Interdisciplinary Trauma Research Unit

Hospital Responsiveness To Family Violence:

12 Month Follow - Up Evaluation

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Te wairere au noa

MINISTRY OF HEALTH
MANATŪ HAUORA

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

12 Month Follow-Up Evaluation

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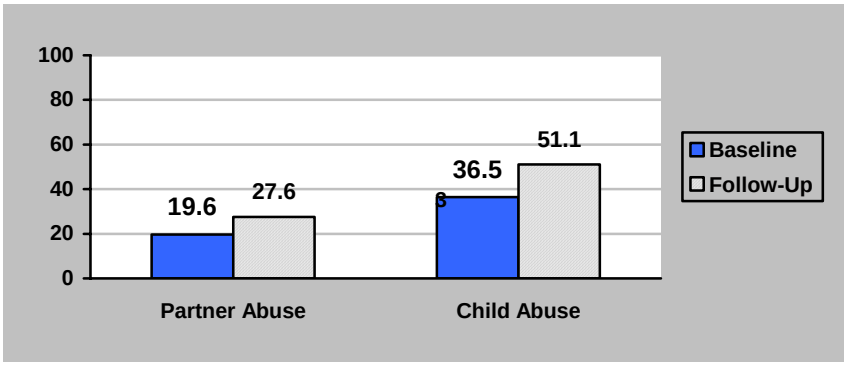
Executive Summary

Family violence (FV) is a priority health issue in Aotearoa/New Zealand - as well as globally - and requires an effective and sustainable health care response. This report is one in a series evaluating health care responsiveness to FV. The first report, published in November 2004, presented baseline hospital FV programme audit findings for the New Zealand acute care (secondary and tertiary) public hospitals (n=25).[1] This report presents 12 month follow-up audit findings and compares them to baseline findings. These quantitative data are one aspect of the overall evaluation, and are the result of applying the modified 'Delphi' tool[a] during hospital site visits; they contribute to the nationwide picture of FV healthcare initiatives across Aotearoa/New Zealand. The audit data answer the following two questions:

1. How are New Zealand District Health Boards (DHBs) performing in terms of institutional support for family violence prevention?
2. Is institutional change sustained over time?

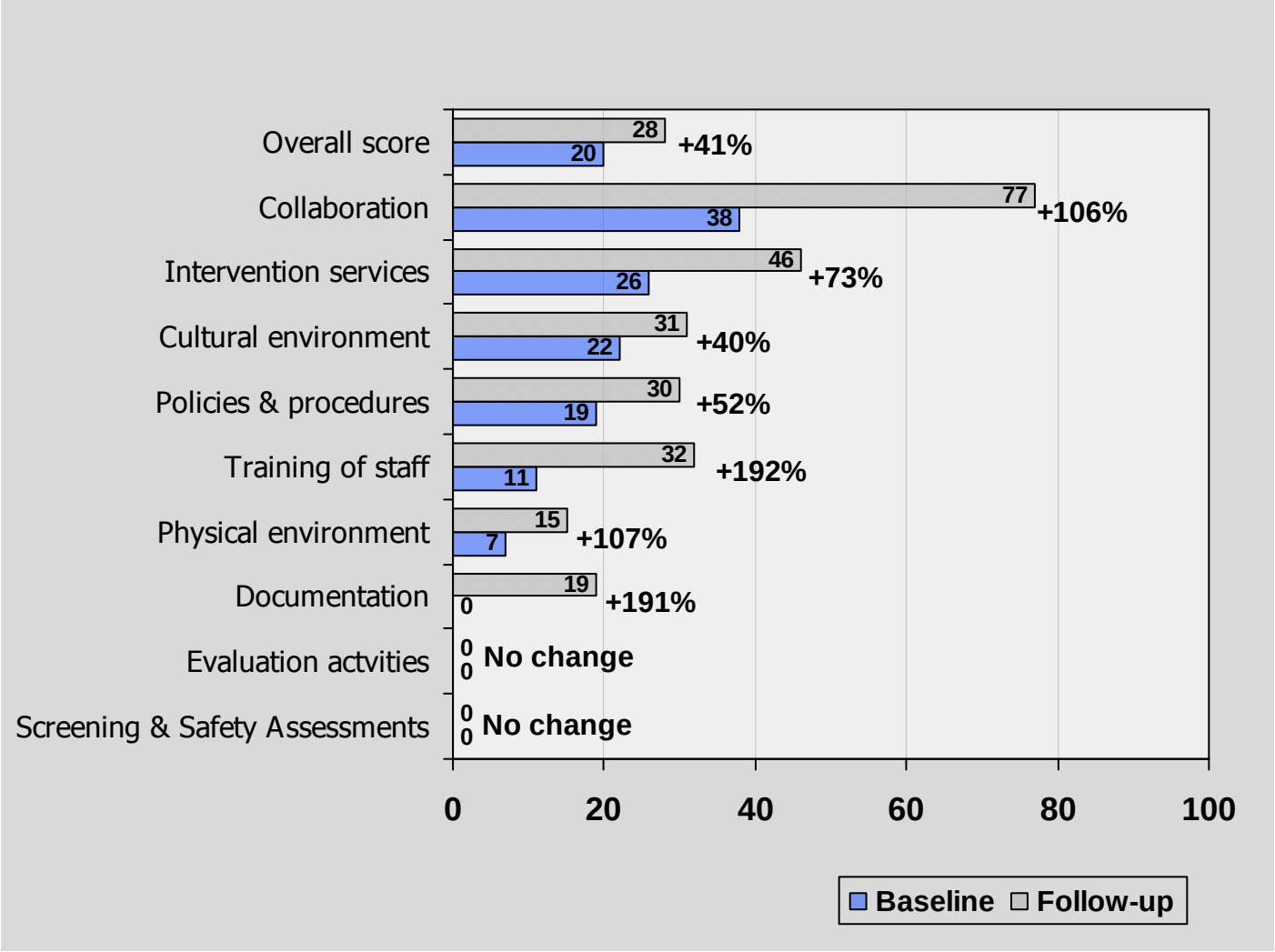
Results of the follow-up audit indicate that significant progress has been made in programme development for responding to both partner abuse and child abuse and neglect (see Figure 1). The median score for partner abuse intervention programmes was 28, an increase of 41% over baseline. The median score for child abuse and neglect intervention programmes was 51, with a similar increase of 40% over baseline. The higher child abuse and neglect intervention scores are indicative of programme longevity compared to partner abuse intervention. Eighty percent of the child abuse programmes have been in existence for longer than 2 years, compared to only 16% of partner abuse programmes.

Figure 1. Baseline and Follow-up Median Hospital Family Violence Programme Audit Scores (n=25)



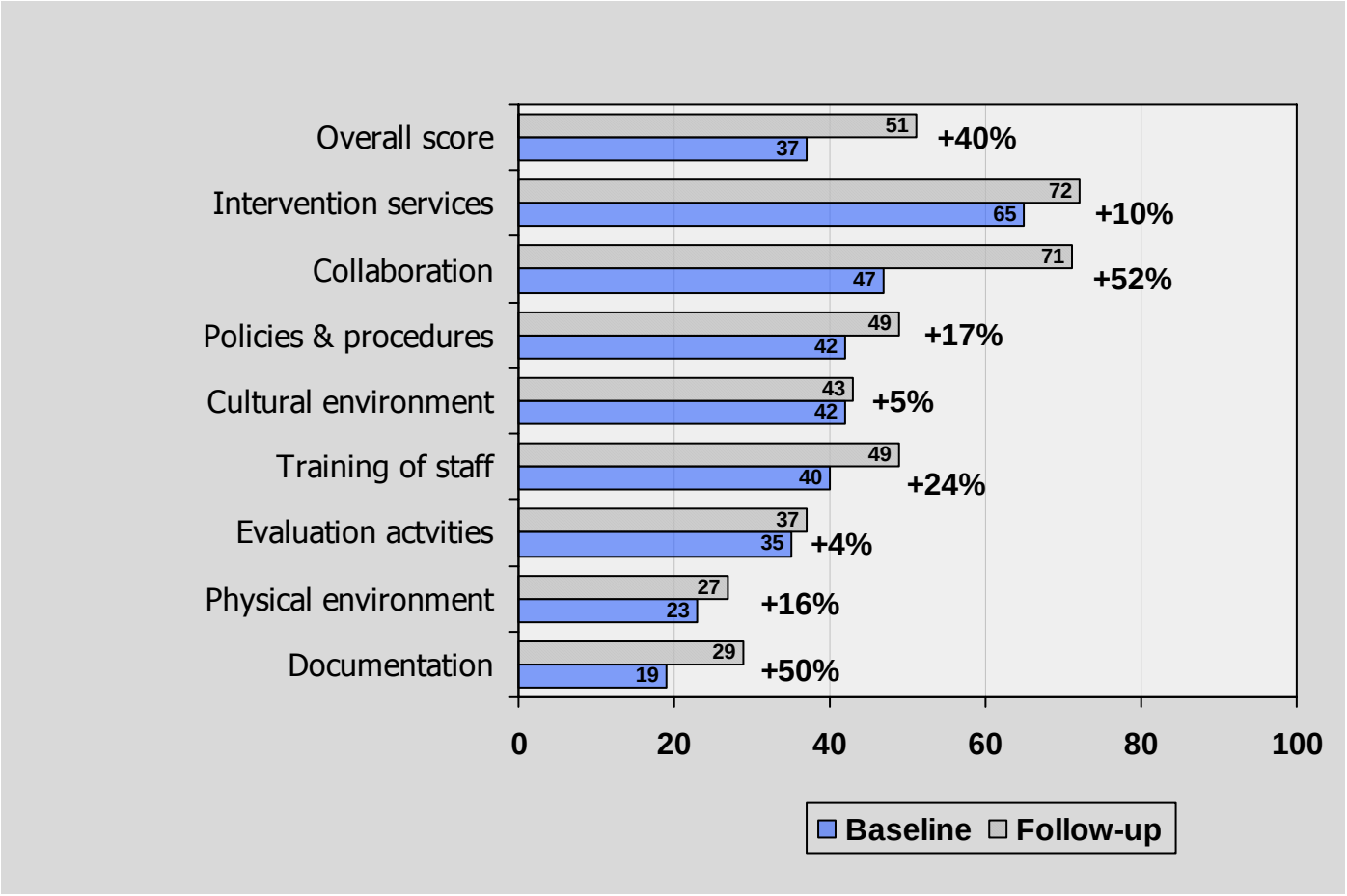
[a] The 'Delphi' tool included two sections, the first addressed partner abuse programme elements and the second addressed child abuse and neglect programme elements. Scores for each section as well as for domains within the sections range from 0 to 100, with higher numbers indicating greater system development.

Figure 2. Partner Abuse Domain Score Changes (Median Scores)



- The most developed partner abuse programme domain is *Collaboration*. This represents within hospital as well as interagency cooperation and is an important prerequisite for partner violence screening in the healthcare setting.
- Improvements were seen in all partner abuse programme domains with the exception of *Evaluation Activities* and *Screening and Safety Assessments*, for which the medians scores remained at 0.

Figure 3. Child Abuse and Neglect Domain Score Changes (Median Scores)



- The most developed child abuse programme domain remains *Intervention Services*, closely followed by *Collaboration*..
- Improvements were seen in all child abuse programme domains, especially for *Collaboration* and *Documentation*.

The follow-up audit demonstrates that significant progress has been made in the short span of 12 months. That said, scores reflect the fact that most hospitals are in the early stages of programme implementation. There remains important work to be done. For example,

- 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.

It is a concern that 9 of the 25 hospitals had no family violence coordinator at the time of the follow-up audit. The overall partner abuse median score was 11 for those hospitals without a coordinator, compared to 40 for the remaining 16 hospitals.

Ten of the 25 hospitals had no child abuse programme coordinator. The overall child abuse median score was 39 for those hospitals without a coordinator, compared to 56 for the remaining 15 hospitals.

Even in those hospitals with programme coordinators, their sustainability is not assured. Family violence programme process indicators are steadily improving. Continued programme resourcing, however, is necessary if appropriate intervention is to be followed by appropriate service delivery and better outcomes.

Family violence is not a new phenomenon, however reluctant people have been to talk about it in the past. Nor is it a problem confined to a few "disturbed" families on the fringes of society. It is a problem that affects the family life of many people, causing distress for individuals, and far-reaching consequences for our society.

J. L. Robson, Social Development Council, 1980[2]

BACKGROUND

Health Policy

The significant social, economic, and health toll of family violence is well documented internationally and in Aotearoa New Zealand.[3-10] The subsequent identification of family violence as a significant public health problem - one that can be prevented – has instigated numerous health policy documents over the past decade. Some of these are listed below.

- 1996 - A *New Zealand Government Statement of Policy on Family Violence*.[11]
- 1997 - *Māori Family Violence in Aotearoa* (Te Puni Kokiri / Ministry of Māori Affairs).[3]
- 1998 – *Family Violence Guidelines for Health Sector Providers to Develop Practice Protocols* (Ministry of Health).[12]
- 2000 - *The New Zealand Health Strategy 2000*[13]
- 2001 - DHB Toolkit: Interpersonal Violence (Ministry of Health).14
- 2002 February – Te Rito: New Zealand Family Violence Strategy (Ministry of Social Development),[15] addressing the priority Crime Reduction Strategy "to reduce family violence and child abuse".
- 2002 November - *He Korowai Oranga* (Māori Health Strategy, 2002)[16]
- 2002 – *Family Violence Intervention Guidelines* (Ministry of Health).[7]

The 2000 *Health Strategy* was important in that "reducing violence in interpersonal relationships, familles, schools and communities" was included as one of 13 priority objectives. These objectives direct the Ministry of Health (MOH) and District Health Boards (DHBs) to focus on actions toward achieving the priority goals. Details suggesting how these strategies were to be addressed were included in The *DHB Toolkit:*

Interpersonal Violence, published in 2001. In that document DHBs were called upon to reduce interpersonal violence by:

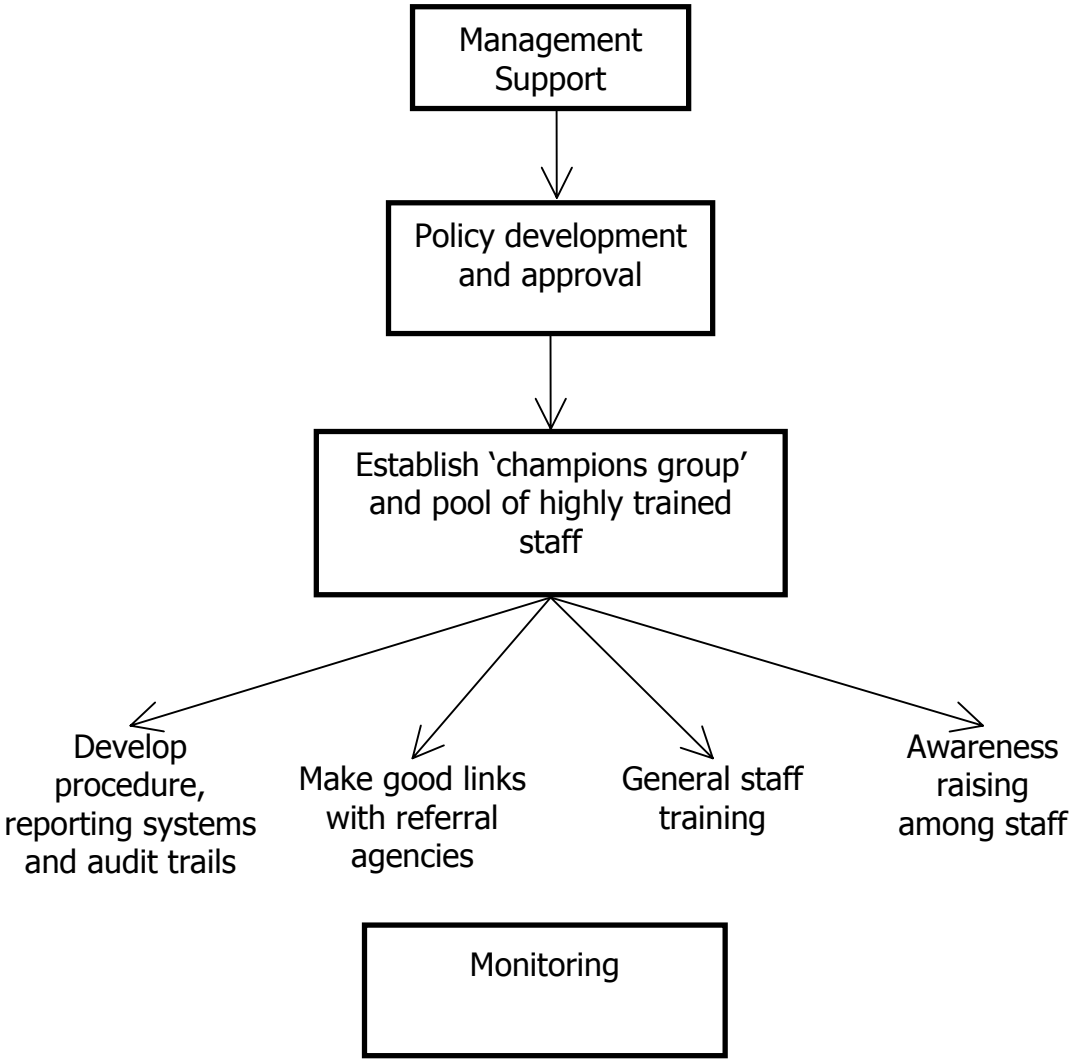
- Using population strategies to reduce violence and
- Promoting institutional change to enable health and disability service providers to identify, assess and refer cases of violence.

Key actions identified in *The Toolkit*[14(p. 14)], and not too different from those called for in the 1998 *Guidelines*[12], were:

- Change institutional response of services to violence through:
  - management support,
  - changes to systems and culture,
  - staff training, and
  - development of best practice and protocols
- Identify and assess victims of violence
- Intervene early to manage cases and prevent reoccurrence
- Refer victims to statutory agencies and NGOs
- Assist NGOs to build and sustain the capacity of their specialist violence services.

To be effective in reducing violence, treating people with respect and dignity and institutional commitment were identified as being necessary. A pathway to institutional change was provided in *The Toolkit* (see Figure 4).

Figure 4. Pathway to institutional change (DHB Toolkit, MOH 2001[14])



The Family Violence Intervention Project

Along with publishing *The Toolkit*, the Ministry of Health initiated the *Family Violence Health Intervention Project* (referred to here as *The Family Violence Project*) to support the health sector's development of an evidence-based response to victims of family violence. The project was initially funded 2001 to 2004 ($2.8 million), and continued for 2004 to 2007 ($2.5 million). Three major objectives were named - and achieved - during the first project period (2001-2004; see Table 1).

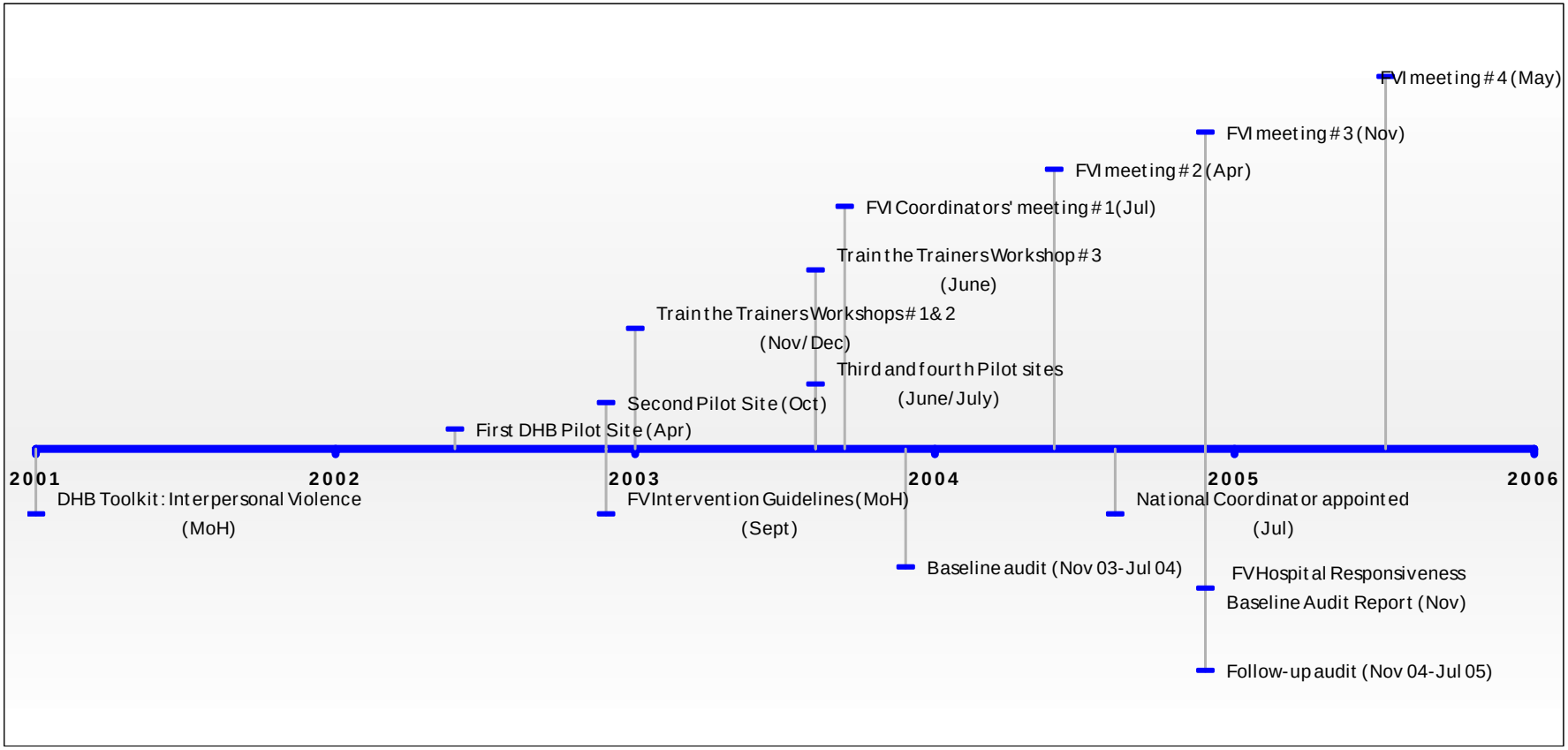
Table 1. Family Violence Project Primary Objectives (2001-2004)

	Objective	Outcome
1	Establish practice procedures to identify, manage and refer victims of family violence	*Family Violence Intervention Guidelines: Child and Partner Abuse*[7] published in November, 2002 (referred to here as *The Guidelines)*[a].
2	Fund health professional training	Funding was made available for health professional education, targeting the following health provider groups: • general practitioners • emergency • paediatric and well-child • sexual healthcare professionals.
3	Pilot FV Guideline implementation	Four DHBs were provided seed money to employ a family violence project coordinator to oversee programme development and Guideline implementation [b]

The time frame of selected Family Violence Project activities is provided in Figure 5. It includes for example, *Train-The–Trainer* workshops for health professionals and the national Family Violence Coordinator meetings, both sponsored by the MOH. It was an expectation, indicated by setting violence as a health priority, that all DHBs would develop family violence programmes and work towards implementing *The Guidelines*. This expectation was formalised in 2004 when family violence intervention became a performance requirement for DHBs.

[a] The reader is referred to *The Guidelines* for definitions and additional background information regarding family violence.
[b] Seventeen DHBs responded to the tender in which 4 were funded.

Figure 5. Selected Family Violence Project Activities 2001-2005



Monitoring

The need to monitor policy outcomes was acknowledged first in the 1998 *Guidelines*, and again in *The Toolkit*. Population surveillance and monitoring can identify trends over time in the prevalence of violence, health consequences, costs and reduced ethnic disparity. These policy outcomes, however, are likely to occur through multi-sectoral and community programmes over the long term. What can be monitored during programme development are process indicators such as the following, noted in *The Toolkit*:

- Protocols in place
- Management support for training and
- Case identification and appropriate referrals.

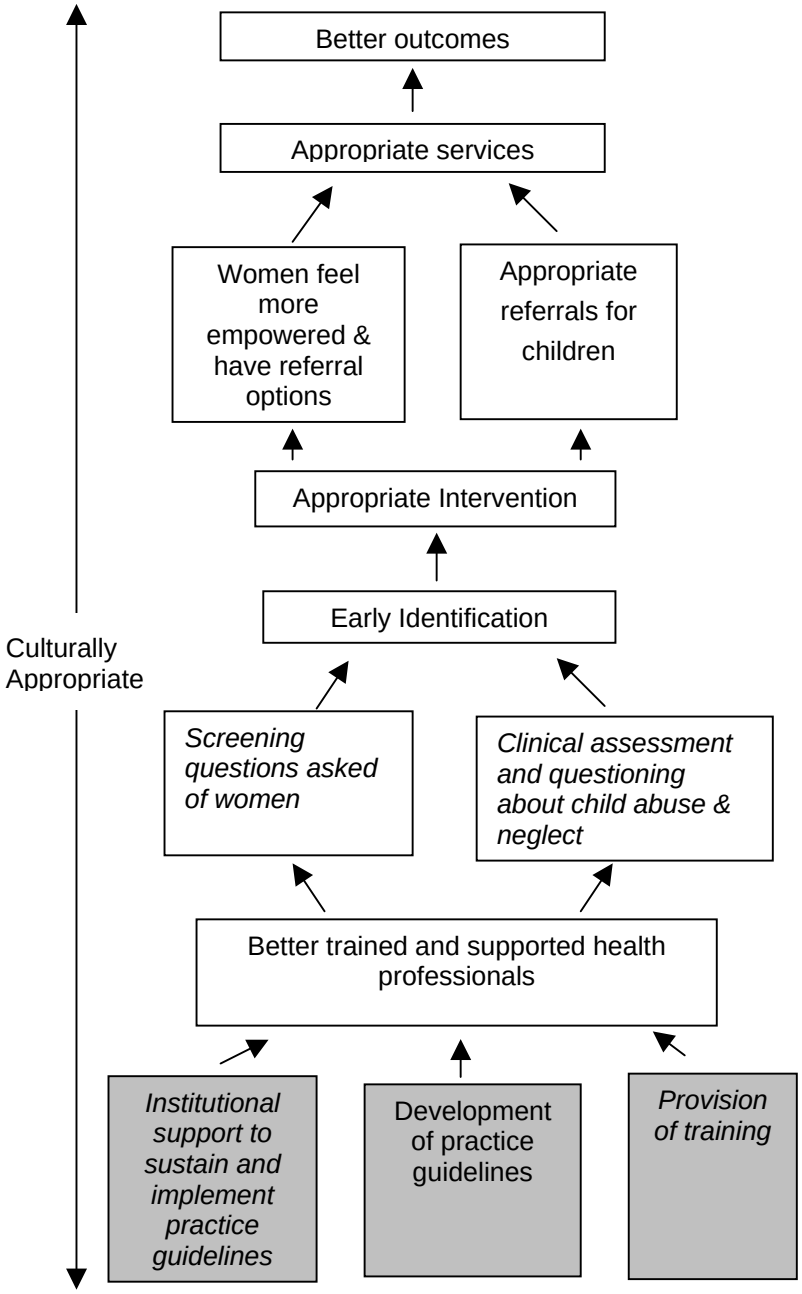
The importance of institutionalising reform to sustain family violence innovations and behavioural change is consistent across the family violence literature. So while training health professionals is key, it is not by itself sufficient in creating change.[17] Providing tools and attending to institutional support increases the likelihood of creating sustainable change. In addition to the indicators noted in *The Toolkit* other 'Institutionalising' components of family violence initiatives include:

- Training health care providers
- Establishing a hospital task force or team
- Establishing specific policies and procedures
- Modifying environments and
- Screening for victimization and enhancing intervention services.

