HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

84 MONTH FOLLOW-UP EVALUATION

MINISTRY OF HEALTH
MANATŪ HAUORA

VIP
violence intervention programme

Interdisciplinary Trauma Research Centre
Te wairere au noa

AUT UNIVERSITY

HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE: 84 MONTH FOLLOW-UP EVALUATION

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This evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal including 30/08/2010).

For more information visit www.aut.ac.nz/vipevaluation

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

Correction
There were minor errors (difference of not more than 2) in previous reports of the 30 month follow up percent of hospitals achieving the target score and child abuse and neglect cultural responsiveness median score. These have been corrected in this report.

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EXECUTIVE SUMMARY

The Ministry 's **Violence Intervention Programme (VIP)** seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. An external evaluation project provides information to District Health Boards (DHBs) and the Ministry about the implementation of VIP. This 84 month follow-up report documents the development of DHB family violence systems responses across six rounds of hospital audits from 2004 to 2011. The data are the result of applying the New Zealand *Partner Abuse Programme* and *Child Abuse and Neglect Programme* evaluation tools to measure system indicators at 27 hospitals (20 DHBs).

The 84 month follow-up evaluation mirrored earlier evaluation processes with the following changes:

- Addition of a self audit component
- Identification (naming) of District Health Boards in national reporting
- Expectation that 75% of hospitals would achieve the target score (70) in both partner abuse and child abuse and neglect programmes by July 2011.

This evaluation answered the following questions:

1. How are New Zealand District Health Boards performing in terms of institutional support for family violence prevention?
2. Is institutional change sustained over time?
3. Do self audit scores accurately represent programme system development?

Key findings

- Programme implementation scores indicate significant growth over time in DHB systems to support family violence prevention and intervention (see Figure 1).
- 24 of 27 (89%) hospitals have achieved the target score (≥ 70) in both partner abuse and child abuse and neglect programmes.

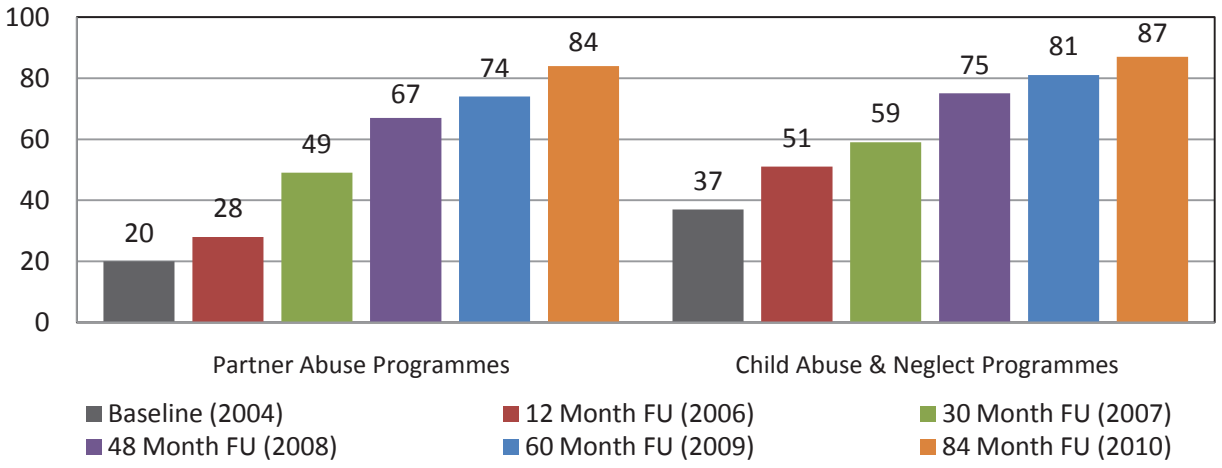


Figure 1. Median Hospital VIP Programme Scores (2004-2011)

Self Audits

The overall partner abuse programme median self audit score was 84, compared to the median external audit score of 85. Among the 24 hospitals submitting near complete self audits (at least 92% of indicators), agreement between self and external overall partner abuse programme scores was 'Almost Perfect'[3] (ICC=.926; 95% confidence interval .83, .97).

The overall child abuse and neglect programme median self audit score was 92, compared to the median external audit score of 87. Among the 24 hospitals submitting near complete self audits (at least 92% of indicators), agreement between self and external child abuse and neglect programme scores was 'Moderate'[3] (ICC=.488; 95% confidence intervals .09, .75), with wide confidence intervals.

All DHBs are scheduled to conduct a second self audit for the 96 month follow up audit round (2011-2012). This second self audit will build on the 84 month process and documentation and support the transition from external to self audit as programmes evidence sustainability.

Cultural Responsiveness and Whānau Ora

VIP recognises culturally responsive health systems contribute to reducing health inequalities. Additional Whānau Ora workforce development funding and resources provided for DHBs in 2010 created opportunities for DHBs to improve service delivery for Māori. As these initiatives are developed, it is anticipated VIP responsiveness to Māori victims of family violence will improve and cultural indicator scores will increase.

10 (37%) partner abuse programmes and 8 (30%) child abuse and neglect programmes have evaluated whether their VIP programme services are effective for Māori.

There have already been increases in cultural responsiveness domain scores between the 60 and 84 month follow up audits. VIP partner abuse cultural responsiveness score increased from 80 to 87, an increase of 7 (9%). VIP child abuse and neglect cultural responsiveness score increased from 75 to 86, an increase of 11 (15%). Therefore with the additional funding and resources it is hoped that there will continue to be increased improvement in this area.

While past under-performing indicators increased in development since the last audit, Whānau Ora workforce development initiatives had not yet been implemented across all DHBs at the time of the 84 month follow up audit.

Conclusions

New Zealand District Health Boards (DHBs) continue to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. Seventeen DHBs have achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes. This 85% achievement rate (17/20 DHBs) exceeds the Ministry of Health's aim for 75% achievement by July 2011. VIP expects 100% of DHBs to achieve the target score by June 2013.

While programmes are doing well overall, there are still significant gaps. Implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse [4] (*The Guidelines*) across target services is still in progress. Many DHBs have yet to roll out their VIP to all targeted services. And for those implementing *The Guidelines,* increasing service delivery and quality continues to present challenges.

BACKGROUND

Family violence (FV) is recognised to have significant social, economic, and health tolls internationally and in Aotearoa New Zealand.[4-12] With the identification of family violence as a preventable public health problem,[13] the Ministry of Health ('the Ministry') began a Family Violence Health Intervention Project in 2001 (see Appendix A). In 2007, The Ministry launched the renamed Violence Intervention Programme (VIP) in District Health Boards (DHBs). VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme is part of the health sector response which is one component of the multi-agency approach to reduce family violence in New Zealand led by Government's Taskforce for Action on Violence within Families.[14]

VIP is premised on a standardised systems approach supported by six programme components funded by the Ministry (Figure 2). These components include:

- District Health Board Family Violence Intervention Coordinators (FVIC)
- Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse
- Resources that include a Ministry Family Violence website, a VIP section on the Health Improvement and Innovation Resource Centre (HIIRC) website, posters, cue cards, pamphlets and VIP Quality Improvement Toolkit
- Technical advice and national networking including a National VIP Manager for DHBs, Whānau Ora Advisor, and national FVIC networking meetings
- National Training contracts
- External evaluation of DHB family violence responsiveness.

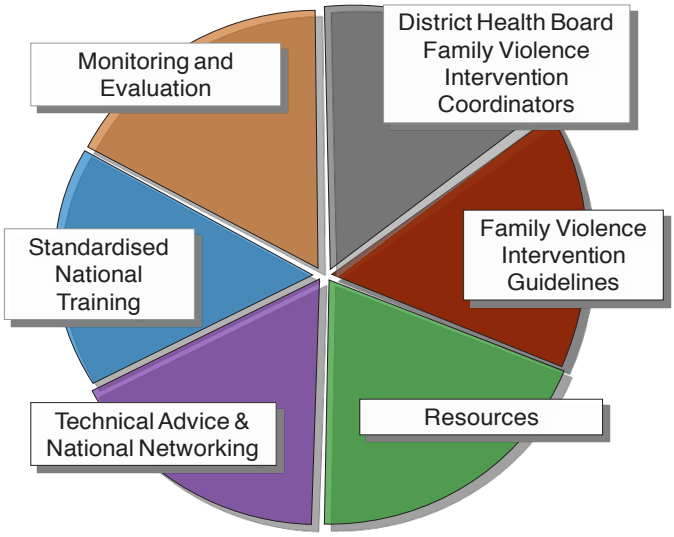


Figure 2. Ministry of Health VIP Systems Support Model (Secondary Care)

The VIP external evaluation project, operating since 2003, provides information to DHBs and the Ministry about the implementation of family violence programmes.[a] This 84 month follow-up report documents the development of DHB family violence systems response across six rounds of hospital audits. This longitudinal data contribute to the nationwide picture of family violence healthcare initiatives across Aotearoa New Zealand acute care services. The quantitative data are the result of applying an audit tool to measure system indicators at 27 hospitals across 20 District Health Boards.

The 84 month follow-up evaluation mirrored earlier evaluation processes[15] with the following changes:

- Addition of a self audit component
- Identification (naming) of District Health Boards in national reporting
- Expectation 75% of hospitals would achieve the target score (70) in both partner abuse and child abuse and neglect programmes by July 2011.

[a] For the full series of evaluation reports go to: www.aut.ac.nz/vipevaulation

A self audit process in conjunction with external audit recognises increasing programme maturity across DHBs, supporting a transition from external audit to self audit (see Appendix C).

A self audit, conducted by the person in charge of the process (such as the FVIC), involves self-examination of the audit evidence against objective audit criteria to facilitate performance improvement. Self audit allows for identification of strengths, weaknesses, opportunities for improvement and prevention of problems (see Self Audit Box).[16,17] The self auditor is also able to incorporate findings immediately into programme planning.

Conducting a self audit in conjunction with an external audit creates the unique opportunity to evaluate and improve programme performance, combining both the auditee knowledge of programme strengths and weaknesses with external, objective assessment of audit criteria.[16,17] Both the external auditor and auditee work together in achieving quality.

Conducting a self audit alongside an external audit also provides the opportunity to evaluate the process and accuracy of self audit. Learning from this, we were able to consider recommendations for future monitoring to ensure programme sustainability and encourage continuing programme quality improvements.

Self Audit Enables:

- Identification of strengths, weaknesses and opportunities for improvement
- Prevention of problems
- A meaningful and effective audit
- Auditor empowerment and motivation
- Auditor interest and initiative for real opportunities for performance improvement (not just compliance)
- Development of audit feedback and strategies that work locally
- Incorporation of findings into strategic planning
- A culture of continuous improvement

This evaluation sought to answer the following questions:

1. How are New Zealand District Health Boards performing in terms of institutional support for family violence prevention?

2. Is institutional change sustained over time?

3. Do self audit scores accurately represent programme system development?

The evaluation is an important component of the Ministry's efforts to reduce and prevent the health impacts of family violence:

> "This evaluation project supports the collaborative development of an evidence-based violence prevention programme to reduce and prevent the health impacts of family violence. Audit processes and reports provide useful information to guide DHB and Ministry decisions and resource investment". (Letter to DHBs, Ministry of Health, August 2010).

METHODS: External and Self Audits

Participation in the audit process was specified in Ministry VIP contracts with DHBs. Eighty-four month follow up site visits were conducted in the 20 DHBs covering 27 acute secondary and tertiary public hospitals across New Zealand (see Appendix B). DHBs were invited to submit self audit data two weeks prior to their scheduled external audit. The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal including 30/08/2010).

Audit Tool

Quantitative external and self audit data were collected applying the *Partner Abuse (PA) Programme Evaluation Tool* and *Child Abuse and Neglect (CAN) Programme Evaluation Tool*. These tools reflect modifications of the *Delphi Instrument for Hospital-Based Domestic Violence Programmes*[18,19] for the bicultural Aotearoa New Zealand context. The audit tools assess programmes against criteria for an ideal programme given current knowledge and expertise.

The *PA Tool* has been used without change across all audit periods. In 2007, a Delphi process with a New Zealand expert panel was conducted to revise the *CAN Tool* to improve its content validity.[2] This *Revised CAN Tool* was subsequently used for the 48, 60 and 84 month follow-up audits.

The audit tools have been available (open access at www.aut.ac.nz/vipevaluation) as interactive excel files since 2008. This format allows users to see measurement notes, enter their indicator data and be provided score results.

The 64 performance measures in the *Revised CAN Tool* and 127 performance measures in the *PA Tool* are categorised into nine domains (see Table 1). The *Screening and Safety Assessment* domain is unique to the PA tool; the *Safety and Security* domain is unique to the CAN tool. The domains reflect components consistent with a systems model approach.[20-22] Each domain score is standardised resulting in a possible score from 0 to 100, with higher scores indicating greater levels of programme development. An overall score is generated using a scheme where some domains are weighted higher than others (see Appendix D for domain weights).

Table 1. Audit Tool Domains

Policies and Procedures	• policies and procedures outline assessment and treatment of victims; mandate identification and training; and direct sustianability
Safety and Security	•children and young people are assessed for safety, safety risks are identified and security plans implemented [CAN tool only]
Physical Environment	• posters and brochures let patients and vistors know it is OK to talk about and seek help for family violence
Institutional Culture	•family violence is recognised as an important issue for the health organisation
Training of Providers	• staff recieve core and refresher training to identify and respond to family violence based on a training plan
Screening and Safety Assessment	• standardised screening and safety assessments are performed [PA tool only]
Documentation	• standardised family violence documentation forms are available
Intervention Services	•checklists guide intervention and access to advocacy services
Evaluation Activities	• activities monitor programme efficiency and whether goals are achieved
Collaboration	•internal and external collaborators are involved across programme processes

Procedure

Evaluation procedures were conducted based on a philosophy of supporting programme leaders in building a culture of improvement. Integrating the evaluation into the VIP systems approach allowed for clear and consistent communication and resources to support audit activities. Details of evaluation processes are outlined in Figure 3 and Appendix C.

The 84 month follow up process began with a letter from the Ministry (dated August 2010) advising DHB Chief Executives of the upcoming 2010-2012 audit rounds and the three changes being implemented for this 84 month follow up round. Changes included a self audit component, naming of DHBs in reports and the expectation to achieve the target score.

External Audit Preparation

Shortly after DHB notification, external audit staff contacted the FVIC (or other DHB designee) by e-mail and telephone to schedule the audit. A confirmatory e-mail identified the site visit date and attached audit instructions (Appendix C).

FVIC were requested to submit an audit day itinerary to the external audit staff outlining audit participants, venue and agenda, to include a debriefing meeting at the end of the site visit day (attended by the evaluator and DHB VIP leaders such as senior management, FVIC, audit participants, and steering group members).

Self Audit Preparation

A session explaining self audit purpose, procedures and best practice processes (such as 'plan ahead') was presented at a national FVIC network meeting in November 2010.

The self audit due date (two weeks in advance of the external audit) was communicated to FVIC in an email.

FVIC were requested to completed and forward self audit documentation including:

1. Partner Abuse Audit Tool
2. Child Abuse and Neglect Audit Tool
3. DHB Characteristics Form

Upon submission of the self audit documents, a member of the external audit team (CG) performed a quality check and followed up with the FVIC, providing the opportunity to complete any missing items and answer any outstanding queries about the audit process.

