MINISTRY OF HEALTH
MANATŪ HAUORA

Interdisciplinary Trauma Research Unit

Te wairere au noa

HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

BASELINE AUDIT FINDINGS

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TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

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Executive Summary

Family violence is recognised as a priority health issue in Aotearoa/New Zealand as well as globally. Systemic change is integral to a sustainable and effective health care response to family violence. This 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.

The aim of this report is to begin building a picture of hospital-based family violence programmes to inform decision makers and practitioners in their efforts to increase competence in the area of family violence. At this early stage of development, it is important to be aware of both areas of weakness and strength.

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 over the period November 2003 to July 2004.

A modified 'Delphi' instrument for evaluating hospital-based family violence programmes was used. 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 domains within the sections range from 0 to 100, with higher numbers indicating greater system development.

Results of the baseline audit indicate that partner abuse initiatives are less well developed than those for child abuse. The overall mean score for Partner Abuse was 21.2 (SD±18.1) compared to 40.2 (SD±18.7) for Child Abuse and Neglect. Highest domain scores for Partner Abuse were achieved for 'Collaboration' (mean=35) and 'Intervention Services' (mean=34). The lowest domain score for Partner Abuse was 'Documentation' (mean=6). The highest domain score for Child Abuse and Neglect was achieved for 'Intervention Services' (mean=62), which scored substantially higher than any other domain. The lowest domain score for Child Abuse and Neglect was 'Hospital Physical Environment' (mean=25).

Scores reflect the fact that many hospitals are in the early stages of programme implementation. This report is provided without individual hospital scores (hospitals received a confidential report including their itemised scores). At this developmental stage, the research team felt it important that hospitals choose improvement goals for themselves rather than compare (and compete) against one another. Indeed, family violence coordinators across the country have begun to meet to share resources and development strategies.

Introduction

Family violence (FV) poses a significant health risk for people in Aotearoa/New Zealand[1-3] and is a priority issue for Maori[2]. In response, the Ministry of Health (MOH) began the Family Violence Project (FVP) in September 2000. A central aim of the FVP is to improve the health sector's response to victims of family violence (see programme logic, Appendix A). Three major initiatives are included in the project:

1. Establish practice procedures to identify, manage and refer victims of family violence;
2. Fund health professional training; and
3. Fund four District Health Boards to hire a Family Violence Project Coordinator.

As part of the FVP, the Ministry of Health (MOH) issued the *Family Violence Intervention Guidelines: Child and Partner Abuse*[4] in November, 2002 (referred to here as *The Guidelines)*[a]. Subsequent to the release of *The Guidelines*, four District Health Boards (DHBs) were awarded tenders to employ a family violence project coordinator. Funding was also made available for health professional education, targeting general practitioners; emergency; paediatric and well-child; and sexual healthcare professionals. There was an expectation that DHBs without specifically funded family violence coordinators would begin implementing *The Guidelines*. This expectation is to be formalised in 2004/2005, when family violence intervention becomes a performance requirement for DHBs.

Evaluation Plan

While educating health professionals is key, it is not by itself sufficient to address the problem of family violence[5]. Providing tools, such as *The Guidelines*, and institutional support increases the likelihood of creating sustainable change[6, 7]. Consistent across the family violence literature is the call that reform must be institutionalised to sustain family violence innovations and behavioural change. 'Institutionalising' components of family violence initiatives can include measures such as:

- training health care providers,
- establishing a hospital task force or team,
- establishing specific policies and procedures,
- modifying environments,
- screening for victimization and
- enhancing intervention services.

As part of monitoring institutional maturation in addressing family violence within the health sector, AUT was contracted by the Ministry of Health to evaluate the implementation of family violence programmes in secondary and tertiary acute

[a] The reader is referred to *The Guidelines* for definitions and additional background information regarding family violence.

care public hospitals across Aotearoa/New Zealand. The evaluation project was approved by the Auckland Ethics Committee (AKY/03/09/218). Central to the evaluation is the measurement of institutional culture.

The evaluation includes three data collection methods:

1. Hospital Audits: Secondary and tertiary acute care public hospitals are being audited on three occasions - at baseline, 12 and 24 months[a] - using a modification of the *Delphi Instrument for Hospital-Based Domestic Violence Programmes* [8] *(*referred to as *The Delphi*).

2. Key Stakeholder Interviews: Approximately twenty semi-structured key stakeholder interviews are being conducted across Aotearoa/New Zealand during the study period to identify enablers and barriers to institutional change in the area of family violence. General practitioner interviews will be included.

3. Focus Groups: Semi-structured focus groups will be conducted following the 12 month follow up audit to contextualise the audit results. Four DHBs will be purposefully sampled. Each focus group will include hospital and key stakeholder representatives, including community stakeholders.

Purpose of Baseline Audit

This report presents the baseline hospital audit findings, one aspect of the broader Family Violence Project evaluation. These quantitative audit findings are the result of applying the modified Delphi tool; they contribute to the nationwide picture of FV initiatives across Aotearoa/New Zealand. In this health services research, quality is measured by examining the structures of the health care system and the processes of health care delivery. The value of the findings is based on the fundamental tenet of healthcare's approach to reducing family violence, 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"[8(p. 2)].

Methods

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 and their corresponding DHBs are listed in Appendix 3 and mapped in Appendix 4. Hospital characteristics are reported in the findings section.

[a] A third audit (at 24 months) was recently contracted for by the Ministry of Health.

Audit Tool

The *Delphi Instrument for Hospital-Based Domestic Violence Programmes*[6, 8, 9] was developed to monitor primary indicators of hospital family violence programme quality. The Delphi has been used extensively in hospital-settings in Pennsylvania and California, and has good internal reliability (alpha=0.97).

The original Delphi was modified for the purpose of this audit. First, the original Delphi addressed partner abuse with only one reference to child abuse and child protection. Because of the high co-occurrence of child abuse and partner abuse[10], we developed, with the assistance of our research team advisors, a Child Abuse and Neglect section that mirrored the original Delphi.

Second, we modified the Delphi to take account of the social-cultural context of Aotearoa/New Zealand. Language was made more appropriate to the New Zealand context (eg., 'law enforcement' replaced by 'police'); questions around Maori and Te Tiriti o Waitangi were integrated; and additional questions on responsiveness to Asian, Pasifika, refugee, and Lesbian Gay Bisexual Transgender (LGBT) community were added to make the tool more inclusive.

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 below; individual audit items are listed in Appendix 2.

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

Scoring

Each 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, again out of 100, is generated using a scheme where some domains are weighted higher than others (domain weights are provided in Appendix 2).

Audit Procedures

There were a number of stages moving from obtaining consent to preparing for the hospital site visit:

1. Initially, a letter of was sent from the Ministry of Health to each CEO outlining the project, followed by an information pack that included an invitation to participate, a letter of endorsement from the Ministry, and details of the audit process (Appendix 5).
2. Sign off (Ethics form, Part V) was then obtained from the appropriate DHB Manager for the hospital(s) identified within their jurisdiction.
3. The person identified to act as a FV Liaison (identified by the manager) was provided with instructions on how to prepare for the audit.
4. The general audit process and scheduling of the audit was communicated by e-mail and telephone.
5. Confirmation of the audit date and a detailed checklist of documents that needed to be collated for the audit (Appendix 6) were posted to the FV Liaison.
6. The FV liaison was asked to coordinate the involvement of others in the site visit as appropriate.
7. A few days prior to the audit, contact was made with the coordinator/liaison to answer any outstanding questions about the audit.

Audits were conducted by trained members of the research team: Eva Neizert and Jo Adams. Drs Jeff Coben and Jane Koziol-McLain 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, social workers; representatives from the paediatric, maternity and emergency wards; as well as hospital management often contributed to the audit.

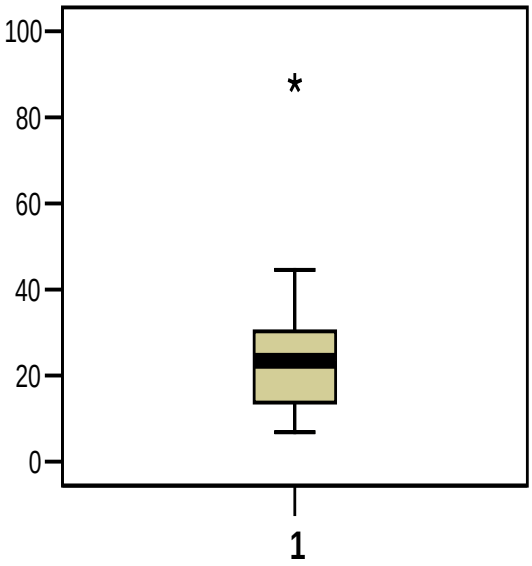
On completion of each site visit an audit report was provided to the FV coordinator or liaison, usually within two weeks, to confirm the accuracy of the audit report. Once confirmed, the finalised hospital report was sent to the CEO, copied to the FV coordinator or liaison.

Baseline Audit Analysis

In this report we present the distribution of overall Partner Abuse and Child Abuse and Neglect scores in tables, graphs (histograms) and box plots. Individual domain scores are presented in graphs (histograms) and box plots. Box plots are especially useful for examining scores across the domains (see *Figure 1: 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.

Figure 1: 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).

Findings

Participating Hospitals

Hospital Characteristics

Hospitals varied in their population base (See Table 1) with the majority (72%) located in areas serving a population of 30,000 or more persons ('main urban'). The proportion of Maori varied from 5% to 44% across hospital catchment areas. Two hospitals were based in areas with a Pacific Island population between 10% and 20%, and three hospitals in areas with an Asian population between 10% and 20%. The average number of hospital beds was 302, ranging from 30 to approximately 1000.

Table 1. Participating Hospital Characteristics (N=25)

	Number of hospitals (%)
Area Category (defined by hospital location)[a]	
Main Urban (> 30,000)	18 (72%)
Secondary Urban (10,000-29,000)	6 (24%)
Minor Urban (1,000-9,999)	1 (4%)
Maori Population[a]	
> 20%	8 (32%)
10% - 20%	9 (36%)
< 10%	8 (32%)
Level of Care	
Secondary	19 (76%)
Tertiary	6 (24%)
Number of Beds (n=22)	
> 400	4 (18%)
250 – 399	5 (23%)
100 – 250	7 (32%)
< 100	6 (27%)

[a] Source: *2001 Census Data,* Statistics New Zealand. Statistical Classification for Urban Area from http://xtabs.stats.govt.nz/eng/statsbyarea/area_main.asp

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.

At the time of the audit, 48% of hospitals had an identified Partner Abuse coordinator; and 56% had a Child Abuse coordinator (this could be a shared position). "Programmes", however, were not in existence at the time of the baseline audit in some hospitals: 40% for partner abuse and 16% for child abuse (whether a "programme" existed was defined by the hospital themselves).

For programmes that were in place, they were significantly more established for child abuse. 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.

Table 2. 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%)

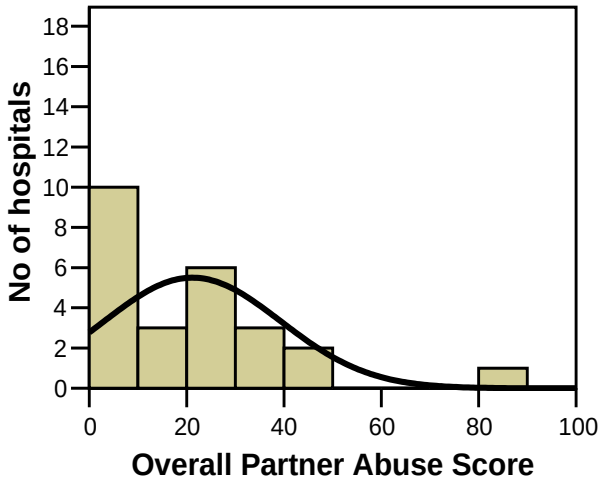
Section 1: Partner Abuse

1.1 Summary of Partner Abuse findings

Most hospitals were in the early stages of developing a system response to partner violence at the time of the baseline (year one) audit. The average overall partner abuse score was 21, with the middle half of scores between 8 and 31. Three hospitals scored above 40, with one achieving a score of 82. The domains with the highest mean scores were 'collaboration' and 'intervention services' and the lowest were 'screening and safety assessment', 'evaluation activities', 'hospital physical environment' and 'documentation'.