Evaluation Project

The Ministry of Health allocated funding for evaluation activities and in 2002 released a request for proposals: *Health Response to Family Violence Evaluation Project*. The project programme logic was subsequently specified (see Figure 6) and AUT was awarded the contract to evaluate the implementation of family violence programmes in secondary and tertiary acute care public hospitals across Aotearoa/New Zealand. Central to the evaluation plan was the measurement of institutional culture over time.

Figure 6. Family Violence Project Programme Logic[a]



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 2. This report primarily responds to the second evaluation question, "Is institutional change sustained over time?", reporting hospital family violence programme audit scores over time.

[a] MOH Adviosory Committee; modified from Duignan, Version 4, 16-10-02

Table 2. Family Violence Project Evaluation Question and Data Collection Methods

Evaluation Question	Data Collection Methods	Reporting
1. 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[19] (referred to as *The Delphi*).	Findings reported to the MOH in November 2004: *Hospital Responsiveneess to Family Violence: Baseline Audit Findings*[1]
2. Is institutional change sustained over time?	Hospital Audits: Audits were repeated 12 months following the baseline audit (see above).	Findings reported in this document.
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.	(analysis and report writing in progress; methods included in Appendix D of this report for review)
4. How are healthcare referral patterns changing?	Health Referrals to Women's Refuge: Women's Refuge provided frequencies of referrals from health over time.	Findings reported in this document.
5. 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 to MOH in November 2005.[20]

METHODS

Follow-up Audit

Setting

The evaluation was conducted nationwide across Aotearoa/New Zealand. All 25 acute secondary and tertiary public hospitals, located within the 21 DHBs, agreed to participate in the audit process. Participating Hospitals, corresponding DHBs and location map links are listed in Appendix A. Hospital characteristics are reported in the findings section. The evaluation project was approved by the Multi- region Ethics Committee (AKY/03/09/218).

Audit Tool

The *Delphi Instrument for Hospital-Based Domestic Violence Programmes*[19] was developed to monitor primary indicators of hospital family violence programme quality. As described in the baseline report,[1] the original Delphi was modified for the purpose of this audit. The modified Delphi (Partner Abuse and Child Abuse and Neglect) includes performance measures sorted among nine domains for Partner Abuse and eight for Child Abuse and Neglect[a]. The Delphi domains are described in Table 3. The modified Delphi tools are accessible at: ***http://www.trauma-research.info/fv_evaluation.htm***.

Each tool domain is standardised resulting in a possible score from 0 to 100, with higher scores indicating greater levels of programme development. An overall Delphi score is generated using a scheme where some domains are weighted higher than others (see Appendix B for domain weights), with a resulting score of 0 to 100.

[a] The 'Screening and Safety Assessment' domain was not applicable for Child Abuse; however, assessment and safety elements were included in the remaining domains.

Table 3. Audit Tool Domains

Domains	Brief Description
Policies & Procedures	Policies and procedures outline the assessment and treatment of family violence victims, mandate routine screening and direct sustainability.
Physical Environment	Attention to the physical environment (posters and brochures) lets patients and visitors know that it is OK to talk about and seek help for family violence.
Cultural Environment	Cultural environment indicators herald recognition of family violence as an important issue for the hospital and maturation of a family violence programme.
Training of Staff	A formal plan should be in place to train hospital staff to identify persons exposed to family violence and how to respond appropriately.
Screening & Safety Assessment	Standardised partner abuse screening and safety assessment instruments are available. Eligible patients are screened for violence.
Documentation	Standardised family violence documentation forms are used with attention to forensic details.
Intervention Services	Interventions checklists are available to guide intervention, with attention to co-occurrence of partner violence and child abuse.
Evaluation Activities	Evaluation activities monitor whether a programme is working efficiently and achieving its goal of system change.
Collaboration	Family violence programmes call for collaboration throughout their processes, from policy and procedure writing to monitoring programme effectiveness. Partnerships within the hospital as well as with external stakeholders such as Women's Refuge are important.

Audit Procedures

The audit procedures for the follow-up audit mirrored those of the baseline audit as described below:

1. A letter of was sent to each CEO alerting them that the follow-up audit was due.
2. The person identified to act as a FV Liaison (either the person involved in the baseline audit, or as identified by the manager) was contacted and the general audit process and scheduling of the audit communicated by e-mail and telephone.
3. Confirmation of the audit date and a detailed checklist of documents that needed to be collated for the audit were sent to the FV Liaison.
4. The FV liaison was asked to coordinate the involvement of others (such as the child protection coordinator) in the site visit as appropriate.

5. A few days prior to the audit, contact was made with the liaison to answer any outstanding questions about the audit.

Follow-up audits were conducted by Jo Adams, a trained member of the research team. Dr Jane Koziol-McLain and Dr Coben participated in auditor training and debriefing. Each audit was conducted over approximately 4 hours. Along with the hospital family violence (FV) programme coordinator or liaison person, child protection coordinators; social workers; representatives from the paediatric, maternity and emergency wards; as well as hospital management often contributed to the audit.

On completion of each site visit an audit report was provided to the FV coordinator or liaison, usually within two weeks, to confirm the accuracy of the audit report. Once confirmed, the finalised hospital report was sent to the CEO, copied to the FV coordinator or liaison.

Audit timeframe

Baseline audits were conducted at all 25 acute care hospitals between November 2003 and July 2004. The goal for the follow-up audit was to revisit each hospital 12 months following the baseline audit. Two hospitals reported that no actions addressing family violence had taken place since the baseline audit. Each of the hospitals was offered a visit by the evaluation team to help direct future DHB activities. One hospital chose for their baseline audit scores to be carried forward, and to not have an audit. The second requested that an audit take place, but be delayed until after a family violence coordinator had been hired. This audit took place 20 months after the baseline audit. Because their scores were not significantly different from baseline, their follow-up scores were imputed as 12 month follow-up scores. The remaining 23 hospital audits were conducted between November 2004 and July 2005 (see Table 4).

- The average time between first (baseline) and follow-up audit was 12.2 months

Table 4. Hospital Audit Schedule

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	TOTAL
Baseline Nov 03–Jul 04	1	3	4	8	5	0	1	1	1	25
Follow-Up Nov 04–Jul 05	1	1	3[a]	8	8	0	0	2	2	25

[a] Includes one hospital that had baseline scores carried over, and a second that had delayed audit scores imputed.

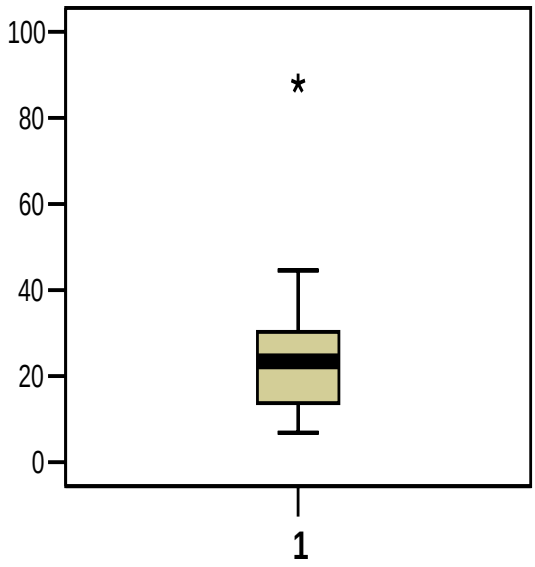
Analysis

Hospital characteristics and Delphi scores were entered in SPSS (Version 12 & 13). In this report we present the distribution of overall Partner Abuse and Child Abuse and Neglect scores in tables, graphs (histograms) and box plots. Baseline, follow-up and change scores (follow-up score minus baseline score) are presented for individual domain and overall Delphi scores. Box plots are especially useful for examining the distribution of scores across the hospitals (see *Figure 7: How to Interpret Box Plots* on the following page). Both domain and overall scores may range from 0-100, with higher scores reflecting a greater level of programme development. The reader is cautioned that across the baseline report[1] and the current report, both mean (mathematical average) and median (middle) scores are used.

Baseline child abuse and neglect programme scores were corrected for one hospital based on review of programme evidence that was made available at the time of the follow-up audit. The overall score for that hospital increased from 61 to 74.

We tested whether scores changed significantly (statistically) over time using paired t-test. Controlling for baseline scores (considering regression to the mean) was deemed not necessary due to a lack of association between baseline scores and change (follow-up minus baseline) scores (partner abuse pearson r = 0.07, p = .74; child abuse pearson r = -.354, p = .083 with a decrease of pearson r to -.21 after removal of a single outlier with a change score of 41). Associations between hospital characteristics and Delphi scores were analysed using repeated measures analysis of variance.

Figure 7: How to Interpret Box Plots



- The length of the box is important. The lower boundary of the box represents the 25th percentile and the upper boundary of the box the 75th percentile. This means that the box includes the middle half of all scores. So, 25% of scores will fall below the box and 25% above the box.
- The thick black line indicates the middle score (median or 50th percentile). This sometimes differs from the mean, which is the arithmetic average score.
- A circle indicates an 'outlier', a value that is outside the general range of scores (1.5 box-lengths from the edge of a box).
- A star indicates an 'extreme' score (3 box-lengths from the edge of a box).
- The whiskers or needles extending from the box indicate the score range, the highest and lowest scores that are not outliers (or extreme values).

Refuge Referrals

Referral data were obtained from Women's Refuge (*Refuge;* also called National Collective of Independent Women's Refuges, NCIWR*)*. Refuge provides residential and community services, as well as information and support services, to women and children experiencing family violence. Women and children can access Refuge services in a number of ways, such as from police (POL400) and from the Refuge telephone crisis line. In some communities non-collective refuges are available. Following nation-wide training, a national Refuge electronic database (using Microsoft Access) was instituted in 2002. The 48 member refuges are responsible for entering data for each of their clients, including residential and community clients. The database separates out initial

contacts for women and children clients new to Women's Refuge services. The source of referral for new clients are termed 'first referral source'.[a] The source of referral for all continuing clients are termed 'contract referral source'. Only women clients are included in the 'first referral source', whereas both women and children are included in 'contract referral source'. Only one referral response is allowed for each service contact. Referral response options for both categories include:

- Community services
- Education services
- Financial services
- NCIWR services
- Health services
- Blank.

'Blank' referrals are very common within the 'first contact referral' and include not only 'missing' data, but also those who self-refer, as that is not a given response option in the database. For the 28,847 clients included in the "first referral" data, referral source was 'blank' for 15,413, representing over half (56%). For the 91,793 "contract referral" data, referral source was 'blank' for 6,300, representing only 6.9%.

Within the "first contact referral" health services category, 'hospital' referral may be selected. Within the "Contract Referral Source" health services category response options include:

- Hospital
- Community mental health service
- Doctor
- Māori health service
- Other health worker
- Plunket
- Mental health worker.

Refuge exported a report that included six-month tallies of the number of referrals from health professionals for the period January 2003 to June 2005 (5, six-month time periods). The data were sorted by District Health Board and hospital that was most closely linked to each refuge.

[a] The separation between "first referral" and "contract referral" sources will be abolished in the Refuge's next database version.

It is important to consider what needs to happen for Refuge data to be a reliable indicator:

1. Health care worker identifies woman as experiencing family violence
2. Health care worker makes a referral to Women's Refuge services
3. Woman contacts Women's Refuge
4. Refuge worker assesses referral source
5. Referral source is accurately entered in the computer database.

Women's Refuge referral source is not an ideal indicator of an appropriate health care intervention. However, as collaboration between hospitals and Women's Refuge develops, we would expect a greater number of healthcare referrals and greater precision in documentation of these same referrals.

FINDINGS

Hospital Family Violence Programmes

Two general indicators of hospital family violence programmes were included in the audit. The first regarded having a designated family violence (partner abuse and or child abuse) coordinator. The second regarded the length of programme existence (see Table 5).

At the time of the follow-up audit:

- 64% of hospitals had an identified Partner Abuse coordinator
- 64% had a Child Abuse coordinator (this could be a shared position).

New programmes were evident in four hospitals since the baseline audit. Six (24%) hospitals, however, continued to have no evidence of a family violence programme. For hospitals with family violence programmes, Child Abuse programmes are significantly more established than for partner abuse.

80% of the Child Abuse Programmes have been in existence for longer than 2 years, compared to only 16% of Partner Abuse Programmes.

Table 5. Hospital Family Violence Programmes (N=25)

	Partner Abuse		Child Abuse	
	Baseline	Follow-up	Baseline	Follow-up
Family Violence Coordinator				
None	13 (52%)	9 (36%)	11 (44%)	9 (36%)
Part-Time	11 (44%)	15 (60%)	9 (36%)	12 (48%)
Full-Time	1 (4%)	1 (4%)	5 (20%)	4 (16%)
Family Violence Programme Maturation (months)				
No programme	10 (40%)	6 (24%)	4 (16%)	0
1-24	13 (52%)	15 (60%)	7 (28%)	5 (20%)
24-48	2 (8%)	3 (12%)	5 (20%)	7 (28%)
>48 months	0 (4%)	1 (4%)	9 (36%)	13 (52%)

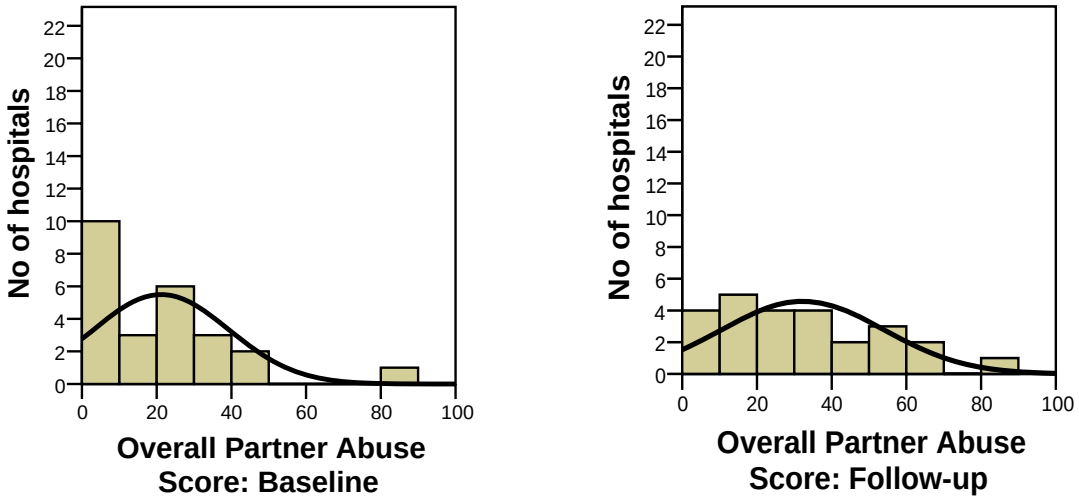
Partner Abuse Audit Findings

Partner Abuse Audit Summary

Most hospitals had a score of less than 50 overall, indicating that they continued to be in the early stages of developing a system response to partner violence at the time of the follow-up audit. However, the average overall partner abuse scores increased significantly from 21 at baseline to 32 at follow-up; an average change score of + 11. Six (24%) hospitals scored 50 or above; and one achieved a score of 89.

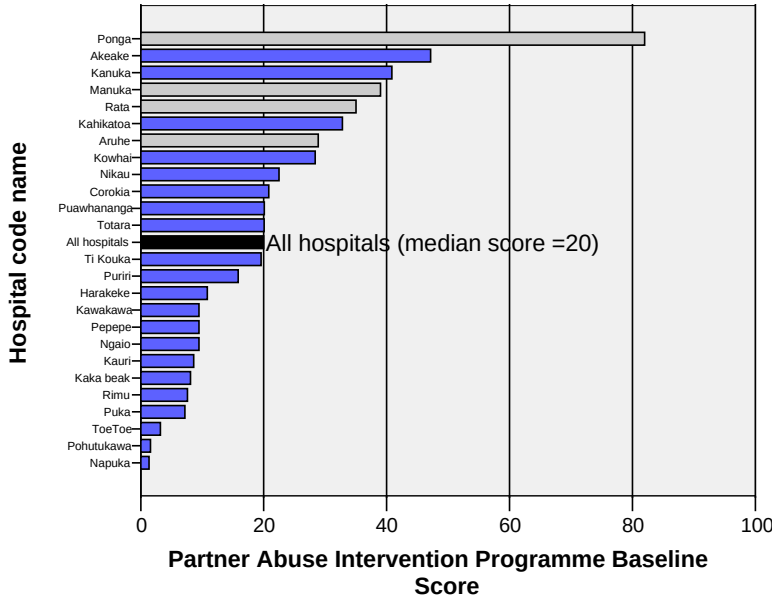
Figure 8 displays the distribution of the overall Partner Abuse Scores at baseline and follow-up among the 25 hospitals. Hospital league tables (anonymised) are provided in Figure 9 for baseline, follow-up and change scores; and median overall and domain scores over time are provided in Figure 10. Boxplots presenting the individual domain baseline and follow-up scores are shown in Figure 11. Table 6 provides the data supporting the displays/figures. Results for each of the nine domains for Partner Abuse are presented individually in the sections that follow. Frequencies for individual Delphi items are provided in Appendix C (Appendix C1: Partner Abuse).

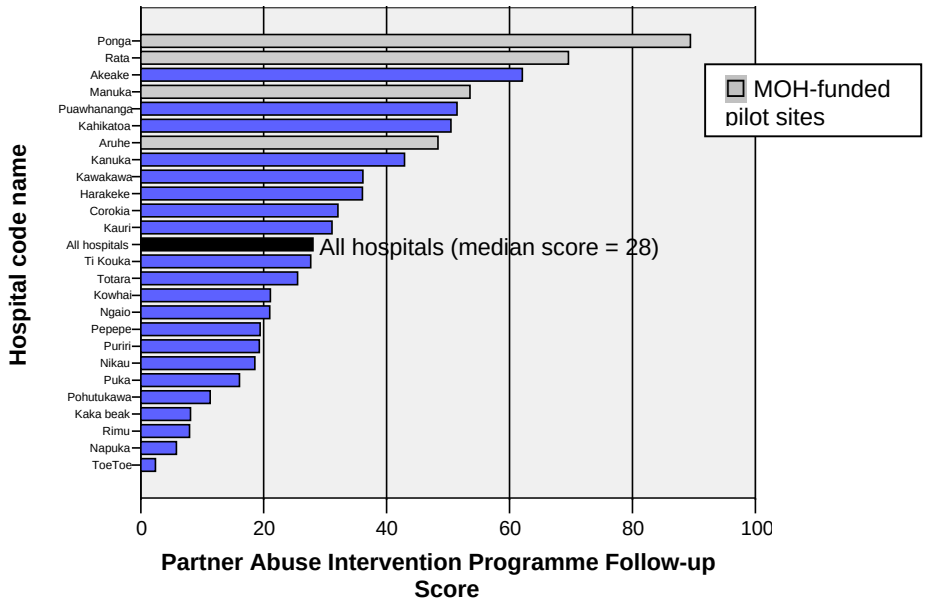
Figure 8. Overall Partner Abuse Scores: Baseline and Follow-up

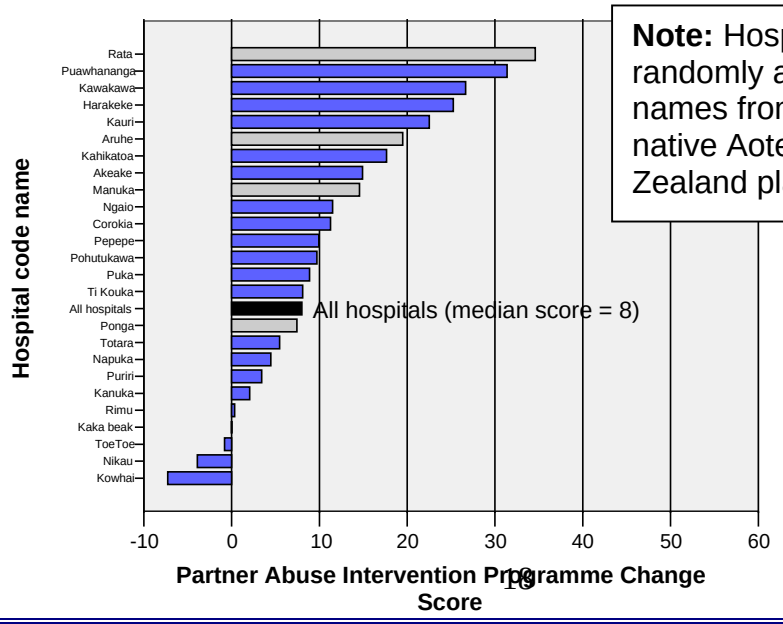


- The average score at follow-up was 32, compared to 21 at baseline.
- The median (50th percentile) score at follow-up was 28 (20 at baseline); half the hospitals scored above 28 and half below.
- Scores for Partner Abuse Programmes ranged from 2 to 89 at follow-up, compared to 1 to 82 at baseline.

Figure 9. Partner Abuse Intervention Hospital League Tables: Baseline, Follow-up and change scores.

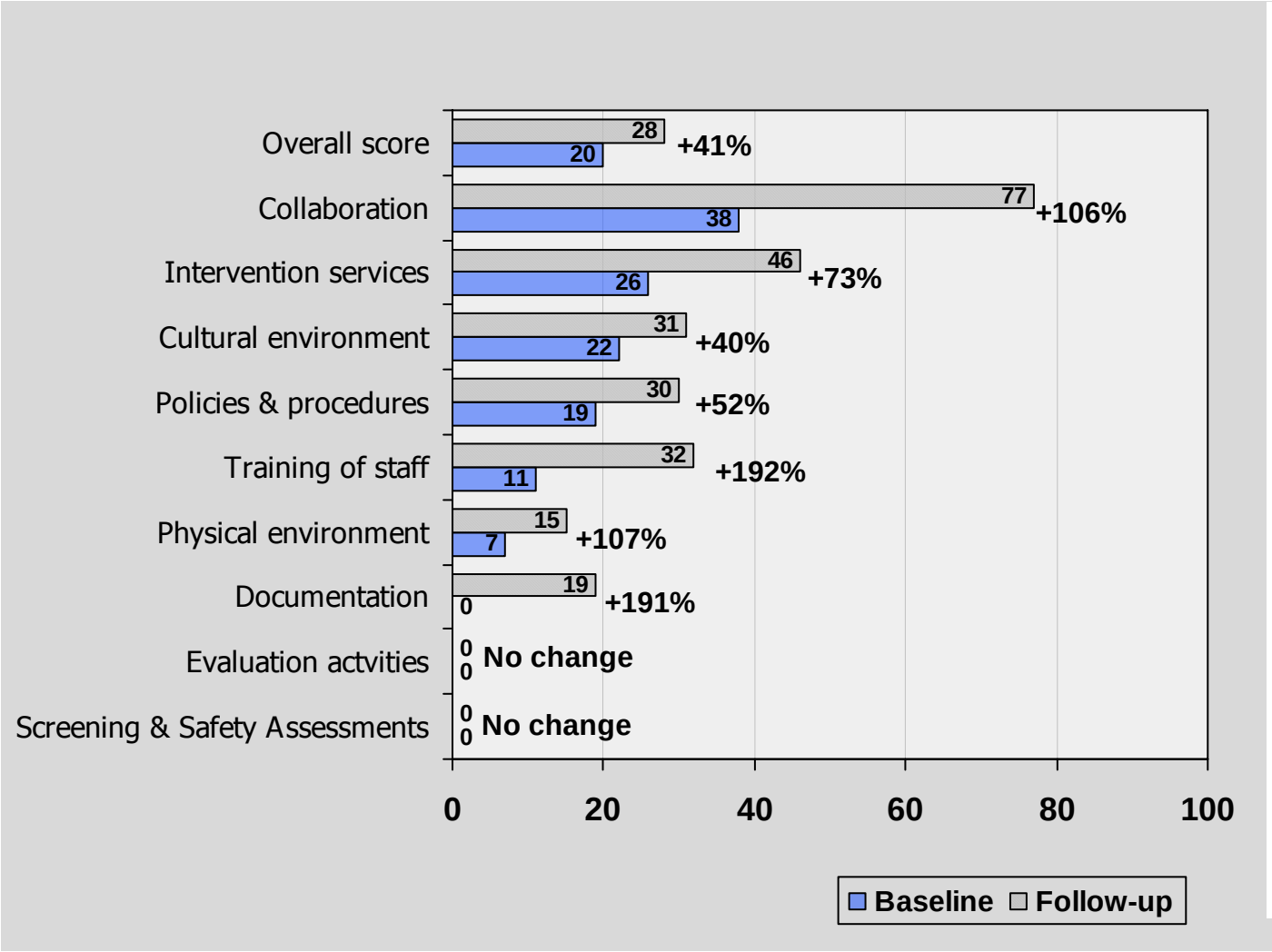






Note: Hospitals have been randomly allocated code names from a selection of native Aotearoa New Zealand plants

Figure 10. Partner Abuse Domain Score Changes (Median Scores)



- The most developed partner abuse programme domain was *Collaboration*.
- Improvements were seen in all partner abuse programme domains with the exception of *Evaluation Activities* and *Screening and Safety Assessments*, for which the medians scores remained at 0.
- The median *Documentation* score had been 0 at baseline, but increased to 19 at follow-up.