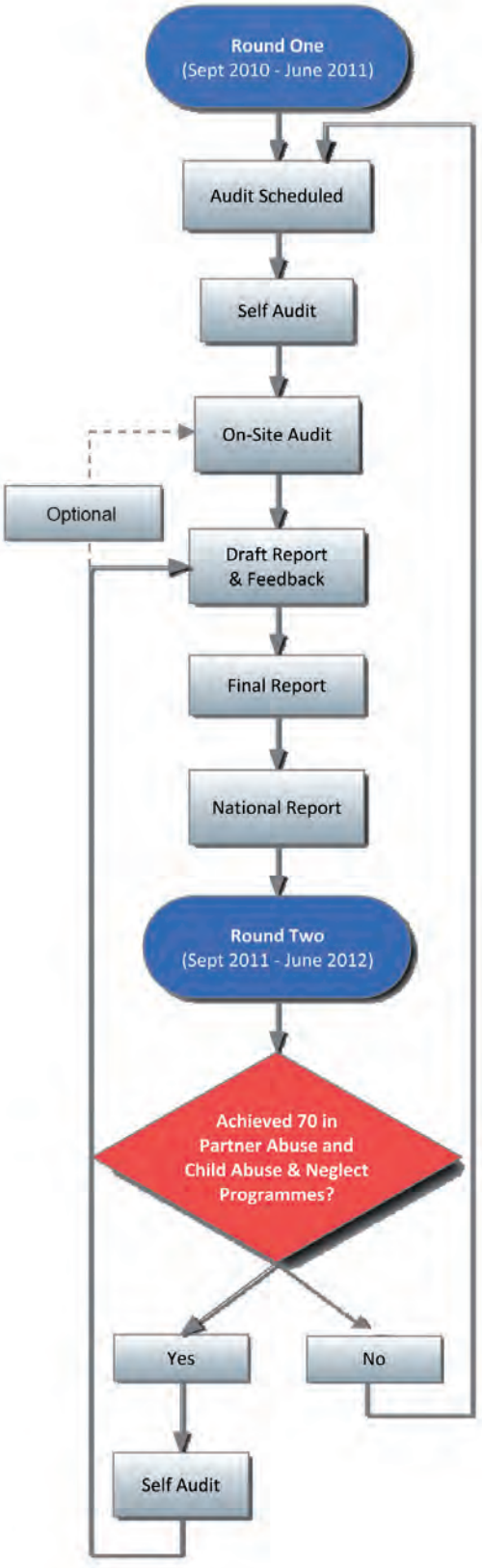


Figure 3. 2010-2012 Evaluation Plan

External Audit Site Visit

One-day site visits were conducted by a member of the external audit team (JKM) who was blinded to self audit reports. Audits progressed according to the itinerary, including an introduction, data collection and debriefing meeting.

External Audit Timeframe

Audits were conducted between October 2010 and May 2011. The average time between baseline and 84 month follow-up audits was 84.5 months (see Table 2).

Table 2. Audit Schedule

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	-	TOTAL
Baseline Nov '03–Jul '04	1	3	4	8	5	0	1	1	1	-	25
12 Month FU Nov '04–Jul '05	1	1	3[a]	8	8	0	0	2	2	-	25
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	-	
30 Month FU Jul '06-Feb '07	0	0	7	6	5	1	0	3	4[b]	-	26
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
48 Month FU Mar '08-Dec '08	4	4	3	2	7	5	1	0	0	1	27
60 Month FU Mar '09-Oct '09	2	2	4	6	1	7	4	1	-	-	27
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	-	
84 Month FU Oct '10-May '11	-	4	2	2	2	5	6	4	2	-	27

Reporting

On completion of each audit a draft report was provided to the DHB FVIC or designee, usually within three weeks. The report included a summary outlining DHB programme progress, strengths and recommendations for improvement, external audit scores and an indicator table of achievements and suggested improvements. Self audit scores (and missing indicators) were also noted within the report. FVIC were asked to involve relevant others (e.g., DHB VIP portfolio managers, steering group members) in the review process and confirm the accuracy of the draft audit report and provide feedback within two weeks. Once confirmed, the finalised report was sent to the DHB Chief Executive, copied to the DHB VIP portfolio manager, FVIC and the Ministry.

Analysis Plan

Self and external audit data were exported from Excel audit tools into an SPSS Statistics (Version 17) file. Score calculations were confirmed between Excel and SPSS files. All analyses were conducted in SPSS.

Both domain and overall scores may range from 0-100, with higher scores reflecting a greater level of programme development.

[a] Includes one hospital that had baseline scores carried over, and a second that had delayed audit scores imputed.
[b] The final audit was conducted 1 February 2007.

In 2004 the 'minimal achievement threshold' (target score) was set at 70 based on international[19] and baseline New Zealand data[23]. The number and proportion of hospitals meeting the threshold over time are reported.

In this report we first present external audit findings. We present baseline, 12, 30, 48, 60 and 84 month follow-up scores for each domain and overall Delphi scores. Box plots and league tables are used to examine the distribution of scores over time (see Appendix E: *How to Interpret Box Plots*). The unit of analysis of hospitals has been maintained across auditing round reports with the exception of 84 month league tables, which are reported by DHB. Recognising the potential of individual DHBs to influence mean scores in such a small population, we favour reporting median scores (and box plots).

Analysis of self audit data began by examining the frequency of missing items. This was followed by assessment of concordance (absolute agreement) between self audit and external audit values for all indicators. Finally, agreement between self and external audit domain and overall scores was assessed using the Intraclass Correlation Coefficient (ICC) using a 2 way mixed, absolute agreement, single value model. Unlike correlation coefficients, ICC takes into account whether scores are systematically higher or lower between raters (external and self auditors in this case). Interpretation of ICC values are based on the adjectives described by Landis and Koch as noted in box to the right,[3] although it has been suggested that higher value cut-offs be used, particularly for clinical measures.[24,25]

Strength of Agreement[3]	
Fair	.21-.4
Moderate	.41-.6
Substantial	.61-.8
Almost Perfect	>.8

FINDINGS: EXTERNAL AUDIT

Partner Abuse Programmes

- *At the 84 month follow-up, the overall partner abuse programme score ranged from 40 to 96, with 84 the typical (median) score.*
- *25 (93%) hospitals reached the target score of 70, compared to 15 (56%) hospitals at the 60 month follow-up audit.*

As demonstrated in Figure 4, partner abuse programme scores have increased substantially over time. Most recently, the median score increased 13%, from 74 at the 60 month follow up audit to 84 at the 84 month follow up. The proportion of hospitals achieving the minimal achievement target score of 70 increased 67% between the 60 and 84 month follow up audits, from 56% (15 hospitals) to 93% (25 hospitals) respectively (see also the section on League tables, page 13). Appendix F provides the data supporting the Figures and Tables in this section.

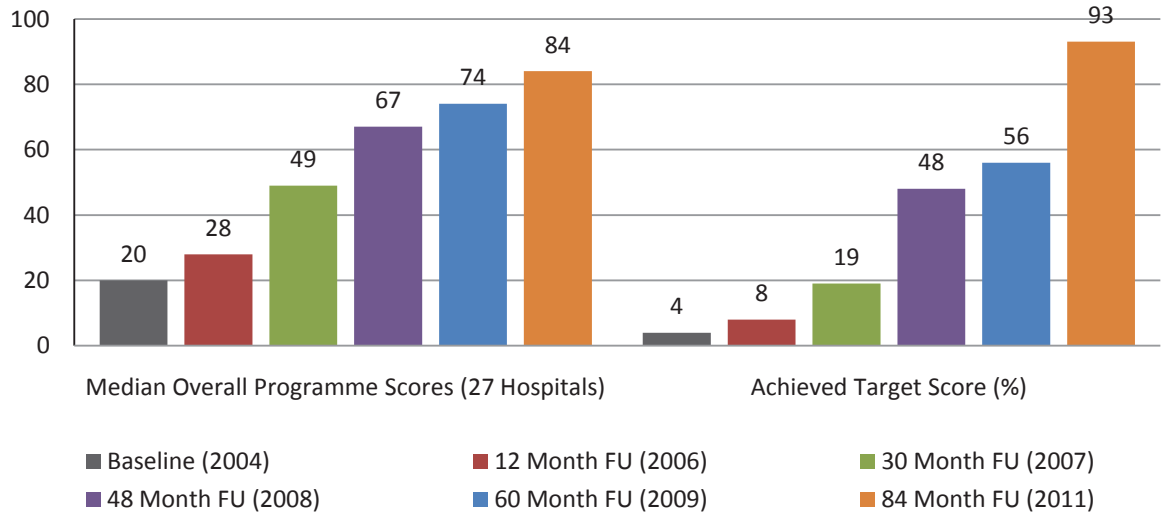


Figure 4. Partner Abuse Programme Scores 2004-2011

The variability in scores over time is evident in Figure 5. At baseline, scores were consistently (SD=18.1) at the lower range of the scale, with a single high scoring outlier. This was followed by a period of wide score variation peaking at the 30 month follow up audit (SD at 12, 30, 48 and 60 month audits = 21.9, 26.2, 21.6 and 20.1 respectively), indicating a period of change. At the 84 month follow up audit scores were again consistent (SD=11.5), but now at the higher range of the scale, with only a single low scoring outlier.

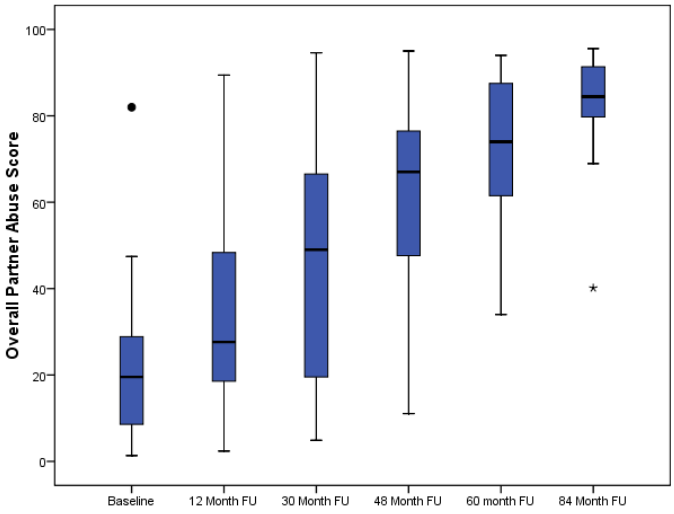


Figure 5. Overall Partner Abuse Score Distributions over Time

Partner Abuse Programme Indicators

Selected high and low achieving partner abuse programme indicators are highlighted below. Frequencies for all the partner abuse programme tool indicators are provided in Appendix G.

All 27 (100%) hospitals employ an identifiable partner abuse intervention programme coordinator.

27 (100%) hospitals have conducted quality improvement activities since the last audit.

26 (96%) hospitals have endorsed policies regarding the assessment and treatment of victims of partner abuse.

26 (96%) hospitals have instituted partner abuse screening in one or more services.

25 (93%) hospitals have a formal partner abuse response training plan.

22 (82%) hospitals conducted one or more chart reviews monitoring partner abuse screening.

12 (44%) hospitals have written procedures outlining security's role in working with partner abuse victims and perpetrators.

12 (44%) hospitals have an Employee Assistance Programme (or similar) that maintains specific policies and procedures for responding to employees experiencing partner abuse.

Partner Abuse Screening

As the majority of programmes have achieved significant infrastructure to support a systems approach for responding to partner abuse, there is increasing attention on evaluating service delivery. The diffusion of partner abuse screening across services and rate of screening in eligible women within those services are useful measures of programme implementation.

The Ministry funds DHBs to implement VIP in the following six targeted services:

- Child Health
  - acute care
  - community
- Maternity
- Sexual Health
- Mental Health
- Alcohol and Drug
- Emergency Department

While all but one DHB had implemented routine screening in at least one service at the time of the 84 month follow up audit, many were still in the process of programme diffusion across targeted services. A minority of DHBs were in the process of providing support for screening beyond the identified Ministry targeted services (such as in medical wards and primary care services).

To assist standardisation of DHB collection of screening data, the *Quality Improvement Toolkit* included an Excel file for screening data entry and analysis. VIP staff were beginning to gain experience in standardising routine collection of screening data (such as frequency of auditing and number of random charts selected), though for the most part, collection remained variable. The reader is cautioned that the summary figure is likely to include significant error and future reporting is recommended with more attention to data collection rigour, with differentiation of screening rates by targeted service.

Based on reporting among the 22 hospitals that had monitored their screening rate across a range of services, the proportion of eligible women screened is improving overtime (Figure 6).

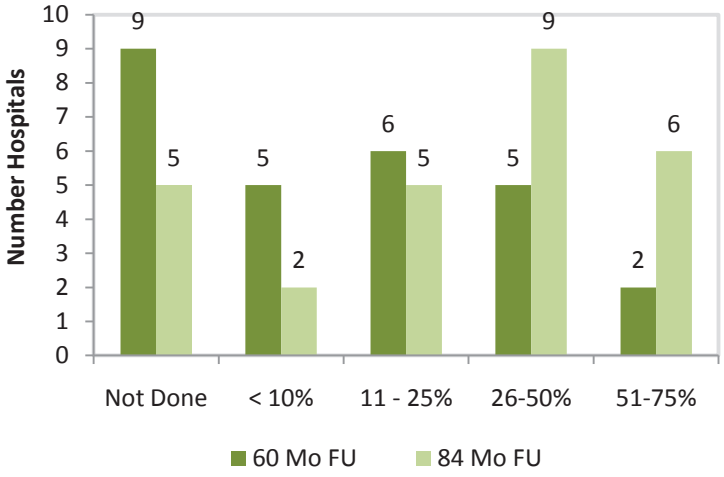


Figure 6. Summary Screening Rate of Eligible Women

One in five hospitals report screening at least half of eligible women in selected services.

It is encouraging that one in five hospitals report screening at least half of eligible women in selected services. Equally, however, it demonstrates that increased attention is needed to promote the diffusion of partner abuse screening in practice. The goal would be for all DHBs to screen near 100% of eligible women.

One measure of screening quality is the rate of partner abuse identified as a result of screening, the 'disclosure rate'. Research[26-28] and practice identify that the quality of screening (including the environment, and screener knowledge and attitude) will influence whether or not a woman will choose to disclose abuse. With New Zealand population past year partner abuse rates among women estimated at 5%,[9,29] we would expect disclosure rates among women seeking health care to be at least that, and most likely higher given a higher use of health services among women who experience abuse.[9,30,31] Disclosure rates (and past year incidence) would be expected to vary across services, with higher rates for example in mental health, alcohol and drug and sexual health services. To date, disclosure rates have not been routinely measured and analysed. Anecdotally, reported disclosure rates are often less than 1%, indicating the need to consider strategies to improve performance.

Other potential measures of service delivery are the rates of completed risk assessment and provision of specialised family violence services (at the time or through referral) to women who disclose abuse. In reviewing selected chart audits, however, there has been little variability, with nearly 100% of identified women receiving referral to specialised services.

Partner Abuse Programme Domains[a]

All nine partner abuse programme domain scores increased between the 60 and 84 month follow up audits (Figure 7). Across partner abuse programme domains at the 84 month follow up audit, *Collaboration* was the highest scoring (median score =100). The median domain score exceeded 70 for all domains with the exception of *Evaluation Activities* (median score = 66), indicating room for further improvement.

[a] Tool domains are described in Table 1 (page 5).