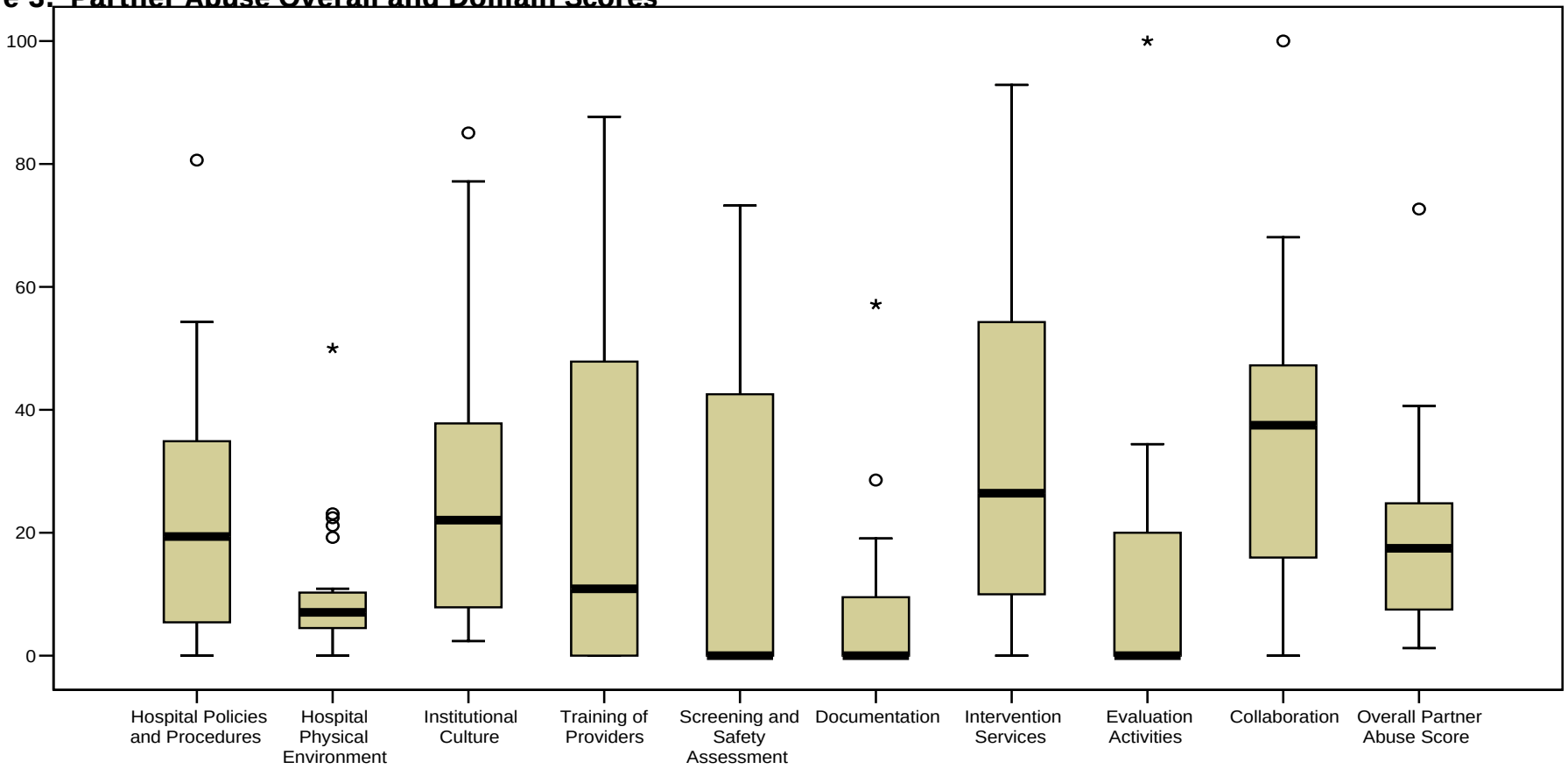
The figure below displays the distribution of the overall Partner Abuse Scores among the 25 hospitals. Partner Abuse overall and domain scores are displayed in box plots on the next page, followed by a table of data supporting the displays.

Figure 2. Overall Partner Abuse Scores



- Scores for Partner Abuse ranged from 1 to 82, with a single hospital scoring well above the others (the next highest was 47).
- The average score was 21.
- The median (50th percentile) score was 20; half the hospitals scored above 20 and half below.

Figure 3. Partner Abuse Overall and Domain Scores



- The Partner Abuse domains with the highest median scores (50th percentile) were 'Collaboration' (38) and 'Intervention Services' (34).
- A substantial proportion of hospitals had 0 scores in the 'Screening', 'Documentation' and 'Evaluation' categories, resulting in median scores of 0 for these three domains. The next lowest domain score was for 'Physical Environment' (8).
- For most domains, a single hospital scored significantly higher than others (the highest score or outlier/extreme score).

Table 3. Partner Abuse Scores

	Mean	SD	Min	Max	Percentile		
					25th	50th	75th
Overall Score	21.2	18.1	1.3	82.0	8.3	19.6	30.8
Domain Scores							
Collaboration	35.4	24.4	0	100.0	15.6	37.5	47.6
Intervention Services	33.6	27.1	0	92.9	9.3	26.4	56.1
Hospital Cultural Environment	27.9	23.3	2.4	85.0	7.9	22.0	40.2
Training of Staff	23.7	27.3	0	87.7	0.0	10.9	48.9
Hospital Policies and Procedures	22.3	20.1	0	80.6	5.0	19.4	36.4
Screening and Safety Assessment	14.3	22.6	0	73.2	0.0	0.0	42.5
Evaluation Activities	11.5	21.8	0	100.0	0.0	0.0	20.0
Hospital Physical Environment	10.1	10.6	0	50.0	4.2	7.1	10.6
Documentation	6.5	13.1	0	57.1	0.0	0.0	9.5

1.2 Partner Abuse: Results for Individual Domains

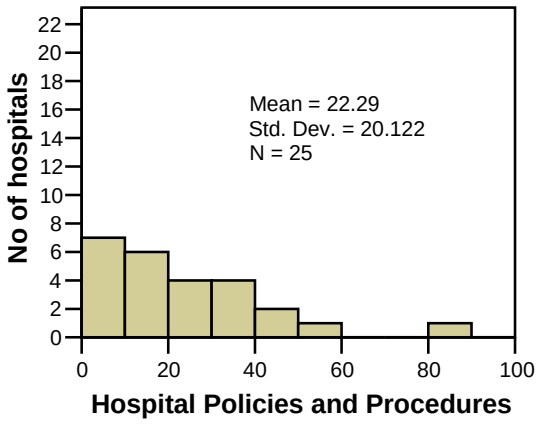
Results for each of the nine domains for Partner Abuse are presented individually in the following sections.

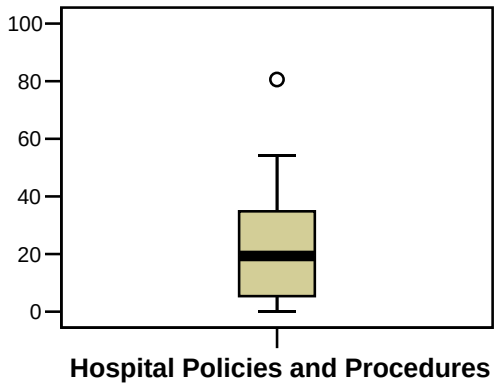
Domain 1: Hospital Policies and Procedures

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 Maori 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 (see p.8).

Policies and procedures were in place in 10 (40%) hospitals at the time of the audit and 14 (56%) had evidence of a family violence task force. Ten (40%) hospitals provided $10,000 or more to their partner abuse programme, predominantly spent on coordinator salary. The remaining hospitals spent less than $10,000 (n=4, 16%) or allocated no funding (n=11, 44. Two (8%) hospitals reported a mandatory routine screening policy.





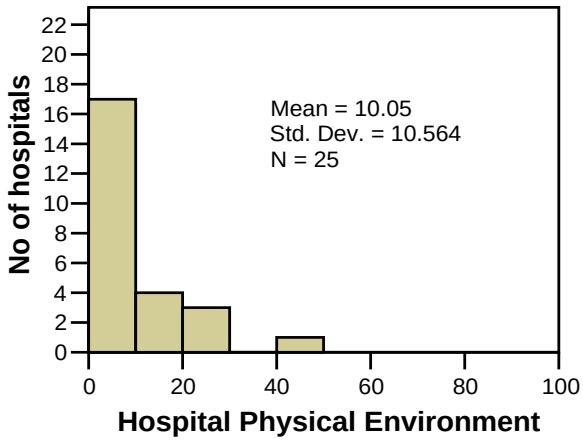
- Hospitals generally scored between 5 and 36 in this domain, with one outlier (score=81).
- The average score was 22, and the median score was 19.

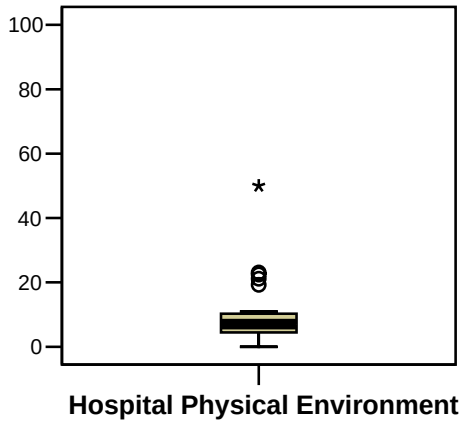
Domain 2: Hospital Physical Environment

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.

While most hospitals (n=20, 80%) had material relating to partner abuse available somewhere in the hospital, in most they were on display in fewer than five areas and many times did not include information on how to access services. Four hospitals had provisions for safe refuge of victims (in patient or respite area).





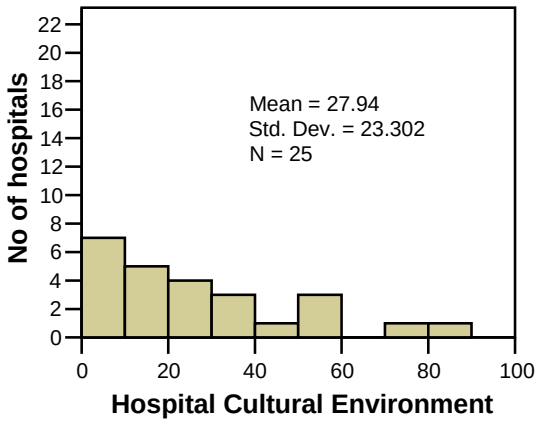
- Most hospitals scored low in this domain.
- Only one hospital scored more than 40.
- The range of scores was very small (SD=11), apart from the outliers.
- The average score was 10 and the median score was 7.

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 (see p. 8);
- 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.

Five (20%) hospitals had conducted an assessment of staff partner abuse knowledge and attitudes within the past 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.



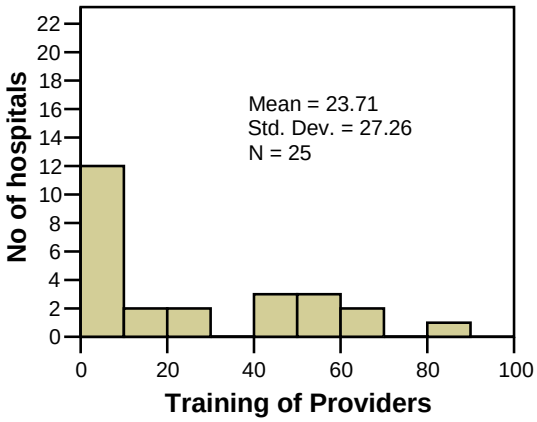
- There was a wide range of scores for this domain.
- The average score was 28 and the median was 22.

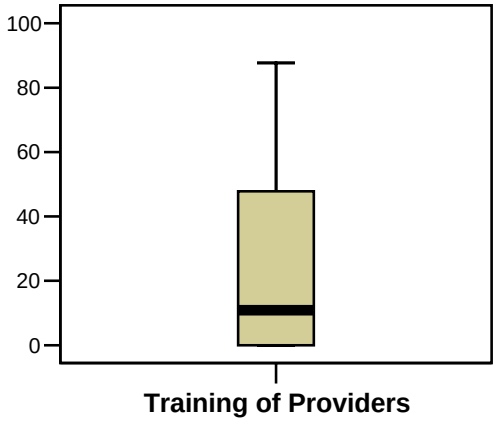
Domain 4: Training of Staff

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.

Five (20%) hospitals had a written plan for partner violence education of staff, though others (n=8) had provided some ad hoc educational sessions. Education provided often included community experts.





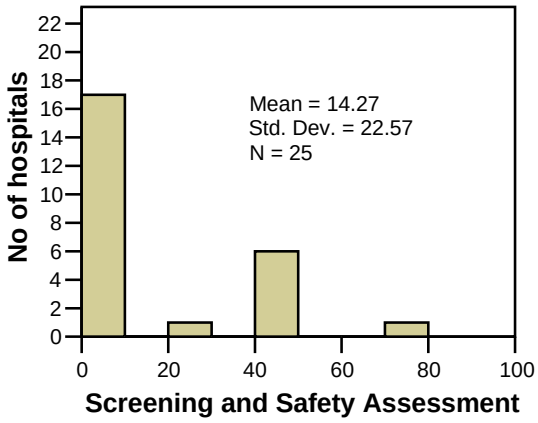
- While the majority (n=16) of hospitals scored low (less than 40) in this domain, 6 scored above 50.
- The mean for this domain was 28 and the median 22.

