MINISTRY OF HEALTH
MANATŪ HAUORA

Interdisciplinary Trauma Research Unit
Te wairere au noa

HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

BASELINE AUDIT FINDINGS

Summary Report

Jane Koziol McLain
Jo Adams
Eva Neizert
Emma Davies
Roma Balzer
Sue Harvey
Jeffrey Coben

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

Acknowledgements

The Research Team would like to thank the DHB family violence programme coordinators, liaisons, and all the others that took part in the site visits. We would also like to thank our research team advisors. We also acknowledge the Ministry of Health for funding the Family Violence Project Evaluation of which this report is a part, and give our appreciation to the MOH family violence project manager, Jo Elvidge.

The Ministry of Health commissioned this report. The views expressed in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.

November 2004

Introduction

This summary report presents the findings of a nationwide audit of acute care public hospitals to document the baseline level of system responsiveness to intimate partner violence and child abuse and neglect.[a]

The value of the findings presented here is based on the tenet that "programs with good structures in place will have an increased likelihood of having a good process of care, and good process increases the likelihood of good outcome"[b(p. 2)]. The quality of healthcare for family violence was measured through a standardised audit process that examined both system stuctures and healthcare delivery processes.

Data Collection

Baseline hospital responsiveness was measured through audits conducted during site visits. All acute care (secondary and tertiary) public hospitals consented to participate (n=25) and were audited by trained researchers over the period November 2003 to July 2004.

A standardised audit instrument for evaluating hospital-based family violence programmes was used (*The Delphi*). The instrument 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 categories within the sections range from 0 to 100, with higher numbers indicating greater system development. The instrument includes performance measures sorted among the categories/domains listed below[c].

Categories	Brief Description
Policies and 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 and Safety Assessment	Standardised partner abuse screening and safety assessment instruments are available. Eligible patients are screening 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.

[a] Please refer to the full report for more detailed presentation of the findings as well as a description of study limitations and strengths.
[b] http://www.ahcpr.gov/research/domesticviol/
[c] The 'Screening and Safety Assessment' domain was not applicable for Child Abuse; however, assessment and safety elements were included in the remaining domains.

Family Violence Programmes in hospitals

- At the time of the audit, 48% of hospitals had an identified partner abuse coordinator.
- 56% of hospitals had a child abuse coordinator (this could be a shared position).
- In over half (56%) of the hospitals, child abuse programmes had been in place for at least two years.
- In contrast, only 8% of hospitals had an identifiable Partner Abuse Programme in place for two or more years (see Table 1).
- Routine screening for family violence was occurring in only two acute care hospitals at the time of this baseline audit.

Table 1. Hospital Family Violence Programmes

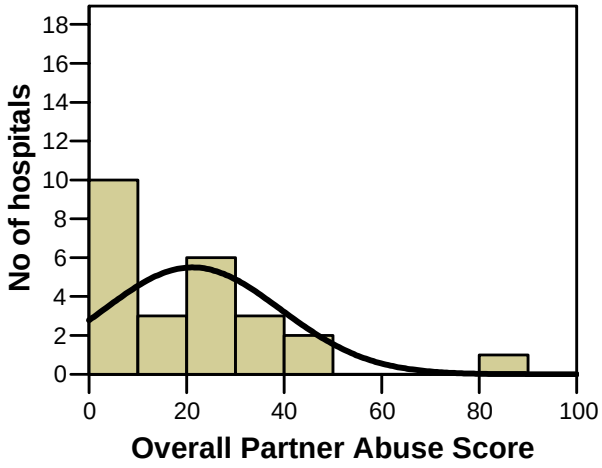
	Partner Abuse	Child Abuse
Family Violence Coordinator		
None	13 (52%)	11 (44%)
Part-Time	11 (44%)	9 (36%)
Full-Time	1 (4%)	5 (20%)
Family Violence Programme Maturation (months)		
No Programme	10 (40%)	4 (16%)
1 – 24	13 (52%)	7 (28%)
24-48	2 (8%)	5 (20%)
>48	0	9 (36%)

Summary of Partner Abuse findings

- Most hospitals were in the early stages of developing a system response to partner abuse at the time of the baseline audit.