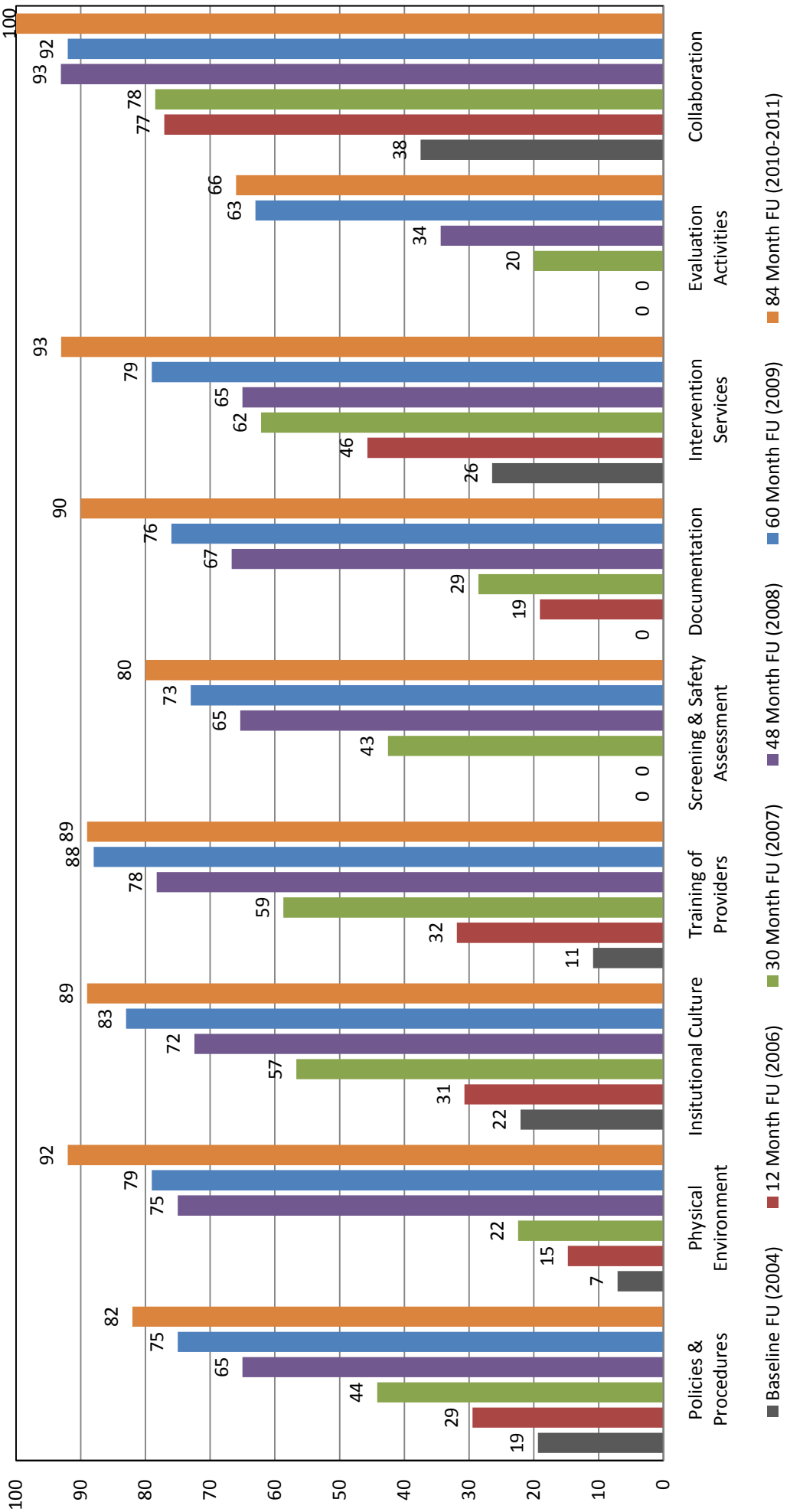


Figure 7. Partner Abuse Programme Domain Median Scores

Partner Abuse Programme League Tables

Hospital league tables provide a pictorial representation of development across the six audit rounds from 2004 to 2010 (Figure 8). The horizontal line indicates the target minimum achievement score of 70. The development of programmes over time apparent in Figure 8 is impressive.

A **DHB** league table for the 84 month follow up audit is presented in Table 3. This table includes the two Southern DHB programmes (Southland and Otago), which at the time of the audit remained unique, with separate VIP steering groups and policies and procedures. The amount of change since the last audit (absolute score difference) ranged from a decrease of 4 to an increase of 46. Seven DHBs had score increases of 15 or more.

Table 3. 84 Month Follow-Up Partner Abuse DHB League Table

		Score	Target (70%)	Change from 60 Month FU	
1	Waitemata	96		1	1%
2	Hawke's Bay	94		1	1%
3	Southern* - Southland	93		2	2%
4	MidCentral	92		25	36%
5	Auckland	92		1	1%
6	Bay of Plenty	91		4	5%
7	Counties Manukau	89		4	5%
8	Wairarapa	89		7	8%
9	Southern* - Otago	88		25	40%
10	West Coast	86		-2	-2%
11	South Canterbury	86		-4	-5%
12	Whanganui	84		17	25%
13	Northland	82		20	33%
14	Nelson Marlborough	81		4	6%
15	Taranaki	81		8	11%
16	Canterbury	80		46	134%
17	Tairawhiti	79		11	16%
18	Waikato	71		34	90%
19	Lakes	70		-4	-5%
20	Capital & Coast	69		35	106%
21	Hutt Valley	40		-4	-10%
	DHB Median	**86**		4	5.7%

Note: Southern DHB VIP scores are reported separately as services have not yet merged across Southland and Otago Hospitals.

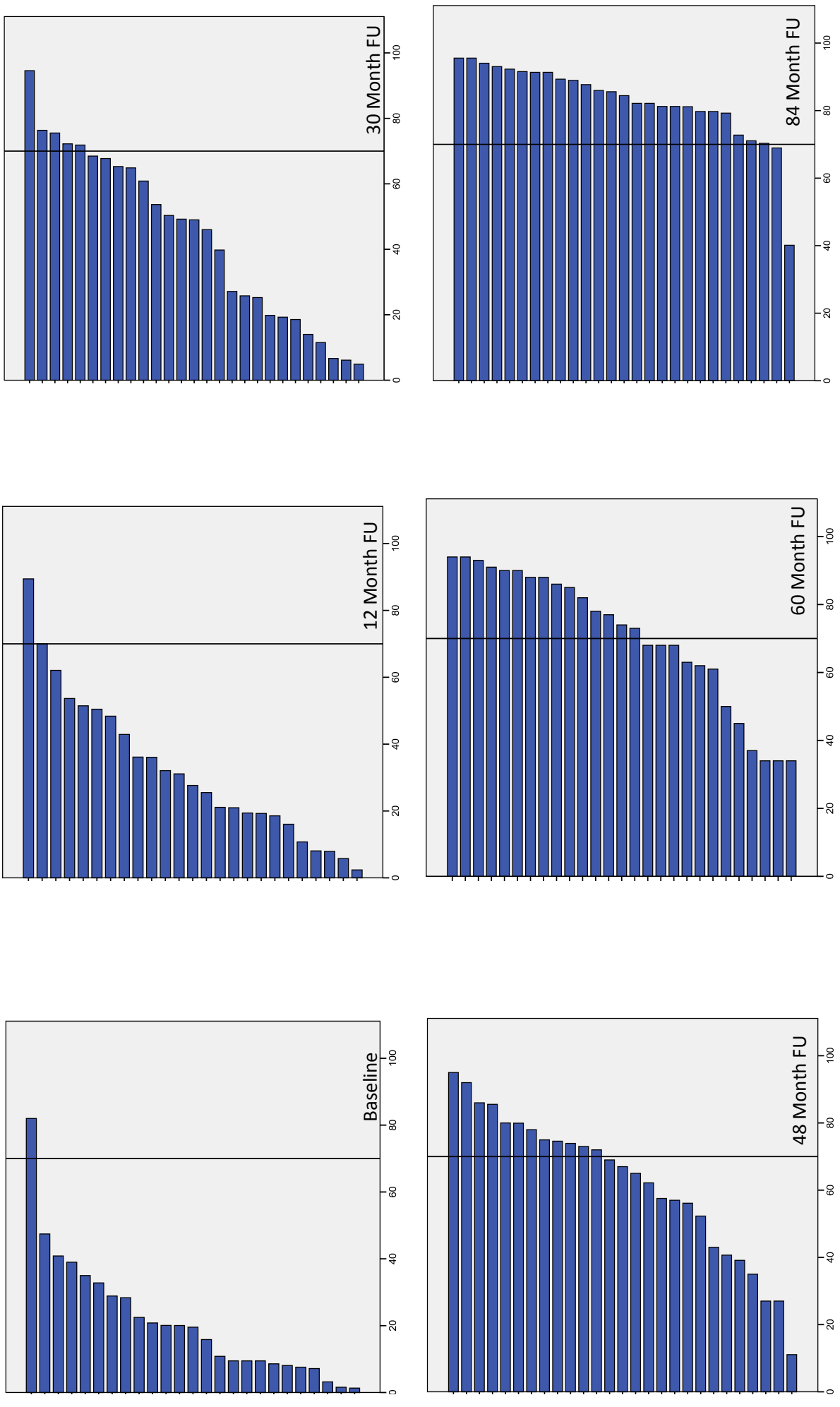


Figure 8. Partner Abuse Intervention Hospital League Tables
Note: Similarly ranked bars do not represent the same hospital across the six graphs.

Child Abuse and Neglect Programmes

- *At the 84 month follow-up, the child abuse and neglect intervention programme score ranged from 61 to 98, with 87 being the median score.*
- *25 (93%) hospitals reached the target score of 70, compared to 21 (78%) at the 60 month follow-up audit.*

As demonstrated in Figure 9, child abuse and neglect programme scores have increased substantially over time. Most recently, the median score increased 7%, from 81 at the 60 month follow up audit to 87 at the 84 month follow up. The proportion of hospitals achieving the minimal achievement target score of 70 increased 19% between the 60 and 84 month follow up audits, from 78% (21 hospitals) to 93% (25 hospitals) respectively. Appendix H provides the data supporting the Figures and Tables in this section.

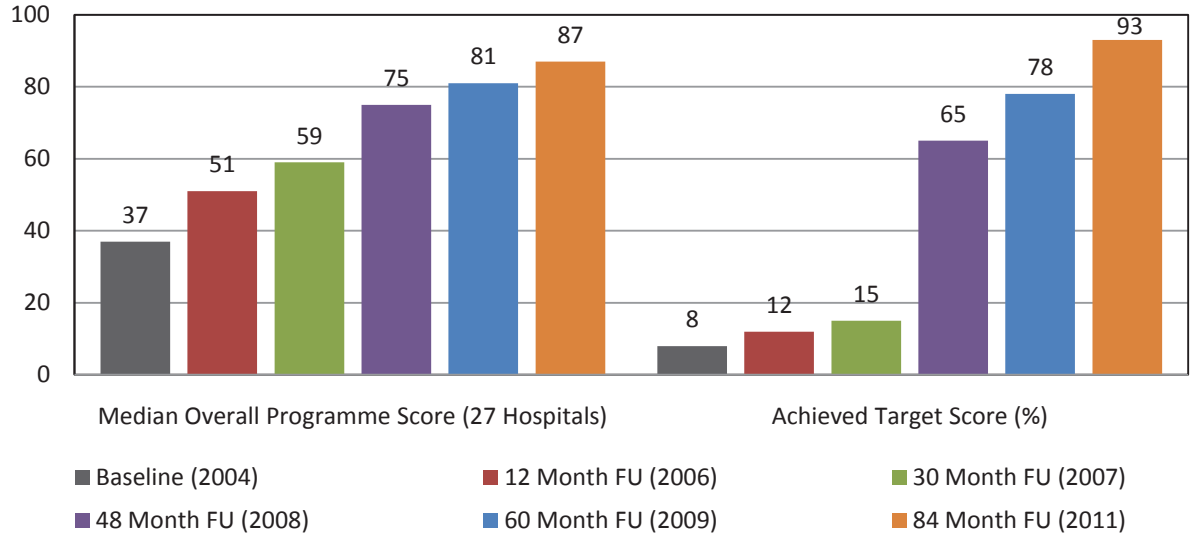


Figure 9: Child Abuse and Neglect Programme Scores (2003-2011)

At baseline, child abuse and neglect programme scores were higher compared to partner abuse programme scores (median =37 vs 20 respectively). There has also been less variability in scores over time (See Figure 10). The maximum score variation for child abuse and neglect programmes was at baseline (SD=19.4) compared to at the 30 month follow up audit for partner abuse programmes. At the 84 month follow up audit, scores were consistently high (SD=8.5) with three low scoring outliers.

Note: To increase content validity, the *Revised CAN Audit Tool* was developed in 2007 and implemented at the 48 month follow up audit.[1,2] The revised tool included an additional 28 indicators and a new *Safety and Security* domain. The 48 month follow up report[1] includes a comparison of the original and revised tool.

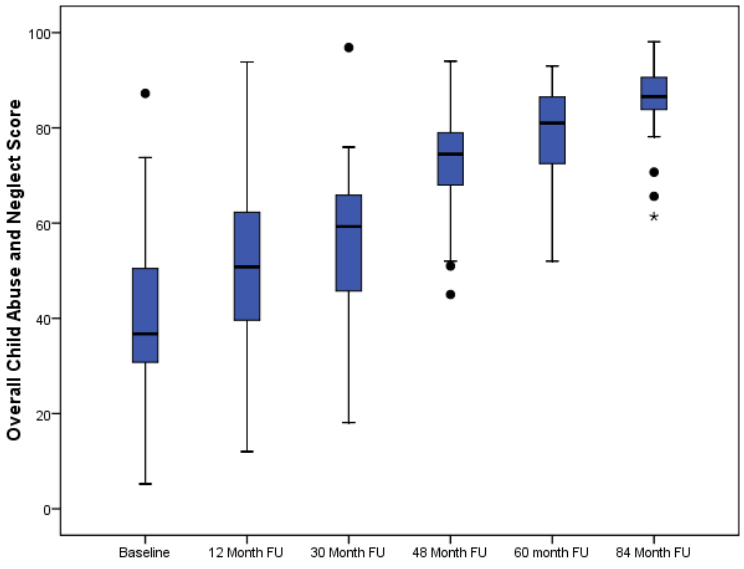


Figure 10: Overall Child Abuse and Neglect Score Distributions over Time

CHILD ABUSE AND NEGLECT PROGRAMME INDICATORS

Selected high and low achieving child abuse and neglect programme indicators are highlighted below. Frequencies for individual child abuse and neglect programme tool indicators are provided in Appendix I.

All 27 (100%) hospitals have a clinical assessment policy for identifying signs and symptoms of child abuse and neglect and for identifying children at risk.

All VIP child abuse and neglect programmes (n=27, 100%) collaborate with Child, Youth and Family and the Police in programme planning and safety planning for children at risk.

25 (93%) hospitals have a local alert system in the acute care setting recording any concerns about children at risk of abuse and neglect.

26 (96%) hospitals achieved the target score in the *Training of Providers* category.

20 (74%) hospitals record, collate and report to the DHB data related to child abuse and neglect assessment referrals and alert placements.

16 (59%) hospitals include their child abuse and neglect programme in their DHB Quality and Risk programme.

11 (41%) hospitals have protocols for collaborative safety planning that explicitly involve primary health providers.

14 (52%) hospitals monitor demographics, risk factors and types of abuse trends.

DHBs have achieved significant infrastructure to support a systems approach for responding to child abuse and neglect that includes collaboration with Child, Youth and Family and the Police. Multi-Disciplinary Team (MDT) processes are improving over time as working relationships within and external to DHBs are developed. It is anticipated that working relationships promoting health and safety for children will further improve as regions adopt the revised national Memorandum of Understanding between DHBs, CYF and Police.

Internal systems for recording abuse and neglect concerns are common among hospitals (93%), though few (30%) include community settings or a national network (30%). It should be noted that a National Child Protection Alert system (NCPAS) has been developed between the Ministry, the NZ Paediatric Society of New Zealand Child Protection Special Interest Group and DHBs. It is anticipated that DHBs will adopt this nationally consistent system incrementally over time to support Child Abuse and Neglect components of VIP programmes.

All DHBs have protocols for safety planning for children identified at risk, though collaborating with primary health care providers is often haphazard, with the majority of DHBs limiting communication to disseminating discharge summaries. Thirteen (48%) hospitals have a coordinated referral process for care transitions of children at risk between secondary and primary care.