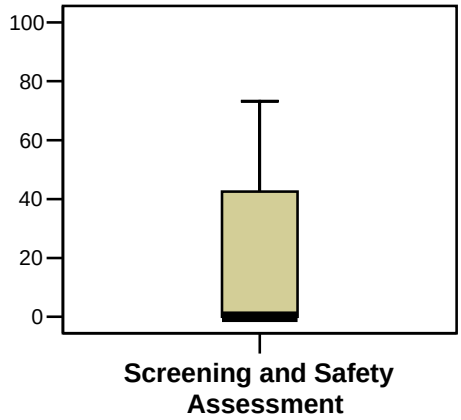
Domain 5: Screening and Safety Assessment

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.

Three (12%) hospitals had a standardised screening instrument available. Two hospitals had conducted chart audits to monitor screening; chart audits identified screening levels between 11% and 25%. Eight (32%) hospitals had a standardised safety assessment discussed with victims who screen positive for partner abuse; 7 (28%) hospitals standardised assessment included assessing the safety of children in the household.





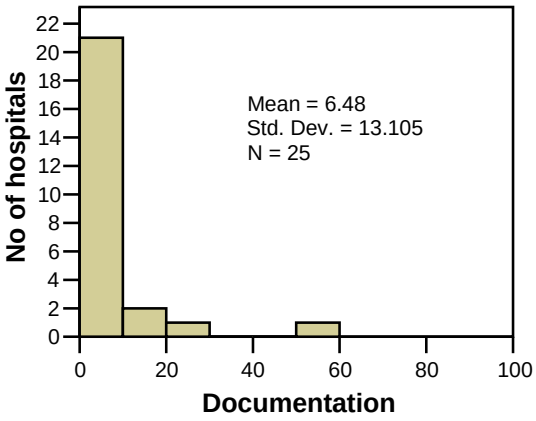
- Over one third of hospitals (n=17) scored less than 10 in this Domain.
- The average score was 14, but the median score was zero.

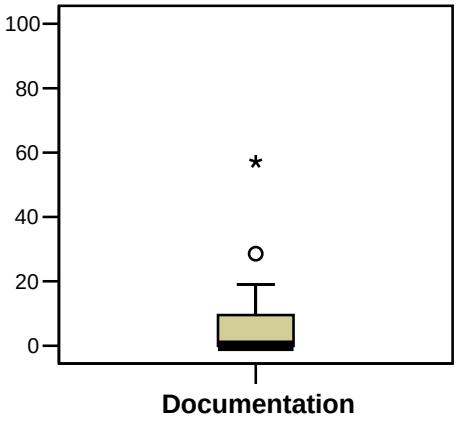
Domain 6: Documentation

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.

Three (12%) hospitals had a standardised documentation form to record partner abuse cases, all three included a body map for noting injuries, but were not consistent in documenting the name of the perpetrator and referrals provided. Eight (32%) hospitals had provisions for forensic photography of injuries, but rarely offered to photograph injuries, relying instead on police photography.





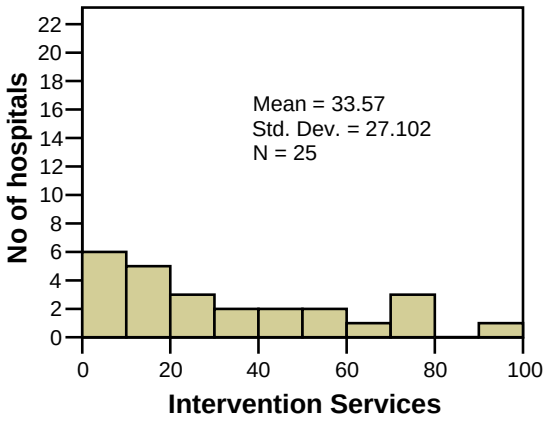
- Scores in this Domain were low.
- The average score was 6 and the median was zero.
- 85% (n=21) scored 10 or less.

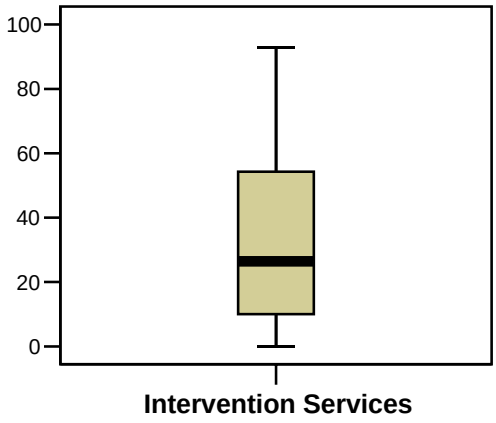
Domain 7: Intervention Services

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 counseling with victims;
- provision of on site legal options counseling;
- services offered for the children of victims; and
- evidence of coordination with services for sexual assault, mental health and substance abuse.

Seven (28%) hospitals had victim advocacy services available during certain hours and 6 (24%) had advocacy services available at all times. Eleven (44%) hospitals provided follow up contact and counseling for victims following an initial assessment. Eight (32%) hospitals evidenced links between their partner abuse programme and sexual assault, mental health and substance abuse screening and treatment programmes.





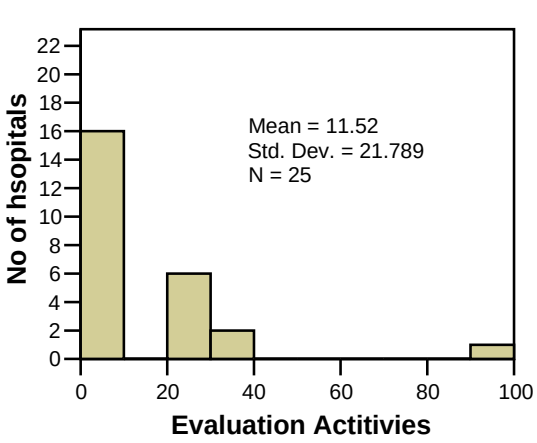
- There was a wide spread of scores in this Domain (SD=27).
- The mean score for this domain was 34 whereas the median score was 26 (the second highest Partner Abuse domain median score).
- 25% of hospitals achieved a score of 50 or greater for the intervention service domain.

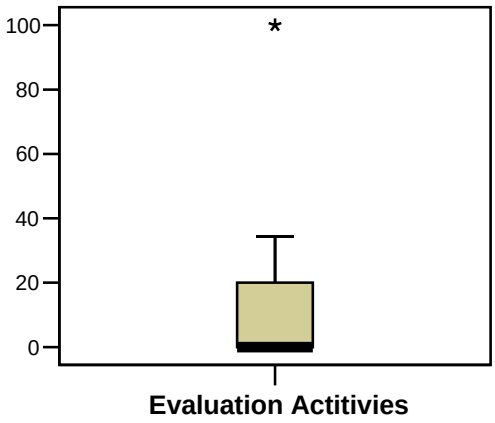
Domain 8: Evaluation Activities

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 Maori.

Two (8%) hospitals had evidence of periodic monitoring of charts to measure programme quality; two (8%) had peer-to-peer case review. Only a single hospital measured client or community satisfaction with their programme. Two hospitals used a *He Taura Tieke* (or equivalent) quality framework to assess services for Maori.





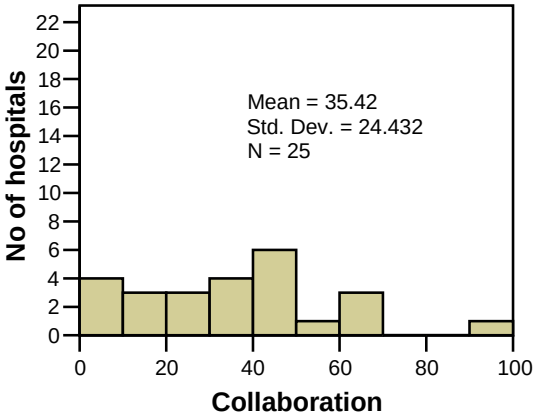
- Almost two thirds of hospitals (64%) scored 10 or less in this category.
- Although the mean score was 12, the median was 0.
- A single hospital scored 100, well above the remaining hospitals.

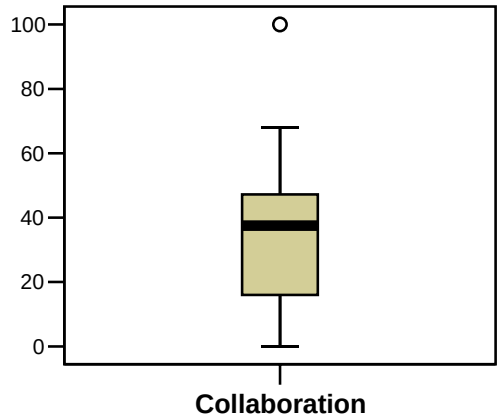
Domain 9: Collaboration

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;
- Maori 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 Maori providers.

Almost all hospitals collaborated with local partner abuse service providers in their community (n=22, 88%) and with local police and courts (n=16, 64%). Collaboration was most often in areas of policy development and staff training. Eighteen (72%) hospitals evidenced some collaboration with Maori providers or representatives in their partner abuse programme; 12 hospitals specifically included the hospital (or DHB) Maori health unit in their partner abuse programme. Half (n=13) of the hospitals noted collaborating with others in their DHB.





- Collaboration was the Partner Abuse domain with the highest mean (35) and median (38) scores.
- Almost half (n=12; 48%) the hospitals scored over 40.
- A single hospital is well above the others with a score of 100.

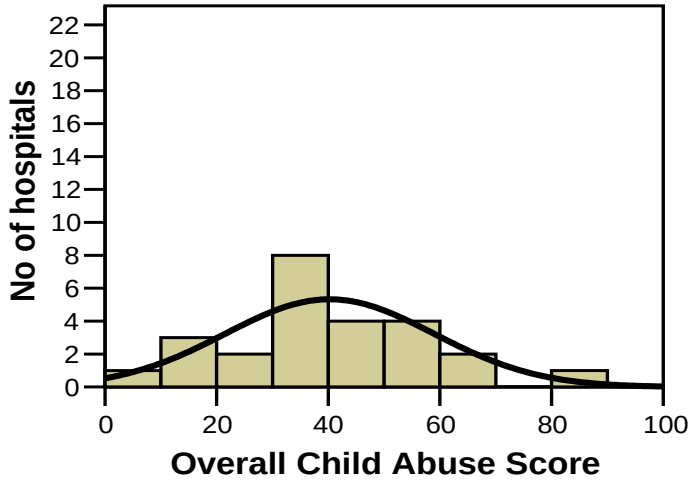
Section 2: Child Abuse and Neglect

2.1 Summary of Child Abuse and Neglect Findings

At baseline, the responsiveness of most hospitals to children at risk for abuse and neglect was higher than for the response to partner abuse[a]. However, the distribution of scores reflected that many hospitals are still in an intermediate stage of development. The average overall child abuse and neglect score was 40, with the middle half of scores between 30 and 52. The domain 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'.

The figure below displays the distribution of child abuse and neglect scores across the 25 participating hospitals. Child Abuse and neglect overall and domain scores are displayed in box plots on the next page, followed by a table of data supporting the displays.