Figure 11. Boxplot of Partner Abuse Programme Domain Overall and Domain Scores at Baseline and Follow-Up

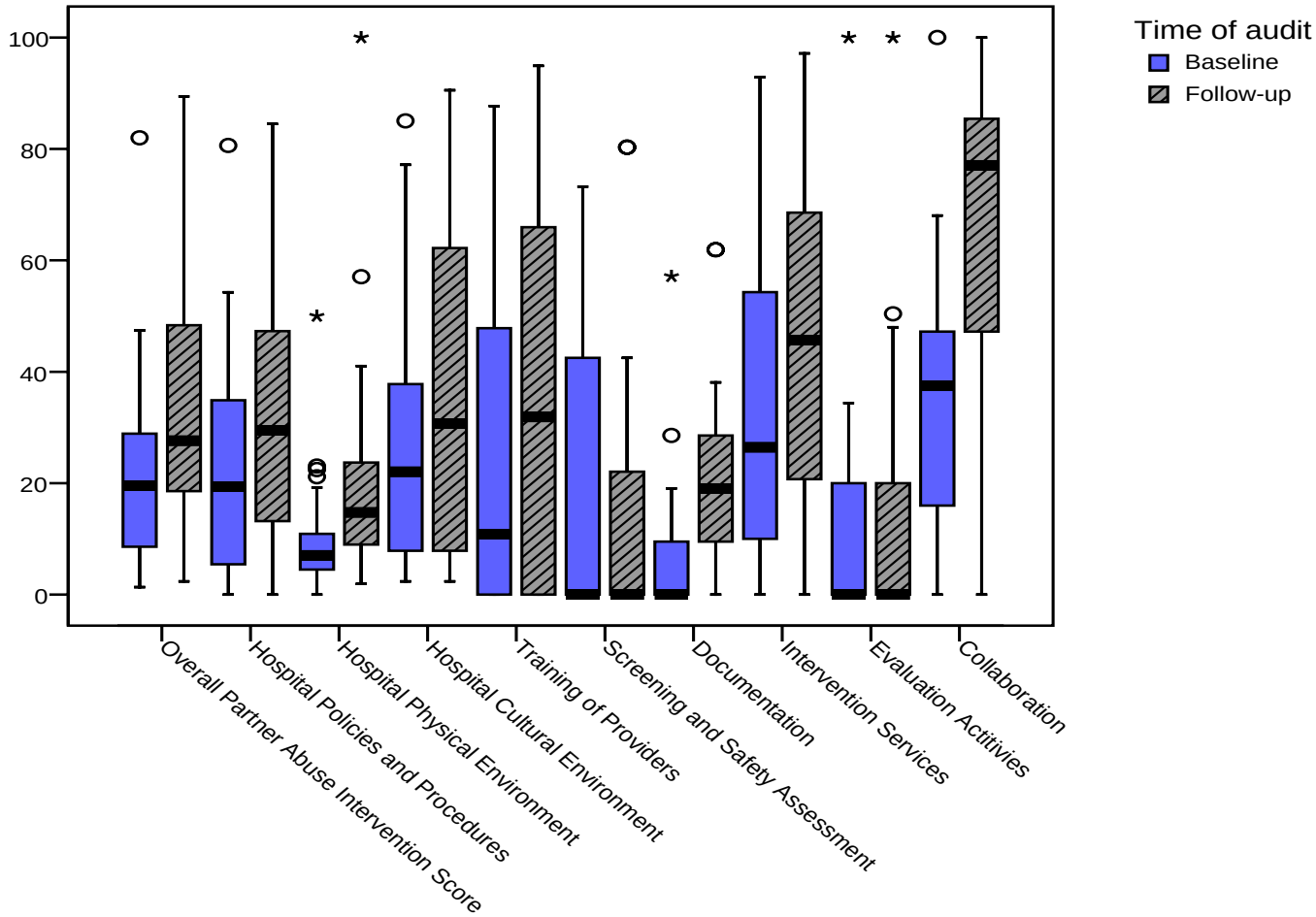


Table 6. Partner Abuse Baseline, Follow-up and Change Scores

	Mean		Mean Diff	SD		Min		Max		Percentile 25th		50th		75th	
	B	***F***		***B***	***F***	***B***	***F***	***B***	***F***	***B***	***F***	***B***	***F***	***B***	***F***
Overall Score	21.2	32.27	11.1	18.1	21.8	1	2	82	89	8.3	17.3	19.6	27.6	30.8	49.4
Domain Scores															
Collaboration	35.4	66.3	30.9	24.4	27.6	0	0	100	100	15.6	42.4	37.5	77.1	47.6	88.5
Intervention Services	33.6	46.3	12.8	27.1	29.3	0	0	93	97	9.3	18.2	26.4	45.7	56.1	72.1
Hospital Cultural Environment	27.9	35.3	7.4	23.3	29.5	2	2	85	91	7.9	7.9	22.0	30.7	40.2	65.8
Training of Staff	23.7	37.0	13.3	27.3	33.3	0	0	88	95	0.0	0.0	10.9	31.9	48.9	67.0
Hospital Policies and Procedures	22.3	31.5	9.3	20.1	23.7	0	0	81	84	5.0	11.6	19.4	29.5	36.4	50.4
Screening and Safety Assessment	14.3	17.1	2.8	22.6	24.8	0	0	73	80	0.0	0.0	0.0	0.0	42.5	32.3
Evaluation Activities	11.5	14.3	2.8	21.8	24.2	0	0	100	100	0.0	0.0	0.0	0.0	20.0	20.0
Hospital Physical Environment	10.1	20.6	10.4	10.6	20.5	0	2	50	100	4.2	9.0	7.1	14.7	10.6	24.0
Documentation	6.5	18.9	12.4	13.1	17.1	0	0	57	62	0.0	9.5	0.0	19.1	9.5	28.6

Notes: ***B*** =baseline; ***F*** =follow-up; Mean Diff = mean change score (follow-up score minus baseline score)

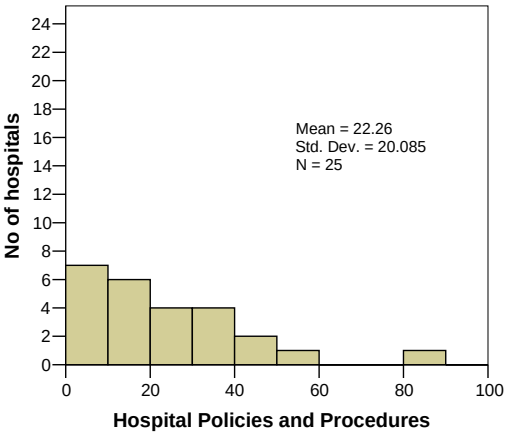
Domain 1: Hospital Policies and Procedures

Scores for this domain were based on evidence for the following:

- official, written hospital policies regarding the assessment and treatment of victims;
- a hospital-based partner abuse working group;
- financial support for the partner abuse programme, including for Māori initiatives;
- mandatory universal screening of all women;
- quality assurance procedures for screening;
- security and safe transport procedures; and
- an identifiable partner abuse coordinator at the hospital.

Policies and procedures were in place in 9 (36%) hospitals at the time of the follow-up audit; and 19 (76%) hospitals had evidence of a family violence working group or task force. The number of hospitals providing $10,000 or more to their partner abuse programme increased from 10 (40%) at baseline to 14 (56%) at follow-up, though 7 continue to provide no funding. Six hospitals reported a mandatory screening policy in at least one area, an increase from two at baseline. Four (16%) of the 6 hospitals reported screening in the emergency department or other outpatient area. Two (8%) hospitals reported screening policies for both inpatient and outpatient areas; inpatient areas included paediatric and maternity units.

Figure 12. Hospital Policies and Procedures: Baseline and Follow-up scores



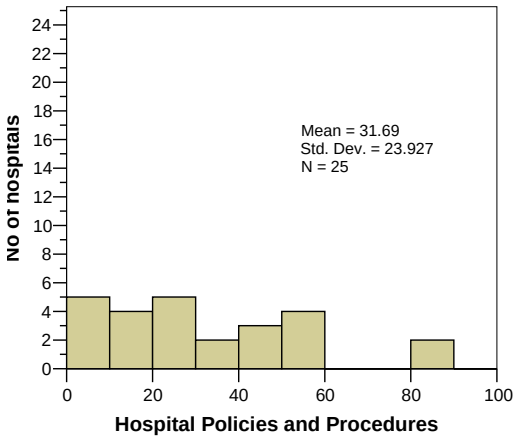
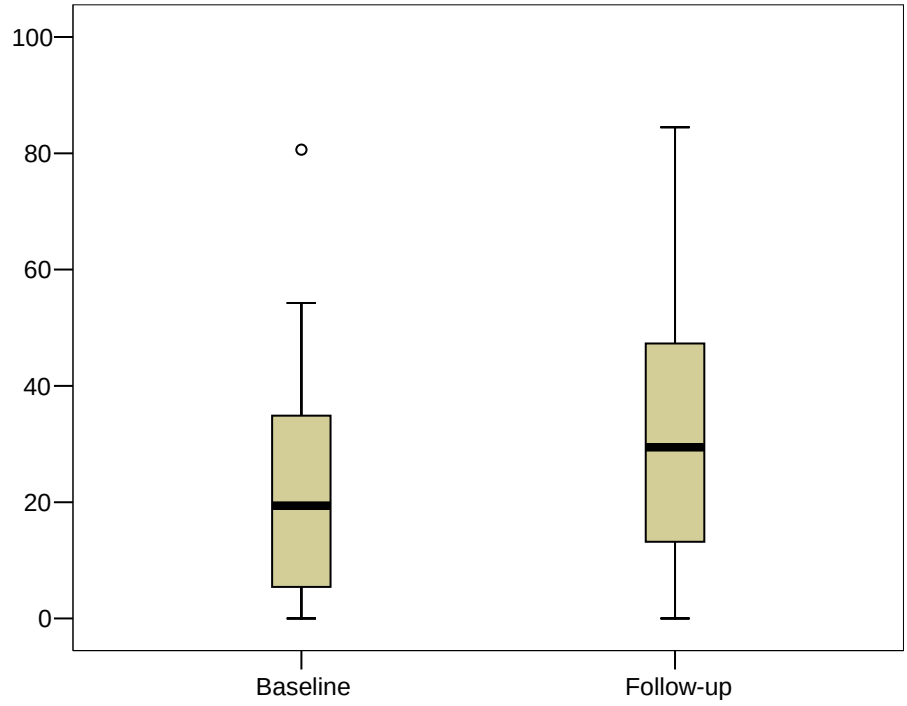


Figure 13. Boxplot of Hospital Policies and Procedures: Baseline and Follow-Up Scores



- The average *Policy and Procedure* score was 22 at baseline compared to 32 at follow-up; a change of + 9.
- The median score was 19 at baseline and 30 at follow-up, an increase of 52%.
- Hospitals generally improved their scores by between 2 and 19 in this domain.

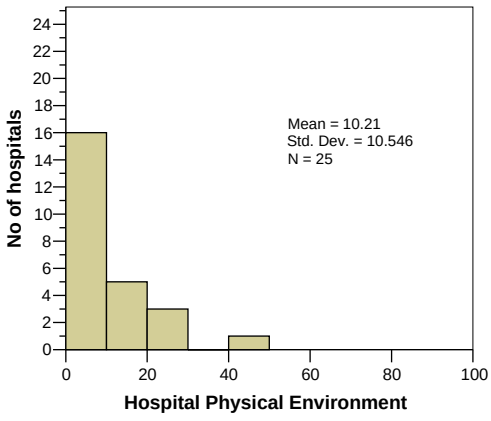
Domain 2: Hospital Physical Environment

Scores for this domain were based on evidence for the following:

- posters and/or brochures related to partner abuse;
- referral information related to partner abuse services;
- provision of temporary refuge for victims.

At follow-up, all hospitals (n=25, 100%) had material relating to partner abuse available somewhere in the hospital, compared with 20 (80%) at baseline. In most hospitals materials were on display in five or more areas. There was less information, however, on how to access services. Seven hospitals (28%) had provisions for safe refuge of victims (in in-patient or respite area).

Figure 14. Hospital Physical Environment: Baseline and Follow-up Scores



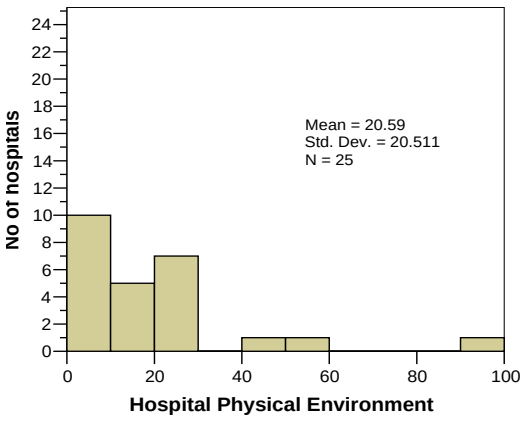
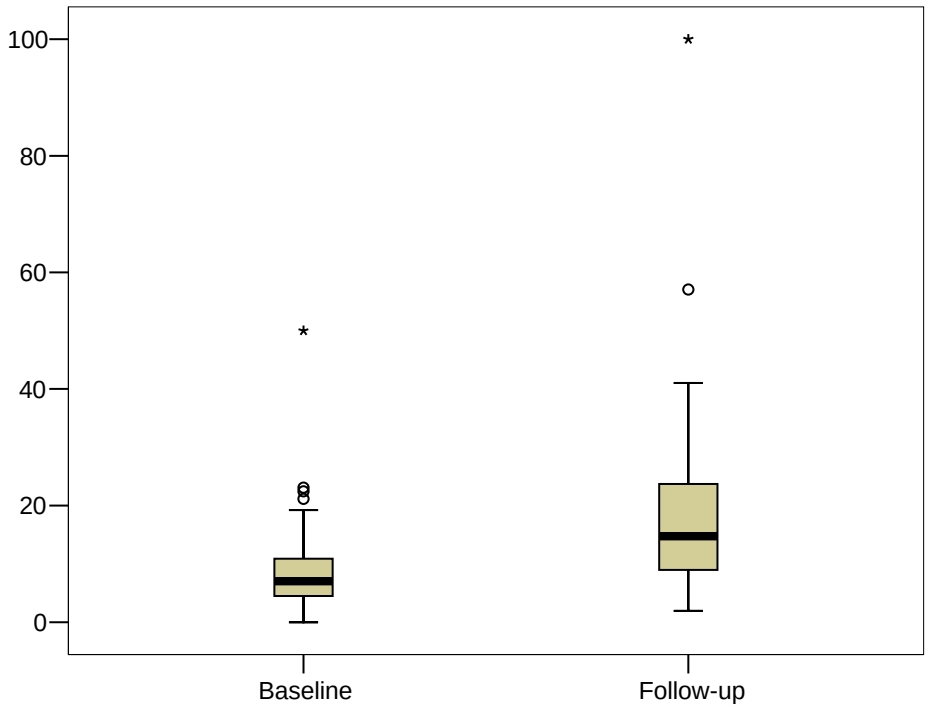


Figure 15. Boxplot of Hospital Physical Environment: Baseline and Follow-Up Scores



- Most hospitals continued to score low in this domain.
- The average *Hospital Physical Environment* score was 10 at baseline compared to 21 at follow-up; with an average difference of + 10.
- The median score was 7 at baseline and 15 at follow-up; an increase of 107%.
- Hospitals generally improved their scores by between 1 and 14 in this domain.

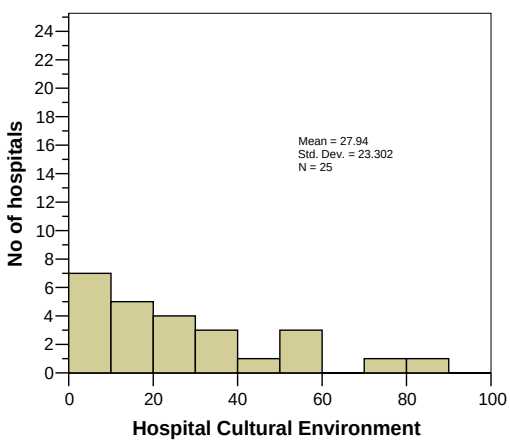
Domain 3: Hospital Cultural Environment

Scores for this domain were based on the following:

- written, formal assessment of staff knowledge and attitude about partner abuse;
- the length the partner abuse programme had been in existence;
- policies and procedures for employees relating to partner abuse;
- addressing of cultural competency issues in the partner abuse programme; and
- participation in preventive outreach and public education campaigns on the topic of partner abuse.

Nine (36%) hospitals had assessed staff knowledge and attitudes about partner abuse in the last three years. Fifteen (80%) hospitals had plans in place for employees experiencing violence. Most hospitals (n=24) had evidence of DHB-wide policies that addressed cultural competence and the provision of interpreters. Some hospitals had participated in one (n=9) or more (n=5) community outreach activities addressing partner abuse in the last 12 months.

Figure 16. Hospital Cultural Environment: Baseline and Follow-up Scores



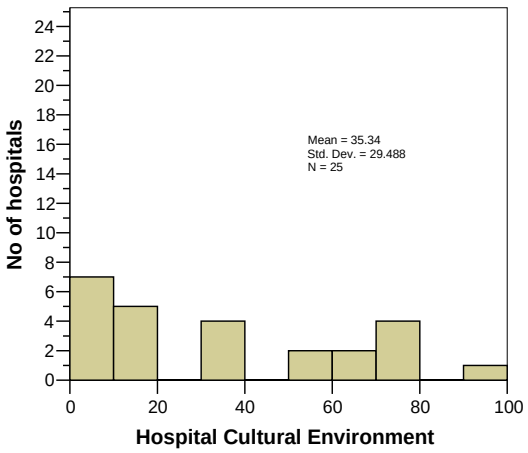
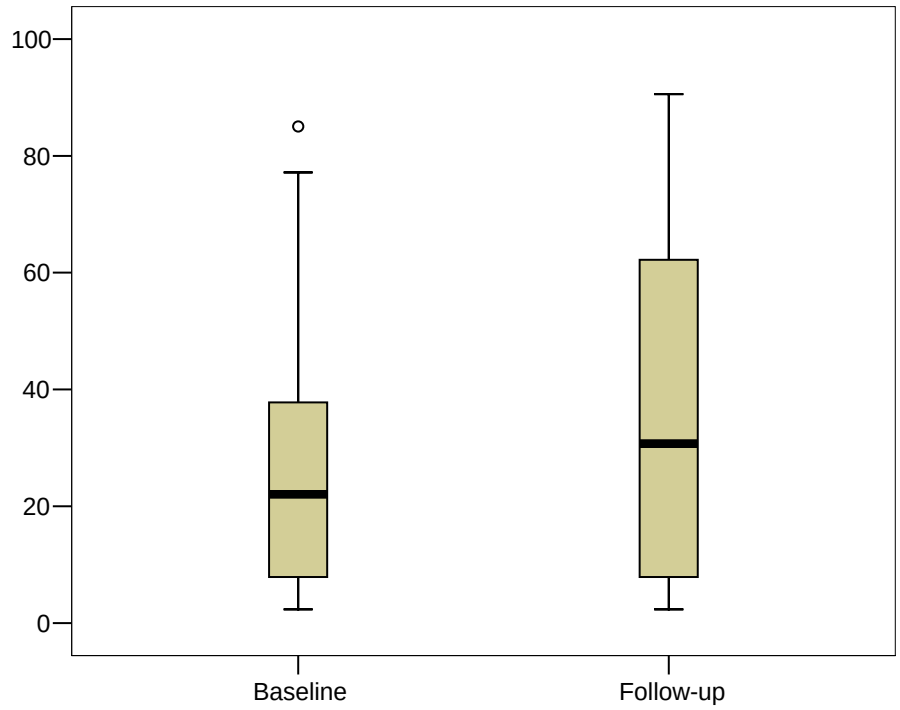


Figure 17. Boxplot of Hospital Cultural Environment: Baseline and Follow-Up Scores



- The average *Hospital Cultural Environment* score was 28 at baseline, increasing to 35 at follow-up; an increase of 7.
- The median score was 22 at baseline and 31 at follow-up, an increase of 41%.

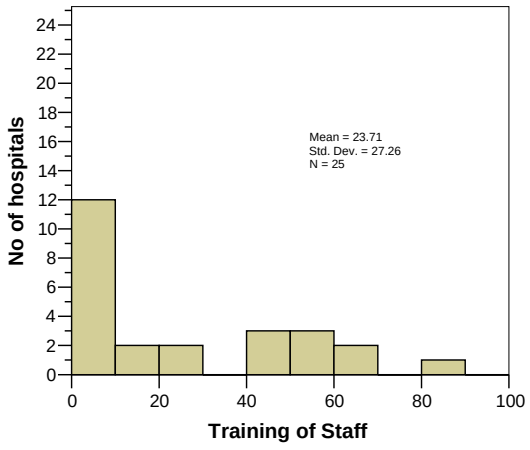
Domain 4: Training of Staff

Scores were based on evidence for the following:

- a formal written training plan for the hospital;
- whether training on partner abuse had been provided for staff in the last 12 months;
- the information included in the training; and
- who the training was provided by.

Nine (36%) hospitals had a written plan for partner abuse staff education; 15 (60%) had provided at least one ad hoc education session during the 12 month audit period. At 11 hospitals, training was provided by a team that included community experts. Among hospitals providing regular, ongoing staff education, paediatric, maternity and emergency department staff were most often included. Training content deficits (reported at 5 or fewer hospitals) included Te Tiriti o Waitangi and the social, historical, cultural and economic context in which family violence may occur in Māori families; information about service providers for ethnic groups other than Pakeha and Māori; and information about abuse in same-sex relationships.

Figure 18. Training of Staff: Baseline and Follow-up Scores



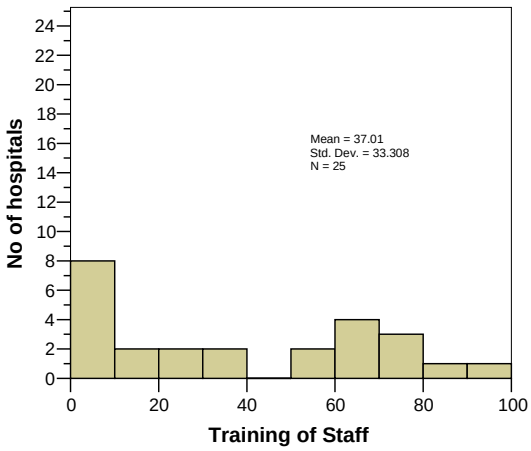
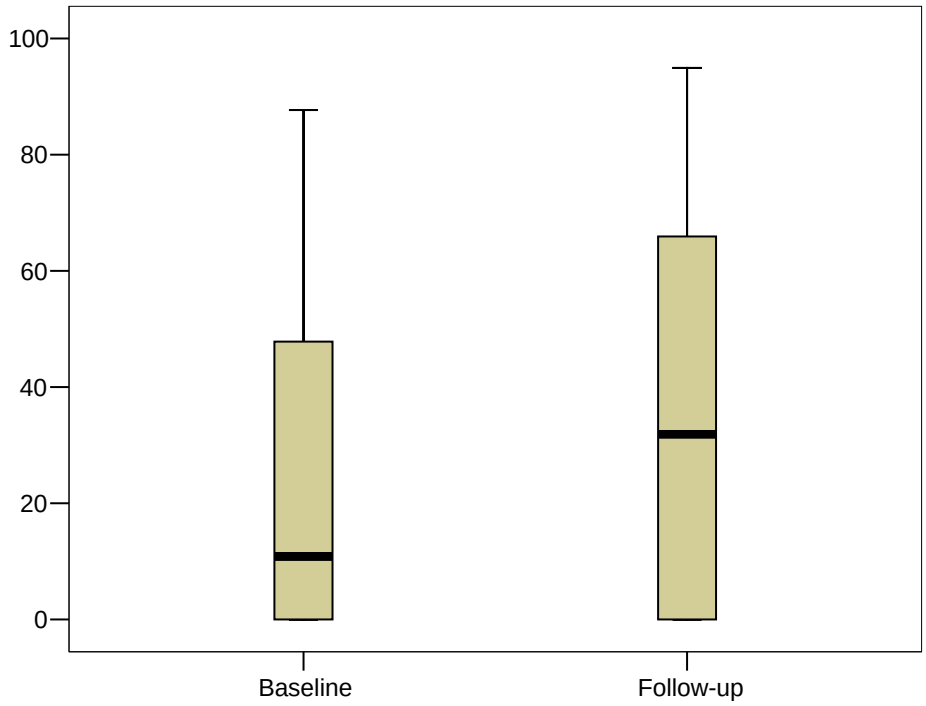


Figure 19. Boxplot of Hospital Training of Staff: Baseline and Follow-Up Scores



- The average hospital *Training of Staff* score was 24 at baseline, increasing to 37 at follow-up; an increase of 13.
- The median score was 11 at baseline and 32 at follow-up, an increase of 191%.

Domain 5: Screening and Safety Assessment

Scores for this domain were based on the following:

- use of a standardised screening instrument incorporated in clinical records;
- percentage of eligible patients with documentation of screening (based on a random sample of charts); and
- use of a standardised safety assessment.

Five (20%) hospitals had a standardised screening instrument available. Three hospitals had conducted chart audits to monitor screening; chart audits in all three hospitals had attained screening levels greater than 25% in the audited departments. Seven hospitals (28%) have a standardised safety assessment for both victims who screen positive for partner abuse; in all 7 cases the safety of children in the household is also assessed.

Figure 20. Screening and Safety Assessment: Baseline and Follow-up Scores

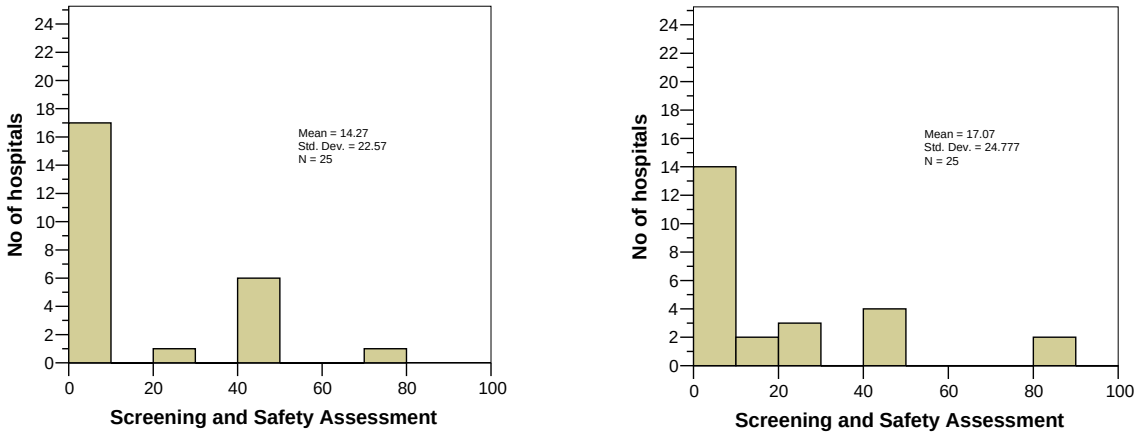
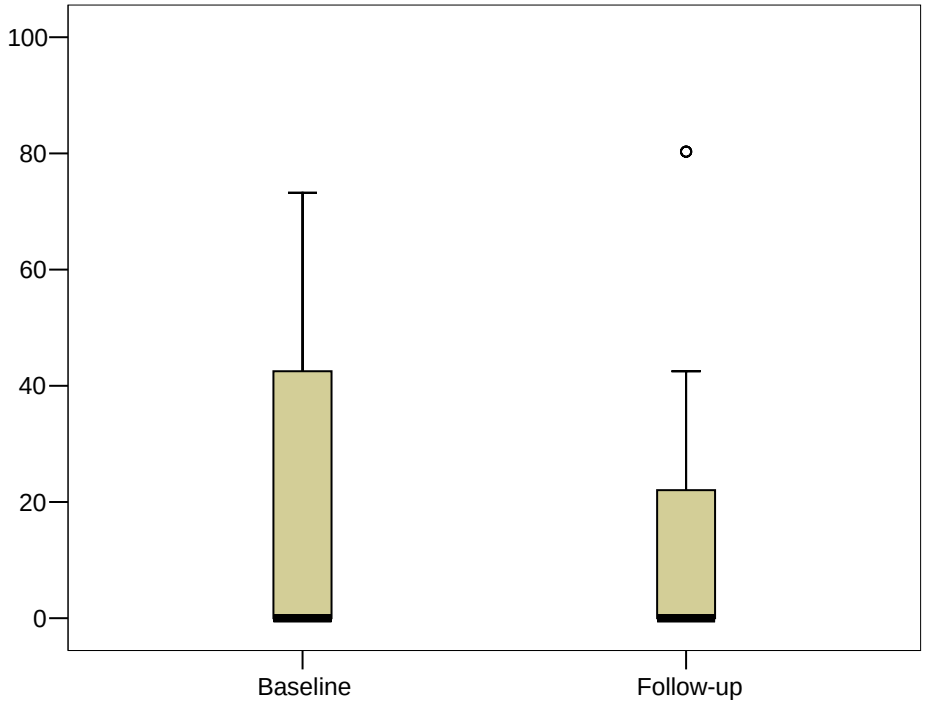


Figure 21. Boxplot of Screening and Safety Assessment: Baseline and Follow-Up Scores



- Most hospitals scored low in this domain.
- The average *Screening and Safety Assessment* score was 14 at baseline, and 17 at following, an increase of 3.
- The median score at both baseline and follow-up was 0.