Child Abuse & Neglect Programme Domains[a]

All nine child abuse and neglect programme domain scores increased between the 60 and 84 month follow up audits, with the largest increase occurring in *Documentation* and *Evaluation Activities* (Figure 11). The median domain score exceeded 70 for all domains. Similar to partner abuse programmes *Evaluation Activities* is the least developed domain, indicating the need for further development in internal quality improvement activities such as including VIP in the DHB Quality and Risk programme and monitoring demographics, risk factors and types of abuse (see *Evaluation Activities* domain indicators on pages 57-58).

[a] Tool domains are described in Table 1 (page 5).

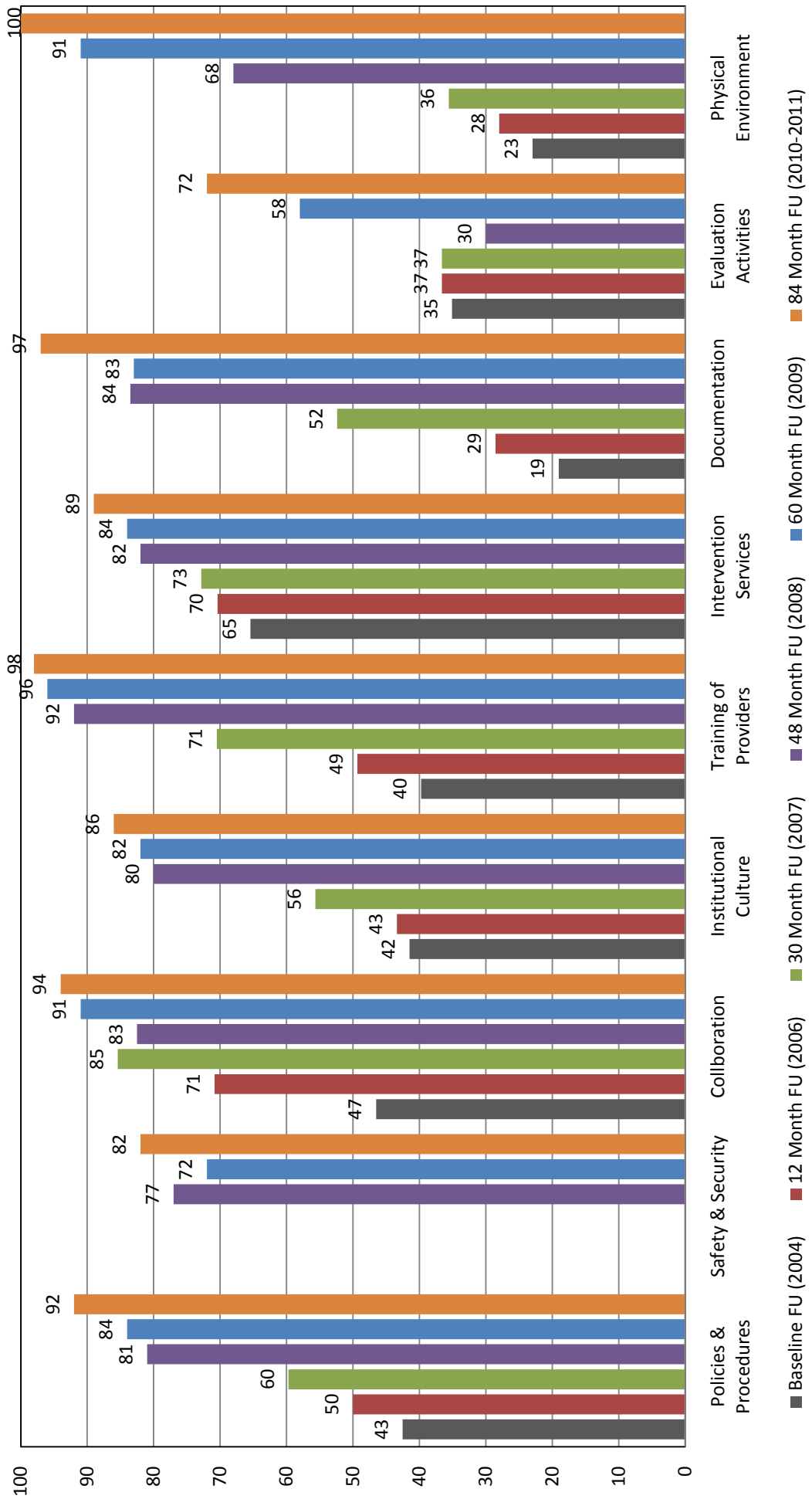


Figure 11: Child Abuse and Neglect Programme Domain Median Scores
Note: The Revised Child Abuse & Neglect audit tool, with the new Safety & Security domain, was implemented beginning with the 48 month follow up audit.

Child Abuse and Neglect Programme League Tables

League tables provide a pictorial representation of development across the six audit rounds from 2004 to 2010 (Figure 12). The horizontal line indicates the target minimum achievement score of 70. The development of programmes over time, particularly between the 30 and 48 month follow up audits, is impressive. While this coincided with the change to the revised audit tool, there was, in fact, high agreement between original and revised audit scores.[1]

A **DHB** league table for the 84 month follow up audit is presented in Table 4. This table includes the two Southern DHB programmes (Southland and Otago Hospitals), which at the time of the audit remained unique, with separate VIP steering groups and policies and procedures. The amount of change since the last audit (absolute score difference) ranged from a decrease of 11 to an increase of 32. Three DHBs had score increases of 15 or more.

Table 4. 84 Month Follow-Up Child Abuse and Neglect DHB League Table

		Score	Target (70%)	Change from 60 Month FU	
1	Waitemata	98		10	11%
2	Auckland	95		13	16%
3	Southern* - Southland	92		2	2%
4	Canterbury	91		4	5%
5	Southern* - Otago	91		5	6%
6	Wairarapa	90		5	6%
7	Hawke's Bay	90		-3	-3%
8	Capital & Coast	87		18	26%
9	West Coast	87		4	5%
10	MidCentral	87		11	14%
11	Northland	87		28	47%
12	Whanganui	86		13	18%
13	Bay of Plenty	86		-1	-1%
14	Nelson Marlborough	85		6	8%
15	Counties Manukau	84		32	62%
16	Taranaki	84		8	11%
17	Waikato	82		10	14%
18	South Canterbury	80		-4	-5%
19	Tairawhiti	71		-7	-9%
20	Lakes	66		-11	-14%
21	Hutt Valley	61		5	9%
	DHB Median	**87**		5	8%

Note: Southern DHB VIP scores are reported separately as services have not yet merged across Southland and Otago Hospitals.

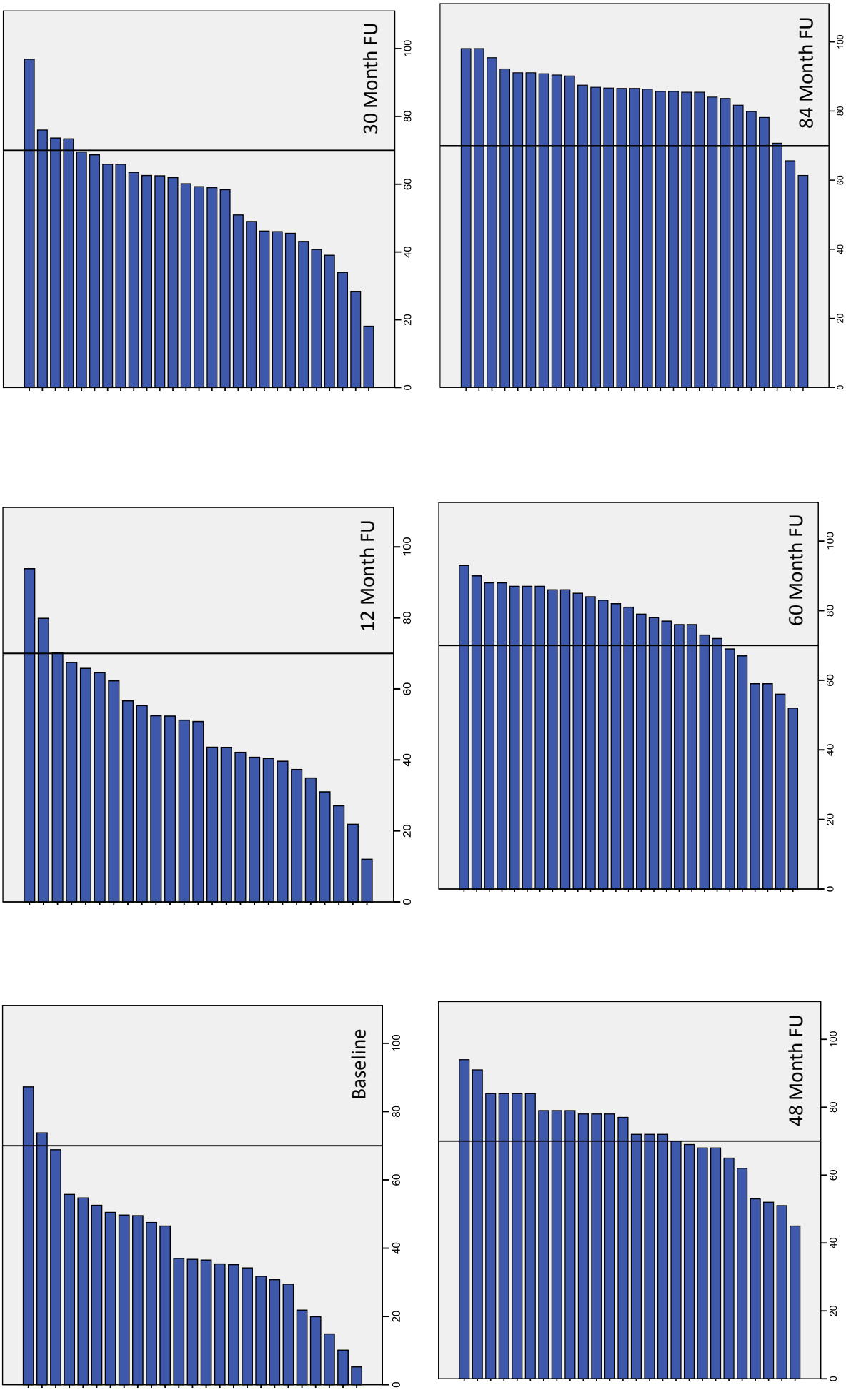


Figure 12. Child Abuse and Neglect Hospital League Tables

Notes: Similarly ranked bars do not represent the same hospital across the six graphs. The Revised CAN audit tool was implemented beginning with the 48 month follow up audit.

Cultural Responsiveness and Whānau Ora

- *84 Month follow-up Partner Abuse programme cultural responsiveness scores ranged from 60 to 97, with a median score of 87.*
- *84 Month follow-up Child Abuse and Neglect programme cultural responsiveness ranged from 39 to 100, with a median score of 86.*

VIP recognises culturally responsive health systems contribute to reducing health inequalities. Additional Whānau Ora workforce development funding and resources provided for DHBs in 2010 created opportunities for DHBs to improve service delivery for Māori. As these initiatives are developed, it is anticipated VIP responsiveness to Māori victims of family violence will improve and cultural indicator scores will increase.

Indicators addressing Māori, Non-Māori non-Pakeha (e.g. Pacific Island, Asian, migrant and refugee) and general cultural issues for planning and implementing a family violence response in the health sector are integrated within the Partner Abuse (n=30) and Child Abuse and Neglect (n=28) audit tools. The following Figure (Figure 13) summarises the sub-set of indicators evaluating cultural responsiveness within VIP programmes across the six evaluation periods.

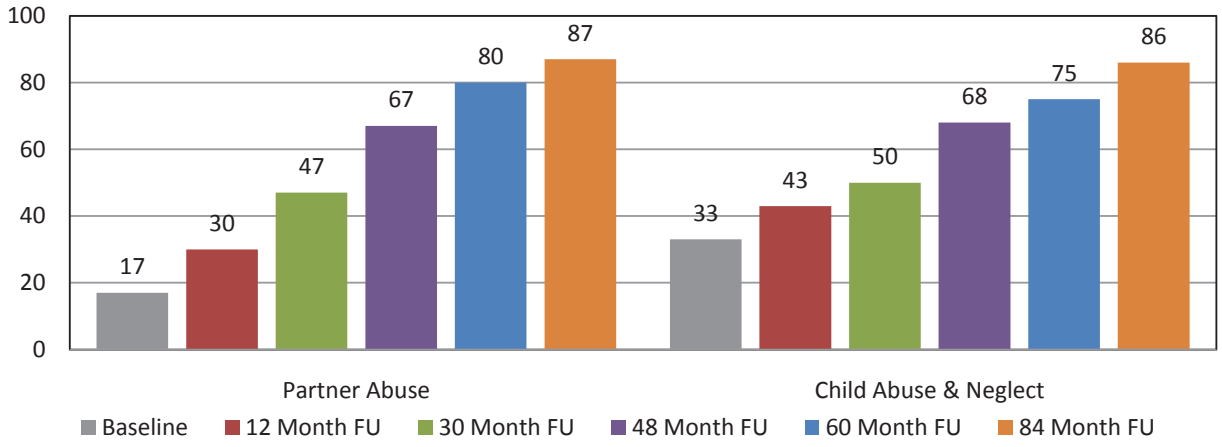


Figure 13. Median Hospital VIP Cultural Responsiveness Scores 2004-2011 (N=27)*
* Child Abuse and Neglect 30 month follow-up score has been corrected.

While 84 month follow-up VIP cultural responsiveness scores are increasing over time, variation across hospitals continues. DHBs have been asked to prioritise improving scores on cultural responsiveness indicators generally and in particular, the four indicators below.

13 (48%) partner abuse programmes and 16 (59%) child abuse and neglect programmes include a non-Māori, non-Pakeha representative on the VIP training team.

10 (37%) partner abuse programmes and 8 (30%) child abuse and neglect programmes have evaluated whether their VIP programme services are effective for Māori.

13 (48%) partner abuse programmes and child abuse and neglect programmes set aside funding specifically for Māori family violence prevention programmes and initiatives.

17 (63%) partner abuse programmes and 15 (56%) child abuse and neglect programmes assess staff on their knowledge and attitude about Māori and family violence.

FINDINGS: SELF AUDITS

In this section we present self audit findings. We provide data about the completeness of self audit submissions and compare self audit scores to external audit scores. This is presented firstly for partner abuse programmes, followed by for child abuse and neglect programmes.

Partner Abuse Programme Self-Audit

- *26 (96%) hospitals submitted a partner abuse programme self audit.*
- *The partner abuse programme self audit score ranged from 54 to 100, with 84 being the median score.*
- *Of partner abuse programme self audit submissions, 5 hospitals had not completed all items. Overall, 1% of indicators were missing.*
- *Absolute agreement between the self and external audit individual indicator values ranged from 46% to 100%.*
- *Self audit partner abuse programme score had 'Almost Perfect Agreement' with the external audit score (ICC=.93).*

Missing Indicators

On first submission, eight hospitals (5 DHBs) submitted a completed partner abuse programme audit tool. Following the quality check procedure (see page 6), 21 (81%) hospital had a completed submission. The rate of missing indicators in final submissions was 1%.

The majority of missing indicators (out of a potential 127 indicators) involved the following (see Appendix J):

- Physical environment
- Participating in preventive outreach
- Collaborating with local programmes in on-site service provision

26 of 27 hospitals submitted a self audit (out of a total of 127 indicators)

21 (78%) completed all indicators
2 (7%) completed all but 2 indicators
1 (4%) completed all but 5 indicators
1 (4%) completed all but 11 indicators
1 (4%) completed all but 15 indicators

Agreement

The overall partner abuse programme median self audit score was 84, compared to the median external audit score of 85. Self and external audit score differences ranged from +20 (self audit score underestimated external audit score) to –8 (self audit score overestimated external audit score). The mean score difference was .32 (Figure 14).

Only two hospitals had a score difference ≥ ± 10. These hospitals represented the two outliers - dots furthest from the agreement line - in Figure 15. They were also the hospitals with the highest number of missing indicators (11 and 15 respectively). Therefore, with > 8% missing indicators, these two hospitals were excluded from the following analysis of self and external score agreement.