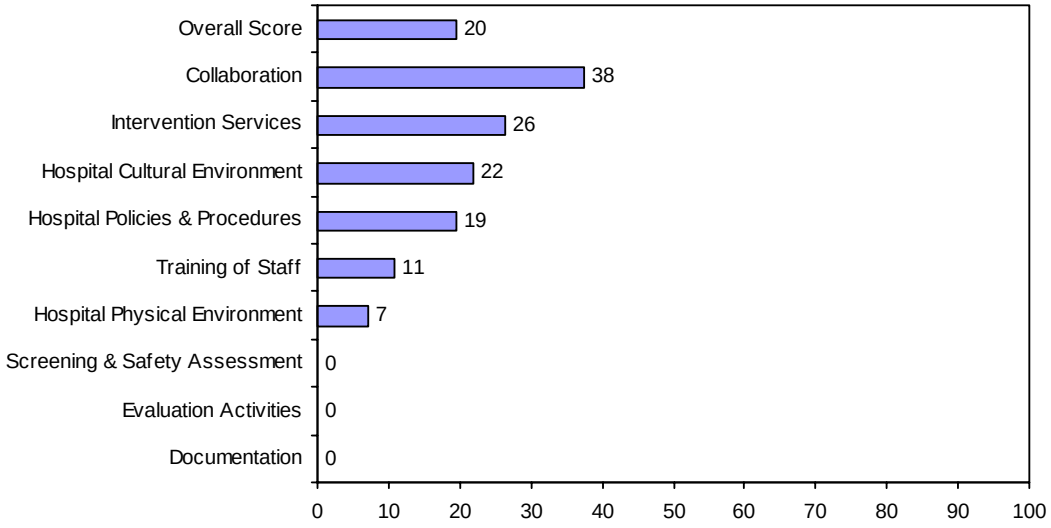
- The average overall partner abuse score was 21. Three hospitals scored above 40, with one achieving a score of 82 (see Figure 1).

Figure 1. Overall Partner Abuse Scores



- The partner abuse categories with the highest mean scores were 'collaboration' and 'intervention services'; the lowest were 'screening and safety assessment', 'evaluation activities', 'hospital physical environment' and 'documentation' (see Figure 2).

Figure 2: Partner Abuse Median (50%) Scores

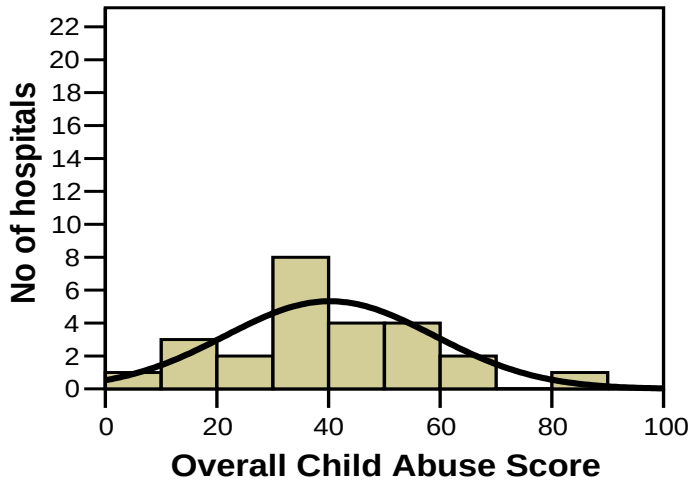


Summary of Child Abuse and Neglect Findings[a]

- At baseline, the responsiveness of most hospitals to children at risk for abuse and neglect reflected that many hospitals are still in an intermediate stage of development.

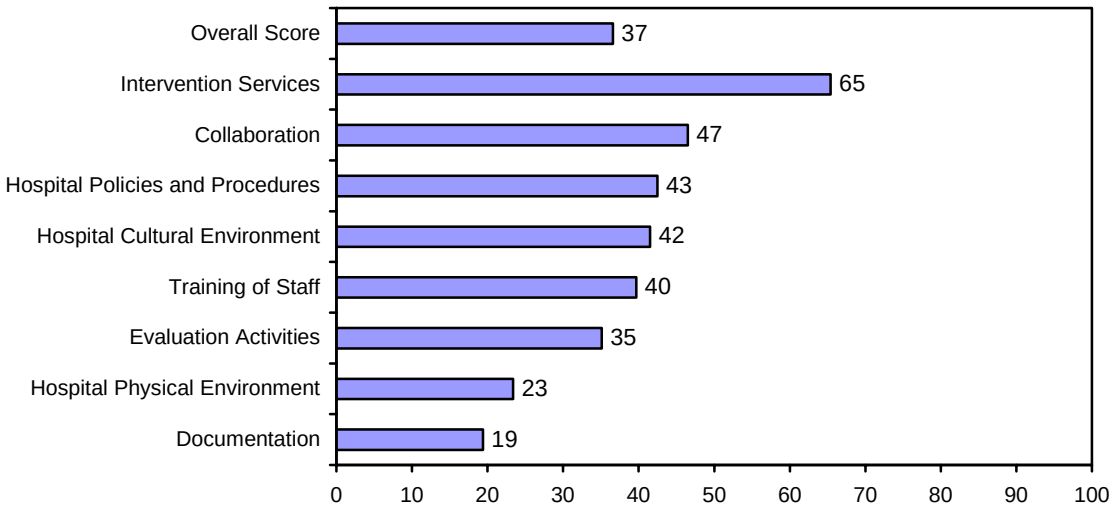
- The average overall child abuse and neglect score was 40 (see Figure 3).