Domain 6: Documentation

Scores for this domain were based on the following:

- use of a standardised instrument to record known or suspected cases of partner abuse; and
- use of forensic photography in the documentation procedure.

Five (20%) hospitals had a standardised documentation form to record partner abuse cases. Nine (36%) hospitals had provisions for forensic photography of injuries, but rarely offered to photograph injuries, relying instead on police photography.

Figure 22. Documentation: Baseline and Follow-up Scores

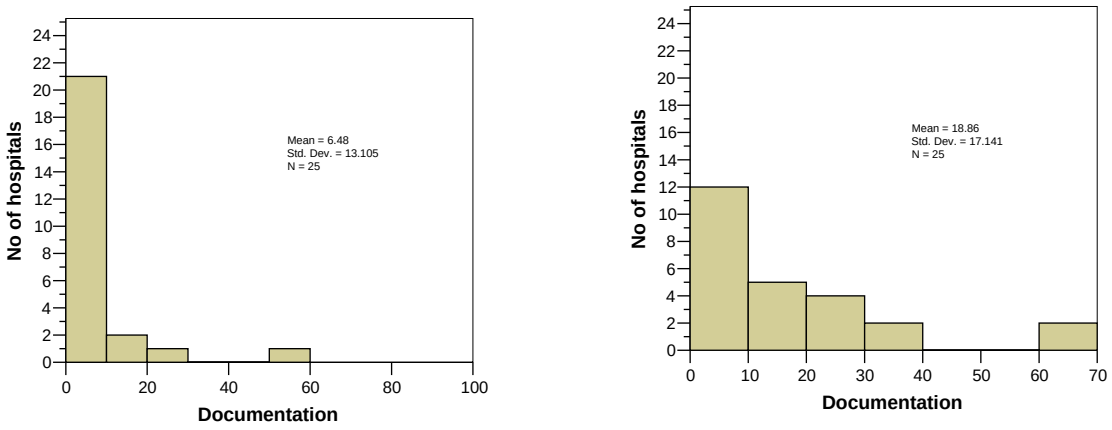
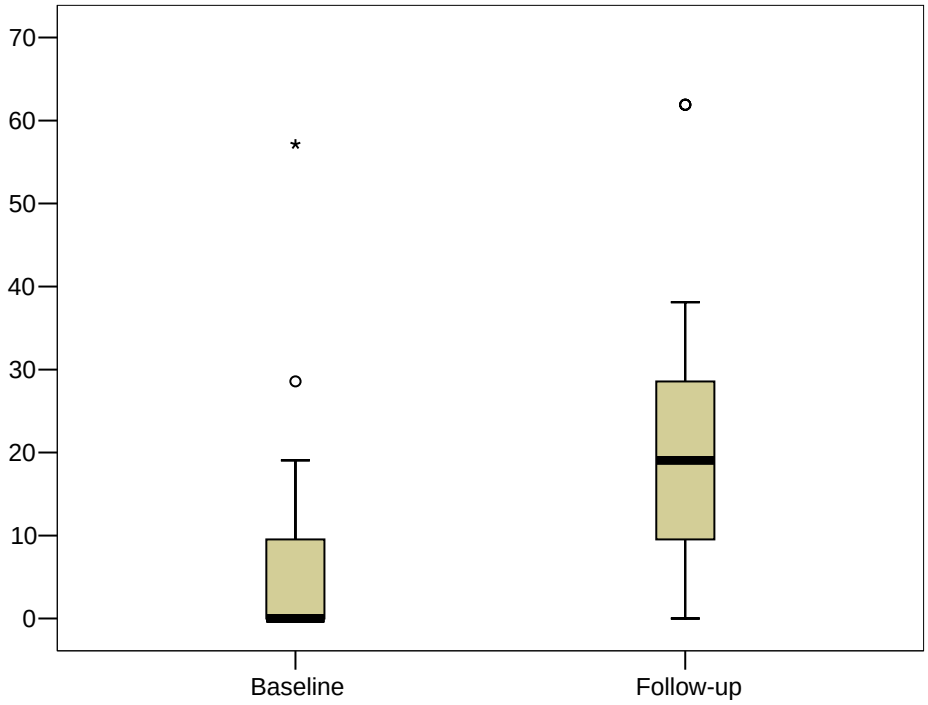


Figure 23. Boxplot of Screening and Safety Assessment: Baseline and Follow-Up Scores



- The average Documentation score was 7 at baseline and 19 at follow-up; an average increase of 12.
- The median score increased from 0 at baseline to 19 at follow-up.

Domain 7: Intervention Services

Scores for this Domain were based on the following:

- use of a standard intervention checklist for use when victims are identified;
- provision of 'on-site' advocacy services;
- use of mental health assessments within the context of the programme;
- provision of transport for victims;
- follow up contact or counselling with victims;
- provision of on site legal options counselling;
- services offered for the children of victims; and
- evidence of coordination with services for sexual assault, mental health and substance abuse.

Eight (32%) hospitals had victim advocacy services available during certain hours and 12 (48%) had advocacy services available at all times. A Māori advocate was available at 14 (56%) hospitals. Fourteen (56%) hospitals provided follow-up contact and counseling for victims following an initial assessment and 17 (68%) offered services for the children of victims.

Figure 24. Intervention Services: Baseline and Follow-up Scores

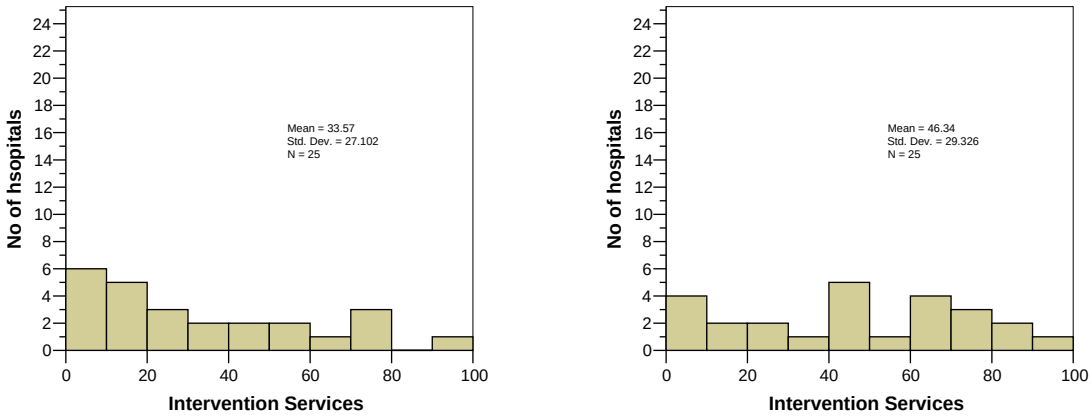
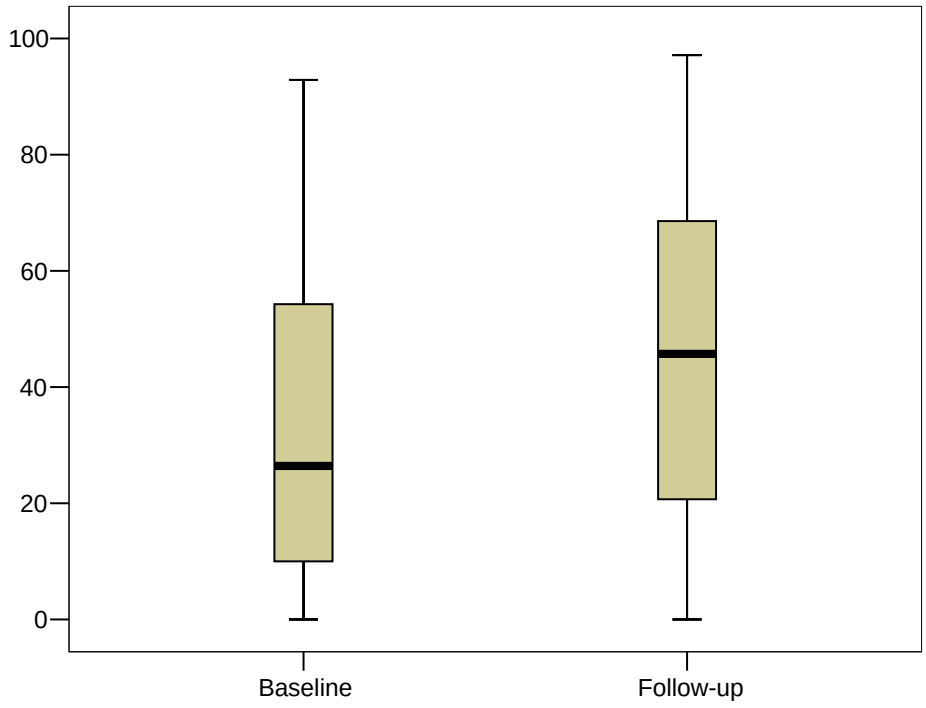


Figure 25. Boxplot of Intervention Services: Baseline and Follow-Up Scores



- The average *Intervention Services score* was 34 at baseline and i46 at follow-up, an increase of 12.
- The median score was 26 at baseline and 46 at follow-up, an increase of 73%.

Domain 8: Evaluation Activities

Scores for this domain were based on evidence for the following:

- formal evaluation procedures to monitor programme quality, including periodic monitoring of charts (chart audits) and peer case reviews;
- standardized performance feedback to staff;
- measurements of client and/or community satisfaction; and
- use of the quality framework He Taura Tieke or equivalent to evaluate effectiveness for Māori.

Eight (32%) hospitals had formal evaluation procedures in place to monitor partner abuse programme quality; three (12%) include periodic chart review (most commonly in the emergency or maternity departments); five (20%) include peer-to-peer case review (most often in maternity). Only a single hospital measured client or community satisfaction with their programme.

Figure 26. Evaluation Activities: Baseline and Follow-up Scores

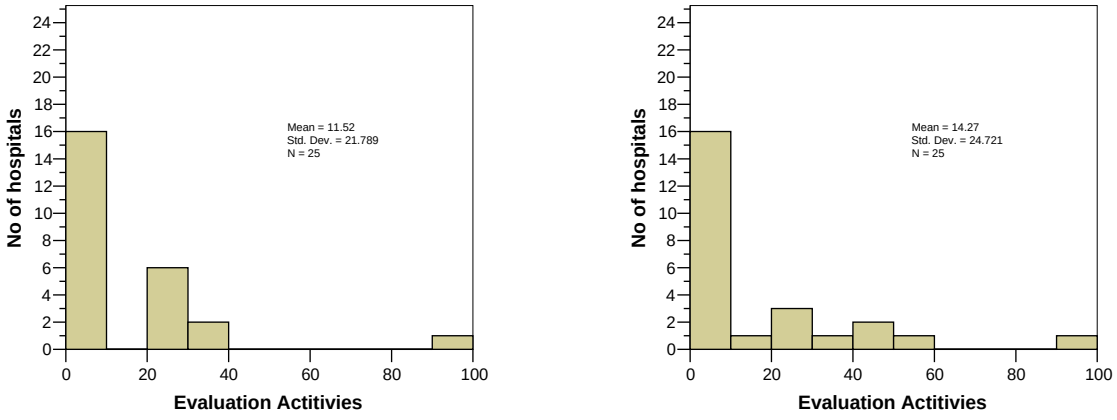
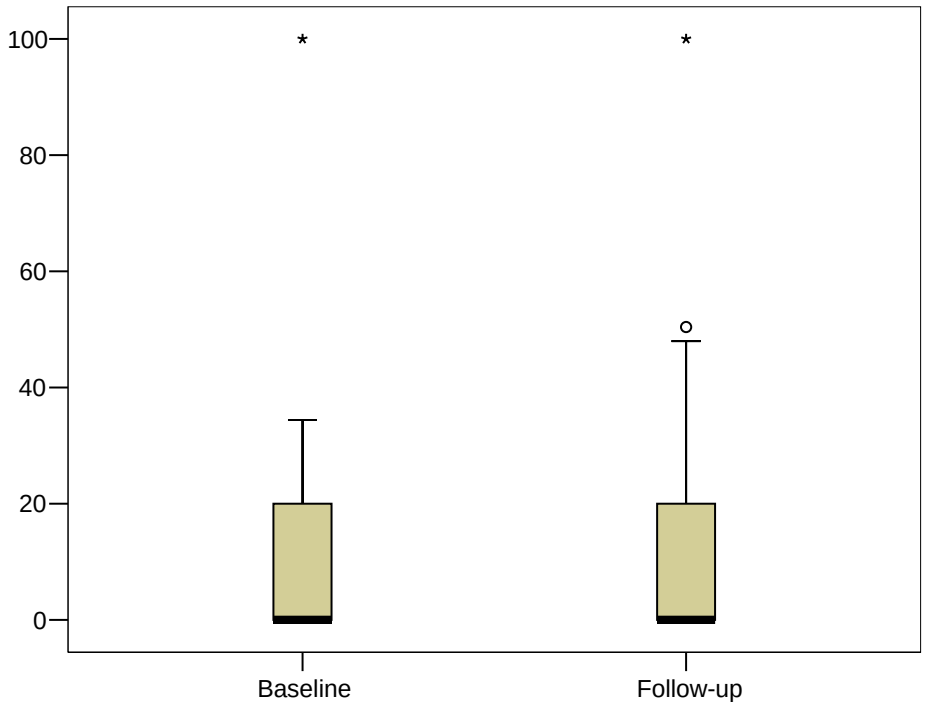


Figure 27. Boxplot of Evaluation Activities: Baseline and Follow-Up Scores



- There was little change in *Evaluation Activities* scores over time.
- The average score was 12 at baseline and 14 at follow-up
- The median score at both baseline and follow-up was 0.

Domain 9: Collaboration

Scores were based on evidence of collaboration with the following:

- local programmes/agencies with: training, policy and procedure development, a working group and on site service provision;
- Māori representatives, representatives from other ethnic groups, and other community agencies/programmes;
- local police and courts; and
- other health care facilities within the same system, and outside the DHB, including with Māori providers.

Almost all hospitals collaborated with local partner abuse service providers in their community (n=24, 96%) and with local police and courts (n=20, 80%). Eighteen (72%) hospitals evidenced collaboration with their Māori health unit. Most hospitals (n=21, 84%) collaborate with another partner abuse programme in the region.

Figure 28. Collaboration: Baseline and Follow-up Scores

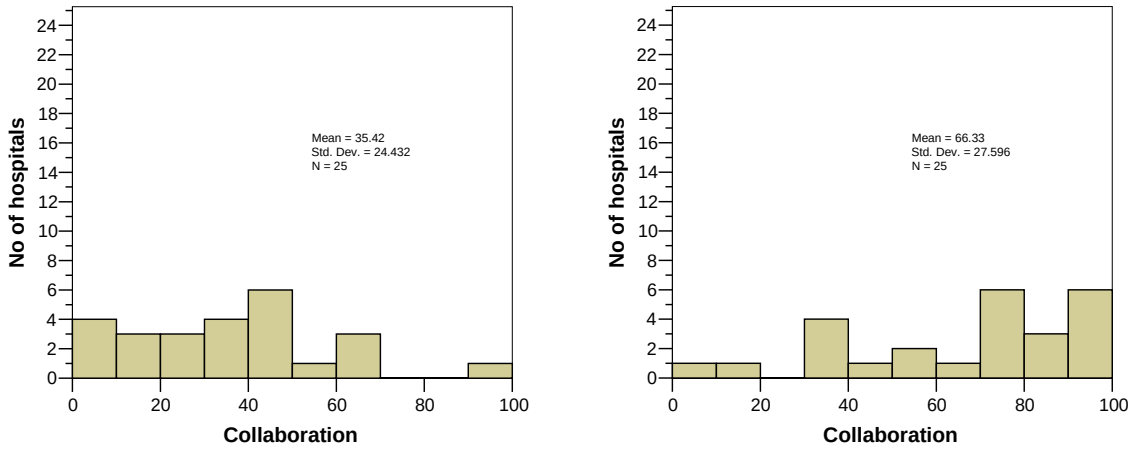
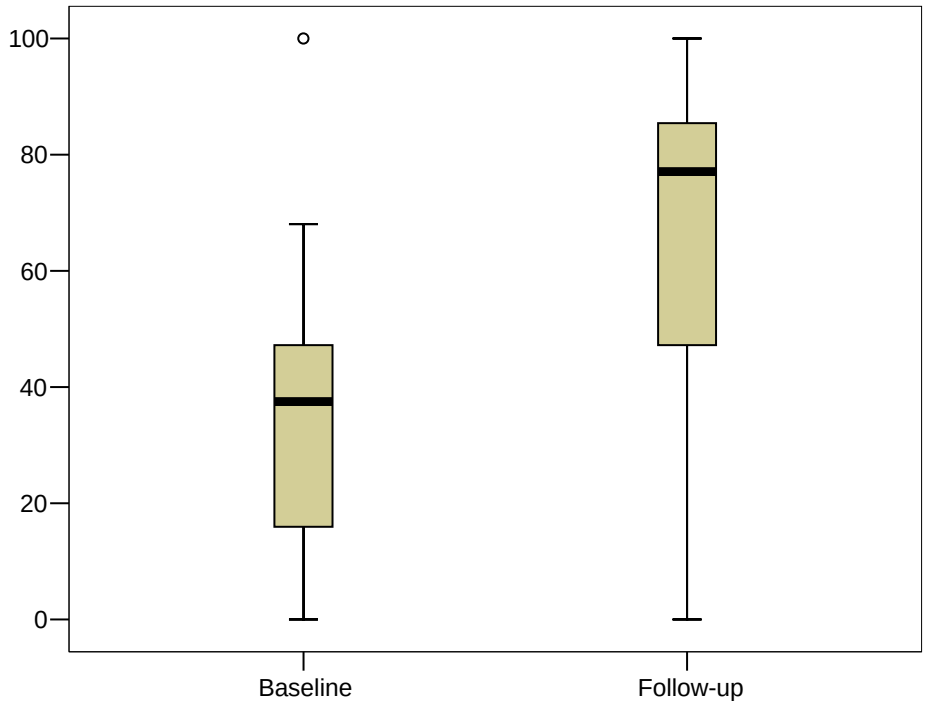


Figure 29. Boxplot of Collaboration: Baseline and Follow-Up Scores



- *Collaboration* had the highest mean and median scores among the nine domains.
- The average collaboration score was 35 at baseline and increased to 66 at follow-up.
- The median score was 38 at baseline and 77 at follow-up, an increase of 106%.

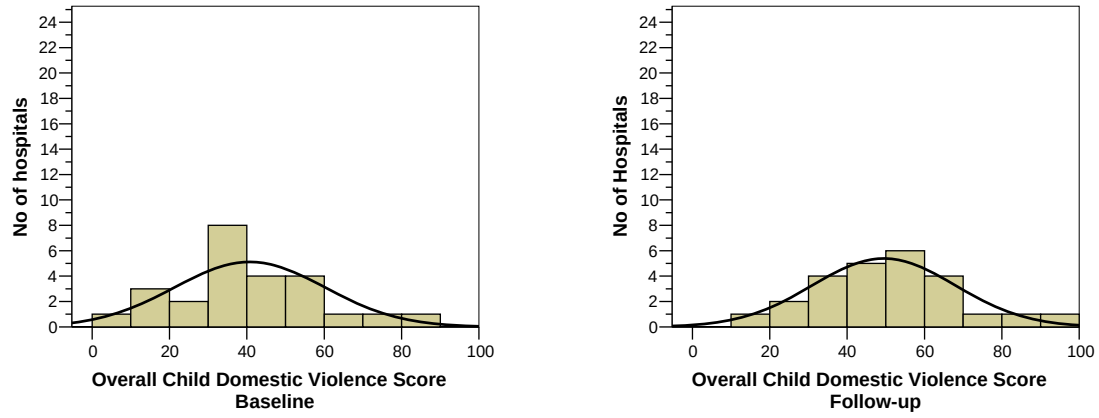
Child Abuse and Neglect Audit Findings

Child Abuse and Neglect Audit Summary

At follow-up - as at baseline - the responsiveness of most hospitals to children at risk for abuse and neglect continued to be higher than for the response to partner abuse[a], though still reflective of an intermediate stage of development. The average overall child abuse and neglect score increased from 41 at baseline to 50 at follow-up; an average change of +9. At least half of the hospitals scored 50 or higher in three domains: *Intervention Services*, *Collaboration* and *Hospital Policies and Procedures*.

Figure 30 displays the distribution of the overall Child Abuse and Neglect programme scores at baseline and follow-up among the 25 hospitals. Median overall and domain scores over time are provided in Figure 31 and hospital league tables are provided in Figure 32 for baseline, follow-up and change scores. Boxplots in Figure 33 display baseline and follow-up scores for each domain; and Table 7 provides the data supporting the figures. Results for each of the eight programme domains are presented individually in the sections that follow. Frequencies for individual Delphi items are provided in Appendix C (Appendix C2: Child Abuse and Neglect).

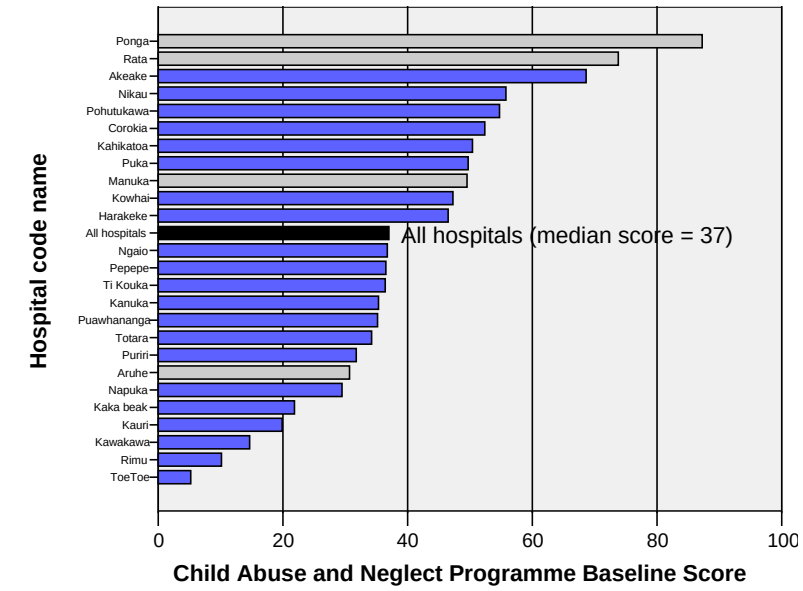
Figure 30. Overall Child Abuse and Neglect Programme Scores: Baseline and Follow-up

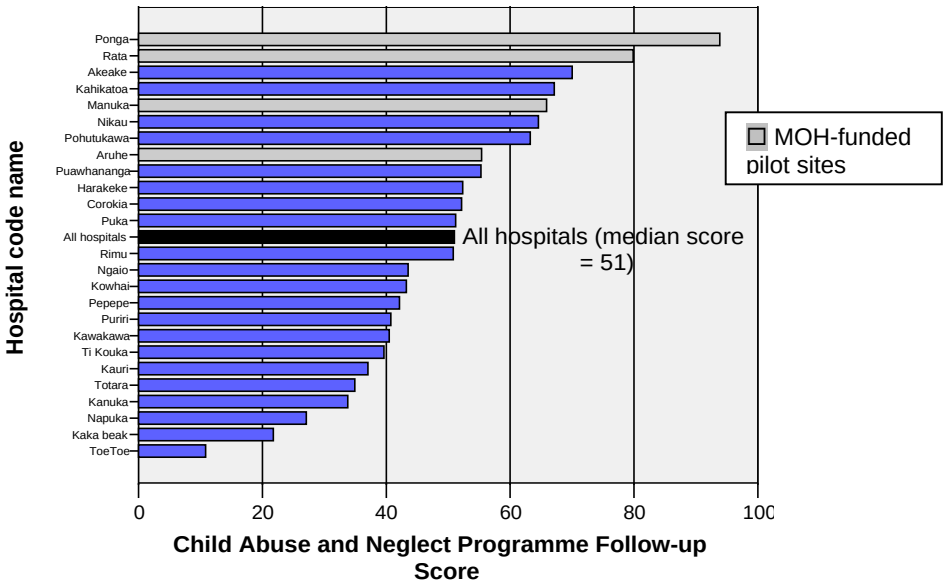


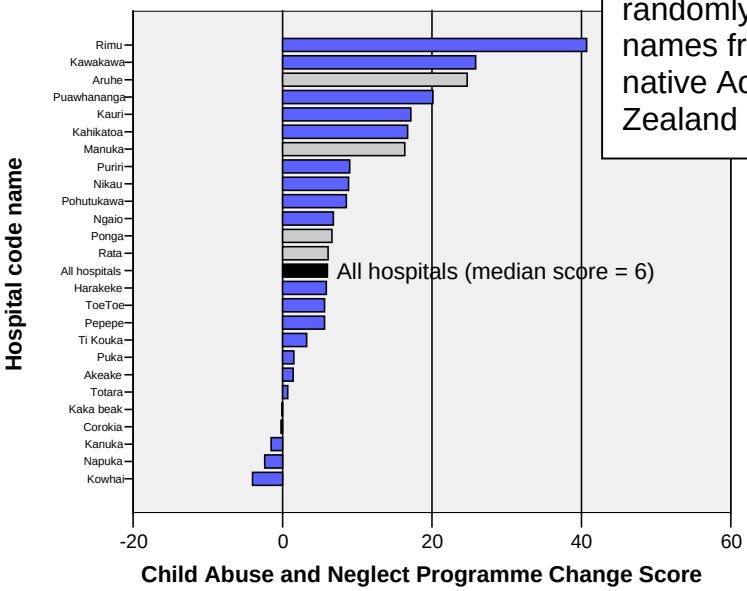
- The average score at follow-up was 50, compared to 41 at baseline.
- The median (50th percentile) score at follow-up was 51, compared to 37 at baseline.
- Scores for Child Abuse and Neglect Programmes ranged from 11 to 94 at follow-up, compared to 5 to 88 at baseline.

[a] The reader is reminder that the Child Abuse and Neglect scores are based on a modified Delphi instrument that is undergoing further development at the time of this report.

Figure 31 . Child Abuse and Neglect Hospital League Tables: Baseline, Follow-up and Change scores.