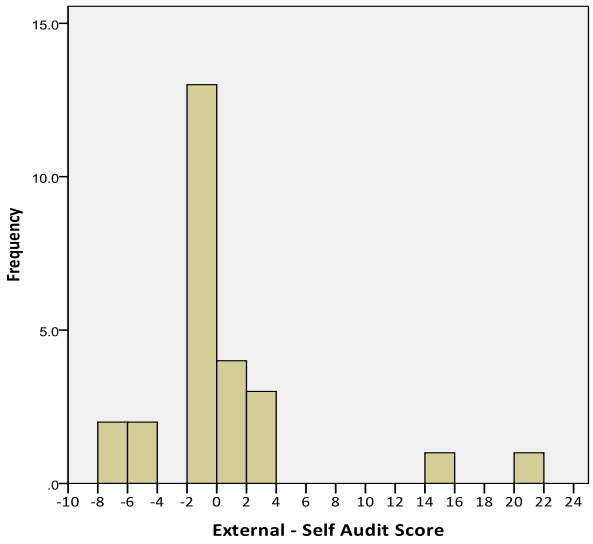
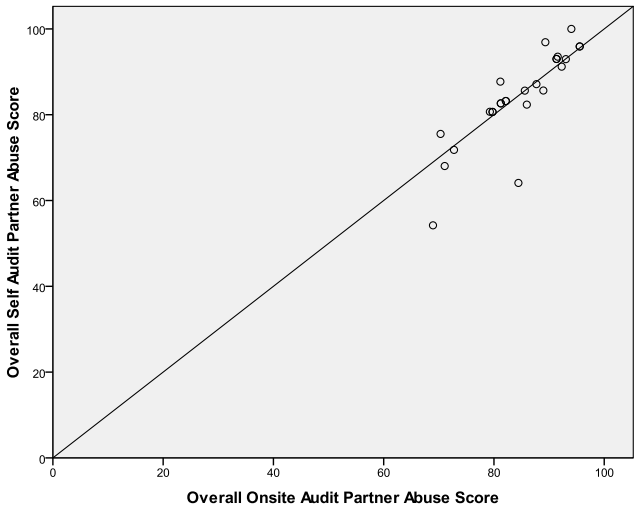


Figure 14. Partner Abuse External and Self Audit Score Difference (n=26)



Note: Line represent perfect agreement

Figure 15. Plot of Partner Abuse Exteral and Self Audit Scores (n=26)

Among the 24 hospitals submitting near complete self audits (at least 92% of indicators), agreement between self and external partner abuse programme domain scores ranged from 'fair' for *Institutional Culture* and *Training of Providers* to 'substantial' for *Evaluation Activities*, *Screening and Safety Assessment* and *Physical Environment* (Table 5).

Agreement between the self and external overall partner abuse programme scores was 'Almost Perfect'[3] (ICC=.926; 95% confidence interval .83, .97).

Table 5. Partner Abuse Programme Self and External Audit Agreement (n=24)

Domain	ICC	Strength of Agreement[3]
Evaluation Activities	.75	Substantial
Screening and Safety Assessment	.74	Substantial
Physical Environment	.72	Substantial
Policies and Procedures	.61	Substantial
Intervention Services	.60	Substantial
Documentation	.56	Moderate
Collaboration	.45	Moderate
Training of Providers	.38	Fair
Institutional Culture	.33	Fair
Overall Score	.93	Almost Perfect

Child Abuse and Neglect Programme Self-Audit

- *26 (96%) hospitals submitted a child abuse and neglect programme self audit.*
- *The child abuse and neglect programme self audit score ranged from 50 to 99, with 92 being the median score.*
- *Of child abuse and neglect programme self audit submissions, 9 (36%) hospitals had not completed all items. Overall, 1.7% of indicators were missing.*
- *Absolute agreement between self and external audit individual indicator values ranged from 40% to 100%.*
- *Self audit child abuse and neglect programme score had 'moderate' agreement with the external audit score (ICC=.49)*

Missing Indicators

On first submission, 6 hospitals (4 DHBs) submitted a completed child abuse and neglect audit tool. Following the quality check procedure (see page 6), 17 (63%) hospitals had a completed submission. The rate of missing indicators in final submissions was 1.7%.

The majority of missing indicators (out of a potential 217 indicators) involved the following (see also Appendix J):

- Evaluation Activities
- Safety and Security

26 of 27 hospitals submitted a self audit (out of a total of 217 indicators)

17 (63%) completed all indicators
3 (11%) completed all but 1 indicator
1 (4%) completed all but 2 indicators
2 (7%) completed all but 3 indicators
1 (4%) completed all but 5 indicators
1 (4%) completed all but 35 indicators

Agreement

The overall child abuse and neglect programme median self audit score was 92, compared to the median external audit score of 87. Self and external audit score differences ranged from +16 (self audit score underestimated external audit score) to –11 (self audit score overestimated external audit score). The mean score difference was -2.7 (Figure 16).

Five hospitals had a score difference of ≥ ± 10 (Figure 17). Only 1 of the 5 hospitals with large score differences had significant numbers of missing indicators. The 2 hospitals with > 8% missing indicators were excluded from the following analysis of self and external score agreement. Of note, the two hospitals with significant missing child abuse and neglect programme indicators were different from the two hospitals with significant missing partner abuse programme indicators.

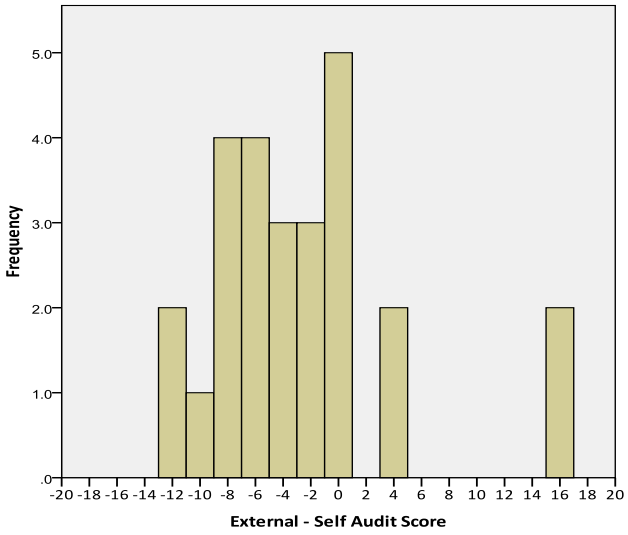
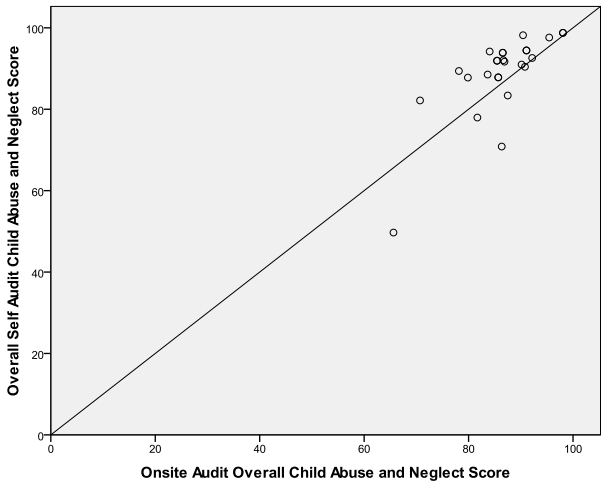


Figure 16. Child Abuse and Neglect Programme External and Self Audit Score Difference (n=26)



Note: Line represents perfect agreement

Figure 17. Plot of Child Abuse and Neglect Programme External and Self Audit Scores (n=26)

Among the 24 hospitals submitting near complete self audits (at least 92% of indicators), agreement between self and external child abuse and neglect programme domain scores ranged from 'slight' for *Physical Environment* to 'moderate' for *Intervention Services*, *Collaboration*, *Institutional Culture*, *Policies and Procedures* and *Evaluation Activities* (Table 6). For *Physical Environment*, the domain with the least agreement, 13 of the 24 sites' domain scores by both self and external audit were 100 (the maximum possible score).

Agreement between the self and external overall child abuse and neglect programme scores was 'Moderate'[3] (ICC=.488; 95% confidence intervals .09, .75), with wide confidence intervals. This compared with 'near perfect' agreement for partner abuse programme score agreement.

Table 6. Child Abuse and Neglect Programme Self and External Audit Agreement (n=24)

Domain	ICC	Strength of Agreement[3]
Intervention Services	.56	Moderate
Collaboration	.56	Moderate
Institutional Culture	.48	Moderate
Policies and Procedures	.48	Moderate
Evaluation Activities	.43	Moderate
Documentation	.31	Fair
Training of Providers	.23	Fair
Safety & Security	.23	Fair
Physical Environment	.04	Slight
Overall Score	.49	Moderate

DISCUSSION

Self Audits

This was the first time DHB family violence programmes had the responsibility for conducting a self audit. Despite programme staff being familiar with the audit tools, the self evaluation process required significant resource. Barriers that were faced in completing the self audit included:

- Lack of resource (particularly time)
- Lack of knowledge and understanding of audit criteria, leading to subjective evaluation
- Lack of a 'self audit plan' (with allocated timeline and resources)
- Lack of technological literacy to meet self audit requirements.

Despite the challenges of self audit, self audit scores generally reflected external audit scores, though agreement was higher for partner abuse programme audit scores (ICC=.93) compared to child abuse and neglect programme audit scores (ICC=.49). The poor results for many of the domains of the child abuse and neglect and some of the partner abuse programme self-audits, in conjunction with feedback from the coordinators, demonstrate the need for improved instructions and training for the self audit.

All DHBs are scheduled to conduct another self audit for the 96 month follow up audit round. This second self audit will build on the 84 month process and documentation. It is expected, therefore, the majority will require significantly less resource.

For self auditing we advocate establishing a 'self audit plan' with senior management, using a framework such as 'Plan, Do, Check, Act'[16,32,33] (see Figure 18). As DHBs transition to self audit only, establishing an audit plan will support programme performance improvements, sustainability and accountability.

PLAN	Identify an audit team, resources (e.g. time), method, focus areas, analysis, dissemination of findings and essentially, formal senior management support.
DO	Communicate the self audit plan to team members, complete audit procedure requirements and refine the Plan as required.
CHECK	Review self audit findings, identify strengths and real opportunities for improvement, prioritize follow-up actions in collaboration with the self audit team, establish action plan with senior management support.
ACT	Review follow-up actions for effectiveness and efficiency, amend action and self audit plans as necessary, and prepare for next self audit.

Figure 18. Self Audit Process: Plan, Do, Study, Act[16,17,32,34]

The MOH VIP 2011-2012 audit plan prescribes that DHBs consistently achieving the target score transition to self audit only. Based on audit data and site visit information, eight DHBs have evidenced programme maturity consistently over time. For these DHBs, the transition to self audit is judged to be sufficient to ensure a sustainable system.

Three DHBs that have not yet achieved the target score will be supported by site visits in addition to self audit for the 96 month follow up audit cycle. There are nine DHBs that met the target score, but have not yet reached a level of programme sustainability. These DHBs will be offered an additional external audit in the 96 month follow up audit cycle.

Strengths and Limitations

Strengths of this evaluation project include using established family violence programme evaluation instruments[2,19,35] and following standard quality improvement processes in auditing.[33] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[20,22,35] In this audit report DHBs are for the first time named against their overall scores. This transparency is appropriate given consistent Ministry-funded national resources supporting VIP in DHBs since 2007 (see Figure 2, page 3).

Our processes of audit planning, site visits and reporting facilitate DHB VIP programme development over time. The evaluation project is also integrated in the VIP management programme, providing the Ministry the ability to target remedial actions in the context of limited resources. Development and implementation of the *VIP Quality Improvement Toolkit* and financial and technical support for DHB Whānau Ora initiatives are two such examples. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed the monitoring of change from 2004 to 2011.

Limitations are important to consider in interpreting the findings and making recommendations based on this evaluation work. These include:

- By design, this study is limited to acute hospital and community services of secondary and tertiary public hospitals provided by DHBs. The VIP does not include services provided by private hospitals which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions.
- Audits provide a snapshot of what is formally in place at the time of the visit. This means that work 'in progress' that may have involved significant effort is not 'counted'. This limitation is modified by having repeated measures over time. The snapshot approach of the audit fosters a 'sense of urgency', supporting timely policy revisions, procedure endorsements and filling of FVIC positions.
- Audit tool scores range from 0 to 100. This means that as programmes mature they approach the top end of the scale and have little room for score improvement, creating a 'ceiling effect'.
- As the VIP programme has evolved, some indicators become 'out of date', such as the partner abuse programme tool requiring monthly (rather than quarterly) governance (steering group) meetings. While we might have altered the tool over time, we chose to hold the tool constant for the sake of comparisons over time.
- Finally, the VIP audit does not include indicators related to the *Family Violence Intervention Guidelines: Elder Abuse and Neglect*,[36] although an increasing number of DHBs have endorsed policies addressing elder abuse and neglect assessment and intervention (n=13 DHBs, 65%).

Conclusions

New Zealand DHBs have continued to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. Seventeen DHBs have achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes. This 85% (17/20) achievement rate exceeds the Ministry of Health's aim for 75% achievement by July 2011.

The majority of DHB Violence Intervention Programmes have policies and procedures in place, good leadership and governance and established collaboration with local government and non-government specialist family violence services. Standardised one day training programmes for clinical staff are supported by service level clinical champions and Family Violence Intervention Coordinators. While programmes are doing well overall, there are still significant gaps.

The most important programme development need continues to be internal quality improvement activities. Evaluation activities have increased over time, supported by the *VIP Quality Improvement Toolkit*. Yet,

furthering the scope of activities, improving measurement rigour and translating internal audit information into VIP quality improvements are areas for further attention.

Aside from programme system developments, implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse [4] (*The Guidelines*) across target services is still in progress. Many DHBs have yet to roll out their VIP to all targeted services. And for those implementing *The Guidelines,* increasing service delivery and quality continues to present challenges. Only 6 of 27 (22%) hospitals have monitoring evidence that at least 50% of eligible women receive a brief partner abuse screening intervention and referral. The indicative DHB screening rate of 35% compares to a 66% screening rate across targeted services in the New South Wales domestic violence 'snapshots' report.[37]

VIP Cultural Responsiveness scores continue to increase over time. Under-performing indicators increased in development since the last audit, though Whānau Ora workforce development initiatives had not yet been implemented across all DHBs at the time of the 84 month follow up audit.

Recommendations

Recommended focus areas for programme development in the next year include:

- Continuing work force development for FVICs in quality improvement activities, including processes, data collection, use of technology, reporting and translating findings into programme quality improvements.
- Continuing to look for opportunities to embed VIP in other DHB systems such as Health Promotion, Human Resources, Information Technology, Security and Quality and Risk.
- Increasing policy and procedure implementation by increasing identification and provision of services to families at risk. Developing strategies for targeted services (see page 10) to support higher levels of screening and delivery of services to women and children in need will address this.
- Improving care transitions between primary and secondary care to promote consistent collaborative risk assessment, safety planning and care pathways.
- Moving from evaluation focussing on implementation to evaluation of performance quality.

The recommendations noted above are within a context of ongoing improvements both within the health sector as well as inter-agency. Three initiatives important to promoting child safety include the development of clinical networks; national health child protection alert system; and the Child, Youth and Family, Police DHB Memorandum of Understanding.

Future Considerations

DHBs are reaching a mature level of VIP development, identified by high programme scores and reduced score variability. Transitioning to self audit, perhaps supported by random spot checks to ensure quality maintenance over time, is therefore appropriate for monitoring programme sustainability.