Figure 3. Overall Child Abuse Scores



- The category with the highest mean score was 'intervention services' followed by 'hospital policies and procedures', 'hospital cultural environment' and 'collaboration'. The lowest domain score was for 'hospital physical environment' (see Figure 4).

Figure 4: Child Abuse and Neglect Median (50%) Scores



[a] The Child Abuse and Neglect scores are based on a new instrument which is still under development.

Associations with Programme Scores

- While the scores represent early programme development, some important characteristics predicted higher scores (see Table 2).

- Higher scores for both partner abuse and child abuse and neglect programmes were associated with having a designated coordinator, having a programme in place for longer, more hospital beds and a larger population base.

Table 2. Hospital Characteristics and Programme Score Associations

		Partner Abuse	Child abuse and neglect
Number of Hospital Beds	< 100	10	28
	100 +	26	47
Location	Secondary/minor urban	17	34
	Main urban	23	43
Programme Coordinator	No	12	30
	Yes	31	49
Length of Programme (months)	0	10	23
	<24	25	36
	24 – 48	55	50
	48+		46

Discussion

Higher audit scores were evident in hospitals with more mature programmes and designated coordinators. In this baseline audit, a single hospital scored significantly higher compared to all others. That hospital's Child Abuse and Neglect programme had been in place for more than four years and a .8 Family Violence Coordinator had been in place for more than a year prior to the audit.

Partner Abuse scores reflect early stages of programme implementation. Despite the prevalence of partner abuse and its immediate and long term health effects, approximately 40% of hospitals (n=10) had not begun developing a Partner Abuse programme at the time of the baseline audit. The baseline partner abuse mean score of 21 compares favourably to the mean score of first year programmes evaluated in a recent US study (19).[a] In that study, programme maturation often took five years of continuing development.

Child abuse and neglect programmes in acute care hospitals were more developed than those for partner abuse. The overall mean score for Child Abuse and Neglect was 40 compared to 21 for Partner Abuse. This difference in scores is not surprising given that child abuse has been the focus of health system development for a longer period of time. In more than half of the hospitals (n=14; 56%) Child abuse and neglect programmes had

[a] Fisher, E.J., & Coben, J.H. (2004). Evaluation of Pennsylvania's Domestic Violence Medical Advocacy Programmes. A report from the Allegheny-Singer Research Institute, Pittsburgh, PA.

been in place for four or more years and designated coordinators were in place. However, little evidence of an active Child Abuse and Neglect programme was found at 16% of the hospitals.

A number of points need to be kept in mind when interpreting the results presented here[a]:

- 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 levels of activity in FV in the whole hospital;

- scores do not recognise measures that were under development, but not yet in place at the time of the audit;

- the Child Abuse and Neglect audit section did not capture all the elements of the more developed programmes;

- to some degree, the audit does not measure whether the policies and procedures are actually being used (eg. referral rates); and

- community-based services were not evaluated.

However, a key strength of the audit was the 100% participation by acute care hospitals across the country. In addition, the audit process brought together partner abuse and child abuse stakeholders to discuss family violence system competencies. Through the audit process many hospitals learned for the first time possible elements of a family violence programme.

It is appropriate that hospitals are currently focusing their efforts on activities aimed at creating a climate where partner abuse screening and intervention can be instituted in a safe and effective manner. With time, appropriate resources, and research explicating effective interventions, we expect that the number of hospitals instituting routine screening will grow in the coming years.

In a climate of increasing attention to the poor Aotearoa/New Zealand statistics for both child abuse and neglect and partner abuse, and in the context of a new national family violence strategy (Te Rito), there is an opportunity for the health care system to make a significant contribution by addressing family violence in a thoughtful, resourceful and effective manner.

[a] Again, the reader is referred to the full report for a full discussion.