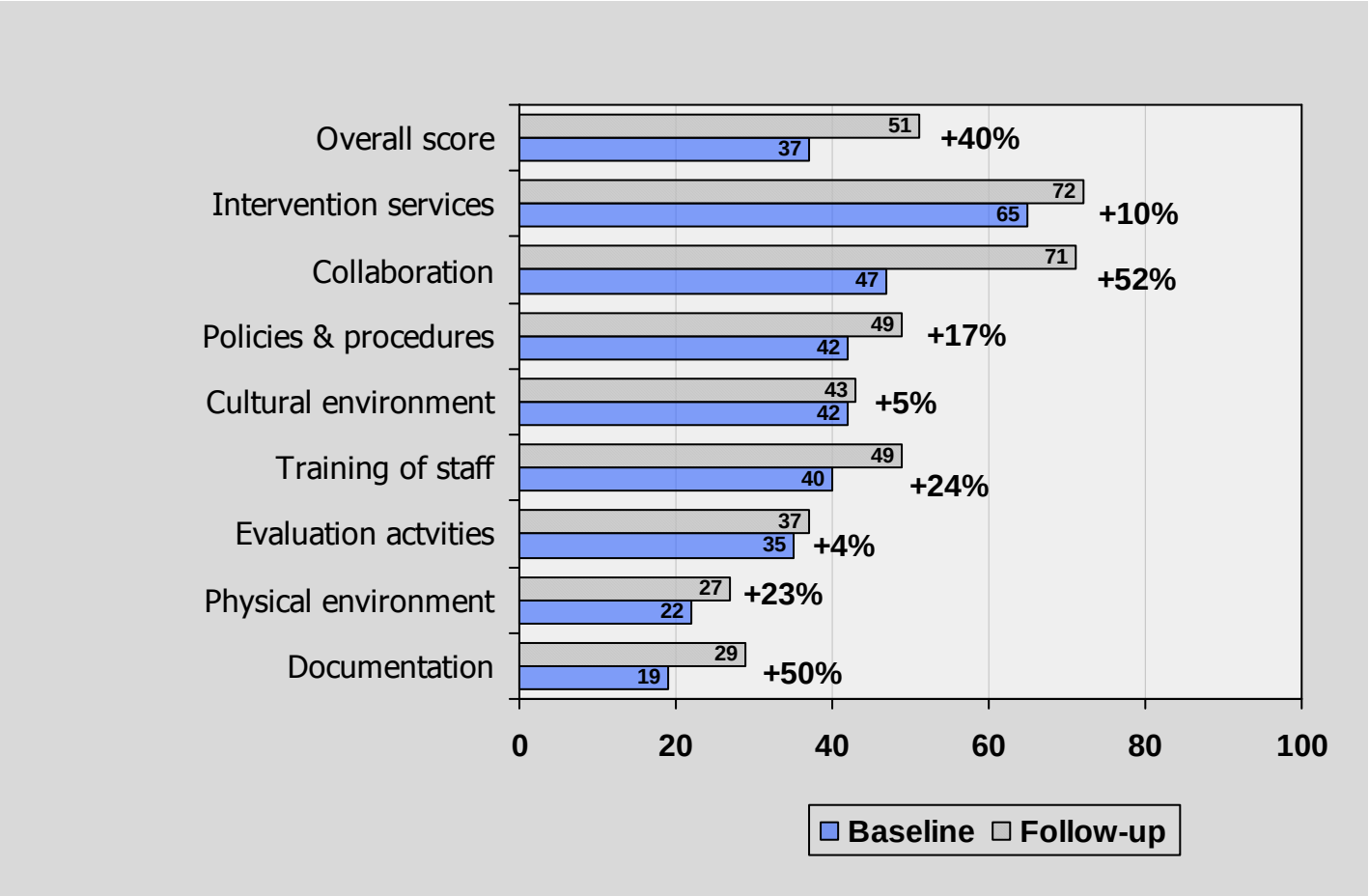






Note: Hospitals have been randomly allocated code names from a selection of native Aotearoa New Zealand plants

Figure 32. Child Abuse and Neglect Domain Score Changes (Median Scores)



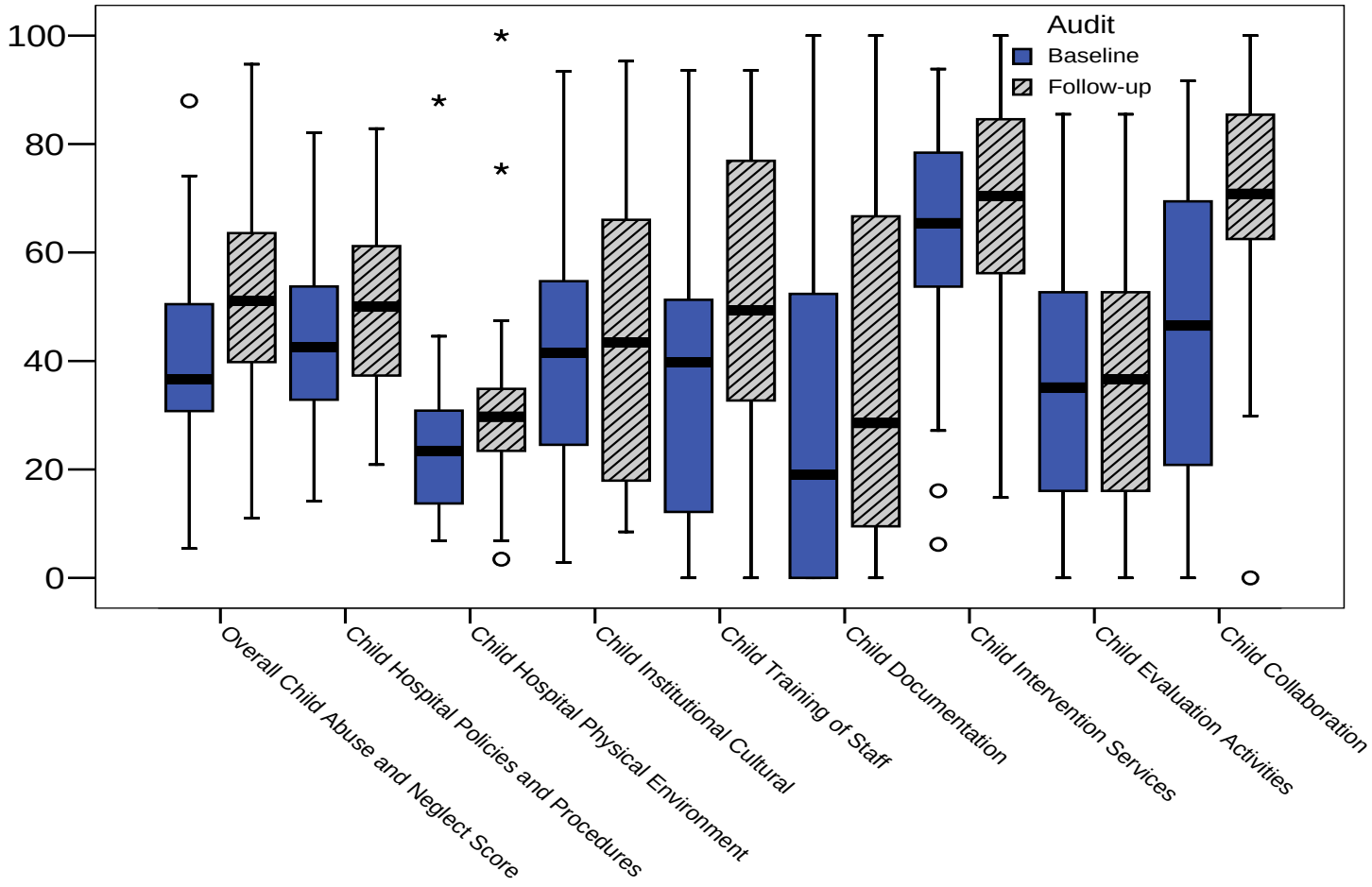
- The most developed child abuse programme domain was *Intervention Services*, followed closely by *Collaboration*.
- Improvements were seen in all child abuse programme domains, especially for *Collaboration* and *Documentation*.

Table 7. Child Abuse Scores

	Mean		Mean Diff	SD		Min		Max		Percentile					
										25th		50th		75th	
	B	***F***		***B***	***F***	***B***	***F***	***B***	***F***	***B***	***F***	***B***	***F***	***B***	***F***
Overall Score	40.6	49.5	8.7	19.5	18.5	5	11	88	94	30.2	38.3	36.6	50.8	51.5	63.9
Domain Scores															
Intervention Services	62.4	68.0	5.6	24.3	20.5	6	15	94	100	52.5	53.7	65.4	72.2	82.7	84.9
Collaboration	45.1	70.7	25.6	27.2	24.2	0	0	92	100	20.8	62.5	46.5	70.8	69.4	88.5
Hospital Policies and Procedures	44.6	51.4	8.8	18.7	17.1	14	21	82	83	32.1	38.4	42.5	49.3	58.2	63.8
Hospital Cultural Environment	40.9	46.2	5.3	23.6	26.9	3	8	93	95	21.2	17.9	41.5	43.4	55.2	66.5
Training of Staff	36.7	51.5	14.8	27.0	29.3	0	0	94	94	9.3	31.1	39.7	49.4	55.1	77.9
Evaluation Activities	31.9	35.1	3.1	24.6	25.8	0	0	85	85	8.0	8.0	35.1	36.6	52.7	52.7
Documentation	30.9	35.6	4.8	33.2	31.3	0	0	100	100	0.0	4.8	19.1	28.6	54.8	66.7
Hospital Physical Environment	23.5	30.1	6.6	15.2	19.1	6	3	88	81	12.3	21.5	21.5	27.2	28.5	33.3

Notes: ***B*** =baseline; ***F*** =follow-up; Mean Diff = mean change score (follow-up score minus baseline score). Baseline scores (B**)** from the 2004 report[1] have been corrected for a weighting error in the '*Hospital Physical Environment*' Domain and revision of one hospital's baseline scores as a result of feedback during the follow-up audit.

Figure 33. Boxplot of Child Abuse and Neglect Programme Overall and Domain Scores at Baseline and Follow-Up



Domain 1: Hospital Policies and Procedures

Scores for this domain were based on evidence for the following:

- official, written hospital policies regarding the assessment and treatment of victims;
- a hospital-based child abuse and neglect working group;
- financial support for the child abuse and neglect abuse programme, including for Māori initiatives;
- a clinical assessment policy for identifying signs and symptoms and for identifying children at high risk;
- quality assurance procedures for implementing the assessment policy including regular chart audits, peer review, supervision and feedback from Child, Youth and Family;
- security and safe transport procedures; and
- an identifiable child abuse and neglect coordinator at the hospital.

Policies and procedures addressing child abuse and neglect were in place at 24 of the 25 hospitals at the time of the 12 month follow-up audit. The policies and procedures included child protection reporting requirements at 76% of hospitals, mandated training for staff at 32% and addressed age-appropriate risk assessment at 20%.

The number of hospitals that had a child abuse and neglect working group increased from 12 (48%) at baseline to 19 (76%) at follow-up. Working groups often met monthly (n=15) and included a Māori representative (n=16); one working group included a youth representative. Sixteen (64%) hospitals funded their child abuse and neglect programme at a sum of $10,000 or greater, with the majority of resources supporting child abuse and neglect programme coordinator salary. Six (24%) hospitals had no evidence of financial support for a child abuse and neglect programme. Nine (36%) reported that there was no identifiable child abuse and neglect coordinator at the hospital. The three hospitals that had financial support but no identifiable coordinator reported that a need for that role had been identified.

Almost all (n=24, 96%) hospitals had a standardised clinical assessment form regarding signs and symptoms of child abuse and neglect. Evidence of Child Youth and Family case feedback was noted at 16 (64%) hospitals and regular peer review at 14 (56%). Few (n=6, 24%) hospitals conducted chart audits to ensure policy implementation.

Figure 34. Hospital Policies & Procedures: Baseline and Follow-up Scores

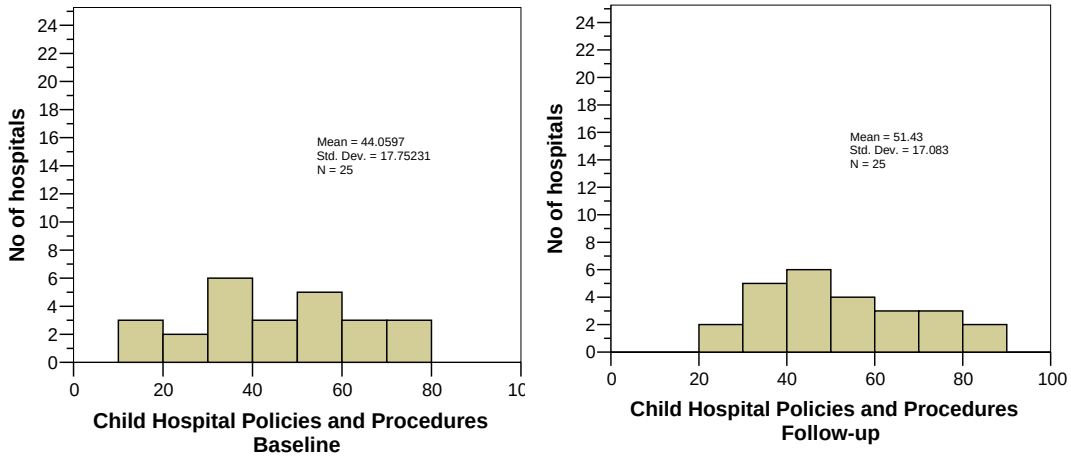
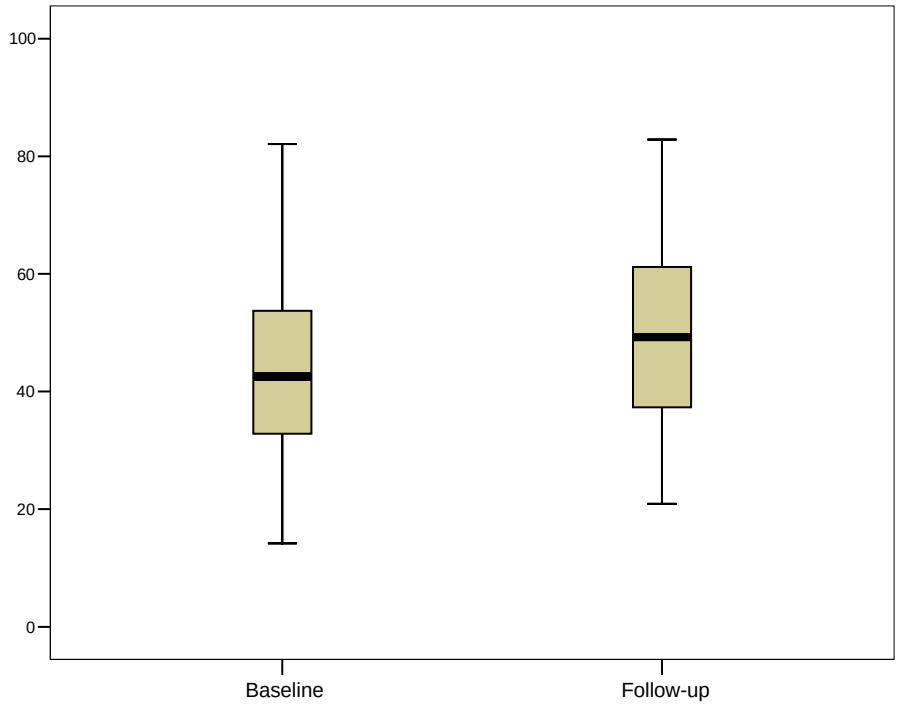


Figure 35. Boxplot of Hospital Policies and Procedures: Baseline and Follow-Up Scores



- The average *Policies & Procedures* score was 45 at baseline compared to 51 at follow-up; an average increase of 7.
- The median was 42 at baseline and 50 at follow-up, an increase of 18%.

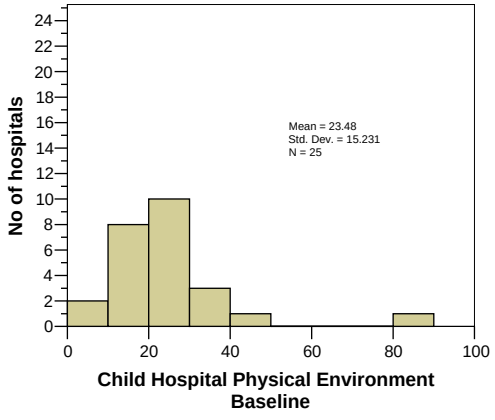
Domain 2: Hospital Physical Environment

Scores for this domain were based on evidence for following:

- posters and images on display to create a 'child-friendly' environment;
- posters and/or brochures, and referral information related to child abuse and neglect (including for Māori, and other ethnic/cultural groups); and
- provisions of temporary shelter for victims.

Child-friendly posters and images were common across all the hospitals. All hospitals had at least one piece of material that addressed child abuse and neglect. Referral information to access resources was present in 5 or more locations at 8 (32%) hospitals. The number of hospitals that had policies that included provisions for temporary safe refuge for children and families awaiting safe accommodation in the community increased from 11 (44%) at baseline to 19 (76%) at follow-up .

Figure 36. Hospital Physical Environment: Baseline and Follow-up Scores



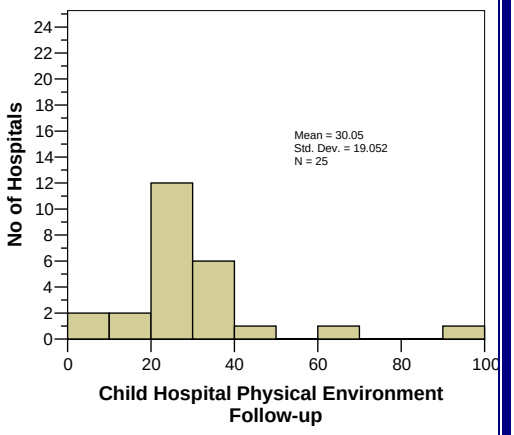
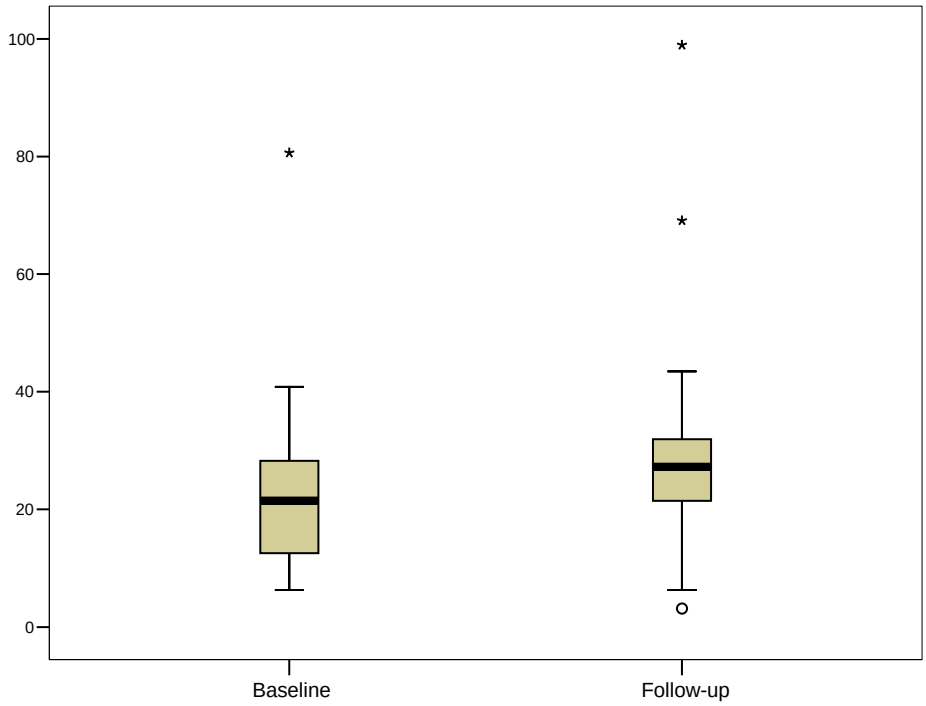


Figure 37. Boxplot of Hospital Physical Environment: Baseline and Follow-Up Scores



- *Hospital Physical Environment* ranked the lowest (based on median scores) amongst all the domains, with little change from baseline to follow-up.
- The average *Hospital Physical Environment* score was 24 at baseline and 31 at follow-up.
- The median score was 22 at baseline and 27 at follow-up, an increase of 23%.

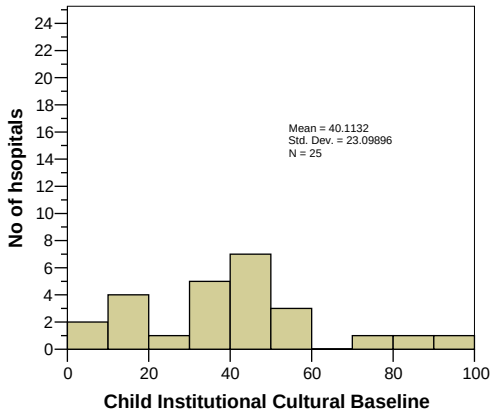
Domain 3: Hospital Cultural Environment

Scores for this domain were based on evidence for the following:

- written, formal assessment of staff knowledge and attitudes about child abuse;
- length the child abuse and neglect programme had been in existence;
- addressing of cultural competency issues; and
- participation in preventive outreach and public education campaigns on the topic of child abuse and neglect.

Eleven (44%) hospitals had formally assessed staff knowledge and attitudes regarding child abuse and neglect within the past three years, most commonly among paediatric, maternity, and emergency department staff. All (n=25) child abuse and neglect programmes addressed cultural competence, though only eight (32%) had child abuse and neglect information in languages other than English. Fifteen (60%) hospitals had participated in at least one preventive outreach public education activity on child abuse and neglect in the past 12 months.

Figure 38. Hospital Cultural Environment: Baseline and Follow-up Scores



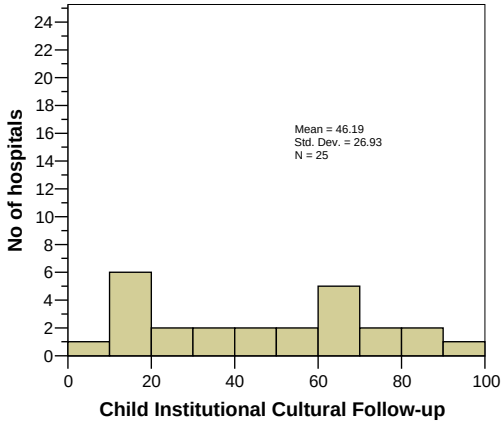
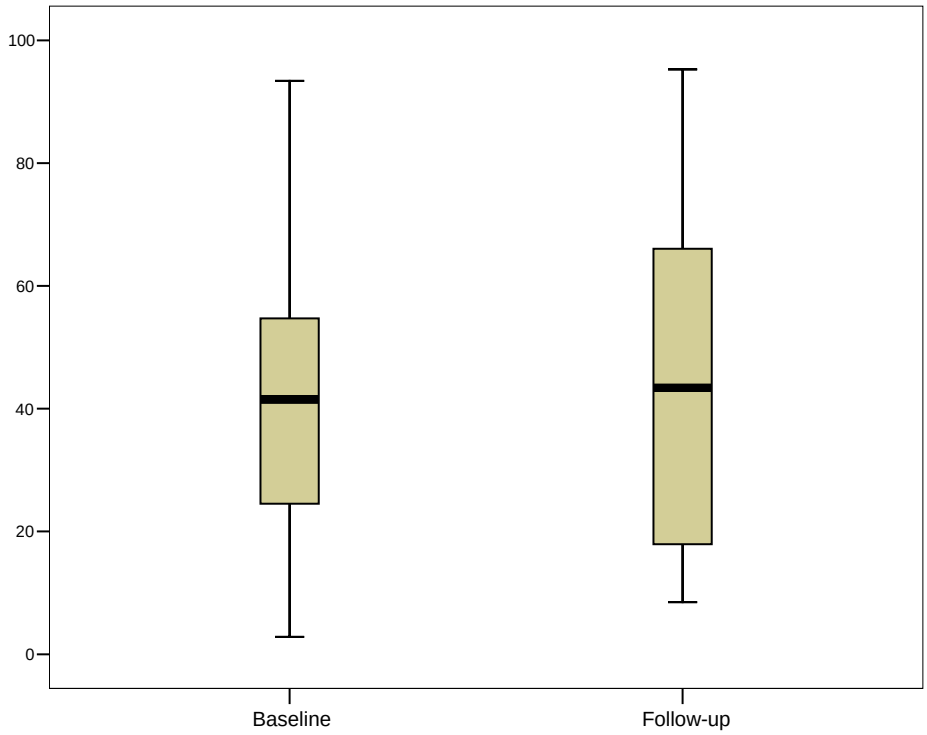


Figure 39. Boxplot of Hospital Cultural Environment: Baseline and Follow-Up Scores



- There was little change in the *Hospital Cultural Environment* domain from baseline to follow-up.
- The average hospital cultural environment score was 41 at baseline and 46 at follow-up.
- The median was 42 at baseline and 43 at follow-up.

Domain 4: Training of Staff

Scores for this domain were based on evidence for the following:

- a formal, written training plan for the hospital;
- whether child abuse and neglect programme training had been provided to staff in the last 12 months;
- specific elements included in the training; and
- who provided the training.

Ten (40%) hospitals had a formal child abuse and neglect programme training plan for staff at follow-up, compared to five (20%) at baseline. In those hospitals with a training plan, regular ongoing education for clinical staff was most commonly provided for the paediatric department. Twenty (80%) hospitals had offered at least one training session (either as part of formal training plan or ad hoc) on child abuse and neglect in the 12 months prior to the audit at follow-up, compared to 7 (28%) hospitals at baseline.

Figure 40. Training of staff: Baseline and Follow-up Scores

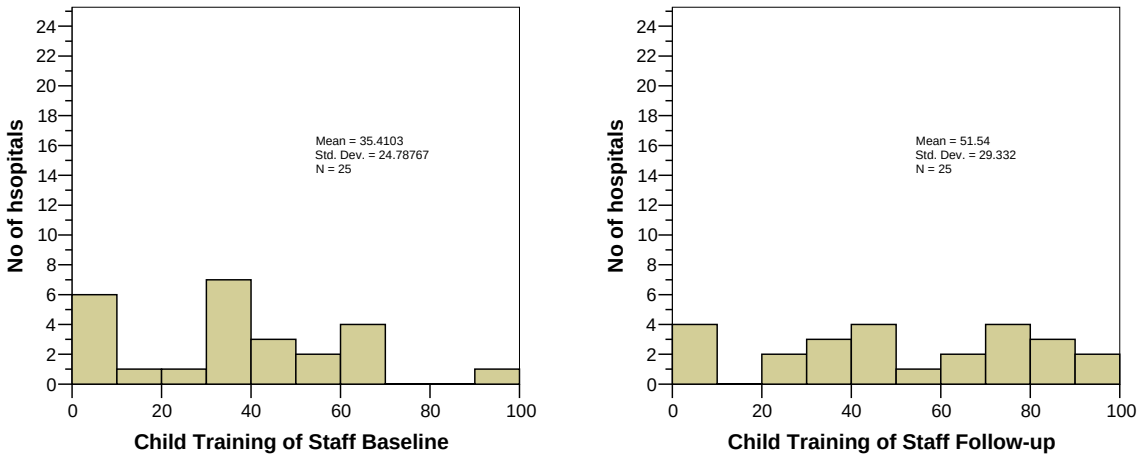
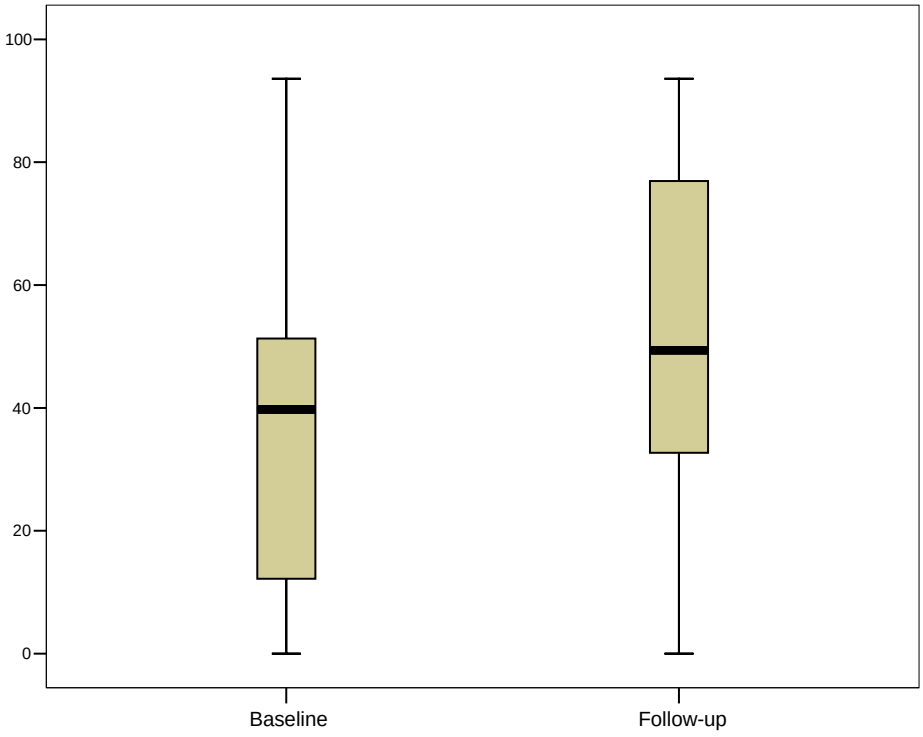


Figure 41. Boxplot of Training of Staff: Baseline and Follow-Up Scores



- The average *Training of Staff* score was 37 at baseline compared to 52 at follow-up; an average increase of 15.
- The median was 40 at baseline and 49 at follow-up, an increase of 24%.