It is time now to focus on improving the quality of the services provided. This shift in focus is consistent with the Ministry's *Statement of Intent* objectives to achieve 'better, sooner and more convenient' health services.[38] Focusing on intermediate outcomes such as partner abuse screening and disclosure rates, specialist mutidisciplinary child protection team meetings and review, client and community partnership outcomes, service innovations and integrations are in order. At present, monitoring of partner abuse screening and disclosure rates and other internal audit activities are haphazard. A plan to support consistent application of the *VIP Quality Improvement Toolkit* should be devised to ensure reliable monitoring data as well as promote using data effectively to inform practice improvements.

The established VIP infrastructure is an important asset to support diffusion of violence prevention and intervention innovations in health systems. As initiatives - such as updated national Family Violence

Intervention Guidelines; the national child protection alert system project led by the Paediatric Society of New Zealand and the Ministry National Health Board; and resources to support a primary health care response - are finalised, the established VIP network is ideally placed to facilitate swift and effective implementation.

Family violence is a complex social problem that is preventable.[6,39,40] Health care settings are an important point of entry for families at risk to receive services to reduce and prevent the health impacts of violence and abuse through early identification, assessment and specialist intervention. The VIP is well placed to monitor and respond to new initiatives and new knowledge supporting a best practice approach to reducing family violence in New Zealand.

REFERENCES

1. Koziol-McLain J, Garrett N, Gear C. *Hospital responsiveness to family violence: 48 month follow-up evaluation report*: Interdisciplinary Trauma Research Unit, Auckland University of Technology; 2009.
2. Wilson D, Koziol-McLain J, Garrett N, Sharma P. A hospital-based child protection programme evaluation instrument: A modified Delphi study. *Int J Qual Health Care.* 2010;22(4):283-293.
3. Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics.* 1977;33(1):159-174.
4. Fanslow J. *Family violence intervention guidelines: Child and partner abuse.* Wellington, New Zealand: Ministry of Health; 2002.
5. Hau'alofa'ia Koloto A. *The Needs of Pacific Peoples When They Are Victims of Crime.* Wellington, New Zealand: Ministry of Justice; 2003.
6. Ellsberg M. Violence against women and the Millennium Development Goals: Facilitating women's access to support. *Int J Gynaecol Obstet.* 2006;94(3):325-332.
7. World Health Organisation. *Preventing child maltreatment: A guide to taking action and generating evidence*. Geneva, Switzerland: WHO; 2006.
8. Balzer R, Haimona D, Henare M, Matchitt V. *Maori family violence in Aotearoa.* Wellington, New Zealand: Te Puni Kokiri (Ministry of Maori Affairs); 1997.
9. Fanslow J, Robinson E. Violence against women in New Zealand: prevalence and health consequences. *N Z Med J.* 2004;117(1206):U1173.
10. Morris A, Reilly J, Berry S, Ransom R. *New Zealand National Survey of Crime Victims 2001.* Wellington: Ministry of Justice; 2003.
11. Young W, Morris A, Cameron N, Haslett S. *New Zealand National Survey of Crime Victims 1996.* Wellington, New Zealand: Victimisation Survey Committee; 1997.
12. Morris A. *Women's Safety Survey 1996.* Wellington, New Zealand: Victimisation Survey Committee; 1997.
13. Ministry of Health. *The New Zealand Health Strategy.* Wellington, New Zealand: Ministry of Health; 2000.
14. Taskforce for Action on Violence Within Families. *The first report.* Wellington, New Zealand: Ministry of Social Development; 2006.
15. Koziol-McLain J, Gear C, Garrett N. *Hospital responsiveness to family violence: 60 month follow-up evaluation report*: Interdisciplinary Trauma Research Unit, Auckland University of Technology; 2010.
16. Karapetrovic S, Willborn W. Self-audit of process performance. *International Journal of Quality & Reliability Management.* 2002;19(1):24-45.
17. Karapetrovic S, Willborn W. Audit and self-assessment in quality management: comparison and compatibility. *Managerial Auditing Journal.* 2001;16(6):366-377.
18. Agency for Health Care Research and Quality. Evaluating domestic violence programs. http://www.ahrq.gov/research/domesticviol. Accessed 10 May,2004.
19. Coben J. Measuring the quality of hospital-based domestic violence programs. *Acad Emerg Med.* 2002;9(11):1176-1183.
20. McCaw B, Berman WH, Syme SL, Hunkeler EF. Beyond screening for domestic violence: a systems model approach in a managed care setting. *Am J Prev Med.* 2001;21(3):170-176.
21. Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *J Paediatr Child Health.* 2008;44(3):92-98.
22. O'Campo P, Kirst M, Tsamis C, Chambers C, Ahmad F. Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Soc Sci Med.* 2011;72(6):855-866.
23. Koziol-McLain J, Adams J, Neitzert E, et al. *Hospital responsiveness to family violence: Baseline audit findings*: Interdisciplinary Trauma Research Unit, Auckland University of Technology; 2004.
24. Shrout PE. Measurement reliability and agreement in psychiatry. *Stat Methods Med Res.* 1998;7(3):301-317.
25. Portney LG, Watkins MP. Statistical measures of validity. *Foundations of Clinical Research: Application to Practice*. 3rd ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2009:585-618.

26. Feder G, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med.* 2006;166(1):22-37.

27. Spangaro JM, Zwi AB, Poulos RG, Man WY. Who tells and what happens: disclosure and health service responses to screening for intimate partner violence. *Health Soc Care Community.* 2010;18(6):671-680.

28. Koziol-McLain J, Giddings L, Rameka M, Fyfe E. Intimate partner violence screening and brief intervention: Experiences of women in two New Zealand Health Care Settings. *Journal of Midwifery and Women's Health.* 2008;53(6):504-510.

29. Ministry of Justice. *The New Zealand Crime and Safety Survey: 2009.* Wellington NZ: Ministry of Justice; 2010.

30. Black MC, Breiding MJ. Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005. *MMWR.* 2008;57(5):113-117.

31. Campbell JC. Health consequences of intimate partner violence. *Lancet.* 2002;359(9314):1331-1336.

32. Russell JP. *The internal auditing pocket guide*. Second ed. Milkwaukee: American Society for Quality; 2007.

33. Karapetrovic S, Willborn W. Audit system: Concepts and practices. *Total Quality Management.* 2001;12(1):13 - 28.

34. Ministry of Health. *Toward Clinical Excellence.* Wellington, NZ: Ministry of Health; 2002.

35. Coben JH, Fisher EJ. Evaluating the implementation of hospital-based domestic violence programs. *Family Violence Prevention and Health Practice.* 2005;1(2):1-11.

36. Glasgow K, Fanslow J. *Family violence intervention guidelines: Elder abuse and neglect.* Wellington: Ministry of Health; 2006.

37. New South Wales Department of Health. *Routine screening for domestic violence program: Snapshot report 3 and 4.* North Sydney Australia: New South Wales Department of Health; 2007.

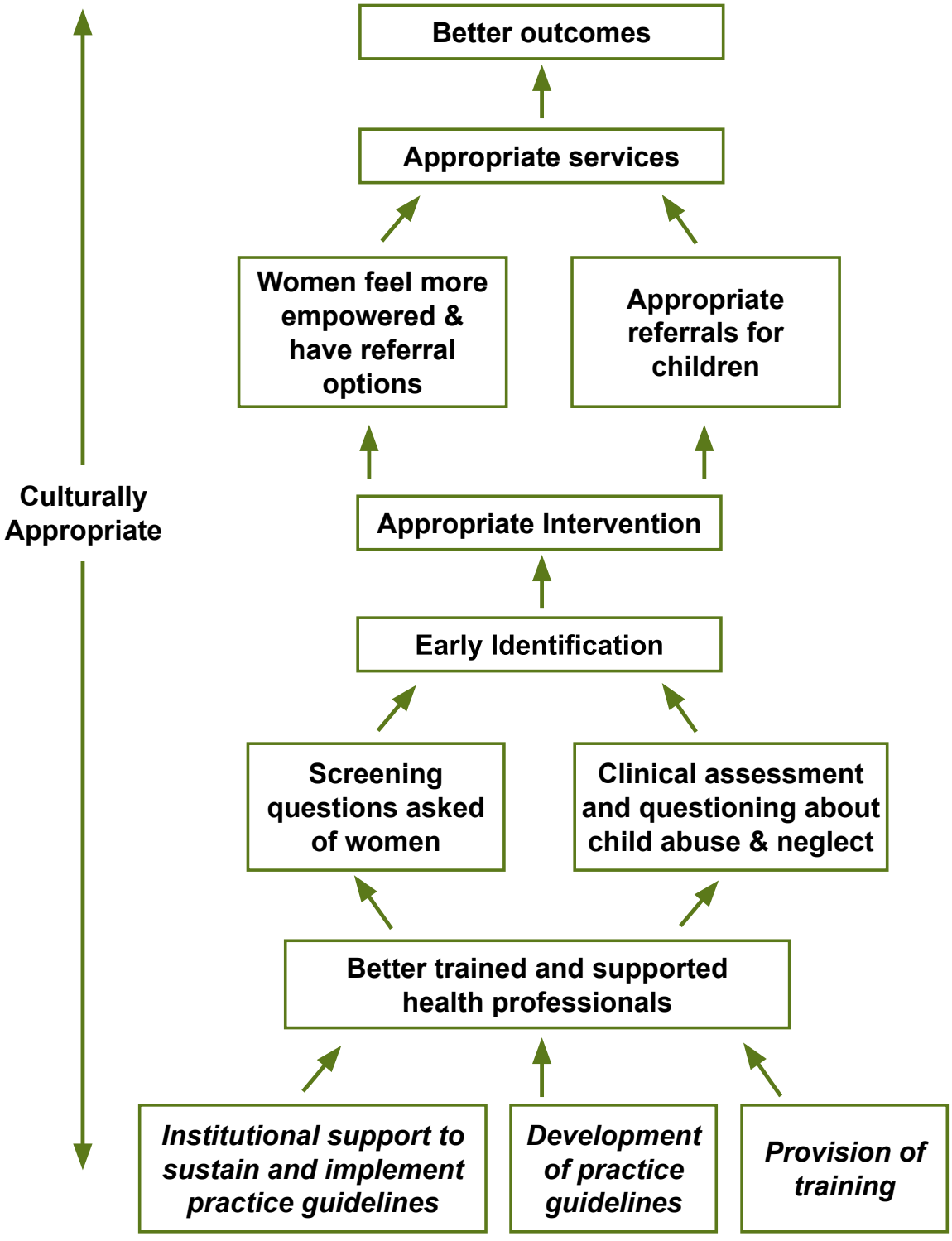
38. Ministry of Health. *Statement of Intent 2011-2014.* Wellington NZ 2011.

39. Pinheiro PS. *World Report on Violence Against Children*. Geneva: United Nations Secretary-General's Study on Violence Against Children; 2006.

40. Garcia-Moreno C, Heise L, Jansen HA, Ellsberg M, Watts C. Public health. Violence against women. *Science.* 2005;310(5752):1282-1283.

APPENDICES

APPENDIX A: Family Violence Project Programme Logic[6]



[6] MOH Advisory Committee; modified from Duignan, Version 4, 16-10-02

APPENDIX B: District Health Board Hospitals

District Health Board	Hospital	Level of care
Northland	Kaitaia	S
	Whangarei	s
Waitemata	North Shore	S
	Waitakere	S
Auckland	Auckland City	T
Counties Manukau	Middlemore	T
Waikato	Waikato	T
	Thames	S
Bay of Plenty	Tauranga	S
	Whakatane	S
Lakes	Rotorua	S
Tairawhiti	Gisborne	S
Taranaki	New Plymouth	S
Hawkes Bay	Hawkes Bay	S
Whanganui	Whanganui	S
MidCentral	Palmerston North	S
Capital and Coast	Wellington	T
Wairarapa	Wairarapa	S
Hutt Valley	Hutt	S
Nelson-Marlborough	Nelson	S
	Wairau	S
Canterbury	Christchurch	T
	Ashburton	S
West Coast	Grey Base	S
South Canterbury	Timaru	S
Southern	Otago	T
	Southland	S

S = secondary service, T = tertiary

Links to DHB Maps: http://www.moh.govt.nz/dhbmaps

APPENDIX C: 2010-2012 Audit Round Process

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VIP FAMILY VIOLENCE INTERVENTION PROGRAMME EVALUATION, 2010-2012
AUDIT INSTRUCTIONS

The VIP audit process is intended to provide opportunities for DHBs to build competence in the area of family violence service delivery, as well as measure progress over time. **Two rounds of audits** will be conducted at the 20 DHBs: the first audit round between 2010 and 2011 and the second between 2011 and 2012. Participation in the audit requires access only to DHB and hospital system-level information and materials. No patient data is required.

The Ministry of health expectation for the 2010-2011 audit round is that **at least 75% of DHBs will achieve the target score** (70/100, set by national and international data in 2004) **for both Partner Abuse and Child Abuse and Neglect programmes.** Alongside the fourth year of VIP funding, auditing will begin to transition from external to self-auditing.

We encourage audit preparation to occur throughout the year. The partner abuse and child abuse and neglect audit tools which include programme indicators and automated scoring (excel spreadsheet) are available to download at: www.aut.ac.nz/vipevaluation.

As discussed at VIP FVIC and managers meetings (May 2010) and Ministry of Health letter to DHB CEO (August 2010), the current audit round has two components, the **Self-Audit** and the **On-Site Audit**. Preparation for the **2010-2011 Audit Round** (September – June) is listed below.

The Self-Audit (approx 40 hours preparation):

1. Complete the DHB Characteristics form *(attached)*.
2. Complete the Partner Abuse and Child Abuse and Neglect excel audit tools.
3. E-mail the above items to Claire Gear at **least 2 weeks** prior to the scheduled on-site visit. Do not submit indicator evidence (such as policies and procedures) with the self-audit.

The On-site Audit (one day):

1. Compile indicator evidence for viewing by the auditor *(see audit tool measurement notes and attached suggested document list)*.
   a. Where the required information is part of a larger document, please flag the appropriate pages.
   b. Print out the *Designated Service Screening Rate Trend* tables (including disclosure trends) from the Quality Improvement Toolkit.
2. Arrange for audit visit with Professor Jane Koziol-McLain (e.g., venue details, transport).
3. Prepare audit day itinerary.
   a. Based on auditor travel, the audit should start between 8.00 am and 9.00 am.
   b. Arrange for a 30 minute debriefing meeting at the end of the audit day (between 4.30 pm and 5.30 pm)
4. In collaboration with portfolio manager, invite attendees to debriefing meeting.

Note: The one-day audit visits are structured to begin with an overview of the programme context followed by audit of both the Partner Abuse and Child Abuse and Neglect programmes using the audit tools. A 'walk-through' is included to note posters and pamphlets on display. All FVICs are expected to attend the day. FVICs and portfolio managers are expected to attend the debriefing meeting.

Reporting:

1. FVICs will receive a draft audit report approximately two weeks following the on-site audit including:
   a. Child abuse and neglect, partner abuse and cultural responsiveness programme scores, summary and recommendations.
   b. Self-Audit and On-Site audit agreement
2. FVICs to provide feedback on draft report in two weeks. ***Please note:*** **Feedback should be limited to correcting errors in scoring or interpretation. DHB plans to act on audit recommendations should be included in VIP reporting to the Ministry of Health.**
3. Final report encompassing feedback is sent to DHB CEO, copied to portfolio managers, FVICs and MOH.
4. A national report and summary documenting VIP programme development across the audit periods will be made available in July 2011.
   Confidentiality: In the past (2003 – 2009), DHBs were not identified in reports in order to support initial programme development. For 2010-2012 audit rounds, audit discussions and individual DHB reports provided by auditors will be kept confidential between the DHB and MOH VIP team. National reports of overall programme and cultural responsiveness scores, however, will identify DHBs (e.g, in league tables).

2011-2012 Audit Round (September - June):

- The second audit round (September 2011 to June 2012) will include a self-audit for all hospitals supplemented by an on-site audit limited to hospitals who do not achieve the MOH target score in round one (70/100 for both Partner Abuse and Child Abuse and Neglect programmes).
- DHBs receive an individualised report outlining their scores and programme recommendations for each audit round.
- These procedures aim to support devolution of external auditing in the future.
- A national report and summary documenting VIP programme development across the audit periods will be made available in July 2012.