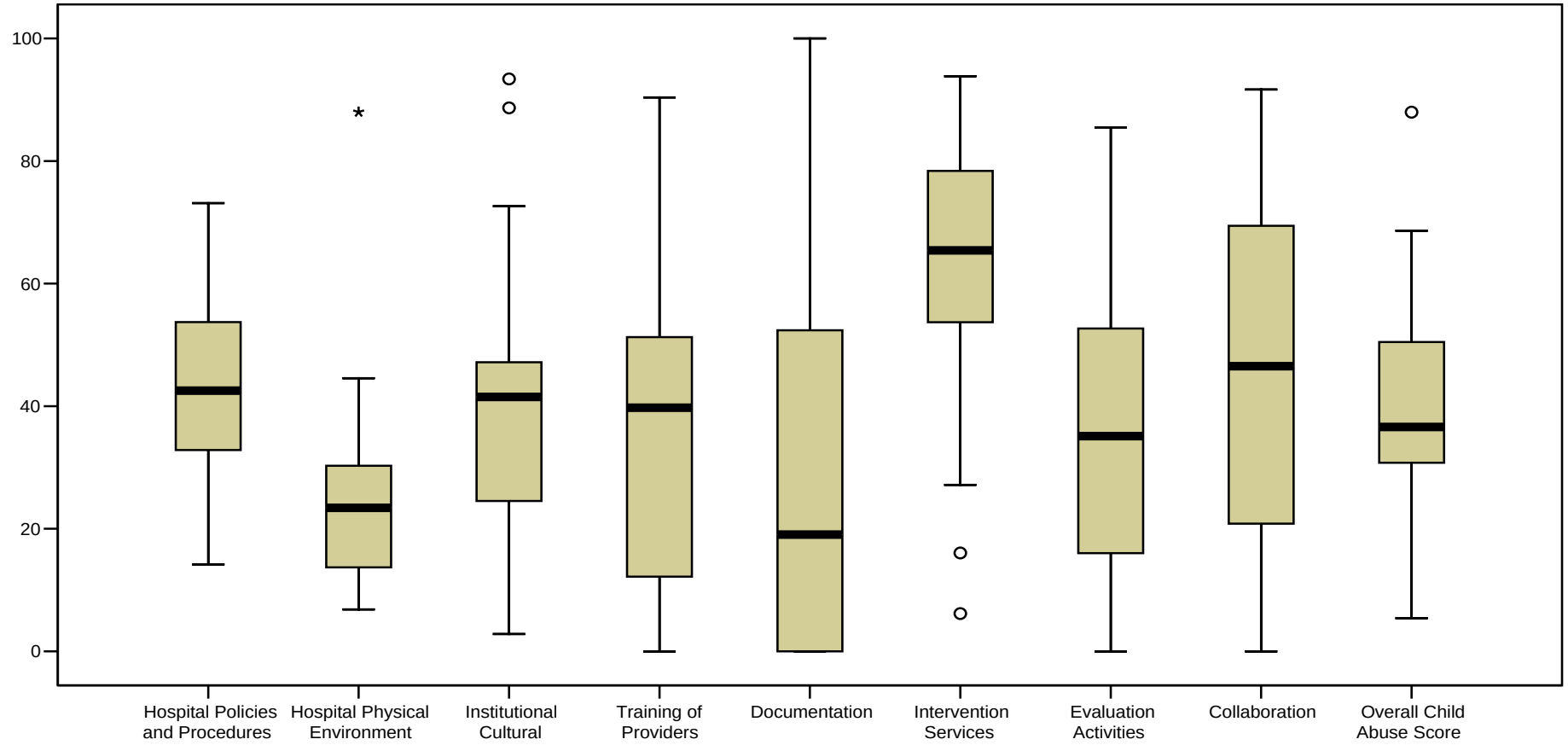
Figure 4. Overall Child Abuse Scores



- Scores for Child Abuse ranged from 5 to 88.
- The average score was 40.
- The median (50th percentile) score was 37; half the hospitals scored above 37 and half below.

[a] The reader is reminder that the Child Abuse and Neglect scores are based on a newly modified Delphi instrument which is still under development. Areas such as neglect, sexual abuse and use of forensic photography require further development .

Figure 5. Child Abuse Summary and Domain Scores



- The domain with the highest median (50th percentile) score was 'Intervention services' (65).
- The domains with the lowest median scores were 'Documentation' (19) and 'Hospital Physical Environment' (23).

Table 4. Child Abuse Scores

	Mean	SD	Min	Max	Percentile		
					25th	50th	75th
Overall NZ Score	40.2	18.7	5.4	88.0	30.2	36.6	51.5
Domain scores							
Intervention Services	62.4	24.3	6.2	93.8	52.5	65.4	82.7
Hospital Policies and Procedures	44.1	17.8	14.2	73.1	32.1	42.5	57.5
Hospital Cultural Environment	40.1	23.1	2.8	93.4	21.2	41.5	50.9
Collaboration	44.8	26.7	0	91.7	20.8	46.5	69.4
Training of Staff	35.4	24.8	0	90.4	9.3	39.7	55.1
Evaluation Activities	31.9	24.6	0	85.5	8.0	35.1	52.7
Documentation	30.3	32.5	0	100.0	0.0	19.4	54.8
Hospital Physical Environment	24.8	16.2	6.9	88.0	13.4	23.4	30.6

2.2 Child Abuse and Neglect: Results for Individual Domains

Results for each of the eight domains for Child Abuse and Neglect are presented in the following sections.

Domain 1: Hospital Policies and Procedures

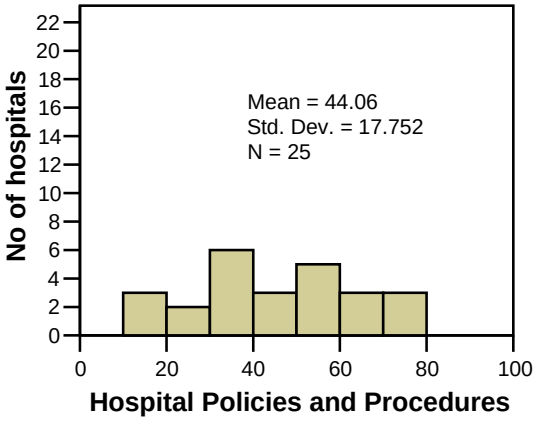
Scores for this domain were based on evidence for the following:

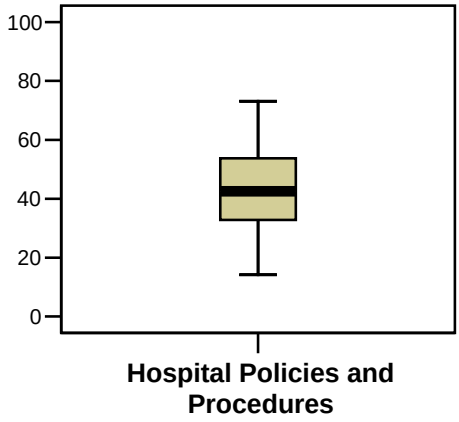
- official, written hospital policies regarding the assessment and treatment of victims;
- a hospital-based child abuse and neglect working group;
- financial support for the child abuse and neglect abuse programme, including for Maori initiatives;
- a clinical assessment policy for identifying signs 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 (see p. 8).

Most hospitals (n=23, 92%) had policies and procedures addressing child abuse and neglect that were current at the time of the audit. These documents often included definitions of child abuse and neglect (68%), defined responsibility regarding risk assessment (76%) and legal reporting (76%); but less often mandated training (32%) or included age-appropriate risk assessment (20%).

Twelve (48%) hospitals had a child abuse and neglect working group and at 10 (40%) hospitals they met at least monthly and included a Maori representative. None of the working groups included a youth representative. Fourteen (56%) hospitals funded their child abuse and neglect programme at a sum of $10,000 or greater, three (12%) funded at lower levels; similar to partner abuse programmes, most resources supported coordinator salary. Eight (32%) hospitals had no evidence of financial support for their Child Abuse and Neglect programme.

Greater than three quarters (n=21, 84%) of hospitals had a standardised clinical assessment regarding signs and symptoms of child abuse and neglect and identifying children at high risk. While 18 (72%) hospitals had evidence of Child Youth and Family case feedback, fewer (12, 48%) had regular peer review and fewer conducted chart audits (n=5, 20%) to ensure policy implementation.





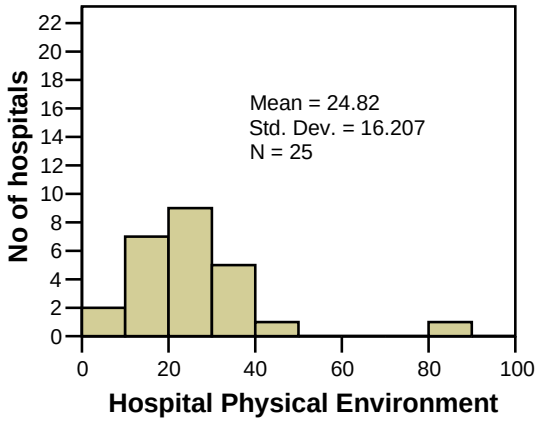
- Over one third (n=9; 36%) of the hospitals scored over 50.
- The mean score was 44 and the median 43.

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 Maori, and other ethnic/cultural groups); and
- provisions of temporary shelter for victims.

Child-friendly posters and images were common across all the hospitals and most had at least one piece of material that addressed child abuse and neglect. Actual referral information to access resources, however, were rarer. Only 5 (20%) hospitals had 5 or more locations were child abuse and neglect referral information was available. Eleven (44%) hospitals had allowances for providing temporary safe refuge for children and families awaiting safe accommodation in the community.



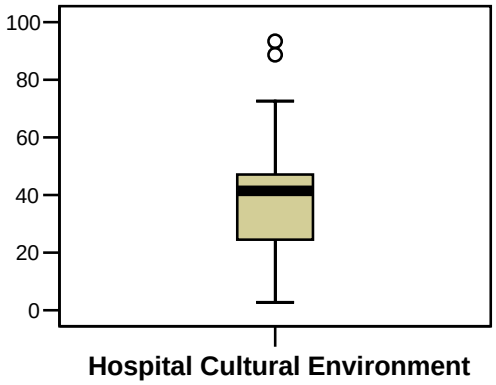
- Nearly three quarters of the hospitals (n=18; 72%) scored 30 or less in this domain, a single hospital scored more than 50.
- The mean score was 25 (lowest among the child abuse and neglect domains) and the median 23.

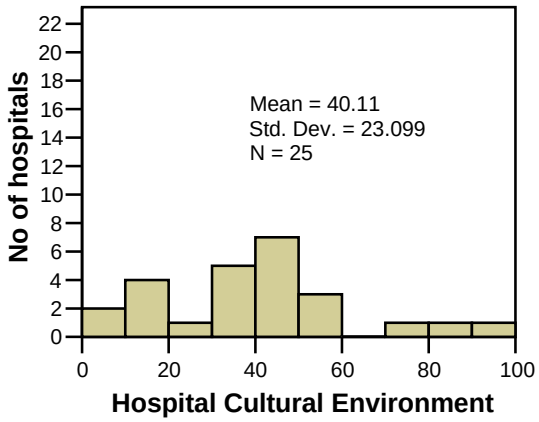
Domain 3: Hospital Cultural Environment

Scores for this domain were based on the following:

- written, formal assessment of staff knowledge and attitude about child abuse;
- the length the child abuse and neglect programme had been in existence (see p. 8);
- addressing of cultural competency issues in the child abuse and neglect programme; and
- participation in preventive outreach and public education campaigns on the topic of child abuse and neglect.

Six (24%) hospitals had formally assessed staff knowledge and attitude regarding child abuse and neglect within the past three years. Most (n=23, 92%) child abuse and neglect programmes addressed cultural competence, though only eight (32%) hospitals had child abuse and neglect information in languages other than English. Many (n=19, 76%) had participated in at least one preventive outreach public education activity on child abuse and neglect in the past 12 months.





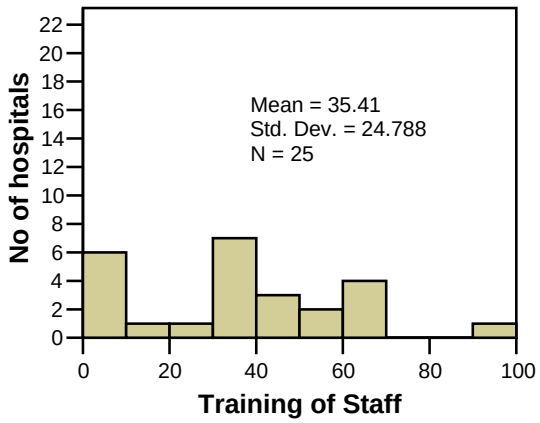
- Over half of the hospitals (52%; n=13) scored between 21 and 51.
- The mean score was 40 and the median score was 42.
- Three hospitals scored above 70.

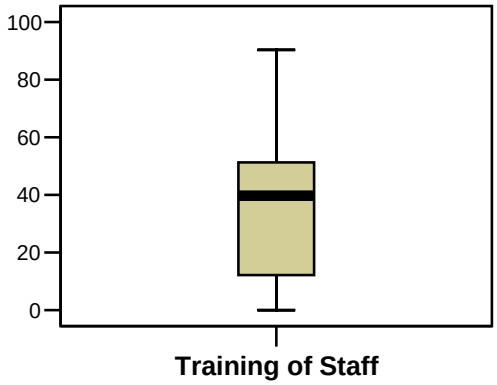
Domain 4: Training of Staff

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

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

Five (20%) of hospitals had a formal training plan for child abuse and neglect staff education, though an additional 7 (28%) had offered at least one ad hoc training session in the past year.