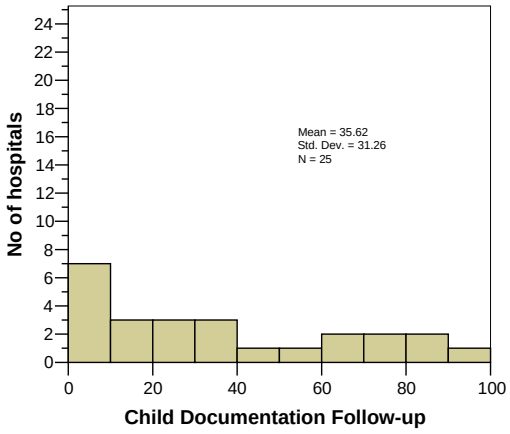
Domain 5: Documentation

Scores for this domain were based on the following:

- use of a standardised instrument to record known or suspected cases of child abuse and neglect; and
- performance of a standardised safety assessment for children.

Over half (n=15, 60%) of the hospitals had a standardised documentation instrument for recording known or suspected cases of child abuse and neglect at follow-up (compared to 13 at baseline). A standardised safety assessment was provided at 13 (52%) hospitals, an increase from 10 (40%) hospitals at baseline. The number of hospitals in which the standardised child abuse and neglect assessment included screening the child's mother for partner abuse increased from six (24%) at baseline to 13 (52%) at follow-up.

Figure 42. Documentation: Baseline and Follow-up Scores



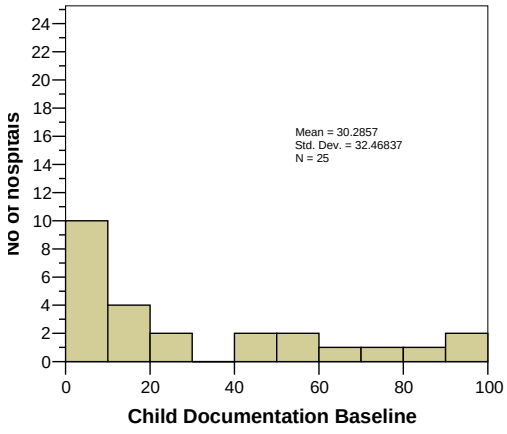
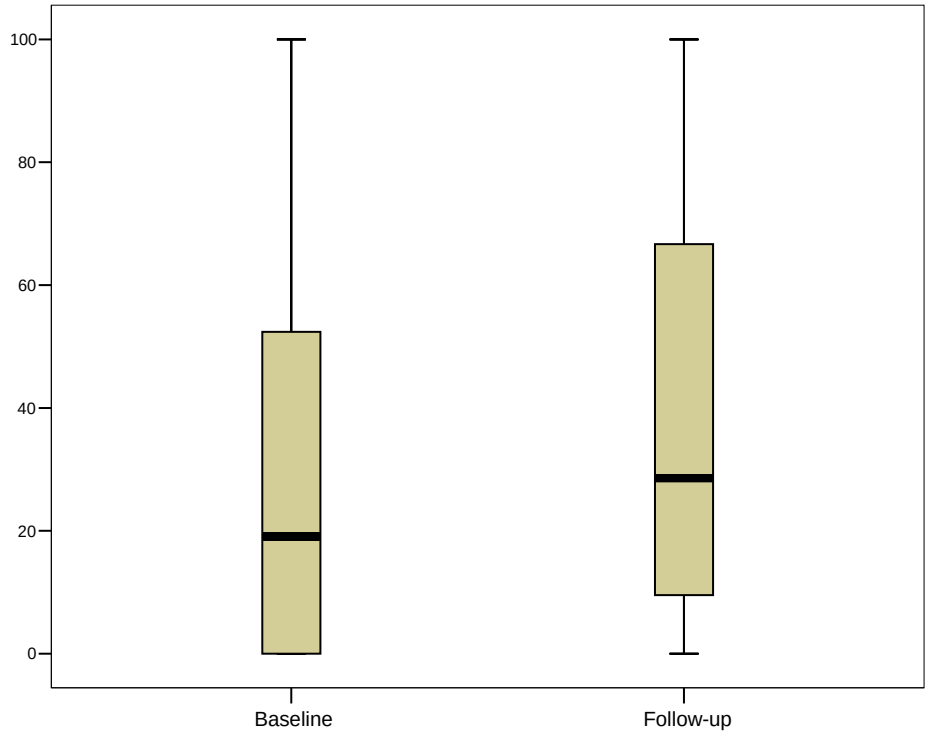


Figure 43. Boxplot of Documentation: Baseline and Follow-Up Scores



- The *Documentation* domain ranked second lowest (based on median scores) amongst all domains.
- The average *Documentation* score was 31 at baseline and 36 at follow-up, an average increase of 5.
- The median score was 19 at baseline and 29 at follow-up, an increase of 50%.

Domain 6: Intervention Services

Scores for this domain were based on the following:

- use of a standard intervention checklist for use when victims are identified;
- provision of 'on-site' child advocacy and protection services;
- use of mental health assessments within the context of the programme;
- provision of transport for victims and their families;
- follow-up contact or counseling with victims;
- provision of 'on-site' legal options counseling;
- services offered for the families of victims; and
- evidence of coordination with services for sexual assault, mental health and substance abuse.

Twenty-two (88%) hospitals had a standardised intervention checklist for when child abuse and neglect was suspected or identified, compared with 17 (68%) at baseline. A member of the child abuse and protection team or designated social worker was available to provide services at all times at 12 (48%) hospitals; in an additional 12 (48%) hospitals the service was available during certain hours. The number of child abuse and neglect programmes offering family violence intervention services for families, and in particular mothers, increased from 8 (32%) at baseline to 13 (52%) at follow-up. Coordination between the hospital child abuse and neglect programme and Child, Youth and Family was evident at the majority of hospitals (n=22, 88%).

Figure 44. Intervention Services: Baseline and Follow-up Scores

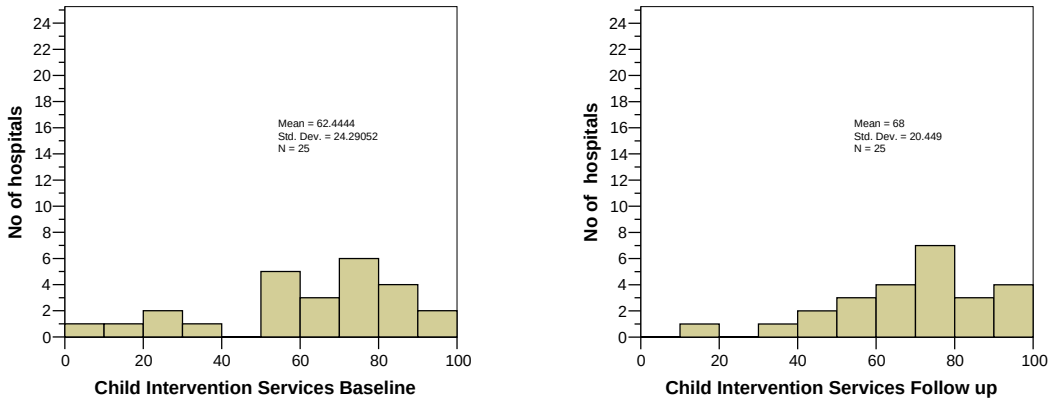
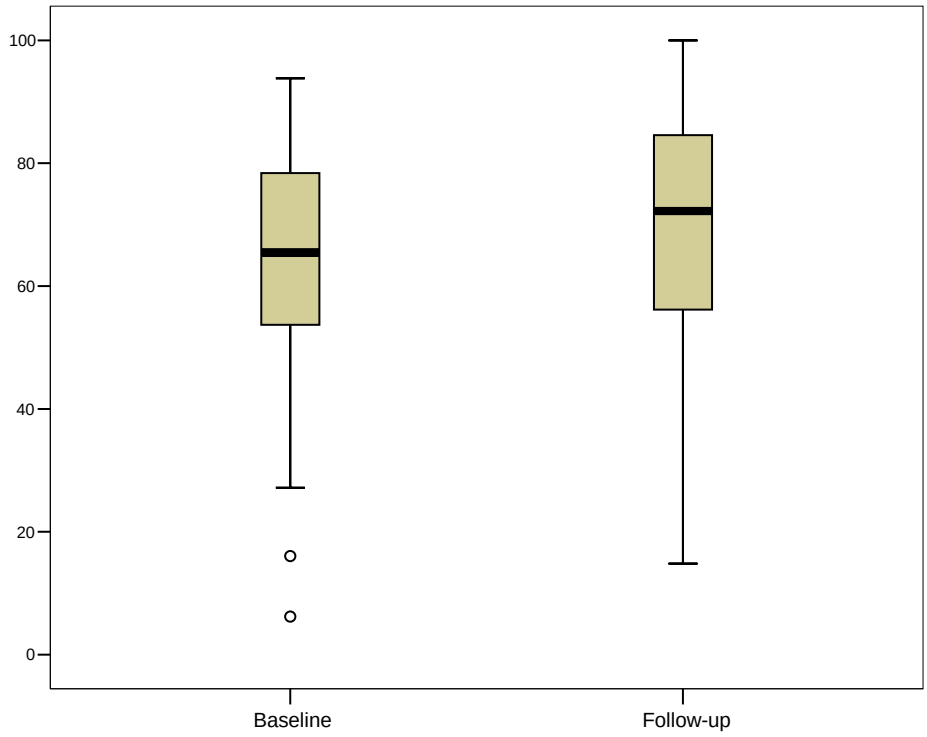


Figure 45. Boxplot of Intervention Services: Baseline and Follow-Up Scores



- The *Intervention Services* ranked the highest (based on median scores) across the eight child abuse and neglect programme domains.
- The average *Intervention Services* domain score was 62 at baseline and 68 at follow-up, an average increase of 6.
- The median was 65 at baseline and 72 at follow-up, an increase of 10%.

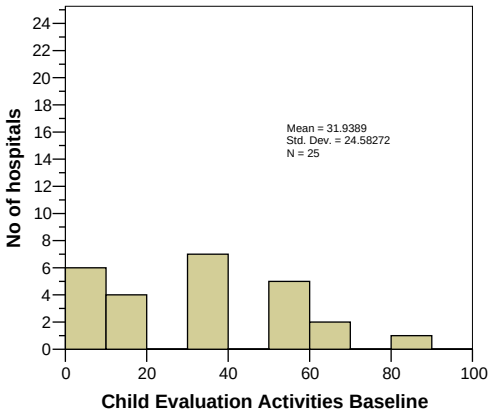
Domain 7: Evaluation Activities

Scores for this domain were based on evidence for the following:

- formal evaluation procedures to monitor programme quality, including periodic monitoring of charts (chart audits) and peer case reviews;
- standardized performance feedback to staff;
- measurements of client and/or community satisfaction; and
- use of the quality framework He Taura Tieke or equivalent to evaluate effectiveness for Māori.

Seventeen (68%) hospitals had evidence of some formal evaluation procedure for monitoring child abuse and neglect programme quality, an increase of two from baseline. Of the 12 (48%) hospitals which monitored the child abuse and neglect clinical assessment policy, the paediatric department was most commonly involved. Nine (36%) hospitals measured outcomes. The number of the hospitals providing staff with feedback on their performance from Child, Youth and Family decreased form 14 (56%) at baseline to 12 (48%) at follow-up. At follow-up, one hospital measured client or community satisfaction with the child abuse and neglect programme and one hospital used He Taura Tieke (or equivalent) quality framework for monitoring quality for Māori clients.

Figure 46. Evaluation Activities: Baseline and Follow-up Scores



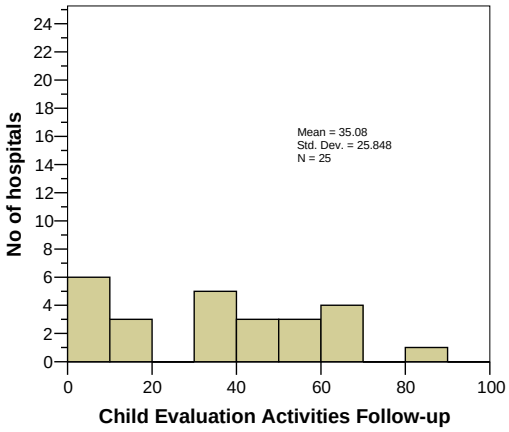
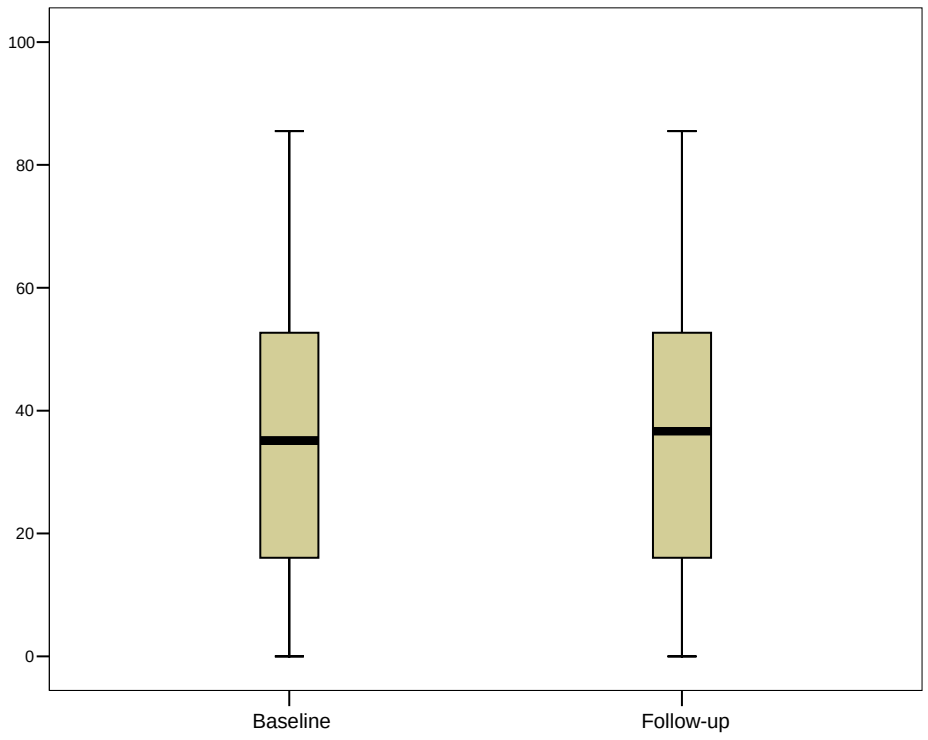


Figure 47. Boxplot of Evaluation Activities: Baseline and Follow-Up Scores



- There was little change in the *Evaluation Activities* domain scores between baseline and follow-up audits.
- *Evaluation Activities* ranked the third lowest (based on median scores) amongst the domains.
- The average *Evaluation Activities* score was 32 at baseline and 35 at follow-up.
- The median was 35 at baseline and 37 at follow-up, an increase of 4%.

Domain 8: Collaboration

Scores for this domain were based on evidence of collaboration with the following:

- NGOs and Child, Youth and Family in child advocacy and protection on site service provision, staff training, policy and procedure development and working group participation;
- Māori representatives, representatives from other ethnic groups, and other community agencies/programmes;
- local police and courts; and
- other health care facilities within the same system, and outside the DHB, including with Māori providers.

Most (n=24, 96%) hospital child abuse and neglect programmes evidenced collaborated with NGOs and Child, Youth and Family. There was an increase in collaboration with NGOs and CYF to provide on-site services from 16 (64%) at baseline to 22 (88%) at follow-up. Community agencies and CYF collaborated in developing hospital policies and procedures at 17 (68%) hospitals and in training hospital staff at 19 (76%) hospitals. Collaboration with police and prosecution agencies (n=24, 96%) was common; collaboration with Māori providers or representatives less so (n=17, 68%). Almost all (n=23, 92%) hospitals collaborated with other providers within their DHB (an increase from n=17 at baseline); and 20 (80%) collaborated with health services outside their DHB (an increase from n=16 at baseline).

Figure 48. Collaboration: Baseline and Follow-up Scores

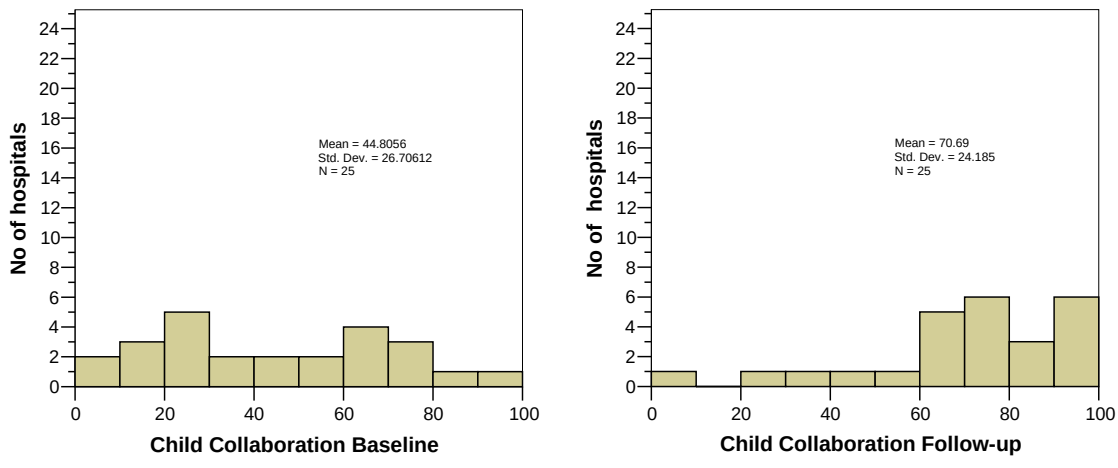
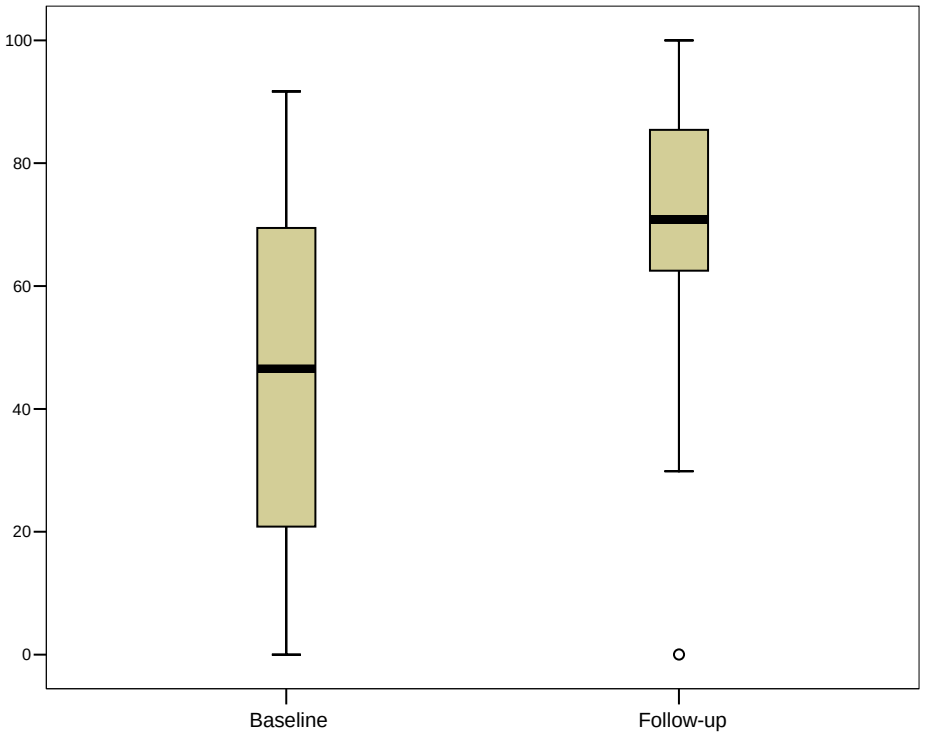


Figure 49. Boxplot of Collaboration: Baseline and Follow-Up Scores

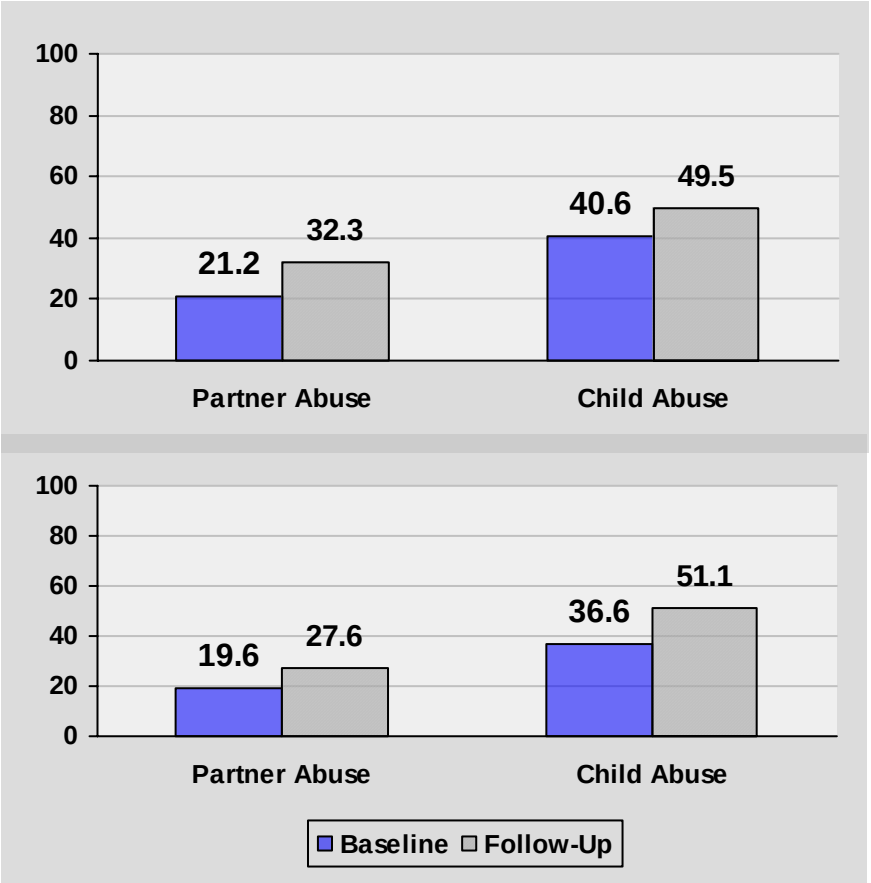


- The *Collaboration* domain score had the largest increase from baseline to follow-up and ranked as the second highest domain at follow-up.
- The average collaboration score was 45 at baseline and 71 at follow-up, an increase of 26.
- The median was 47 at baseline and 71 at follow-up, an increase of 52%.

Associations with Audit Scores

A primary interest in this 12 month follow-up audit was to document change over time. The changes in median and mean scores are presented in Figure 50. Mean programme scores increased significantly for both partner abuse (mean increase = 11.08, paired t statistic = 5.08, p <.001) and child abuse (mean increase = 9.0, paired t statistic = 4.2, p <.001).

Figure 50. Baseline and Follow-up Hospital Family Violence Programme Audit Scores (n=25)



Audit scores were also examined by selected hospital characteristics. Follow-up partner abuse programme scores were significantly higher in hospitals that had a family violence coordinator compared to those that did not, and in hospitals with more mature programmes (see Table 8). While main urban hospitals and those with more than 100 beds tended to have higher scores at follow-up, the associations were not statistically significant.

Examining change over time, there was a significant effect of having a family violence coordinator (f=17.9, p <.001, see Figure 51). The mean

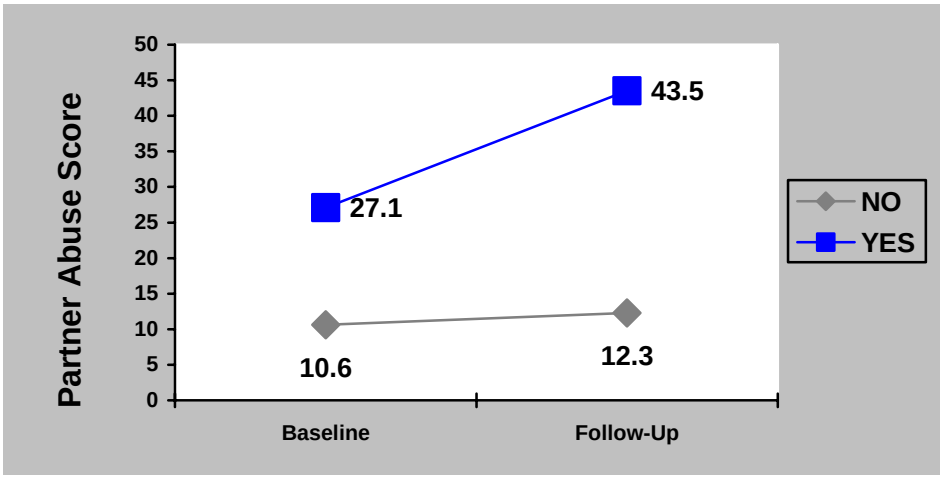
partner abuse programme score increase (follow-up minus baseline) was less than 2 at hospitals without family violence coordinators, versus 15 at hospitals with a family violence coordinator.

Table 8. Partner Abuse Audit Scores Over Time by Hospital Characteristics

Mean ± SEM	N	Follow-up Score	P	Change Score	P
Family Violence Coordinator			<.001		<.001
No	9	12.3 ± 2.2		1.6 ± 1.9	
Yes	16	43.5 ± 4.8		16.4 ± 2.4	
Programme Maturation (months)			.002		.159
No programme	6	12.2 ± 2.8		3.6 ± 2.2	
1-24	15	33.6 ± 4.2		13.5 ± 2.5	
> 24	4	57.6 ± 14.6		13.1 ± 8.8	
Hospital Beds			.158		.983
< 100	6	21.2 ± 6.0		11.2 ± 4.8	
≥ 100	19	35.8 ± 5.2		11.1 ± 2.5	
Location			.295		.475
Minor/secondary urban	8	25.5 ± 6.0		8.8 ± 3.1	
Main urban	17	35.5 ± 5.7		12.2 ± 2.9	

Note: Follow-up score p value relates to ANOVA test for difference in mean follow up score by group. Change score p relates to repeated measures ANOVA interaction term time * hospital characteristic.

Figure 51. Partner Abuse Programme Score over time by presence or absence of a family violence coordinator.