Audit Support:

Audit support is available through various means. Regional FVICs may be the first point of contact. FVIC, particularly those new to the role, are encouraged to discuss audit preparation with the VIP National Manager. Please contact Claire Gear with queries about the audit tool or process. The Ministry of Health contact person is Sue Zimmerman. Please feel free to contact her on (09) 580 9145 or Sue_Zimmerman@moh.govt.nz in regards to the study.

Concerns: For concerns regarding the process or conduct of the audit please contact Jane Koziol-McLain or Sue Zimmerman.

Research Team:

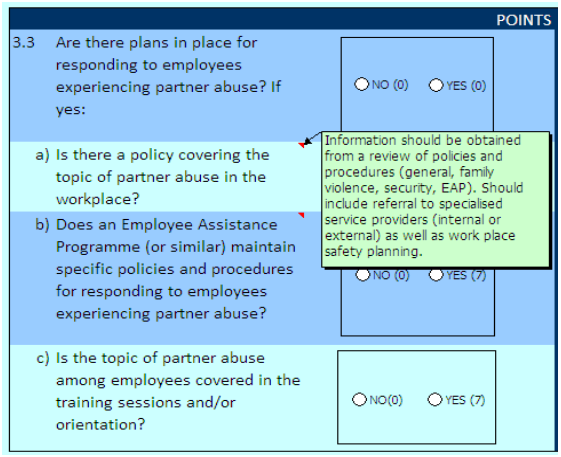
The on-site audits will be conducted by Professor Jane Koziol-McLain supported by Claire Gear.

Claire Gear, BSocSci (Hons) Research Officer Interdisciplinary Trauma Research Unit School of Health Care Practice Auckland University of Technology (09) 921 9999 x7152 claire.gear@aut.ac.nz	Professor Jane Koziol-McLain, PhD, RN Principal Investigator Interdisciplinary Trauma Research Unit School of Health Care Practice Auckland University of Technology (09) 921 9670 jkoziolm@aut.ac.nz

Gathering Evidence for your Audit:
Evidence is required to support scoring throughout the audit tools.
The audit tool indicators and measurement notes should be read to identify the required evidence to be collated.

Listed below is a range of documents that might be reviewed during the audit. We suggest you plan for the audit over an extended time period, completing the self-audit and evidence collection tool category by category.

Hover over the red triangles to view measurement notes



Suggested Documents:

- All written policies, protocols and procedures relevant to family violence (partner abuse & child abuse and neglect) and relevant department-specific policies and procedures regarding family violence e.g. security policy, interpreter policy.
- Documentation of the DHB'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 Māori and non-Maori/non-Pakeha (eg., Asian, Pacific Peoples, Lesbian Gay Bisexual Transgendered) women and children.
- Formal training plan, schedules of planned trainings for employees and materials used and/or distributed in any family violence training for staff
- Standardised forms or checklists (electronic or hard copy) used for family violence programmes including:
  - Domestic violence screening forms
  - Assessment, Intervention and referral forms
  - Consent to photograph forms for family violence cases
  - Intervention checklists for staff to use when victims are identified
  - Child abuse and neglect referral forms
- Information on quality improvement activities (refer to VIP Quality Improvement Toolkit) such as:
  - Assessments of staff attitude and knowledge of family violence
  - Chart audits to assess for family violence screening, detection and intervention
  - Other documented quality improvement activities
- Documentation of 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 governance, training, programme development, or service delivery
- Information on financial resources that the DHB provides for the family violence programme, including funding specifically for Maori initiatives (Whanau Ora), training, etc.
- 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.

PLEASE REFER TO AUDIT TOOLS AND MEASUREMENT NOTES REGARDING SPECIFIC INDICATORS

APPENDIX D: Delphi Scoring Weights

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

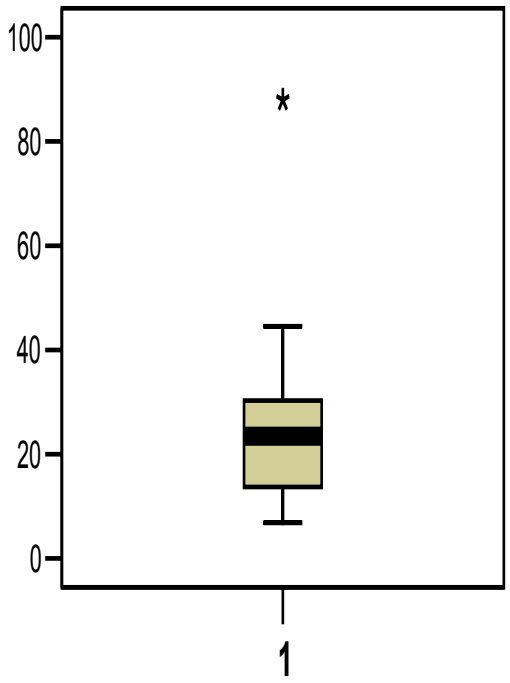
The weightings used for this study are provided below.

Domain	Partner Abuse	Child Abuse & Neglect	Revised Child Abuse & Neglect
1. Policies and Procedures	1.16	1.16	1.21
2. Physical Environment	0.86	0.86	.95
3. Institutional Culture	1.19	1.19	1.16
4. Training of staff	1.15	1.15	1.16
5. Screening and Safety Assessment	1.22	N/A	N/A
6. Documentation	0.95	0.95	1.05
7. Intervention Services	1.29	1.29	1.09
8. Evaluation Activities	1.14	1.14	1.01
9. Collaboration	1.04	1.04	1.17
10. Safety and Security	N/A	N/A	1.20

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

Total score for Child Abuse & Neglect = sum across domains (domain raw score*weight)/8.78

APPENDIX E: 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).

APPENDIX F. Partner Abuse Baseline and Follow-Up Scores

	Mean						Median						Hospitals Achieving Target Score (≥70) n (%)					
	B	***F_{12}***	***F_{30}***	***F_{48}***	***F_{60}***	***F_{84}***	***B***	***F_{12}***	***F_{30}***	***F_{48}***	***F_{60}***	***F_{84}***	***B***	***F_{12}***	***F_{30}***[b]	***F_{48}***	***F_{60}***	***F_{84}***
Overall Score	21.2	32.3	45.9	61.9	70.6	**82.8**	19.6	27.6	49.2	66.9	74.4	**84.4**	1 (4%)	2 (8%)	5 (19%)	13[a] (48%)	15 (56%)	**25 (93%)**
Standard Deviation	*18.1*	*21.9*	*26.2*	*21.6*	*20.1*	***11.5***												
Domain Scores																		
Policies and Procedures	22.3	31.5	47.0	59.3	66.2	**76.9**	19.4	29.5	48.8	62.0	75.1	**82.1**	1 (4%)	2 (8%)	7 (26%)	11 (41%)	16 (59%)	**20 (74%)**
Physical Environment	10.2	20.6	36.6	68.2	71.6	**84.9**	7.1	14.7	23.1	75.0	78.8	**91.3**	0 (0%)	1 (4%)	4 (15%)	16 (59%)	16 (59%)	**23 (85%)**
Institutional Culture	27.9	35.3	51.3	63.9	73.0	**86.2**	22.1	30.7	59.0	72.4	83.4	**88.9**	2 (8%)	5 (20%)	8 (30%)	15 (56%)	16(59%)	**23 (85%)**
Training of Providers	23.7	37.0	46.9	64.6	77.5	**89.1**	10.9	31.9	58.7	78.2	88.4	**89.1**	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	**26 (96%)**
Screening and Safety Assessment	14.3	17.1	34.5	55.8	60.2	**76.3**	0.0	0.0	42.5	65.3	73.2	**80.3**	1 (4%)	2 (8%)	5 (19%)	13 (48%)	15 (56%)	**18 (67%)**
Documentation	6.5	18.9	35.2	62.2	68.2	**78.1**	0.0	19.1	28.6	66.6	76.1	**90.4**	0 (0%)	0 (0%)	2 (7%)	12 (44%)	14 (52%)	**22 (82%)**
Intervention Services	33.6	46.3	57.1	62.1	76.3	**88.3**	26.4	45.7	62.1	65.0	79.2	**92.8**	4 (16%)	6 (24%)	9 (33%)	11 (41%)	17 (63%)	**24 (89%)**
Evaluation Activities	11.5	14.3	30.0	40.2	53.6	**69.6**	0.0	0.0	20.0	34.4	63.2	**66.4**	1 (4%)	1 (4%)	4 (15%)	6 (22%)	11 (41%)	**13 (48%)**
Collaboration	35.4	66.3	71.6	84.6	89.9	**96.3**	37.5	77.1	78.5	93.0	91.6	**100.0**	1 (4%)	15 (60%)	19 (70%)	23 (85%)	25 (93%)	**27 (100%)**

Notes: ***B*** =Baseline; ***F_{12}*** =12 month follow-up; ***F_{30}*** = 30 month follow-up; ***F_{48}*** = 48 month follow-up; ***F_{60}*** =60 month follow-up; ***F_{84}*** = 84 month follow-up; 70 is selected benchmark score

[a] Includes one hospital score which was rounded up during analysis; [b] 30 month follow-up percentages corrected.