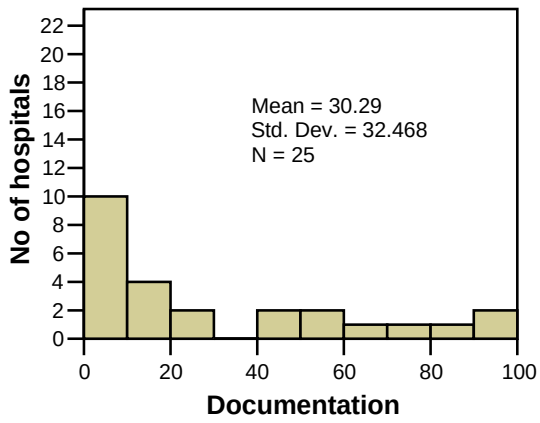
- One quarter of the hospitals scored below 10.
- The mean score was 35 and the median score was 40.

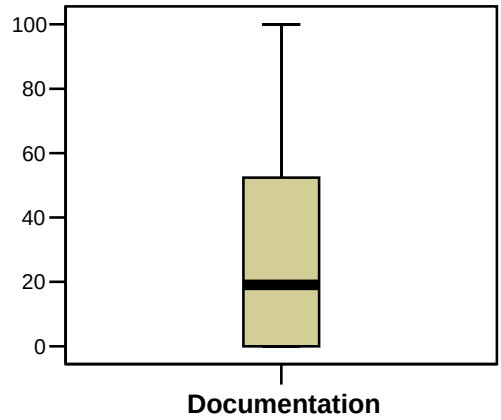
Domain 5: Documentation

Scores for this domain were based on the following:

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

Half (n=13, 52%) of the hospitals had a standardised documentation instrument for recording known or suspected cases of child abuse and neglect. A standardised safety assessment was provided at 10 (40%) hospitals. In only six (24%) hospitals did the standardised assessment include screening the child's mother for partner abuse.





- There was a wide dispersion of scores in this domain (SD=33), with scores ranging from 0 to 100.
- The mean score was 30.
- Half of the hospitals scored less than 20, with a cluster of hospitals (n=10) scoring less than 10.

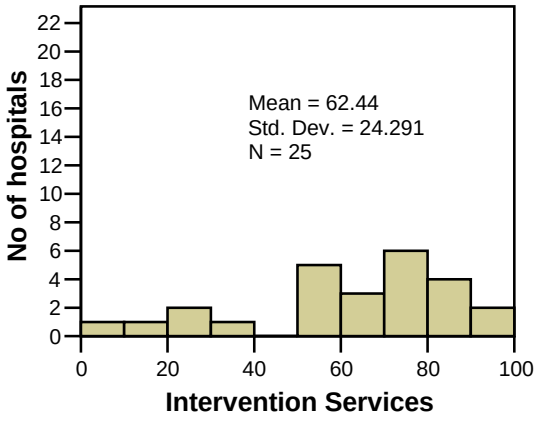
[a] The reader is again reminded that there are important omissions in the current version of the CAN Delphi. For example, no information is collected at present on the use of forensic photography. The version used for this baseline audit requires further development.

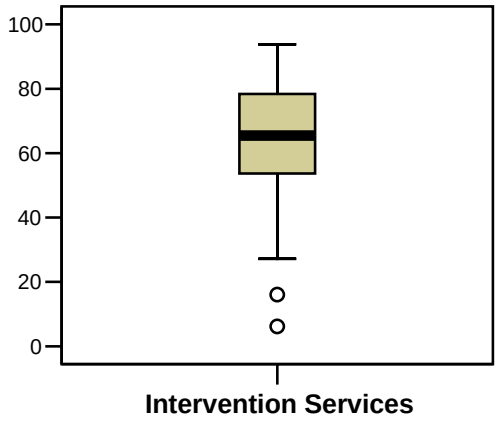
Domain 6: Intervention Services

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.

Over half (n=17, 68%) of the hospitals had a standardised intervention checklist for when child abuse and neglect were identified. Most had a member of the child abuse and protection team or designated social worker available to provide services at all times (n=16, 64%) or during certain hours (n=7, 28%). The child abuse and neglect programme offered family violence intervention services for the families, and in particular mothers, in only 8 (32%) hospitals. There was generally evidence of coordination between the hospital child abuse and neglect programme and Child, Youth and Family (n=21, 84%).





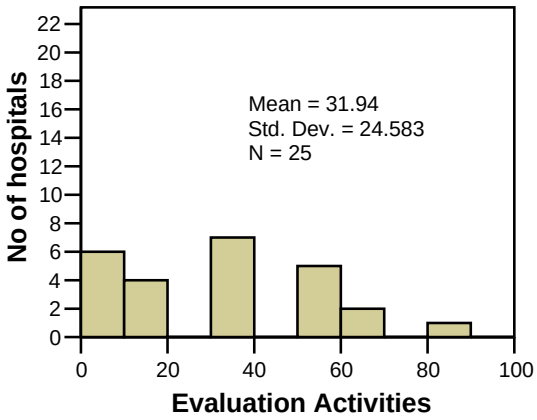
- The mean score for this domain was 62, the highest among all domains.
- The majority of hospitals scored high; 80% (n=20) scored above 50 and 25% scored above 83.
- This is the only domain where outliers represented low scores.

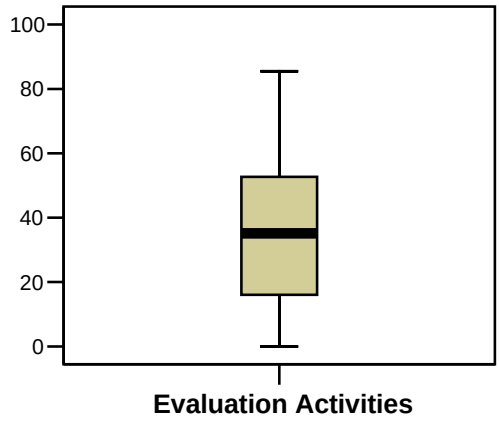
Domain 7: Evaluation Activities

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 Maori.

Fifteen (60%) hospitals had evidence of some formal evaluation procedure for monitoring child abuse and neglect programme quality, though only seven (28%) measured outcomes. Over half (n=14, 56%) of the hospitals provide staff with feedback on their performance from Child, Youth and Family. Two hospitals measured client or community satisfaction with the child abuse and neglect programme and two hospitals used He Taura Tieke (or equivalent) quality framework for monitoring quality for Maori clients.





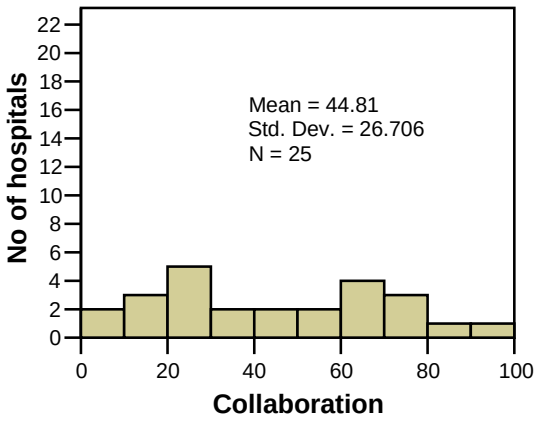
- Scores for this domain were variable (SD=25).
- 25% of hospitals scored less than 8; 50% scored less than 35.
- The mean score was 32.

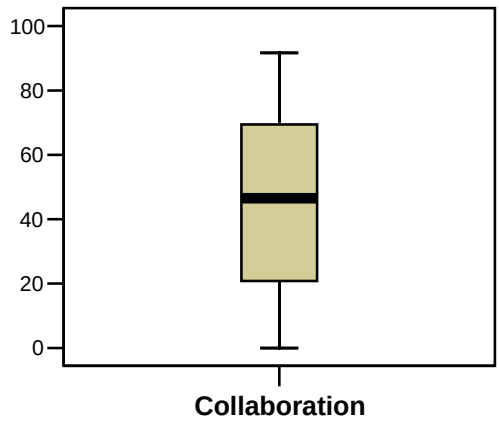
Domain 8: Collaboration

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;
- Maori 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 Maori providers.

Most (n=23, 92%) hospital child abuse and neglect programmes involved collaboration with NGOs and Child, Youth and Family. Collaboration commonly occured with regard to providing on-site services (n=16, 64%), developing policies and procedures (n=17, 68%), and training (n=15, 60%). Collaboration with Maori providers or representatives was common (n=19, 76%) as was with police and prosecution agencies (n=23, 92%). Seventeen (69%) hospitals collaborated with other providers within their DHB.





- Scores were widely distributed (SD=27).
- The mean score was 45 and the median score was 47.
- 25% of scores were less than 21 and 25% were above 69.

Section 3: Associations with Delphi Scores

While the Delphi scores represent early programme development, some important characteristics predicted higher scores (Table 5). Having a designated coordinator was associated with significantly higher scores, as was the length of the programme.[a] Small hospitals (with less than 100 beds) typically had lower scores than larger hospitals. A similar association was found for location, although this was not significant and notably three of the eight hospitals identified as being located in 'secondary urban' populations had over 100 beds. The association of higher scores with having a designated coordinator, a programme in place for longer, more hospital beds and a larger population base applied to both partner abuse and child abuse and neglect programme scores.

Table 5. Hospital Characteristics and Delphi Score Associations

	Partner Abuse			Child abuse and neglect		
	n	Score	p	n	Score	P
Number of Hospital Beds						
< 100	6	10.0 ± 7.0	.012	6	27.5 ± 15.0	.033
100 +	16	26.3 ± 20.5		16	46.9 ± 18.5	
Location						
Secondary/minor urban	8	16.7 ± 13.9	.353	8	34.1 ± 13.6	.206
Main urban	17	23.3 ± 19.8		17	43.1 ± 20.4	
Programme Coordinator						
No	13	11.7 ± 11.2	.004	11	29.6 ± 14.1	.009
Yes	12	31.4 ± 19.0		14	48.6 ± 18.0	
Length of Programme (months)						
0	10	9.9 ± 7.4	.001	4	22.6 ± 13.1	.021
<24	13	24.6 ± 13.6		7	36.1 ± 12.0	
24 – 48	2	55.2 ± 37.9		5	49.8 ± 24.9	
48+	0			9	46.0 ±17.4	

[a] Both having a coordinator and length of programme are elements included in the Delphi scoring; those elements themselves, however, could not independently account for the differences in overall programme scores.

Discussion

Summary of findings

Results of the baseline audit indicate that child abuse and neglect programmes in Aotearoa/New Zealand acute care hospitals are more developed than those for partner abuse. The overall mean score for the Child Abuse and Neglect Delphi was 40.2 (SD±18.7) compared to 21.2 (SD±18.1) for Partner Abuse. This 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 been in place for four or more years and designated coordinators were in place. Twenty-five percent (n=7) of hospitals had an overall Child Abuse and Neglect programme score greater than 50. Despite having greater development, and some exemplary programmes, there were a number of cases where child abuse and neglect programmes were poorly resourced. There was little evidence of an active Child Abuse and Neglect programme at 16% of the hospitals.

The highest domain scores for child abuse and neglect programmes were achieved for 'Intervention Services' (mean=62.4), which scored substantially higher than any other domain. The lowest domain score for Child Abuse and Neglect was 'Hospital Physical Environment' (mean=24.8).

Hospital scores for partner abuse programmes were consistently lower than for child abuse and neglect, both for overall scores and across the domains. Overall, Partner Abuse scores hovered at the lower end of the scale; the overall score and seven of the nine domains had a median score less than 25. Highest domain scores for Partner Abuse were achieved for 'Collaboration' (mean=35) and 'Intervention Services' (mean=34). The lowest domain score for Partner Abuse was 'Documentation' (mean=6).

Partner Abuse scores reflect early stages of programme implementation and lack of targeted resources to support the programme. 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.

Higher Delphi scores were evident in hospitals with more mature programmes and designated coordinators. 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)[11]. In that study, programme maturation often took five years of continuing development. In this baseline audit, a single hospital scored significantly higher compared to all others. That hospital's Child Abuse and Neglect Programme has been in place for more than four years, a .8 Family Violence Coordinator had been in place for more than a year prior to the audit.

Audit Limitations

Several potential biases to the audit scores were noted by the evaluation team. 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 baseline scores, it is important to be aware that scores 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. In addition, hospitals that were audited later in the nine month data collection period had the advantage of other events and resources that occurred over time. An example of this is the two MOH sponsored family violence coordinator meetings (the first was held in November 2003 and the second in April 2004). However, it is hoped that the follow up audit will capture further programme development across all the hospitals.

During the course of conducting the baseline audits the audit team became aware of a number of limitations to the Child Abuse and Neglect Delphi as it currently stands. The Child Abuse and Neglect Delphi 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. And yet, the current audit significantly extended the information available from the Paediatric Society's 2003 DHB Scorecard[a].

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, such as referral rates. 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 the current level 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, this report had 100% participation by acute care hospitals across the country.