Follow-up child abuse abuse programme scores were significantly higher in hospitals that had a child abuse coordinator compared to those that did not, and in larger hospitals (see Table 9). While hospitals with more mature programmes and those located in main urban hospitals tended to have higher scores at follow-up, the associations were not statistically significant. Examining change over time, there were no significant interactions between hospital characteristics and change over time.

Table 9. Child Abuse Audit Scores Over Time by Hospital Characteristics

Mean ± SEM	n	Follow-up score	p	Change Score	p
Child Abuse Coordinator			.04		.825
No	9	38.9 ± 5.7		9.4 ± 4.7	
Part-Time	12	52.3 ± 5.1		9.6 ± 2.8	
Full-Time	4	65.0 ± 5.7		5.8 ± 2.1	
Programme Maturation (months)			.411		.120
No programme	0	0		0	
1-24	5	42.2 ± 8.5		14.7 ± 3.9	
24-48	7	46.0 ± 8.7		2.6 ± 1.4	
≥ 48	13	54.2 ± 4.3		10.1 ± 3.4	
Hospital Beds			.026		.783
< 100	6	35.2 ± 5.9		7.9 ± 3.9	
100 +	19	54.0 ± 4.0		9.3 ± 2.5	
Location			.054		.243
Minor/secondary urban	8	39.2 ± 5.9		5.3 ± 2.1	
Main urban	17	54.3 ± 4.3		10.6 ± 2.9	

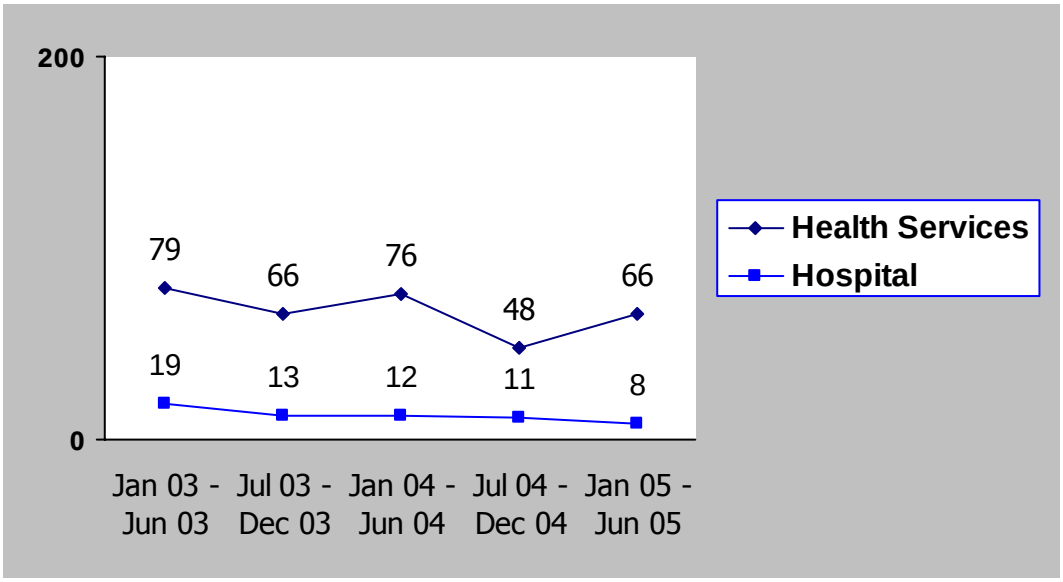
Note: Follow-up score p value relates to ANOVA test for difference in mean follow up score by group. Change score p relates to repeated measures ANOVA interaction term time * hospital characteristic.

Women's Refuge Referrals

First Referral Sources

For the 26,880 *First Referral* clients, legal services accounted for the largest named referral source (n=5983, 22%); health service referral accounted for a small proportion (n=335, 1.2%). Of the 335 health service referrals, 63 were noted to be 'hospital' referrals. No increase in referrals from health services broadly, or hospital services specifically was apparent (Figure 52).

Figure 52. Women's Refuge Health Service Referrals (First Referral Sources)



Individual hospitals contributed from 0 to 7 referrals across the 42 month period (see Table 10). The numbers of hospital 'first referrals' were too small to support analysis of DHB and audit score.

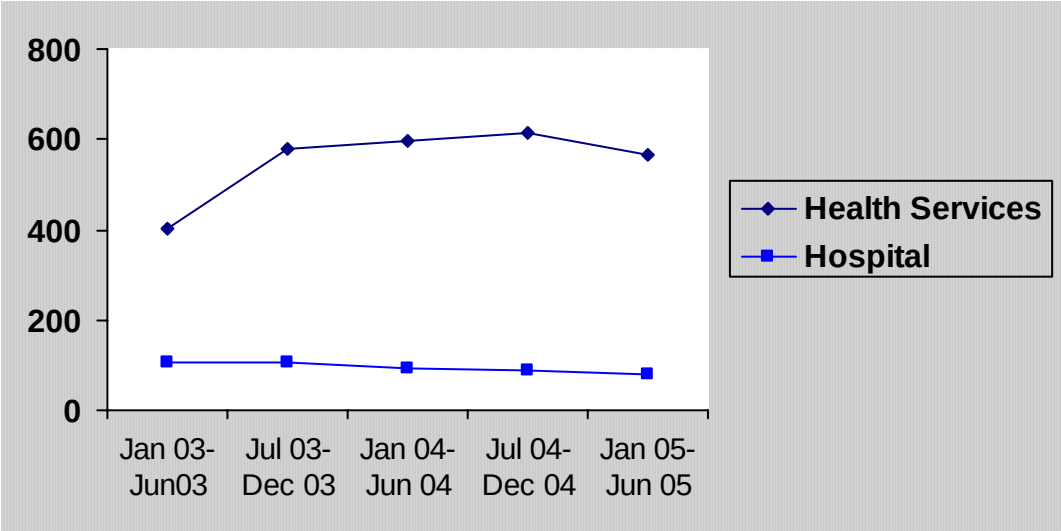
Table 10. Hospital 'First Referral Source' To Women's Refuge over 42 month period

Number of Hospitals	**4**	**5**	**3**	**4**	**4**	**2**	**0**	**2**
Number of Referrals per hospital	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Contract Referral Sources

There were 91,659 services included in the *Contract Referral* data over the 42 month period. Like *First Referrals,* referrals from 'legal services' accounted for the largest named referral source (n=30,854, 34%); 'health service' referral accounted for a small proportion (n=2,760, 3.0%). Of the 2,760 'health service' referrals, 'Māori health services' contributed the largest number (n=1,023), followed by 'Other health workers' (n=835); 472 were noted to be 'hospital' referrals. No increase in referrals from hospitals occurred over the reporting period (see Figure 53).

Figure 53. Women's Refuge Health Service Referrals (Contracted Services)



Individual hospitals contributed from 0 to 57 (mean=20; median=14) 'contracted services' referrals across the 42 month period. There was no association between overall partner abuse score and number of referrals over the period. The number of referrals had a trend of association with overall child abuse score (pearson r=0.32), indicating it would be worthwhile to separate woman from children refuge referrals.

DISCUSSION

Results of the follow-up audit indicate that significant progress has been made in programme development for responding to both partner abuse and child abuse and neglect. The overall median score for Partner Abuse programmes was 28, an increase of 41% over baseline. The overall median score for Child Abuse and Neglect programmes was 51, with a similar increase of 40% over baseline. The higher Child Abuse programme scores are indicative of programme longevity compared to Partner Abuse. Eighty percent of the Child Abuse Programmes have been in existence for longer than 2 years, compared to only 16% of Partner Abuse Programmes.

The follow-up audit demonstrates that significant progress has been made in the short span of 12 months. That said, scores reflect the fact that most hospitals are in the early stages of programme implementation. There remains important work to be done. For example,

- 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.

It is a concern that 9 of the 25 hospitals had no family violence coordinator at the time of the follow-up audit. The overall partner abuse median score was 11 for those hospitals without a coordinator, compared to 40 for the remaining 16 hospitals.

Ten of the 25 hospitals had no child abuse programme coordinator. The overall child abuse median score was 39 for those hospitals without a coordinator, compared to 56 for the remaining 15 hospitals.

Audit Limitations

The limitations that were noted in the first baseline audit report remain. First, hospital scores sometimes reflected the activities of one particular unit or service within the hospital where family violence intervention activities were well developed, rather than necessarily being representative of the hospital as a whole. And second, in interpreting scores, it is important to be aware that they do not recognise measures that were under development, but not yet in place at the time of the audit. Therefore, hospitals with very new programmes, but who had invested resources in aspects of programme development, would not necessarily score highly in those areas. Continuing to auditing longitudinally provides a mechanism to capture the implementation of programme planning.

We acknowledge that the Child Abuse and Neglect Delphi used in the baseline and 12 month follow-up audit did not capture all the elements of the more developed programmes, such as attention to procedures for sexual abuse investigations including forensic photography; role delineation between hospital child protection and Child Youth and Family; and child abuse alerting systems. Yet, as pointed out in the baseline report, the audit significantly extended the information available from the Paediatric Society's 2003 DHB Scorecard[a]. A Delphi process has begun to address the content validity issues of the tool prior to the next audit round.

And finally, to some degree, the Delphi does not measure whether the policies and procedures are actually being used[b]. It is important that the results of the audit tool are balanced with more outcome based measures. This hospital audit focused on system indicators rather than quality of services provided. As Senge warns, focusing on performance indicators alone can lead to "looking good without being good" (1990, p. 333).

Audit Strengths

Despite the limitations noted above, this audit contributes significantly to our understanding of hospital programme development addressing family violence. That audit scores were based on a contracted evaluator conducting site visits offered a distinct advantage over prior reviews that have relied on self-report. In addition, baseline and 12 month follow-up audits allowed the tracking of change over time.

Furthermore, while this audit report focuses on audit scores, it is important to appreciate the potential that the audit process served as a lever for system change. The evaluation procedures involved in the audit required active participation by stakeholders within hospitals, thus increasing the likelihood of

[a] The 2003 DHB Scorecard included five child abuse indicators. The findings may be accessed at: http://www.paediatrics.org.nz/default.asp?id=2&mnu=2&ACT=5&content=141

[b] The exception to this is item 5.2 on the partner abuse Delphi which asks for screening rates

feeding back evaluation findings into further programme development. Through the audit process many hospitals learned the important elements of a family violence programme.

Conclusions

Even in those hospitals with programme coordinators, their sustainability is not assured. Family violence programme process indicators are steadily improving. Continued programme resourcing, however, is necessary if appropriate intervention is to be followed by appropriate service delivery and better outcomes.

This audit documents the intermediate stage of developing health care system responsiveness to child abuse and neglect, and beginning stage of developing responsiveness to partner abuse. It is appropriate that hospitals are currently focusing their efforts on activities such as forming interdisciplinary working groups, developing policies and procedures, instituting training and making links with community service providers prior to instituting screening and intervention. These institutional developments are aimed at creating a climate where screening and intervention can be instituted in a safe and effective manner. With time and further research explicating effective interventions, we expect that the number of hospitals instituting routine screening for partner abuse will grow in the coming years. This will not become a reality, however, without appropriate allocation of resources. This report, like the baseline report, supports an association between dedicated family violence coordinators and system development.

Without allocating dedicated funding to family violence programmes and without designated coordinators, the health system is likely to continue to collude with a society that continues to minimise violence against women and children. In addition, we are likely to continue to underestimate the prevalence and effect of FV on the health of many of the clients we serve.

While this evaluation provides important information to guide and monitor further system development, it is important to iterate that it is only one aspect of an effective healthcare family violence strategy. This audit focused on responsiveness of acute care hospitals. Community healthcare responsiveness is another important area in need of development and evaluation. Indeed, District Health Boards are required to deliver a family violence programme across the entire DHB and in some cases, particularly in rural areas, it may be more important for community-based services to participate in family violence prevention.

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Appendix A: *Participating DHBs and Hospitals*

District Health Board	Hospital	Level of care	Audit date (mm.yy)
Northland	Kaitaia	S	07.04
	Whangarei	S	05.04
Waitemata	North Shore	S	11.03
Auckland	Auckland/Starship	T	03.04
Counties/Manukau	Middlemore	T	02.04
Waikato	Hamilton	T	12.03
Bay of Plenty	Tauranga	S	02.04
	Whakatane	S	02.04
Lakes District	Rotorua	S	12.03
Tairawhiti	Gisborne	S	01.04
Taranaki	New Plymouth	S	03.04
Hawkes Bay	Hawkes Bay	S	03.04
Whanganui	Wanganui	S	02.04
Midcentral	Palmerston North	S	03.04
Capital and Coast	Wellington	T	01.04
Wairarapa	Masterton	S	12.03
Hutt Valley	Lower Hutt	S	01.04
Nelson-Marlborough	Nelson	S	08.04
	Wairau	S	06.04
Canterbury	Christchurch	T	02.04
	Ashburton	S	03.04
West Coast	Greymouth	S	02.04
South Canterbury	Timaru	S	01.04
Otago	Dunedin	T	02.04
Southland	Invercargill	S	02.04

Links to DHB Maps:

http://www.moh.govt.nz/moh.nsf/0/387E1AAA0D074DA4CC256A5A00003334/$File/DHBmap.pdf

http://www.moh.govt.nz/moh.nsf/0/A564BA52AE2A5943CC256A3A00820CC9/$File/North-Island04.pdf

http://www.moh.govt.nz/moh.nsf/0/A564BA52AE2A5943CC256A3A00820CC9/$File/South_Island04.pdf

Appendix B: *Delphi Scoring (weighting scheme)*

The reader is referred to the original Delphi scoring guidelines available at: http://www.ahcpr.gov/research/domesticviol/.

The weightings used for this study are provided below.

Domain	Partner Abuse	Child Abuse & Neglect
1. Policies and Procedures	1.16	1.16
2. Physical Environment	0.86	0.86
3. Cultural Environment	1.19	1.19
4. Training of staff	1.15	1.15
5. Screening and Safety Assessment	1.22	N/A
6. Documentation	0.95	0.95
7. Intervention Services	1.29	1.29
8. Evaluation Activities	1.14	1.14
9. Collaboration	1.04	1.04

Total score for Partner Abuse= sum across domains (domain raw score * weight)/10

Total score for CAN = sum across domains (domain raw score*weight)/9.

Appendix C1: *Partner Abuse Delphi Tool- baseline & follow-up results*

Category 1. Hospital Policies and Procedures

	Scores for each item (ie. points if 'yes') in brackets	Baseline Yes	%	Follow-up Yes	%
1.1	Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? (1) If yes, do these policies:	10	40	9	36
	a) define partner abuse? (2)	8	32	9	36
	b) mandate training on partner abuse for any staff? (2)	4	16	5	20
	c) advocate universal screening for women anywhere in the hospital? (2)	4	16	6	24
	d) define who is responsible for screening? (2)	3	12	4	16
	e) address documentation? (2)	7	28	8	32
	f) address referral of victims? (2)	8	32	8	32
	g) address legal reporting requirements? (2)	5	20	6	24
	h) address the responsibilities to, and needs of, Maori? **(2)**	**3**	**12**	**6**	**24**
	i) address the needs of other cultural and/or ethnic groups? **(2)**	**3**	**12**	**5**	**20**
	k) address the needs of LGBT clients? **(2)**	**2**	**8**	**2**	**8**
1.2	Is there evidence of a hospital-based partner abuse working group? (3) If yes, does the working group:	15	60	19	76
	a) meet at least every month? (2)	12	48	14	56
	b) include representative(s) from more than two departments? (2) List represented departments: 14 Emergency 15 Paediatric 14 Maternity 12 Mental Health Other: Social Work 7; Public Health 5; Maori Health 4;Child & Family Services 4; Pacific Health 4; Medical Services 3;Home Care Services 2; Older Persons 2;Asian Health 1; Therapy Services 1;	15	60	19	76
	c) include representative(s) from the security department? (2)	0	0	7	28
	d) include physician(s) from the medical staff? (2)	12	48	16	64

	e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? (2)	4	16	9	36
	f) include representative(s) from hospital administration? (2)	13	52	16	64
	g) include Maori representative(s)? **(2)**	**12**	**48**	**17**	**68**
1.3	Does the hospital provide direct financial support for the partner abuse programme? (0) If yes, how much annual funding? (*Choose one*):	14	52	18	72
	a) < $5000/year(6)	1	4	1	4
	b) $5000-$10,000/year(12)	3	12	3	12
	c) > $10,000/year(17)	10	40	14	56
1.3a	Is funding set aside specifically for Maori programmes and initiatives? **(0)** If yes, how much annual funding? (*Choose one):*	**1**	**4**	**1**	**4**
	a) < $5000/year**(6)**	**1**	**4**	**1**	**4**
	b) > $5000/year**(12)**	**0**	**0**	**0**	**0**
1.4	Is there a mandatory universal screening policy in place? (0) If yes, does the policy require screening of all women: (*choose one*)	5	20	6	24
	a) in the emergency department (ED) or any other out-patient area? (6)	0	0	3	12
	b) in in-patient units only? (6)	0	0	0	0
	c) in more than one out-patient area? (10)	0	0	1	4
	d) in both in-patient and out-patient areas? (14) List departments: 1Emergency 2 Paediatric 2 Maternity 1 Mental Health Other: SCBU 1; Public Health Nurses 1; Child Health 1	5	20	2	8
1.5	Are there quality assurance procedures in place to ensure partner abuse screening? (0) If yes, are there:	5	20	6	24
	a) regular chart audits to assess screening? (9) List departments: 2 Emergency 1 Paediatric 2 Maternity 0 Mental Health Other: Outpatient Services 1	2	8	3	12

	b) positive reinforcers to promote screening? (6) List departments: 2 Emergency 1 Paediatric 2 Maternity 0 Mental Health Other: Outpatient Services 1	2	8	3	12	
	c) is there regular supervision? **(6)** List departments 1 Emergency 3 Paediatric 2 Maternity 0 Mental Health Other: Outpatients Services 1; SCBU 1	**3**	**12**	**6**	**24**	
1.6	Are there procedures for security measures to be taken when victims of partner abuse are identified? (0) If yes, are there:	11	44	12	48	
	a) written procedures that outline the security department's role in working with victims and perpetrators? (6)	3	12	8	32	
	b) procedures that include name/phone block for victims admitted to hospital? (3)	3	12	6	24	
	c) procedures that include provisions for safe transport from the hospital to shelter? (3)	1	4	4	16	
	d) do these procedures take into account the needs of Maori? **(3)**	**3**	**12**	**4**	**16**	
1.7	Is there an identifiable partner abuse coordinator at the hospital? (0) If yes is it a: (*choose one*)	12	48	16	64	
	a) part time position or included in responsibilities of someone with other responsibilities? (8)	11	44	15	68	
	b) full-time position with no other responsibilities? (12)	1	4	1	4	
Total NZ Score for Category 1 (Sum of all points)=						/129
Standardised NZ Score for Category 1=						/100
International Delphi Score for Category 1 (Sum of all 'unbold' points) =						/100

Category 2. Hospital Physical Environment

		Baseline Yes	%	Follow-up Yes	%
2.1	Are there posters and/or brochures related to partner abuse on public display in the hospital?	20	80	25	100
	If yes, total number of *locations* (up to 35): 0 1-2 3-5 6-10 11-20 35	 5 4 7 7 1 1	 20 16 28 28 4 4	 0 6 8 6 3 2	 0 24 32 24 12 8
	Are there Maori images related to partner abuse on public display in the hospital?	**9**	36	17	68
	If yes, total number *locations (up to 17)* 0 1-2 3-5 6-10 11-17	 **16** **7** **2** **0** **0**	 64 28 8 0 0	 8 9 4 2 2	 32 36 16 8 8
2.2	Is there referral information (eg., local or national phone numbers) related to partner abuse services on public display in the hospital? (Can be included on the posters/brochure noted above).	20	80	24	96
	If yes, total number *locations* (up to 35): 0 1-2 3-4 5-10 11-20 32-35	 5 7 7 3 2 0	 20 28 28 12 8 0	 1 4 8 8 2 1	 4 16 32 32 8 4
	Is there referral information related to Maori providers of partner abuse services on public display in the hospital?	**8**	32	20	80
	If yes, total number *locations (up to 17)* 0 1-2 3-4 5-10 11-17	 **17** **7** **1** **0** **0**	 68 28 4 0 0	 5 7 5 6 2	 20 28 20 24 8
	Is there referral information related to partner abuse services for particular ethnic or cultural group (other than Maori or Pakeha) on public display in the hospital?	4	**16**	**7**	**28**
	If yes, total number *locations (up to 17)* 0 1 2 17	 21 4 0 0	 **84** **16** **0** **0**	 **18** **5** **1** **1**	 **72** **20** **4** **4**

2.3	Does the hospital provide temporary (<24 hours) safe shelter for victims of partner abuse who cannot go home or cannot be placed in a community-based shelter? (0) If yes: (*choose one a-c and answer d*)	4	**16**	**7**	**28**	
	a) Victims are permitted to stay in ED until placement is secured.(15)	0	0	1	4	
	b) Victims are provided with safe respite room, separate from ED, until placement is secured.(25)	1	4	2	8	
	c) In-patient beds are available for victims until placement is secured.(30)	3	12	4	16	
	d) Does the design and use of the safe shelter support Maori cultural beliefs and practices?**(5)**	**5**	**20**	**6**	**24**	
Total NZ Score for Category 2 (Sum of all points)=						/127
Standardised NZ Score for Category 2=						/100
International Delphi Score for Category 2 (Sum of all 'unbold' points) =						/100

Note: Consider the conduciveness of hospital environment to routine screening (eg., privacy)

Category 3. Hospital Cultural Environment

		Baseline Yes	%	Follow-up Yes	%
3.1	In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about partner abuse? (0) If yes, which groups have been assessed?	5	20	11	44
	a) nursing staff (7) Participating Departments: 5 Emergency 4 Paediatric 4 Maternity 2 Mental Health Other: Child Services 2; SCBU 2	5	20	9	36
	b) medical staff (7) Participating Departments: 5 Emergency 4 Paediatric 4 Maternity 2 Mental Health Other:	5	20	7	28
	c) administration (8)	4	16	7	28
	d) other staff/employees (7)	3	12	8	32
	If yes, did the assessment address staff knowledge and attitude about Maori and partner abuse? **(7)**	**1**	**4**	**1**	**4**
3.2	How long has the hospital's partner abuse programme been in existence? (*Choose one*):				
	a) 1-24 months (3)	13	52	15	60
	b) 24-48 months (6)	2	8	3	12
	c) >48 months (11)	0	0	1	4
3.3	Does the hospital have plans in place for responding to employees experiencing partner abuse? If yes: (0)	15	60	15	60
	a) Is there a hospital policy covering the topic of partner abuse in the workplace? (7)	2	8	1	4
	b) Does the Employee Assistance Program maintain specific policies and procedures for dealing with employees experiencing partner abuse? (7)	9	36	6	24
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation? (7)	10	40	10	40
3.4	Does the hospital's partner abuse programme address cultural competency issues? If yes: (0)	24	96	24	96
	a) Does the hospital's policy specifically recommend universal screening regardless of the patient's cultural background? (6)	4	16	4	16
	b) Are cultural issues discussed in the hospital's partner abuse training programme? (3)	9	36	10	40

	c) Are translators/interpreters available for working with victims if English is not the victim's first language? (4)	22	88	25	100	
	d) Are referral information and brochures related to partner abuse available in languages other than English? (4)	5	20	6	24	
3.5	Does the hospital participate in preventive outreach and public education activities on the topic of partner abuse? (0) If yes, is there documentation of: (*choose one a-b and answer c*)	14	56			
	a) 1 programme in the last 12 months? (15)	9	36	5	20	
	b) >1 programme in the last 12 months?(20)	5	20	10	40	
	c) Does the hospital collaborate with Maori community organizations and providers to deliver preventive outreach and public education activities? **(20)**	8	**32**	**12**	**48**	
Total NZ Score for Category 3 (Sum of all points)=						/127
Standardised NZ Score for Category 3=						/100
International Delphi Score for Category 3 (Sum of all 'unbold' points) =						/100

Category 4. Training of Providers

		Baseline Yes	%	Follow-up Yes	%
4.1	Has a formal training plan been developed for the institution? If yes: (10)	5	20	9	36
	a) Does the plan include the provision of regular, ongoing education for clinical staff? (10) Participating Departments: 3 Emergency 4 Paediatric 3 Maternity 1 Mental Health Other: Child & Youth Services 1	4	16	8	32
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff? (10)	2	8	7	28
4.2	During the past 12 months, has the hospital provided training on partner abuse:				
	a) as part of the mandatory orientation for new staff? Participating departments: (15) 2 Emergency 3 Paediatric 5 Maternity 1 Mental Health Other: Enrolled nurses 1 Women's Health Services 1 Children's Services 2	3	12	6	24
	b) to members of the clinical staff via colloquia or other sessions? (15)	5	20	15	60
4.3	Does the hospital's training/education on partner abuse include information about:				
	a) definitions of partner abuse? (1)	10	40	14	56
	b) dynamics of partner abuse? (1)	11	44	14	56
	c) epidemiology? (1)	9	36	13	52
	d) health consequences? (1)	9	36	13	52
	e) strategies for screening? (1)	9	36	12	48
	f) risk assessment? (1)	7	28	11	44
	g) documentation? (1)	10	40	13	52
	h) intervention? (1)	8	32	13	52
	i) safety planning? (1)	10	40	9	36
	j) community resources? (1)	5	20	14	56
	k) reporting requirements? (1)	6	24	10	40
	l) legal issues? (1)	6	24	12	48
	m) confidentiality? (1)	9	36	12	48
	n) cultural competency? (1)	7	28	10	40
	o) clinical signs/symptoms? (1)	9	36	14	56
	p) Maori models of health? **(1)**	**3**	**12**	**6**	**24**

	q) risk assessment for children of victims? **(1)**	**6**	**24**	**11**	**44**	
	r) the social, cultural, historic, and economic context in which Maori family violence occurs? **(1)**	**2**	**8**	**5**	**20**	
	s) te Tiriti o Waitangi? **(1)**	**3**	**12**	**5**	**20**	
	t) Maori service providers and community resources? **(1)**	**7**	**28**	**13**	**52**	
	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Maori? **(1)**	**3**	**12**	**5**	**20**	
	v) partner abuse in same-sex relationships? **(1)**	**3**	**12**	**5**	**20**	
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships? **(1)**	**1**	**4**	**3**	**12**	
4.4	Is the partner abuse training provided by: (*choose one a-d and answer e-f*)					
	a) no training provided (0)	12	48	11	44	
	b) a single individual? (0)	2	8	2	8	
	c) a team of hospital employees only? (15) List departments represented: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	0	0	1	4	
	d) a team, including community expert(s)? (25)	11	44	11	44	
	If provided by a team, does it include:					
	e) a Maori representative? **(15)**	**7**	**28**	10	**40**	
	f) a representative(s) of other ethnic/cultural groups? **(15)**	**2**	**8**	**2**	**8**	
Total NZ Score for Category 4 (Sum of all points)=						/138
Standardised NZ Score for Category 4=						/100
International Delphi Score for Category 4 (Sum of all 'unbold' points) =						/100

