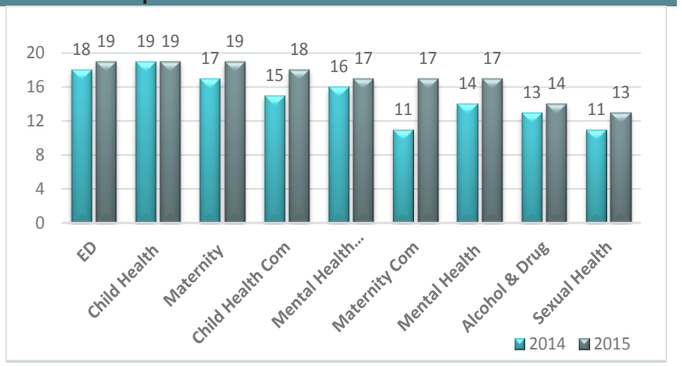


***Figure 4.** VIP Service Implementation increased between 2014 and 2015*

## Partner Abuse Programmes

***2015 Follow-Up Results:***

- 80% (n=16) of DHBs provide an on-site victim advocacy service at all times; 4 (20%) provide victim advocacy services at certain times.
- 60% (n=12) of DHBs incorporate Screening and Safety Assessment documentation in clinical records for all charts in outpatient and inpatient areas; 8(40%) incorporate documentation in two or more outpatient areas.
- 80% (n=16) of DHBs have specific policies and procedures for dealing with employees experiencing partner abuse.

**Evaluation Activities**
75% (n=15) of DHBs achieved the MoH Target Score ≥ 80 in the PA Evaluation Activity domain (scores ranged from 14 to 100). All DHBs are encouraged to enhance their VIP service to children, women, families and whānau through evaluation and quality improvement activities.

## Child Abuse and Neglect Programmes

***2015 Follow-Up Results:***

- 95% (n=19) of DHBs have established National Child Protection Alert Systems (NCPAS). One DHB's patient information system has delayed participation.
- 55% (n=11) of DHBs had a full time identifiable child protection coordinator; 35% (n=7) of DHBs had a part-time coordinator ≥ 0.5 FTE (full time equivalent); 10% (n=2) of DHBs had a part-time coordinator < 0.5 FTE.
- 95% (n=19) of DHBs provide temporary safe shelter for victims of child abuse and their families who cannot go home or cannot be placed in a community-based shelter until CYF or a refuge intervene.

95% (n=19) of DHBs' child abuse and neglect programme is evident in the DHB quality and risk programme.

70% (n=14) of DHBs use a standardised referral form and process for police notification of child protection concerns.