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[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

In some cases the audit visit was the first occasion of bringing together partner abuse and child abuse stakeholders to discuss family violence system competencies. Information on partner abuse and child abuse and neglect activities was collected together in the same site visit. In the process, gaps, contradictions and the need for more links were revealed. The process of the audit having a relatively 'seamless' information collection system as part of the audit highlighted the need for similar seamless service delivery.

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

Conclusions

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 documents 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.

In a climate of increasing attention to the poor Aotearoa/New Zealand statistics for both child abuse and neglect and partner abuse, 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.

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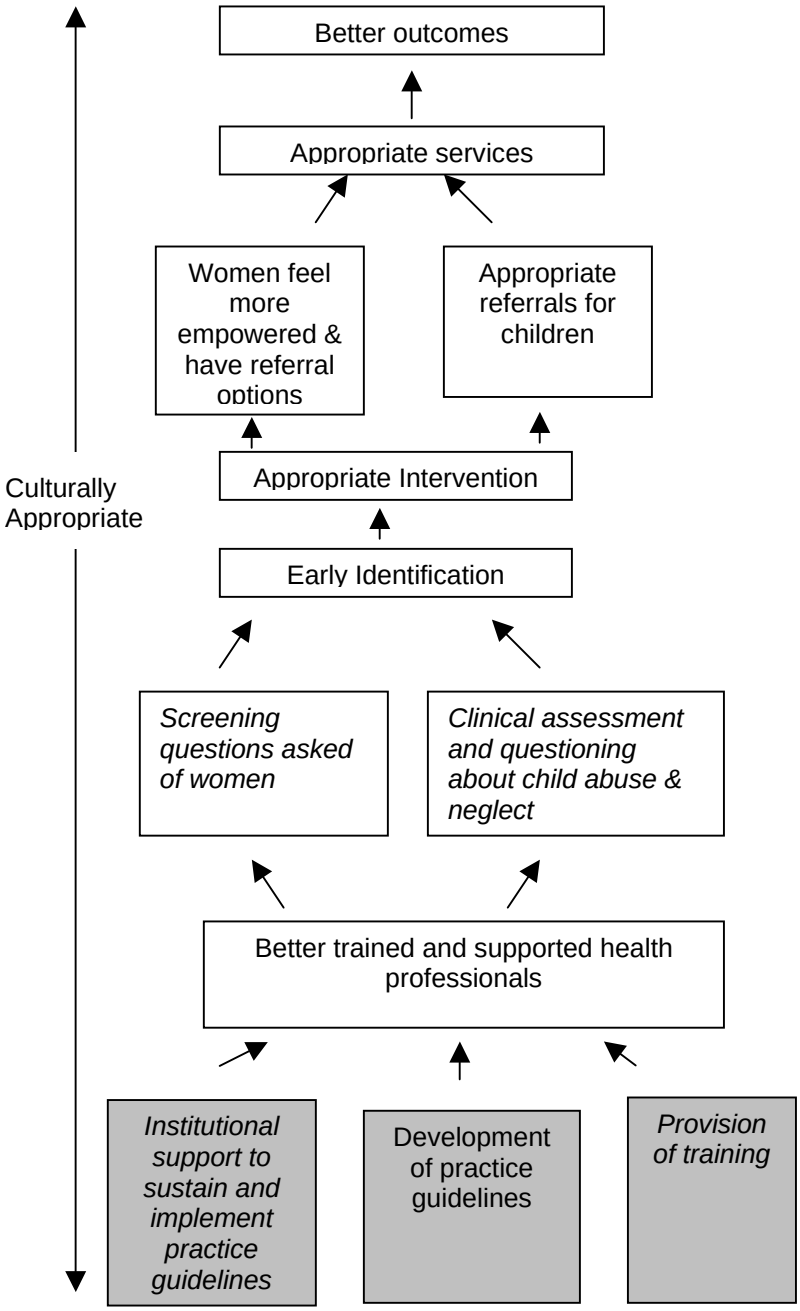
Appendix 1: Family Violence Project Programme Logic[a]



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

Appendix 2: Modified Delphi Tools

a. PARTNER ABUSE PROGRAMME DELPHI

Category 1. Hospital Policies and Procedures

1.1	Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do these policies:	__No (0)	__Yes (1)
	a) define partner abuse?	__No (0)	__Yes (2)
	b) mandate training on partner abuse for any staff?	__No (0)	__Yes (2)
	c) advocate universal screening for women anywhere in the hospital?	__No (0)	__Yes (2)
	d) define who is responsible for screening?	__No (0)	__Yes (2)
	e) address documentation?	__No (0)	__Yes (2)
	f) address referral of victims?	__No (0)	__Yes (2)
	g) address legal reporting requirements?	__No (0)	__Yes (2)
	h) address the responsibilities to, and needs of, Maori?	__**No (0)**	__**Yes (2)**
	i) address the needs of other cultural and/or ethnic groups?	__**No (0)**	__**Yes (2)**
	k) address the needs of LGBT clients?	__**No (0)**	__**Yes (2)**
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the working group:	__No (0)	__Yes (3)
	a) meet at least every month?	__No (0)	__Yes (2)
	b) include representative(s) from more than two departments? List represented departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (2)
	c) include representative(s) from the security department?	__No (0)	__Yes (2)
	d) include physician(s) from the medical staff?	__No (0)	__Yes (2)
	e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?	__No (0)	__Yes (2)
	f) include representative(s) from hospital administration?	__No (0)	__Yes (2)
	g) include Maori representative(s)?	__**No (0)**	__**Yes (2)**
1.3	Does the hospital provide direct financial support for the partner abuse programme? If yes, how much annual funding? (*Choose one*):	__No (0)	__Yes (0)
	a) < $5000/year		__Yes (6)
	b) $5000-$10,000/year	or	__Yes (12)
	c) > $10,000/year	or	__Yes (17)
1.3a	Is funding set aside specifically for Maori programmes and initiatives? If yes, how much annual funding? (*Choose one):*	__**No (0)**	__**Yes (0)**
	a) < $5000/year		__**Yes (6)**

	b) > $5000/year	**or**	__**Yes (12)**
1.4	Is there a mandatory universal screening policy in place? If yes, does the policy require screening of all women: (*choose one*)	__No (0)	__Yes (0)
	a) in the emergency department (ED) or any other out-patient area?		__Yes (6)
	b) in in-patient units only?	or	__Yes (6)
	c) in more than one out-patient area?	or	__Yes (10)
	d) in both in-patient and out-patient areas? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	or	__Yes (14)
1.5	Are there quality assurance procedures in place to ensure partner abuse screening? If yes, are there:	__No (0)	__Yes (0)
	a) regular chart audits to assess screening? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (9)
	b) positive reinforcers to promote screening? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (6)
	c) is there regular supervision? List departments □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	**__No (0)**	**__Yes (6)**
1.6	Are there procedures for security measures to be taken when victims of partner abuse are identified? If yes, are there:	__No (0)	__Yes (0)
	a) written procedures that outline the security department's role in working with victims and perpetrators?	__No (0)	__Yes (6)
	b) procedures that include name/phone block for victims admitted to hospital?	__No (0)	__Yes (3)
	c) procedures that include provisions for safe transport from the hospital to shelter?	__No (0)	__Yes (3)

	d) do these procedures take into account the needs of Maori?	**__No (0)**	**__Yes (3)**
1.7	Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (*choose one*)	__No (0)	__Yes (0)
	a) part time position or included in responsibilities of someone with other responsibilities?		__Yes (8)
	b) full-time position with no other responsibilities?	or	__Yes (12)
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

2.1	Are there posters and/or brochures related to partner abuse on public display in the hospital?	__No (0)	__Yes (0)
	If yes, list total number of *locations* (up to 35): List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health __ Other		(____)
	Are there Maori images related to partner abuse on public display in the hospital?	**__No (0)**	**__Yes (0)**
	If yes, list total number *locations (up to 17)* List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health __ Other		**(____)**
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).	__No (0)	__Yes (0)
	If yes, list total number *locations* (up to 35): List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health __ Other	__No (0)	(____)
	Is there referral information related to Maori providers of partner abuse services on public display in the hospital?	**__No (0)**	**__Yes (0)**
	If yes, list total number *locations (up to 17)* List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health __ Other		**(____)**
	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?	__No (0)	__Yes (0)
	If yes, list total number *locations (up to 17)* List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health __ Other		(____)

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? If yes: (*choose one a-c and answer d*)	__No (0)	__Yes (0)
	a) Victims are permitted to stay in ED until placement is secured.		__Yes (15)
	b) Victims are provided with safe respite room, separate from ED, until placement is secured.	or	__Yes (25)
	c) In-patient beds are available for victims until placement is secured.	or	__Yes (30)
	d) Does the design and use of the safe shelter support Maori cultural beliefs and practices?	**__No (0)**	**__Yes (5)**
Total NZ Score for Category 2 (Sum of all points)=			**/156**
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

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? If yes, which groups have been assessed?	__No (0)	__Yes (0)
	a) nursing staff Participating Departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (7)
	b) medical staff Participating Departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (7)
	c) administration	__No (0)	__Yes (8)
	d) other staff/employees	__No (0)	__Yes (7)
	If yes, did the assessment address staff knowledge and attitude about Maori and partner abuse?	__**No (0)**	__**Yes (7)**
3.2	How long has the hospital's partner abuse programme been in existence? (*Choose one*):		
	a) 1-24 months		__Yes (3)
	b) 24-48 months	or	__Yes (6)
	c) >48 months	or	__Yes (11)
3.3	Does the hospital have plans in place for responding to employees experiencing partner abuse? If yes:	__No (0)	__Yes (0)
	a) Is there a hospital policy covering the topic of partner abuse in the workplace?	__No (0)	__Yes (7)
	b) Does the Employee Assistance Program maintain specific policies and procedures for dealing with employees experiencing partner abuse?	__No (0)	__Yes (7)
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation?	__No (0)	__Yes (7)
3.4	Does the hospital's partner abuse programme address cultural competency issues? If yes:	__No (0)	__Yes (0)
	a) Does the hospital's policy specifically recommend universal screening regardless of the patient's cultural background?	__No (0)	__Yes (6)
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	__No (0)	__Yes (6)
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	__No (0)	__Yes (3)
	d) Are referral information and brochures related to partner abuse available in languages other than English?	__No (0)	__Yes (4)

3.5	Does the hospital participate in preventive outreach and public education activities on the topic of partner abuse? If yes, is there documentation of: (*choose one a-b and answer c*)	__No (0)	__Yes (0)
	a) 1 programme in the last 12 months?		__Yes (15)
	b) >1 programme in the last 12 months?	or	__Yes (20)
	c) Does the hospital collaborate with Maori community organizations and providers to deliver preventive outreach and public education activities?	**__No (0)**	**__Yes (20)**
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

4.1	Has a formal training plan been developed for the institution? If yes:	__No (0)	__Yes (10)
	a) Does the plan include the provision of regular, ongoing education for clinical staff? Participating Departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (10)
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	__No (0)	__Yes (10)
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: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (15)
	b) to members of the clinical staff via colloquia or other sessions?	__No (0)	__Yes (15)
4.3	Does the hospital's training/education on partner abuse include information about:		
	a) definitions of partner abuse?	__No (0)	__Yes (1)
	b) dynamics of partner abuse?	__No (0)	__Yes (1)
	c) epidemiology?	__No (0)	__Yes (1)
	d) health consequences?	__No (0)	__Yes (1)
	e) strategies for screening?	__No (0)	__Yes (1)
	f) risk assessment?	__No (0)	__Yes (1)
	g) documentation?	__No (0)	__Yes (1)
	h) intervention?	__No (0)	__Yes (1)
	i) safety planning?	__No (0)	__Yes (1)
	j) community resources?	__No (0)	__Yes (1)
	k) reporting requirements?	__No (0)	__Yes (1)
	l) legal issues?	__No (0)	__Yes (1)
	m) confidentiality?	__No (0)	__Yes (1)
	n) cultural competency?	__No (0)	__Yes (1)
	o) clinical signs/symptoms?	__No (0)	__Yes (1)
	p) Maori models of health?	**__No (0)**	**__Yes (1)**
	q) risk assessment for children of victims?	**__No (0)**	**__Yes (1)**
	r) the social, cultural, historic, and economic context in which Maori family violence occurs?	**__No (0)**	**__Yes (1)**
	s) te Tiriti o Waitangi?	**__No (0)**	**__Yes (1)**
	t) Maori service providers and community resources?	**__No (0)**	**__Yes (1)**