Category 5. Screening and Safety Assessment

		Baseline Yes	%	Follow-up Yes	%	
5.1	Does the hospital use a standardized instrument, with at least 3 questions, to screen patients for partner abuse? If yes, is this instrument: (*choose one*) (0)	3	12	4	16	
	a) included, as a separate form, in the clinical record? (20)	0	0	3	12	
	b) incorporated as questions in the clinical record for all charts in ED or other out-patient area? (25)	0	0	0	0	
	c) incorporated as questions in the clinical record for all charts in two or more out-patient areas? (30)	0	0	0	0	
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas? (36)	1	4	1	4	
5.2	What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area)?					
	a) Not done or not applicable (0)	23	92	22	88	
	b) 0% - 10% (4)	0	0	0	0	
	c) 11% - 25% (9)	2	8	0	0	
	d) 26% - 50% (18)	0	0	1	4	
	e) 51% - 75% (28)	0	0	1	8	
	f) 76% - 100% (37)	0	0	0	0	
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this: (27)	8	32	7	28	
	a) also assess the safety of any children in the victim's care?	**7**	**28**	**7**	**28**	
Total NZ Score for Category 5 (Sum of all points)=						/127
Standardised NZ Score for Category 5=						/100
International Delphi Score for Category 5 (Sum of all 'unbold' points) =						/100

Category 6. Documentation

		Baseline Yes	%	Follow-up Yes	%	
6.1	Does the hospital use a standardized documentation instrument to record known or suspected cases of partner abuse? If yes, does the form include: (0)	3	12	5	20	
	a) information on the results of partner abuse screening? (10)	1	4	9	36	
	b) the victim's description of current and/or past abuse? (10)	2	8	4	16	
	c) the name of the alleged perpetrator and relationship to the victim? (10)	1	4	2	8	
	d) a body map to document injuries? (10)	3	12	6	24	
	e) information documenting the referrals provided to the victim? (10)	1	4	4	16	
	f) in the case of Maori, information documenting whether the individual was offered a Maori advocate? **(5)**	**0**	**0**	**3**	**12**	
6.2	Is forensic photography incorporated in the documentation procedure? (0) If yes:	8	32	9	36	
	a) Is a fully operational camera with adequate film available in the treatment area? (10)	1	4	7	28	
	b) Do hospital staff receive on-going training on the use of the camera? (10)	2	8	2	8	
	c) Do hospital staff routinely offer to photograph all abused patients with injuries? (10)	1	4	1	4	
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries? (10)	5	20	12	48	
	e) Do medical or nursing staff (not social work or a partner abuse advocate) photograph all injuries for medical documentation purposes, even if police obtain their own photographs for evidence purposes? (10)	0	0	1	4	
Total NZ Score for Category 6 (Sum of all points)=						/105
Standardised NZ Score for Category 6=						/100
International Delphi Score for Category 6 (Sum of all 'unbold' points) =						/100

Category 7. Intervention Services

		Baseline Yes	%	Follow-up Yes	%	
7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified? (14)	7	28	7	28	
7.2	Are "on-site" victim advocacy services provided? If yes, *choose one a-b and answer c-d)*: (0)	13	52	20	80	
	a) A trained victim advocate provides services during certain hours. (10)	7	28	8	32	
	b) A trained victim advocate provides service at all times. (20)	6	24	12	48	
	c) is a Maori advocate is available “on-site” for Maori victims? (20)	**8**	**32**	**14**	**56**	
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Maori is available onsite? If yes, list ethnicity: (20)	**3**	**12**	**6**	**24**	
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose one*) (0)	14	56	15	60	
	a) available, when indicated? (5)	8	32	13	52	
	b) performed routinely? (9)	6	24	2	8	
7.4	Is transportation provided for victims, if needed?	3	12	6	24	
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment? (15)	11	44	14	56	
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims? (9)	13	52	12	48	
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims? (11)	15	60	17	68	
7.8	Is there evidence of coordination between the hospital partner abuse programme and sexual assault, mental health and substance abuse screening and treatment? (12)	8	32	13	52	
Total NZ Score for Category 7 (Sum of all points)=						/140
Standardised NZ Score for Category 7=						/100
International Delphi Score for Category 7 (Sum of all ‘unbold’ points) =						/100

Category 8. Evaluation Activities

		Baseline Yes	%	Follow-up Yes	%	
8.1	Are any formal evaluation procedures in place to monitor the quality of the partner abuse programme? (25) If yes:	8	32	8	32	
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening? (18) Participating departments: 2 Emergency 1 Paediatric 2 Maternity 0 Mental Health Other: Outpatient Services 1	2	8	3	12	
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse? (17) Participating departments: 2 Emergency 2 Paediatric 3 Maternity □ Mental Health Other:	2	8	5	20	
8.2	Do health care providers receive standardized feedback on their performance and on patients? (21)	1	4	3	12	
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme? (19)	2	4	1	4	
8.4	Is the quality framework *He Taura Tieke* (or an equivalent) used to evaluate whether services are effective for Maori? **(25)**	**2**	**8**	**1**	**4**	
Total NZ Score for Category 8 (Sum of all points)=						/125
Standardised NZ Score for Category 8=						/100
International Delphi Score for Category 8 (Sum of all 'unbold' points) =						/100

Category 9. Collaboration

		Baseline Yes	%	Follow-up Yes	%	
9.1	Does the hospital collaborate with local partner abuse programmes? (0) If yes,	22	88	24	96	
	a) which types of collaboration apply:					
	i) collaboration with training? (10)	9	36	15	60	
	ii) collaboration on policy and procedure development? (10)	11	44	17	68	
	iii) collaboration on partner abuse working group? (10)	6	24	18	72	
	iv) collaboration on site service provision? (12)	10	40	18	72	
	b) is collaboration with					
	i) Maori provider(s) or representative(s)? **(10)**	**18**	72	**23**	**92**	
	iii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Maori? **(10)**	**4**	**16**	**9**	**36**	
	c) List collaborating partner abuse programmes:					
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes, which types of collaboration apply: (0)	16	64	20	80	
	a) collaboration with training? (11)	4	16	12	48	
	b) collaboration on policy and procedure development? (11)	5	20	14	56	
	c) collaboration on partner abuse working group? (12)	3	12	18	72	
	c) List collaborating agencies (eg., police, courts):					
9.3	Is there collaboration with the partner abuse programme of other health care facilities? (0) If yes, which types of collaboration apply:	21	84	22	88	
	a) within the same health care system? (12)	13	52	19	76	
	If yes, with a Maori health unit? **(12)**	**12**	**48**	**18**	**72**	
	b) with other systems in the region? (12)	18	72	21	84	
	If yes, with a Maori health provider? (12)	**2**	**8**	**13**	**52**	
Total NZ Score for Category 9 (Sum of all points)=						/144
Standardised NZ Score for Category 9=						/100
International Delphi Score for Category 9 (Sum of all 'unbold' points) =						/100

Appendix C2: *Child Abuse and Neglect Delphi Tool- baseline & follow-up results*

Category 1. Hospital Policies and Procedures

	Scores for each item (ie. points if 'yes') in brackets	Baseline Yes	%	Follow-up Yes	%
1.1	Are there official, written hospital policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? (1) If yes, do these policies:	23	92	24	96
	a) define child abuse and neglect? (2)	17	68	21	84
	b) mandate training on child abuse and neglect for any staff? (2)	8	32	8	32
	c) outline age-appropriate protocols for risk assessment? (2)	5	20	5	20
	d) define who is responsible for risk assessment? (2)	19	76	22	88
	e) address the issue of contamination? (2)	11	44	16	64
	f) address documentation?(2)	21	84	23	92
	g) address referrals for children and their families? (2)	22	88	24	96
	h) address child protection reporting requirements? (2)	19	76	19	76
	i) address the responsibilities to, and needs of, Maori? (2)	14	56	16	64
	i) address the needs of other cultural and/or ethnic groups? (2)	12	48	15	60
1.2	Is there evidence of a hospital-based child abuse and neglect working group? (3) If yes, does the working group:	12	48	19	76
	a) meet at least every month?	10	40	15	60
	b) include representatives from more than two departments? (2) List represented departments: 12 Emergency 15 Paediatric 12 Maternity 10 Mental Health, including Child and Youth Mental Health Other: Social Work 5; Maori Health 3; Children's Services 2; Public Health 1; Therapy Services 1; Medical Services 1	12	48	18	72
	c) include representative(s) from the security department? (2)	2	8	4	16
	d) include physician(s) from the medical staff? (2)	11	44	17	68
	e) include representative(s) from Child Youth and Family? (2)	3	12	8	32

	f) include representative(s) from hospital administration? (2)	11	44	16	64
	g) include representative(s) from an agency or programme involved in partner abuse advocacy? (2)	2	8	5	20
	h) include representative(s) from community-based children's services? (2)	1	4	7	28
	i) include at least two youth representatives? (2)	0	0	1	4
	j) include Maori representative(s)?(2)	10	40	16	64
1.3	Does the hospital provide direct financial support for the child abuse and neglect programme? (0) If yes, how much annual funding? (*Choose one of a-c and answer d*):	17	68	19	76
	a) < $5000/year (6)	2	8	0	0
	b) $5000-$10,000/year (12)	1	4	3	12
	c) > $10,000/year (17)	14	56	16	64
	d) Is funding set aside specifically for Maori programmes and initiatives? (0) If yes, how much annual funding?	5	20	2	8
	i) < $5000/year (6)	3	12	1	4
	ii) > $5000/year (12)	2	8	1	4
1.4	Is there a clinical assessment policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? (0) If yes, does the policy include children: (choose one)	23	92	24	96
	a) in the emergency department (ED) or any other out-patient area? (6)	1	4	3	12
	b) in in-patient units only? (6)	0	0	0	0
	c) in more than one out-patient area? (10)	1	4	1	4
	d) in both in-patient and out-patient areas? (14) List departments: 10 Emergency 10 Paediatric 10 Maternity 7 Mental Health, including Child and Youth Mental Health Other: SCBU 1; Sexual Health 1; Community Health 1; Child Development 1; Ambulatory Care 1; Obs & Gyne 1	21	84	20	80
1.5	Are there quality assurance procedures in place to ensure the clinical assessment policy for identifying child abuse and neglect is implemented? (0) If yes:	18	72	18	72

	a) are there regular chart audit to assess whether signs and symptoms of child abuse and neglect are investigated? (5) List departments: 3 Emergency 5 Paediatric 3 Maternity 2 Mental Health, including Child and Youth Mental Health Other: SCBU 1	5	20	6	24
	b) is there regular peer review? (5) List departments: 3 Emergency 7 Paediatric 5 Maternity 5 Mental Health, including Child and Youth Mental Health 4 Other: Social Work 2; PHNs 1; Sexual Abuse cases 1	12	48	14	56
	c) is there regular supervision? (5) List departments: 1 Emergency 5 Paediatric 3 Maternity 2 Mental Health, including Child and Youth Mental Health Other: Social Workers 4	11	44	11	44
	d) is there regular feedback from Child Youth and Family (CYF)? (5)	18	72	16	64
1.6	Are there procedures for security measures to be taken when suspected cases of child abuse and neglect are identified and the child is perceived to be at immediate risk? (0) If yes, are there:	12	48	12	48
	a) written procedures that outline the security department's role in working with victims and their families and perpetrators? (6)	4	16	10	40
	b) procedures that include name/phone block for children and their families admitted to hospital? (3)	1	4	3	12
	c) procedures that include provisions for safe transport from the hospital to shelter? (3)	2	8	5	20
	d) do these procedures take into account the needs of Maori? (3)	2	8	4	16
1.7	Is there an identifiable child protection coordinator at the hospital? (0) If yes is it a: (*choose one*)	14	56	16	64
	a) part time position or included in responsibilities of someone with other responsibilities? (8)	9	36	12	48
	b) full-time position with no other responsibilities? (12)	5	20	4	16

Total Score for Category 1 (Sum of all points) =				**/134**
Standardised Score for Category 1 =				**/100**

Category 2. Hospital Physical Environment

		Baseline Yes	%	Follow-up Yes	%
2.1	Are posters and images that are of relevance to children and young people on public display in the hospital so as to create a 'child-friendly' environment? (0)	25	100	25	100
	If yes, total number of *locations* (up to 35): 0 1-2 3-5 6-10 11-20 35	 0 4 7 3 9 2	 0 16 28 12 36 8	 0 2 7 7 7 2	 0 8 28 28 28 8
	Are there posters and/or brochures related to child abuse and neglect, including posters and/or brochures about children's rights, on public display in the hospital? (0)	24	96	25	100
	If yes, total number of *locations* (up to 35): 0 1-2 3-5 6-10 11-20 35	 1 4 7 10 2 1	 4 16 28 40 8 4	 0 2 8 8 4 3	 0 8 32 32 16 4
	Are there Maori images related to child abuse and neglect on public display in the hospital? (0)	18	72	22	88
	If yes, total number *locations (up to 17)* 0 1-2 3-5 6-10 11-17	 7 11 4 2 1	 28 44 16 8 4	 3 11 4 4 3	 12 44 16 16 12
2.2	Is there referral information (local or national phone numbers) related to child advocacy and therapeutic services on public display in the hospital? (Can be included on the posters/brochure noted above). (0)	21	84	21	84
	If yes, total number *locations* (up to 35): 0 1-2 3-4 5-10 11-20 32-35	 4 10 6 3 1 1	 16 40 24 12 4 4	 4 5 8 6 1 1	 16 20 32 24 4 4

	Is there referral information related to Maori providers of child advocacy services on public display in the hospital? (0)	8	32	9	36	
	If yes, list total number *locations (up to 17)* List number per department: 0 1-2 3-5 6-10 11-17	 17 5 2 0 1	 68 20 8 0 4	 16 7 1 0 1	 64 28 4 0 4	
	Is there referral information related to child advocacy services for particular ethnic or cultural group (other than Maori or Pakeha) on public display in the hospital?	3	12	3	12	
	If yes, total number *locations (up to 17)* 0 1-2 3-4 5-10 11-17	 22 2 0 1 0	 88 8 0 4 0	 22 2 0 0 1	 88 8 0 0 4	
2.3	Does the hospital provide temporary (<24 hours) safe shelter for victims of child abuse and neglect and their families who cannot go home or cannot be placed in a community-based shelter? (0) If yes: (*choose one a-c and answer d*)	15	60	19	76	
	a) Children and their families are permitted to stay in ED until placement is secured. (15)	1	4	0	0	
	b) Children and their families are provided with safe respite room, separate from ED, until placement is secured. (25)	0	0	0	0	
	c) In-patient beds are available for children and their families until placement is secured. (30)	14	56	19	76	
	d) Does the design and use of the safe shelter support Maori cultural beliefs and practices? (5)	17	68	17	68	
Total Score for Category 2 (Sum of all points) =						**/191**
Standardised Score for Category 2 =						**/100**

Category 3. Institutional Culture

		Baseline Yes	%	Follow-up Yes	%
3.1	In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about child abuse and neglect? (0) If yes, which groups have been assessed?	6	24	11	44
	a) nursing staff (7) Participating Departments: 6 Emergency 6 Paediatric 5 Maternity 3 Mental Health, including Child and Youth Mental Health Other:	6	24	10	40
	b) medical staff (0&) Participating Departments: 5 Emergency 4 Paediatric 4 Maternity 3 Mental Health, including Child and Youth Mental Health Other:	5	20	7	28
	c) administration (8)	2	8	8	32
	d) other staff/employees (7)	2	8	9	36
	If yes, did the assessment address staff knowledge and attitude about Maori and child abuse and neglect? (7)	0	0	1	4
3.2	How long has the hospital's child abuse and neglect programme been in existence? (*Choose one*):				
	a) 1-24 months (3)	7	28	5	20
	b) 24-48 months (6)	5	20	7	28
	c) >48 months (11)	9	36	13	52
3.3	Does the hospital's child abuse and neglect programme address cultural competency issues? (0) If yes:	23	92	25	100
	a) Does the hospital's policy specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background? (6)	18	72	18	72
	b) Are cultural issues discussed in the hospital's child abuse and neglect training programme? (6)	17	68	16	64
	c) Are translators/interpreters available for working with victims if English is not the victim's first language? (3)	23	92	25	100
	d) Are referral information and brochures related to child abuse and neglect available in languages other than English? (4)	8	32	8	32

3.4	Does the hospital participate in preventive outreach and public education activities on the topic of child abuse and neglect? (0) If yes, is there documentation of: (*choose one of a-b and answer c)*	19	76	15	60	
	a) 1 programme in the last 12 months? (15)	9	36	4	16	
	b) >1 programme in the last 12 months? (20)	10	40	11	44	
	c) Does the hospital collaborate with Maori community organizations and providers to deliver preventive outreach and public education activities? (20)	9	36	9	36	
Total Score for Category 3 (Sum of all points) =						**/106**
Standardised Score for Category 3 =						**/100**

Category 4. Training of Providers

		Baseline Yes	%	Follow-up Yes	%
4.1	Has a formal training plan been developed for the institution? (10) If yes:	5	20	10	40
	a) Does the plan include the provision of regular, ongoing education for clinical staff? (10) Participating Departments: 6 Emergency 8 Paediatric 6 Maternity 5 Mental Health, including Child and Youth Mental Health Other:	5	20	11	44
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff? (10)	2	8	10	40
4.2	During the past 12 months, has the hospital provided training on child abuse and neglect:				
	a) as part of the mandatory orientation for new staff? Participating departments: (15) 1 Emergency 3 Paediatric 1 Maternity 1 Mental Health, including Child and Youth Mental Health Other: All nursing staff 3	7	28	6	24
	b) to members of the clinical staff via colloquia or other sessions? (15)	8	32	20	80
4.3	Does the hospital's training/education on child abuse and neglect include information about:				
	a) definitions of child abuse and neglect? (1)	17	68	21	84
	b) dynamics of child abuse and neglect? (1)	16	64	21	84
	c) child advocacy (1)	16	64	20	80
	d) child-focused interviewing (1)	12	48	17	68
	e) issues of contamination (1)	12	48	18	72
	f) ethical dilemmas? (1)	11	44	19	76
	g) conflict of interest (1)	11	44	17	68
	h) epidemiology? (1)	15	60	18	72
	i) health consequences? (1)	17	68	20	80
	j) identifying high risk indicators? (1)	16	64	21	84
	k) physical signs and symptoms? (1)	15	60	21	84
	l) documentation? (1)	15	60	20	80
	m) intervention? (1)	16	64	21	84
	n) safety planning? (1)	13	52	18	72
	o) community resources? (1)	14	56	19	76

	p) child protection reporting requirements? (1)	17	68	21	84	
	q) linking with Child Youth and Family? (1)	17	68	21	84	
	r) confidentiality? (1)	13	52	18	72	
	s) age appropriate assessment and intervention? (1)	11	44	18	72	
	t) cultural competency? (1)	11	44	13	52	
	u) link between partner violence and child abuse and neglect? (1)	15	60	19	76	
	v) Maori models of health? (1)	13	12	6	24	
	w) the social, cultural, historic, and economic context in which Maori family violence occurs? (1)	3	24	9	36	
	x) te Tiriti o Waitangi? (1)	6	20	10	40	
	y) Maori service providers and community resources? (1)	5	36	15	60	
	z) Service providers and community resources for ethnic and cultural groups other than Pakeha and Maori? (1)	9	20	10	40	
4.4	Is the child abuse and neglect training provided by: (*choose one of a-d and answer e-f)*					
	a) no training provided (0)	5	20	3	12	
	b) a single individual? (10)	5	16	3	12	
	c) a team of hospital employees only? (15) List departments represented: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	4	28	5	20	
	d) a team, including community expert(s)? (25)	7	36	14	56	
	If provided by a team, does it include:	9				
	e) a Child Youth and Family statutory social worker? (15)	12	48	15	60	
	f) a Maori representative? (15)	10	40	9	36	
	g) a representative(s) of other ethnic/cultural groups? (15)	4	16	2	8	
Total Score for Category 4 (Sum of all points) =						**/156**
Standardised Score for Category 4 =						**/100**

Category 5. Documentation

		Baseline Yes	%	Follow-up Yes	%	
5.1	Does the hospital use a standardized documentation instrument to record known or suspected cases of child abuse and neglect? If yes, does the form include:	13	52	15	60	
	a) information generated by risk assessment?	7	28	9	36	
	b) the victim or caregiver's description of current and/or past abuse?	8	32	9	36	
	c) the name of the alleged perpetrator and relationship to the victim?	4	16	5	20	
	d) a body map to document injuries?	11	44	16	64	
	e) information documenting the referrals provided to the victim and their family?	9	36	10	40	
	f) in the case of Maori, information documenting whether the victim and their family were offered a Maori advocate?	4	16	4	16	
5.2	Is a standardised safety assessment performed for children? If yes:	10	40	13	52	
	a) Does this also assess the safety of the child's mother?	6	24	4	16	
Total Score for Category 5 (Sum of all points) =						**/105**
Standardised Score for Category 5 =						**/100**

Category 6. Intervention Services

		Baseline Yes	%	Follow-up Yes	%
6.1	Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified? (14)	17	68	21	84
6.2	Are child protection services available "on-site"? If yes, *choose one of a-b and answer c-d*: (0)	23	92	24	96
	a) A member of the child protection team or social worker provides services during certain hours. (10)	7	28	12	48
	b) A member of the child protection team or social worker provides service at all times. (20)	16	64	12	48
	c) A Maori advocate or social worker is available “on-site” for Maori victims. (20)	20	80	21	84
	d) An advocate of ethnic and cultural background other Pakeha and Maori is available onsite. (20) If yes, list ethnicity:	9	36	10	40
6.3	Are mental health/psychological assessments performed within the context of the programme? (0) If yes, are they: (*choose one of a-b and answer c*)	19	76	20	80
	a) available, when indicated? (5)	13	52	16	64
	b) performed routinely? (9)	6	24	4	16
	c) age-appropriate? (10)	19	76	21	84
6.4	Is transportation provided for victims and their families, if needed? (10)	3	12	9	36
6.5	Does the hospital child abuse and neglect programme include follow-up contact and counselling with victims after the initial assessment? (15)	17	68	20	80
6.6	Does the hospital child abuse and neglect programme offer and provide on-site legal options counselling for the families of suspected child abuse and neglect victims? (9)	19	76	13	52
6.7	Does the hospital child abuse and neglect programme offer and provide family violence intervention services for the families, and in particular mothers, of abused children? (11)	8	32	13	52
6.8	Is there evidence of coordination between the hospital child abuse and neglect programme and the partner abuse and sexual assault programmes? (12)	18	72	20	80

6.9	Is there evidence of coordination with CYF? (12)	21	84	22	88	
Total Score for Category 6 (Sum of all points) =						**/162**
Standardised Score for Category 6 =						**/100**

Category 7. Evaluation Activities

		Baseline Yes	%	Follow-up Yes	%	
7.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:	15	60	17	68	
	a) Do evaluation activities include periodic monitoring of the implementation of the child abuse and neglect clinical assessment policy? Participating departments: 2 Emergency 7 Paediatric 3 Maternity 2 Mental Health, including Child and Youth Mental Health Other: Social Work 1; Child Development 1; Public Health 1; Nursing 1	6	24	12	48	
	b) Is the evaluation process standardised? Participating departments: 3 Emergency 4 Paediatric 2 Maternity 1 Mental Health, including Child and Youth Mental Health Other:	11	44	10	40	
	c) Do evaluation activities measure outcomes, either for entire child abuse and neglect programme or components thereof?	7	28	9	36	
7.2	Do health care providers receive standardized feedback on their performance and on patients from CYF?	14	56	12	48	
7.3	Is there any measurement of client satisfaction and/or community satisfaction with the child abuse and neglect programme?	2	8	1	4	
7.4	Is the quality framework *He Taura Tieke* (or an equivalent) used to evaluate whether services are effective for Maori?	2	8	1	4	
Total Score for Category 7 (Sum of all points) =						**/131**
Standardised Score for Category 7 =						**/100**

Category 8. Collaboration

		Baseline Yes	%	Follow-up Yes	%	
8.1	Does the hospital collaborate with NGO and CYF child advocacy and protection ? (0) If yes,	23	92	24	96	
	a) which types of collaboration apply:					
	i) collaboration with training? (10)	15	60	19	76	
	ii) collaboration on policy and procedure development? (10)	17	68	17	68	
	iii) collaboration on child abuse and neglect task force? (10)	5	20	19	76	
	iv) collaboration on site service provision? (12)	16	64	22	88	
	b) is collaboration with:					
	i) Maori provider(s) or representative(s)? (10)	19	76	21	84	
	ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Maori? (10)	6	24	8	32	
	List collaborating organisations:					
8.2	Does the hospital collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? (0) If yes, which types of collaboration apply:	23	92	24	96	
	a) collaboration with training? (11)	5	20	11	44	
	b) collaboration on policy and procedure development? (11)	10	40	11	44	
	c) collaboration on child abuse and neglect task force? (12)	4	16	18	72	
	List collaborating agencies:					
8.3	Is there collaboration with the child abuse and neglect programme of other health care facilities? (0) If yes, which types of collaboration apply:	20	80	21	84	
	a) within the same health care system? (12)	17	68	23	92	
	If yes, with a Maori health unit? (12)	11	44	22	88	
	b) with other systems in the region? (12)	20	80	20	80	
	If yes, with a Maori health provider? (12)	6	24	17	68	
Total NZ Score for Category 8 (Sum of all points) =						**/144**
Standardised NZ Score for Category 8 =						**/100**

Appendix D: *Key Stakeholder and Focus Group Interviews-Methods*

Key Stakeholder Interviews

Key stakeholder interviews were conducted to gather information addressing the following evaluation question, "What may need to be done to enhance sustainability over time for professionals and organisations?" The interviews were semi-structured, following an interview guide. The interview guide included questions such as the following[a]:

- What are the barriers to implementing family violence policies in your setting/profession?
- What are the enablers of organizational/professional change?
- To what extent does your setting/profession integrate services with other agencies involved in family violence such as the police, courts, Child Youth and Family and Women's Refuge?
- How has the MOH FVP impacted the health sector's delivery of services to maximise women and children's safety?

Participants

Family violence coordinators and liaisons were purposefully targeted to gather information from a wide variety of hospital contexts such as rural and urban, naïve and mature programmes, family violence and child protection coordinators.

Procedure

Selected interviewees were invited to participate using an informed consent process. For those who agreed, interviews were conducted in a private space within their workplace and audiotape recorded.

Data management and analysis

A trained transcriber, having signed a confidentiality agreement, created a written version of the audiotaped interviews using standard methods. Research team members audited transcripts for accuracy. Data were analysed using content analysis (Ezzy, 2002; Patton, 1990). Categories of analysis 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.

[a] Full details of the Interview Guides available at: http://www.trauma-research.info/fv_evaluation.htm

Focus Groups

Focus groups were conducted to gather information, along with key stakeholder interviews, to address the following evaluation question, "What may need to be done to enhance sustainability over time for professionals and organisations?" The semi-structured focus groups were conducted following the 12 month audit. The focus group interview guide included questions such as the following[12]:

- 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 District Health Boards for focus group interviews was based on the maturity of organisations (high and low) and their degree of improvement (high and low) over the two data collection points. Seven to 12 participants were invited for each group, to include representatives from the District Health Board as well as local community stakeholders. Participants included, for example, social workers, physicians, nurses, family violence coordinators, managers, child protection workers and community women's advocates.

Procedure

Family violence coordinators in the selected District Health Boards were first contacted to discuss the potential of their site hosting a focus group. If agreed to, following an informed consent process, a day and time was agreed to. Focus groups were held at the hospital site with a research team moderator and assistant moderator and followed standard focus group methods. 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.

Focus group data management and analysis

A trained transcriber, having signed a confidentiality agreement, created a written version of the audiotaped focus groups using standard methods.[22-25] Research team members audited transcripts for accuracy. Data were analysed using content analysis (Ezzy, 2002; Patton, 1990). Categories of analysis 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.