	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Maori?	**__No (0)**	**__Yes (1)**
	v) partner abuse in same-sex relationships?	**__No (0)**	**__Yes (1)**
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships?	**__No (0)**	**__Yes (1)**
4.4	Is the partner abuse training provided by: (*choose one a-d and answer e-f*)		
	a) no training provided		__Yes (0)
	b) a single individual?	Or	__Yes (10)
	c) a team of hospital employees only? List departments represented: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	Or	__Yes (15)
	d) a team, including community expert(s)?	Or	__Yes (25)
	If provided by a team, does it include:		
	e) a Maori representative?	**__No (0)**	**__Yes (15)**
	f) a representative(s) of other ethnic/cultural groups?	**__No (0)**	**__Yes (15)**
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

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*)	__No (0)	__Yes (0)
	a) included, as a separate form, in the clinical record?		__Yes (20)
	b) incorporated as questions in the clinical record for all charts in ED or other out-patient area?	or	__Yes (25)
	c) incorporated as questions in the clinical record for all charts in two or more out-patient areas?	or	__Yes (30)
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas?	or	__Yes (36)
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		__Yes (0)
	b) 0% - 10%	or	__Yes (4)
	c) 11% - 25%	or	__Yes (9)
	d) 26% - 50%	or	__Yes (18)
	e) 51% - 75%	or	__Yes (28)
	f) 76% - 100%	or	__Yes (37)
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this:	__No (0)	__Yes (27)
	a) also assess the safety of any children in the victim's care?	**__No (0)**	**__Yes (27)**
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

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:	__No (0)	__Yes (0)
	a) information on the results of partner abuse screening?	__No (0)	__Yes (10)
	b) the victim's description of current and/or past abuse?	__No (0)	__Yes (10)
	c) the name of the alleged perpetrator and relationship to the victim?	__No (0)	__Yes (10)
	d) a body map to document injuries?	__No (0)	__Yes (10)
	e) information documenting the referrals provided to the victim?	__No (0)	__Yes (10)
	f) in the case of Maori, information documenting whether the individual was offered a Maori advocate?	**__No (0)**	**__Yes (5)**
6.2	Is forensic photography incorporated in the documentation procedure? If yes:	__No (0)	__Yes (0)
	a) Is a fully operational camera with adequate film available in the treatment area?	__No (0)	__Yes (10)
	b) Do hospital staff receive on-going training on the use of the camera?	__No (0)	__Yes (10)
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	__No (0)	__Yes (10)
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	__No (0)	__Yes (10)
	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?	__No (0)	__Yes (10)
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

7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	__No (0)	__Yes (14)
7.2	Are "on-site" victim advocacy services provided? If yes, *choose one a-b and answer c-d)*:	__No (0)	__Yes (0)
	a) A trained victim advocate provides services during certain hours.		__Yes (10)
	b) A trained victim advocate provides service at all times.	or	__Yes (20)
	c) is a Maori advocate is available “on-site” for Maori victims?	__**No (0)**	__**Yes (20)**
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Maori is available onsite? If yes, list ethnicity:	__**No (0)**	__**Yes (20)**
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose one*)	__No (0)	__Yes (0)
	a) available, when indicated?		__Yes (5)
	b) performed routinely?	or	__Yes (9)
7.4	Is transportation provided for victims, if needed?	__No (0)	__Yes (10)
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment?	__No (0)	__Yes (15)
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims?	__No (0)	__Yes (9)
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims?	__No (0)	__Yes (11)
7.8	Is there evidence of coordination between the hospital partner abuse programme and sexual assault, mental health and substance abuse screening and treatment?	__No (0)	__Yes (12)
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

8.1	Are any formal evaluation procedures in place to monitor the quality of the partner abuse programme? If yes:	__No (0)	__Yes (25)
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening? Participating departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (18)
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse? Participating departments: □ Emergency □ Paediatric □ Maternity □ Mental Health Other:	__No (0)	__Yes (17)
8.2	Do health care providers receive standardized feedback on their performance and on patients?	__No (0)	__Yes (21)
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme?	__No (0)	__Yes (19)
8.4	Is the quality framework *He Taura Tieke* (or an equivalent) used to evaluate whether services are effective for Maori?	**__No (0)**	**__Yes (25)**
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

9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	__No (0)	__Yes (0)
	a) which types of collaboration apply:		
	i) collaboration with training?	__No (0)	__Yes (10)
	ii) collaboration on policy and procedure development?	__No (0)	__Yes (10)
	iii) collaboration on partner abuse working group?	__No (0)	__Yes (10)
	iv) collaboration on site service provision?	__No (0)	__Yes (12)
	b) is collaboration with		
	i) Maori provider(s) or representative(s)?	__**No (0)**	__**Yes (10)**
	iii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Maori?	__**No (0)**	__**Yes (10)**
	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:	__No (0)	__Yes (0)
	a) collaboration with training?	__No (0)	__Yes (11)
	b) collaboration on policy and procedure development?	__No (0)	__Yes (11)
	c) collaboration on partner abuse working group?	__No (0)	__Yes (12)
	c) List collaborating agencies (eg., police, courts):		
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	__No (0)	__Yes (0)
	a) within the same health care system?	__No (0)	__Yes (12)
	If yes, with a Maori health unit?	__**No (0)**	__**Yes (12)**
	b) with other systems in the region?	__No (0)	__Yes (12)
	If yes, with a Maori health provider?	__**No (0)**	__**Yes (12)**
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

b. CHILD ABUSE AND NEGLECT PROGRAMME DELPHI

Category 1. Hospital Policies and Procedures

1.1	Are there official, written hospital policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If yes, do these policies:	__No (0)	__Yes (1)
	a) define child abuse and neglect?	__No (0)	__Yes (2)
	b) mandate training on child abuse and neglect for any staff?	__No (0)	__Yes (2)
	c) outline age-appropriate protocols for risk assessment?	__No (0)	__Yes (2)
	d) define who is responsible for risk assessment?	__No (0)	__Yes (2)
	e) address the issue of contamination?	__No (0)	__Yes (2)
	f) address documentation?	__No (0)	__Yes (2)
	g) address referrals for children and their families?	__No (0)	__Yes (2)
	h) address child protection reporting requirements?	__No (0)	__Yes (2)
	i) address the responsibilities to, and needs of, Maori?	__No (0)	__Yes (2)
	i) address the needs of other cultural and/or ethnic groups?	__No (0)	__Yes (2)
1.2	Is there evidence of a hospital-based child abuse and neglect working group? If yes, does the working group:	__No (0)	__Yes (3)
	a) meet at least every month?	__No (0)	__Yes (2)
	b) include representatives from more than two departments? List represented departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (2)
	c) include representative(s) from the security department?	__No (0)	__Yes (2)
	d) include physician(s) from the medical staff?	__No (0)	__Yes (2)
	e) include representative(s) from Child Youth and Family?	__No (0)	__Yes (2)
	f) include representative(s) from hospital administration?	__No (0)	__Yes (2)
	g) include representative(s) from an agency or programme involved in partner abuse advocacy?	__No (0)	__Yes (2)
	h) include representative(s) from community-based children's services?	__No (0)	__Yes (2)
	i) include at least two youth representatives?	__No (0)	__Yes (2)
	j) include Maori representative(s)?	__No (0)	__Yes (2)
1.3	Does the hospital provide direct financial support for the child abuse and neglect programme? If yes, how much annual funding? (*Choose one of a-c and answer d*):	__No (0)	__Yes (0)

	a) < $5000/year		__Yes (6)
	b) $5000-$10,000/year	or	__Yes (12)
	c) > $10,000/year	or	__Yes (17)
	d) Is funding set aside specifically for Maori programmes and initiatives? If yes, how much annual funding?	__No (0)	__Yes (0)
	i) < $5000/year		__Yes (6)
	ii) > $5000/year		__Yes (12)
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? If yes, does the policy include children: (choose one)	__No (0)	__Yes (0)
	a) in the emergency department (ED) or any other out-patient area?		__Yes (6)
	b) in in-patient units only?	or	__Yes (6)
	c) in more than one out-patient area?	or	__Yes (10)
	d) in both in-patient and out-patient areas? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	or	__Yes (14)
1.5	Are there quality assurance procedures in place to ensure the clinical assessment policy for identifying child abuse and neglect is implemented? If yes:	__No (0)	__Yes (0)
	a) are there regular chart audit to assess whether signs and symptoms of child abuse and neglect are investigated? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (5)
	b) is there regular peer review? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (5)

	c) is there regular supervision? List departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (5)
	d) is there regular feedback from Child Youth and Family (CYF)?	__No (0)	__Yes (5)
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? If yes, are there:	__No (0)	__Yes (0)
	a) written procedures that outline the security department's role in working with victims and their families and perpetrators?	__No (0)	__Yes (6)
	b) procedures that include name/phone block for children and their families admitted to hospital?	__No (0)	__Yes (3)
	c) procedures that include provisions for safe transport from the hospital to shelter?	__No (0)	__Yes (3)
	d) do these procedures take into account the needs of Maori?	__No (0)	__Yes (3)
1.7	Is there an identifiable child protection coordinator at the hospital? If yes is it a: (*choose one*)	__No (0)	__Yes (0)
	a) part time position or included in responsibilities of someone with other responsibilities?		__Yes (8)
	b) full-time position with no other responsibilities?	or	__Yes (12)
Total Score for Category 1 (Sum of all points) =			**/134**
Standardised Score for Category 1 =			**/100**

Category 2. Hospital Physical Environment

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?	__No (0)	__Yes (0)
	If yes, list total number of *locations* (up to 35): List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health, including Child and Youth Mental Health __ Other		(____)
	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?	__No (0)	__Yes (0)
	If yes, list total number of *locations* (up to 35): List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health, including Child and Youth Mental Health __ Other		(____)
	Are there Maori images related to child abuse and neglect on public display in the hospital?	__No (0)	__Yes (0)
	If yes, list total number *locations (up to 17)* List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health, including Child and Youth Mental Health __ Other		(____)
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).	__No (0)	__Yes (0)
	If yes, list total number *locations* (up to 35): List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health, including Child and Youth Mental Health __ Other		(____)
	Is there referral information related to Maori providers of child advocacy services on public display in the hospital?	__No (0)	__Yes (0)

	If yes, list total number *locations (up to 17)* List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health, including Child and Youth Mental Health __ Other		(____)
	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?	__No (0)	__Yes (0)
	If yes, list total number *locations (up to 17)* List number per department: __ Emergency __ Paediatric __ Maternity __ Mental Health, including Child and Youth Mental Health __ Other		(____)
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? If yes: (*choose one a-c and answer d*)	__No (0)	__Yes (0)
	a) Children and their families are permitted to stay in ED until placement is secured.		__Yes (15)
	b) Children and their families are provided with safe respite room, separate from ED, until placement is secured.	or	__Yes (25)
	c) In-patient beds are available for children and their families until placement is secured.	or	__Yes (30)
	d) Does the design and use of the safe shelter support Maori cultural beliefs and practices?	__No (0)	__Yes (5)
Total Score for Category 2 (Sum of all points) =			**/175**
Standardised Score for Category 2 =			**/100**

Category 3. Institutional Culture

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? If yes, which groups have been assessed?	__No (0)	__Yes (0)
	a) nursing staff Participating Departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (7)
	b) medical staff Participating Departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (7)
	c) administration	__No (0)	__Yes (8)
	d) other staff/employees	__No (0)	__Yes (7)
	If yes, did the assessment address staff knowledge and attitude about Maori and child abuse and neglect?	__No (0)	__Yes (7)
3.2	How long has the hospital's child abuse and neglect programme been in existence? (*Choose one*):		
	a) 1-24 months		__Yes (3)
	b) 24-48 months	or	__Yes (6)
	c) >48 months	or	__Yes (11)
3.3	Does the hospital's child abuse and neglect programme address cultural competency issues? If yes:	__No (0)	__Yes (0)
	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?	__No (0)	__Yes (6)
	b) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	__No (0)	__Yes (6)
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	__No (0)	__Yes (3)
	d) Are referral information and brochures related to child abuse and neglect available in languages other than English?	__No (0)	__Yes (4)
3.4	Does the hospital participate in preventive outreach and public education activities on the topic of child abuse and neglect? If yes, is there documentation of: (*choose one of a-b and answer c)*	__No (0)	__Yes (0)
	a) 1 programme in the last 12 months?		__Yes (15)
	b) >1 programme in the last 12 months?	or	__Yes (20)

	c) Does the hospital collaborate with Maori community organizations and providers to deliver preventive outreach and public education activities?	__No (0)	__Yes (20)
Total Score for Category 3 (Sum of all points) =			**/106**
Standardised Score for Category 3 =			**/100**

Category 4. Training of Providers

4.1	Has a formal training plan been developed for the institution? If yes:	__No (0)	__Yes (10)
	a) Does the plan include the provision of regular, ongoing education for clinical staff? Participating Departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (10)
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	__No (0)	__Yes (10)
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: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (15)
	b) to members of the clinical staff via colloquia or other sessions?	__No (0)	__Yes (15)
4.3	Does the hospital's training/education on child abuse and neglect include information about:		
	a) definitions of child abuse and neglect?	__No (0)	__Yes (1)
	b) dynamics of child abuse and neglect?	__No (0)	__Yes (1)
	c) child advocacy	__No (0)	__Yes (1)
	d) child-focused interviewing	__No (0)	__Yes (1)
	e) issues of contamination	__No (0)	__Yes (1)
	f) ethical dilemmas?	__No (0)	__Yes (1)
	g) conflict of interest	__No (0)	__Yes (1)
	h) epidemiology?	__No (0)	__Yes (1)
	i) health consequences?	__No (0)	__Yes (1)
	j) identifying high risk indicators?	__No (0)	__Yes (1)
	k) physical signs and symptoms?	__No (0)	__Yes (1)
	l) documentation?	__No (0)	__Yes (1)
	m) intervention?	__No (0)	__Yes (1)
	n) safety planning?	__No (0)	__Yes (1)
	o) community resources?	__No (0)	__Yes (1)
	p) child protection reporting requirements?	__No (0)	__Yes (1)
	q) linking with Child Youth and Family?	__No (0)	__Yes (1)
	r) confidentiality?	__No (0)	__Yes (1)
	s) age appropriate assessment and intervention?	__No (0)	__Yes (1)
	t) cultural competency?	__No (0)	__Yes (1)
	u) link between partner violence and child abuse and neglect?	__No (0)	__Yes (1)

	v) Maori models of health?	__No (0)	__Yes (1)
	w) the social, cultural, historic, and economic context in which Maori family violence occurs?	__No (0)	__Yes (1)
	x) te Tiriti o Waitangi?	__No (0)	__Yes (1)
	y) Maori service providers and community resources?	__No (0)	__Yes (1)
	z) Service providers and community resources for ethnic and cultural groups other than Pakeha and Maori?	__No (0)	__Yes (1)
4.4	Is the child abuse and neglect training provided by: (*choose one of a-d and answer e-f)*		
	a) no training provided		__Yes (0)
	b) a single individual?	Or	__Yes (10)
	c) a team of hospital employees only? List departments represented: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	Or	__Yes (15)
	d) a team, including community expert(s)?	Or	__Yes (25)
	If provided by a team, does it include:		
	e) a Child Youth and Family statutory social worker?	__**No (0)**	__Yes (15)
	f) a Maori representative?	__**No (0)**	__Yes (15)
	g) a representative(s) of other ethnic/cultural groups?	__No (0)	__Yes (15)
Total Score for Category 4 (Sum of all points) =			**/156**
Standardised Score for Category 4 =			**/100**

Category 5. Documentation

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:	__No (0)	__Yes (0)
	a) information generated by risk assessment?	__No (0)	__Yes (10)
	b) the victim or caregiver's description of current and/or past abuse?	__No (0)	__Yes (10)
	c) the name of the alleged perpetrator and relationship to the victim?	__No (0)	__Yes (10)
	d) a body map to document injuries?	__No (0)	__Yes (10)
	e) information documenting the referrals provided to the victim and their family?	__No (0)	__Yes (10)
	f) in the case of Maori, information documenting whether the victim and their family were offered a Maori advocate?	__No (0)	__Yes (5)
5.2	Is a standardised safety assessment performed for children? If yes:	__No (0)	__Yes (25)
	a) Does this also assess the safety of the child's mother?	__No (0)	__Yes (25)
Total Score for Category 5 (Sum of all points) =			**/105**
Standardised Score for Category 5 =			**/100**

Category 6. Intervention Services

6.1	Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified?	__No (0)	__Yes (14)
6.2	Are child protection services available "on-site"? If yes, *choose one of a-b and answer c-d*:	__No (0)	__Yes (0)
	a) A member of the child protection team or social worker provides services during certain hours.		__Yes (10)
	b) A member of the child protection team or social worker provides service at all times.	Or	__Yes (20)
	c) A Maori advocate or social worker is available “on-site” for Maori victims.	__No (0)	__Yes (20)
	d) An advocate of ethnic and cultural background other Pakeha and Maori is available onsite. If yes, list ethnicity:	__No (0)	__Yes (20)
6.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose one of a-b and answer c*)	__No (0)	__Yes (0)
	a) available, when indicated?		__Yes (5)
	b) performed routinely?	Or	__Yes (9)
	c) age-appropriate?	__No (0)	__Yes (10)
6.4	Is transportation provided for victims and their families, if needed?	__No (0)	__Yes (10)
6.5	Does the hospital child abuse and neglect programme include follow-up contact and counseling with victims after the initial assessment?	__No (0)	__Yes (15)
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?	__No (0)	__Yes (9)
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?	__No (0)	__Yes (11)
6.8	Is there evidence of coordination between the hospital child abuse and neglect programme and the partner abuse and sexual assault programmes?	__No (0)	__Yes (12)
6.9	Is there evidence of coordination with CYF?	__No (0)	__Yes (12)
Total Score for Category 6 (Sum of all points) =			**/162**
Standardised Score for Category 6 =			**/100**

Category 7. Evaluation Activities

7.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:	__No (0)	__Yes (25)
	a) Do evaluation activities include periodic monitoring of the implementation of the child abuse and neglect clinical assessment policy? Participating departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (18)
	b) Is the evaluation process standardised? Participating departments: □ Emergency □ Paediatric □ Maternity □ Mental Health, including Child and Youth Mental Health Other:	__No (0)	__Yes (5)
	c) Do evaluation activities measure outcomes, either for entire child abuse and neglect programme or components thereof?	__No (0)	__Yes (18)
7.2	Do health care providers receive standardized feedback on their performance and on patients from CYF?	__No (0)	__Yes (21)
7.3	Is there any measurement of client satisfaction and/or community satisfaction with the child abuse and neglect programme?	__No (0)	__Yes (19)
7.4	Is the quality framework *He Taura Tieke* (or an equivalent) used to evaluate whether services are effective for Maori?	__No (0)	__Yes (25)
Total Score for Category 7 (Sum of all points) =			**/131**
Standardised Score for Category 7 =			**/100**

Category 8. Collaboration

8.1	Does the hospital collaborate with NGO and CYF child advocacy and protection ? If yes,	__No (0)	__Yes (0)
	a) which types of collaboration apply:		
	i) collaboration with training?	__No (0)	__Yes (10)
	ii) collaboration on policy and procedure development?	__No (0)	__Yes (10)
	iii) collaboration on child abuse and neglect task force?	__No (0)	__Yes (10)
	iv) collaboration on site service provision?	__No (0)	__Yes (12)
	b) is collaboration with:		
	i) Maori provider(s) or representative(s)?	__No (0)	__Yes (10)
	ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Maori?	__No (0)	__Yes (10)
	List collaborating organisations:		
8.2	Does the hospital collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply:	__No (0)	__Yes (0)
	a) collaboration with training?	__No (0)	__Yes (11)
	b) collaboration on policy and procedure development?	__No (0)	__Yes (11)
	c) collaboration on child abuse and neglect task force?	__No (0)	__Yes (12)
	List collaborating agencies:		
8.3	Is there collaboration with the child abuse and neglect programme of other health care facilities? If yes, which types of collaboration apply:	__No (0)	__Yes (0)
	a) within the same health care system?	__No (0)	__Yes (12)
	If yes, with a Maori health unit?	__No (0)	__Yes (12)
	b) with other systems in the region?	__No (0)	__Yes (12)
	If yes, with a Maori health provider?	__No (0)	__Yes (12)
Total NZ Score for Category 8 (Sum of all points) =			**/144**
Standardised NZ Score for Category 8 =			**/100**

Appendix 3: 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 4: 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

Appendix 5: DHB Maps

Link to:

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 6: Letter to DHB

30 September 2003

Dear

Re: Family Violence Response Evaluation

The Ministry of Health has contracted AUT to audit the implementation of the Family Violence Intervention Guidelines (see attached letter).

I am writing to, firstly, provide you with details about the audit process, secondly, seek your consent as part of the ethics approval process and, thirdly, introduce you to key members of the research team.

The Audit Process
All secondary and tertiary acute care hospitals in Aotearoa/New Zealand will be audited twice; once at baseline and again twelve months later. The on-site audit, which takes approximately four hours, covers nine domains ranging from screening and assessment to cultural competency.

The Family Violence Project Liaison at your hospital will need approximately 4 to 24 hours to prepare materials for the audit. Please note that only aggregate hospital data will be examined in the audit. The audit does not involve any review of patient records.

I would like to stress that the audit process is a collaborative exercise that aims to build the capacity of acute care hospitals to respond effectively to women and children at risk for family violence. To this end, each hospital is provided with a confidential report within approximately one week of the audit.

The research team understands that hospitals around Aotearoa/New Zealand will for a variety of reasons have different strengths and weaknesses in this area. Some will only just be beginning to implement family violence programmes. The purpose of this audit is to assist you in programme implementation by identifying how your site can, firstly, improve on weaknesses in the way it currently responds to family violence and, secondly, continue to build on its strengths.

Confidentiality
A coding system will be used to protect the identity of each hospital. The Family Violence Project Liaison will be informed of the code assigned to your hospital. This code allows you to identify your performance in relation to other hospitals. The Ministry of Health will be provided with the codes for in-house use only. DHBs also will not be identified in any reports or publications.

Ethical Approval
The Auckland Regional Health and Disability Ethics Committee, which is the lead committee for this application, has requested that the General Manager or CEO of every participating hospital complete a declaration of approval.

I enclose a one page summary of our research proposal along with a copy of our ethics application, which provides a more detailed description of the audit. We request that you complete the ***Part V: Declaration***, which is appended to the front of the ethics application for your convenience, and return it to us as soon as possible in the freepost envelope provided.

If you have any questions about the ethics approval process or the declaration, please do not hesitate to contact me.

Scheduling
Once we have received your Part V declaration and submitted it to Ethics Committee, Eva Neitzert will contact the Family Violence Project Liaison at your hospital to arrange a convenient time for the audit. Audits will be conducted between October 2003 and March 2004.

Research Team
The audit is being conduct by a team of researchers led by myself, Dr Jane Koziol-McLain. Please contact me by telephone (09 917 9670) or email (jane.koziol-mclain@aut.ac.nz) if you have any questions regarding your participation.

A full-time Research Officer, Eva Neitzert, will be conducting the on-site hospital audits. Please direct questions and comments about the audit process to her. She can be contacted by telephone (09 917 9999 x 7115) and email (eva.neitzert@aut.ac.nz).

The Ministry of Health contact person for this project is Jo Elvidge. Please also feel free to contact her on 04 496 2000 or jo_elvidge@moh.govt.nz in regards to the study.

Kind regards,

Assoc-Prof Jane Koziol-McLain, PhD RN
Interdisciplinary Trauma Research Unit (ITRU)

Cc: Family Violence Project Liaison/Co-ordinator

Appendix 7: Audit Document Checklist

Documents for Family Violence Evaluation

- All written hospital policies, protocols and procedures regarding family violence

- Relevant department-specific policies and procedures regarding family violence (eg., Emergency Department, Security Department, Maternity Services)

- Documentation of the hospital's family violence working group or committee including:
  - Roster of participating individuals, departments, and agencies
  - Schedule of meeting dates
  - Prior meeting minutes or notes

- Any documents relating to policies, protocols, procedures, or services for Maori women and children

- Any documents relating to policies, protocols, procedures, or services for women and children of other specific ethnic and cultural groups (eg., Asian, Pacific Peoples, LGBT)

- Materials used and/or distributed in any family violence training for hospital staff

- Schedules of planned trainings or strategic plans for training employees

- Forms or checklists used for family violence programmes including:
  - Domestic violence screening forms
  - Standardised documentation forms
  - Consent to photograph forms for family violence cases
  - Intervention checklists for staff to use when victims are identified
  - Standardised safety assessment forms
  - Referral forms

- Documentation of hospital intervention procedures, including relationships with external agencies

- Information on prior evaluations used as part of the programme including:
  - Assessments of staff attitude and knowledge of family violence
  - Prior chart audits to assess for family violence screening
  - Other documented evaluation procedures

- Documentation of hospital preventive outreach and public education on the topic of family violence

- Documentation of any collaborations/links with community organisations and government agencies for the purposes of training, programme development, or service delivery

- Information on financial resources that the hospital provides for the family violence program, including funding for staff involved in family violence programme co-ordination

- Information on support services for employees who are victims or perpetrators of domestic violence

- Copies of brochures, pamphlets, or referral cards for victims of family violence and the public in the hospital

  If routine screening has been introduced in your hospital, a chart review to determine compliance should also be conducted. Please review a random sample of charts from areas of the hospital where routine screening has been introduced (eg., the Emergency Department). The percentage of female patients who were screened for family violence, based on chart documentation, should be recorded.