APPENDIX G: Partner Abuse Delphi Item Analysis

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
CATEGORY 1. POLICIES AND PROCEDURES							
1.1	Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do policies:	10 (40%)	9 (36%)	21 (78%)	21 (78%)	22 (82%)	**26 (96%)**
	a) define partner abuse?	8 (32%)	9 (36%)	20 (74%)	21 (78%)	22 (82%)	**26 (96%)**
	b) mandate training on partner abuse for any staff?	4 (16%)	5 (20%)	18 (67%)	19 (70%)	20 (74%)	**26 (96%)**
	c) advocate universal screening for women anywhere in the hospital?	4 (16%)	6 (24%)	16 (59%)	20 (74%)	21 (78%)	**26 (96%)**
	d) define who is responsible for screening?	3 (12%)	4 (16%)	17 (63%)	20 (74%)	22 (82%)	**26 (96%)**
	e) address documentation?	7 (28%)	8 (32%)	19 (70%)	20 (74%)	21 (78%)	**26 (96%)**
	f) address referral of victims?	8 (32%)	8 (30%)	21 (78%)	20 (74%)	21 (78%)	**26 (96%)**
	g) address legal reporting requirements?	5 (20%)	6 (24%)	16 (60%)	19 (70%)	21 (78%)	**26 (96%)**
	h) address the responsibilities to, and needs of, Māori?	3 (12%)	6 (24%)	18 (67%)	17 (63%)	22 (82%)	**26 (96%)**
	i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups?	3 (12%)	5 (20%)	17 (63%)	12 (44%)	18 (67%)	**26 (96%)**
	k) address the needs of LGBT clients?	2 (8%)	2 (8%)	8 (30%)	11 (41%)	15 (56%)	**19 (70%)**
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the group:	15 (60%)	19 (76%)	19 (70%)	26 (96%)	26 (96%)	**27 (100%)**
	a) meet at least every month?	12 (48%)	14 (56%)	16 (59%)	22(82%)	14 (52%)	**8 (30%)**
	b) include representative(s) from more than two departments?	15 (60%)	19 (76%)	18 (67%)	26 (96%)	27 (100%)	**27 (100%)**
	c) include representative(s) from the security department?	0 (0%)	7 (28%)	7 (26%)	15 (56%)	16 (59%)	**18 (67%)**
	d) include physician(s) from the medical staff?	12 (48%)	16 (64%)	16 (59%)	24 (89%)	24 (89%)	**24 (89%)**
	e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?	4 (16%)	9 (36%)	14 (52%)	21 (78%)	21 (78%)	**25 (93%)**
	f) include representative(s) from hospital administration?	13 (52%)	16 (64%)	17 (63%)	21 (78%)	25 (93%)	**27 (100%)**
	g) include Māori representative(s)?	12 (48%)	17 (68%)	19 (70%)	24 (89%)	27 (100%)	**27 (100%)**
1.3	Does the hospital provide direct financial support for the partner abuse programme? If yes, how much annual funding? (*Choose one*):	14 (52%)	18 (72%)	18(67%)	21 (78%)	16 (59%)	**22 (81%)**
	a) < $5000/year	1 (4%)	1 (4%)	1 (4%)	0 (0%)	1 (4%)	**1 (4%)**
	b) $5000-$10,000/year	3 (12%)	3 (12%)	0 (0%)	1 (4%)	0 (0%)	**1 (4%)**
	c) > $10,000/year	10 (40%)	14 (56%)	17 (63%)	20 (74%)	15 (56%)	**20 (74%)**
1.3a	Is funding set aside specifically for Māori programmes and initiatives? If yes, how much annual funding?	1 (4%)	1 (4%)	2 (8%)	5 (19%)	9 (33%)	**13 (48%)**
	a) < $5000/year	1 (4%)	1 (4%)	1 (4%)	0 (0%)	1 (4%)	**2 (7%)**
	b) > $5000/year	0 (0%)	0 (0%)	1 (4%)	5 (19%)	8 (30%)	**11 (41%)**
1.4	Is there a mandatory universal screening policy in place? If yes, does the policy require screening of all women:	5 (20%)	6 (24%)	9 (33%)	19 (70%)	23 (85%)	**26 (96%)**
	a) in the emergency department (ED) or any other out-patient area?	0 (0%)	3 (12%)	1 (4%)	0 (0%)	2 (7%)	**2 (7%)**
	b) in in-patient units only?	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**
	c) in more than one out-patient area?	0 (0%)	1 (4%)	8 (30%)	1 (4%)	0 (0%)	**0 (0%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
	d) in both in-patient and out-patient areas?	5 (20%)	2 (8%)	10 (37%)	18 (67%)	21 (78%)	**24 (89%)**
1.5	Are there quality assurance procedures in place to ensure partner abuse screening? If yes:	5 (20%)	6 (24%)	10 (37%)	16 (59%)	20 (74%)	**23 (85%)**
	a) regular chart audits to assess screening?	2 (8%)	3 (12%)	10 (37%)	15 (56%)	18 (67%)	**23 (85%)**
	b) positive reinforcers to promote screening?	2 (8%)	3 (12%)	5 (19%)	9 (33%)	18 (67%)	**22 (82%)**
	c) is there regular supervision?	3 (12%)	6 (24%)	11 (40%)	14 (52%)	13 (48%)	**12 (44%)**
1.6	Are there procedures for security measures to be taken when victims of partner abuse are identified? If yes, are there:						
	a) written procedures that outline the security department's role in working with victims and perpetrators?	3 (12%)	8 (32%)	11 (40%)	10 (37%)	15 (56%)	**12 (44%)**
	b) procedures that include name/phone block for victims admitted to hospital?	3 (12%)	6 (24%)	8 (30%)	12 (44%)	17 (63%)	**20 (74%)**
	c) procedures that include provisions for safe transport from the hospital to shelter?	1 (4%)	4 (16%)	7 (26%)	13 (48%)	13 (48%)	**17 (63%)**
	d) do these procedures take into account the needs of Māori?	3 (12%)	4 (16%)	6 (22%)	9 (33%)	8 (30%)	**13 (48%)**
1.7	Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (*choose one*)	12 (48%)	16 (64%)	17 (63%)	21 (78%)	26 (96%)	**27 (100%)**
	a) part time position or included with other responsibilities?	11 (44%)	15 (68%)	15 (56%)	14 (52%)	8 (30%)	**13 (48%)**
	b) full-time position with no other responsibilities?	1 (4%)	1 (4%)	2 (7%)	7 (26%)	18 (67%)	**14 (52%)**
CATEGORY 2. PHYSICAL ENVIRONMENT							
2.1	Are there posters and/or brochures related to partner abuse on public display in the hospital? If yes, total number of *locations* (up to 35):	20 (80%)	25 (100%)	26 (96%)	27 (100%)	27 (100%)	**27 (100%)**
	0	5 (20%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	**0 (0%)**
	1-5	1 (44%)	14 (56%)	4 (15%)	2 (7%)	0 (0%)	**0 (%)**
	6-10	7 (28%)	6 (24%)	10 (37%)	3 (11%)	0 (0%)	**0 (%)**
	11-20	1 (4%)	3 (12%)	6 (22%)	3 (11%)	3 (11%)	**1 (4%)**
	21-35	1 (4%)	2 (8%)	6 (22%)	19 (70%)	24 (89%)	**26 (96%)**
	Are there Māori images related to partner abuse on public display in the hospital? If yes, total number locations (up to 17):	9 (36%)	17 (68%)	23 (85%)	27 (100%)	27 (100%)	**27 (100%)**
	0	16 (64%)	8 (32%)	4 (15%)	0 (0%)	0 (0%)	**0 (0%)**
	1-5	9 (36%)	13 (50%)	8 (30%)	6 (22%)	3 (11%)	**1 (4%)**
	6-10	0 (0%)	2 (8%)	6 (22%)	6 (22%)	4 (15%)	**0 (%)**
	11-17	0 (0%)	2 (8%)	7 (26%)	15 (56%)	20 (74%)	**26 (96%)**
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). If yes, total number locations (up to 35):	20 (80%)	24 (96%)	26 (96%)	27 (100%)	27 (100%)	**27 (100%)**
	0	5 (20%)	1 (4%)	1 (4%)	0 (0%)	0 (0%)	**0 (0%)**
	1-4	14 (56%)	12 (48%)	3 (11%)	3 (11%)	1 (4%)	**0 (0%)**
	5-10	4 (16%)	8 (32%)	10 (38%)	2 (7%)	0 (0%)	**0 (0%)**
	11-20	2 (8%)	2 (8%)	8 (30%)	5 (19%)	5 (19%)	**3 (11%)**
	21-35	0 (0%)	2 (8%)	5 (19%)	17 (63%)	21 (78%)	**23 (85%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
	Is there referral information related to Māori providers of partner abuse services on public display in the hospital? If yes, total number locations (up to 17):	8 (32%)	20 (80%)	24 (89%)	24 (89%)	24 (89%)	**25 (93%)**
	0	17 (68%)	5 (20%)	3 (11%)	3 (11%)	3 (11%)	**2 (7%)**
	1-4	8 (32%)	12 (48%)	7 (26%)	4 (15%)	4 (15%)	**0 (0%)**
	5-10	0 (0%)	6 (24%)	9 (33%)	10 (37%)	5 (19%)	**2 (7)**
	11-17	0 (0%)	2 (8%)	6 (22%)	10 (37%)	15 (44%)	**23 (85%)**
	Is there referral information related to non- Māori non-Pakeha on public display? If yes, total number locations (up to 17):	4 (16%)	7 (28%)	13 (48%)	23 (85%)	21 (79%)	**25 (93%)**
	0	21 (84%)	18 (72%)	14 (52%)	4 (15%)	6 (22%)	**2 (7%)**
	1	4 (16%)	5 (20%)	6 (22%)	0 (0%)	2 (7%)	**0 (0%)**
	2-6	0 (0%)	1 (4%)	4 (15%)	9 (33%)	7 (26%)	**4 (15 %)**
	7-17	0 (0%)	1 (4%)	3 (11%)	14 (52%)	12 (44%)	**21 (78%)**
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*)	4 (16%)	7 (28%)	10 (37%)	22 (82%)	16 (59%)	**20 (74%)**
	a) Victims are permitted to stay in ED until placement is secured.	0 (0%)	1 (4%)	2 (7%)	1 (4%)	0 (0%)	**1 (4%)**
	b) Victims are provided with safe respite room, separate from ED, until placement is secured.	1 (4%)	2 (8%)	0 (0%)	1 (4%)	0 (0%)	**0 (0%)**
	c) In-patient beds are available for victims until placement is secured.	3 (12%)	4 (16%)	8 (30%)	20 (74%)	16 (59%)	**19 (70%)**
	d) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	5 (20%)	6 (24%)	7 (26%)	16 (59%)	15 (56%)	**18 (67%)**
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 partner abuse? If yes, which groups have been assessed?						
	a) nursing staff	5 (20%)	9 (36%)	13 (48%)	16 (59%)	19 (70%)	**26 (96%)**
	b) medical staff	5 (20%)	7 (28%)	6 (22%)	14 (52%)	15 (56%)	**19 (70%)**
	c) administration	4 (16%)	7 (28%)	7 (26%)	13 (48%)	15 (56%)	**19 (70%)**
	d) other staff/employees	3 (12%)	8 (32%)	8 (30%)	15 (56%)	19 (70%)	**25 (93%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse?	1 (4%)	1 (4%)	1 (4%)	6 (22%)	9 (33%)	**17 (63%)**
3.2	How long has the hospital's partner abuse programme been in existence?						
	1-24 months	13 (52%)	15 (60%)	7 (26%)	5 (19%)	8 (30%)	**3 (11%)**
	24-48 months	2 (8%)	3 (12%)	9 (33%)	5 (19%)	5 (19%)	**5 (19%)**
	>48 months	0 (0%)	1 (4%)	3 (11%)	13 (48%)	14 (52%)	**19 (70%)**
3.3	Does the hospital have plans in place for responding to employees experiencing partner abuse?	15 (60%)	15 (60%)	16 (59%)	21 (78%)	22 (82%)	**25 (93%)**
	a) Is there a hospital policy covering the topic of partner abuse in the workplace?	2 (8%)	1 (4%)	11 (41%)	11 (41%)	14 (52%)	**25 (93%)**
	b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with employees experiencing partner abuse?	9 (36%)	6 (24%)	13 (48%)	5 (19%)	12 (44%)	**12 (44%)**
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation?	10 (40%)	10 (40%)	16 (59%)	22 (82%)	25 (93%)	**25 (93%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
3.4	Does the hospital's partner abuse programme address cultural competency issues? If yes:						
	a) Does the hospital's policy specifically recommend universal screening regardless of the patient's cultural background?	4 (16%)	4 (16%)	17 (63%)	21 (78%)	21 (78%)	**26 (96%)**
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	9 (36%)	10 (40%)	14 (52%)	19 (70%)	23 (85%)	**25 (93%)**
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	22 (88%)	25 (100%)	26 (96%)	23 (85%)	25 (93%)	**27 (100%)**
	d) Are referral information and brochures related to partner abuse available in languages other than English?	5 (20%)	6 (24%)	11 (41%)	23 (85%)	27 (100%)	**27 (100%)**
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: (*a or b and answer c*)	14 (56%)	15 (60%)	20 (74%)	23 (85%)	24 (89%)	**27 (100%)**
	a) 1 programme in the last 12 months?	9 (36%)	5 (20%)	8 (30%)	1 (4%)	4 (15%)	**0 (0%)**
	b) >1 programme in the last 12 months?	5 (20%)	10 (40%)	12 (44%)	22 (82%)	20 (74%)	**27 (100%)**
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	8 (32%)	12 (48%)	17 (63%)	21 (78%)	24 (89%	**24 (89%)**
CATEGORY 4. TRAINING OF PROVIDERS							
4.1	Has a formal training plan been developed for the institution? If yes:	5 (20%)	9 (36%)	16 (59%)	18 (67%)	24 (89%)	**25 (93%)**
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	4 (16%)	8 (32%)	15 (56%)	19 (70%)	24 (89%)	**26 (96%)**
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	2 (8%)	7 (28%)	15 (56%)	14 (52%)	16 (59%)	**21 (78%)**
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?	3 (12%)	6 (24%)	12 (44%)	16 (59%)	19 (70%)	**26 (96%)**
	b) to members of the clinical staff via colloquia or other sessions?	5 (20%)	15 (60%)	17 (63%)	22 (82%)	27 (100%)	**27 (100%)**
4.3	Does the hospital's training/education on partner abuse include information about:						
	a) definitions of partner abuse?	10 (40%)	14 (56%)	15 (56%)	24 (89%)	23 (85%)	**25 (93%)**
	b) dynamics of partner abuse?	11 (44%)	14 (56%)	15 (56%)	24 (89%)	25 (93%)	**27 (100%)**
	c) epidemiology?	9 (36%)	13 (52%)	14 (52%)	25 (93%)	25 (93%)	**27 (100%)**
	d) health consequences?	9 (36%)	13 (52%)	14 (52%)	25 (93%)	25 (93%)	**27 (100%)**
	e) strategies for screening?	9 (36%)	12 (48%)	12 (44%)	18 (67%)	23 (85%)	**24 (89%)**
	f) risk assessment?	7 (28%)	11 (44%)	12 (44%)	21 (78%)	22 (82%)	**27 (100%)**
	g) documentation?	10 (40%)	13 (52%)	12 (44%)	23 (85%)	24 (89%)	**23 (85%)**
	h) intervention?	8 (32%)	13 (52%)	13 (48%)	23 (85%)	23 (85%)	**25 (93%)**
	i) safety planning?	10 (40%)	9 (36%)	11 (41%)	20 (74%)	22 (82%)	**24 (89%)**
	j) community resources?	5 (20%)	14 (56%)	12 (44%)	24 (89%)	25 (93%)	**25 (93%)**
	k) reporting requirements?	6 (24%)	10 (40%)	12 (44%)	22 (82%)	22 (82%)	**27 (100%)**
	l) legal issues?	6 (24%)	12 (48%)	12 (44%)	19 (70%)	22 (82%)	**27 (100%)**
	m) confidentiality?	9 (36%)	12 (48%)	12 (44%)	25 (93%)	22 (82%)	**27 (100%)**
	n) cultural competency?	7 (28%)	10 (40%)	10 (37%)	21 (78%)	21 (78%)	**26 (96%)**
	o) clinical signs/symptoms?	9 (36%)	14 (56%)	14 (52%)	22 (82%)	25 (93%)	**24 (89%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
	p) Māori models of health?	3 (12%)	6 (24%)	7 (26%)	17 (63%)	20 (74%)	**23 (85%)**
	q) risk assessment for children of victims?	6 (24%)	11 (44%)	12 (44%)	24 (89%)	24 (89%)	**27 (100%)**
	r) social, cultural, historic, and economic context in which Māori family violence occurs?	2 (8%)	5 (20%)	6 (22%)	17 (63%)	17 (63%)	**22 (82%)**
	s) te Tiriti o Waitangi?	3 (12%)	5 (20%)	4 (15%)	15 (56%)	18 (67%)	**23 (85%)**
	t) Māori service providers and community resources?	7 (28%)	13 (52%)	12 (44%)	24 (89%)	25 (93%)	**24 (89%)**
	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	3 (12%)	5 (20%)	7 (26%)	18 (67%)	24 (89%)	**23 (85%)**
	v) partner abuse in same-sex relationships?	3 (12%)	5 (20%)	8 (30%)	21 (78%)	22 (82%)	**25 (93%)**
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships?	1 (4%)	3 (12%)	5 (19%)	16 (59%)	20 (74%)	**19 (70%)**
4.4	Is the partner abuse training provided by: (*choose one a-d and answer e-f*)						
	a) no training provided	12 (48%)	11 (44%)	8 (30%)	2 (7%)	1 (4%)	**0 (0%)**
	b) a single individual?	2 (8%)	2 (8%)	8 (30%)	3 (11%)	3 (11%)	**0 (%)**
	c) a team of hospital employees only?	0 (0%)	1 (4%)	1 (4%)	1 (4%)	3 (11%)	**1 (4%)**
	d) a team, including community expert(s)?	11 (44%)	11 (44%)	10 (37%)	21 (78%)	20 (74%)	**26 (96%)**
	If provided by a team, does it include:						
	e) a Māori representative?	7 (28%)	10 (40%)	8 (30%)	16 (59%)	19 (70%)	**25 (93%)**
	f) a representative(s) of other ethnic/cultural groups?	2 (8%)	2 (8%)	1 (4%)	2 (7%)	12 (44%)	**13 (48%)**
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)	3 (12%)	4 (16%)	7 (26%)	21 (78%)	20 (80%)	**27 (100%)**
	a) included, as a separate form, in the clinical record?	0 (0%)	3 (12%)	5 (19%)	2 (7%)	0 (0%)	**0 (0%)**
	b) incorporated as questions in the clinical record for all charts in ED or other out-patient area?	0 (0%)	0 (0%)	0 (0%)	6 (22%)	5 (19%)	**4 (15%)**
	c) incorporated as questions in the clinical record for all charts in two or more out-patient areas?	0 (0%)	0 (0%)	0 (0%)	3 (11%)	10 (37%)	**16 (59%)**
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas?	1 (4%)	1 (4%)	3 (11%)	10 (37%)	8 (30%)	**7 (26%)**
5.2	What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area)?						
	Not done or not applicable	23 (92%)	22 (88%)	17 (63%)	13 (48%)	9 (33%)	**5 (19%)**
	0% - 10%	0 (0%)	0 (0%)	3 (11%)	7 (26%)	5 (19%)	**2 (8%)**
	11% - 25%	2 (8%)	0 (0%)	1 (4%)	1 (4%)	6 (22%)	**5 (19%)**
	26% - 50%	0 (0%)	1 (4%)	4 (15%)	2 (7%)	5 (19%)	**9 (33%)**
	51% - 75%	0 (0%)	1 (8%)	1 (4%)	3 (11%)	2 (7%)	**6 (22%)**
	76% - 100%	0 (0%)	0 (0%)	1 (4%)	1 (4%)	0 (0%)	**0 (%)**
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this:	8 (32%)	7 (28%)	15 (60%)	20 (74%)	21 (78%)	**26 (96%)**
	a) also assess the safety of any children in the victim's care?	7 (28%)	7 (28%)	14 (52%)	20 (74%)	21 (78%)	**26 (96%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
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:	3 (12%)	5 (20%)	13 (48%)	19 (70%)	25 (93%)	**27 (100%)**
	a) information on the results of partner abuse screening?	1 (4%)	9 (36%)	14 (52%)	19 (70%)	25 (93%)	**27 (100%)**
	b) the victim's description of current and/or past abuse?	2 (8%)	4 (16%)	9 (33%)	15 (56%)	15 (56%)	**19 (70%)**
	c) the name of the alleged perpetrator and relationship to the victim?	1 (4%)	2 (8%)	10 (37%)	17 (63%)	16 (59%)	**18 (67%)**
	d) a body map to document injuries?	3 (12%)	6 (24%)	10 (37%)	13 (48%)	18 (67%)	**21 (78%)**
	e) information documenting the referrals provided to the victim?	1 (4%)	4 (16%)	11 (41%)	18 (67%)	20 (74%)	**26 (96%)**
	f) in the case of Māori, information documenting whether the individual was offered a Māori advocate?	0 (0%)	3 (12%)	5 (19%)	11 (41%)	9 (33%)	**19 (70%)**
6.2	Is forensic photography incorporated in the documentation procedure? If yes:						
	a) Is a fully operational camera with adequate film available in the treatment area?	1 (4%)	7 (28%)	11 (41%)	23 (85%)	24 (89%)	**25 (93%)**
	b) Do hospital staff receive on-going training on the use of the camera?	2 (8%)	2 (8%)	8 (30%)	14 (52%)	21 (78%)	**21 (78%)**
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	1 (4%)	1 (4%)	2 (7%)	15 (56%)	8 (30%)	**11 (41%)**
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	5 (20%)	12 (48%)	17 (63%)	21 (78%0	23 (85%)	**22 (82%)**
	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?	0 (0%)	1 (4%)	3 (11%)	16 (59%)	19 (70%)	**22 (82%)**
CATEGORY 7. INTERVENTION SERVICES							
7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	7 (28%)	7 (28%)	16 (59%)	22 (82%)	22 (82%)	**26 (96%)**
7.2	Are on-site victim advocacy services provided? If yes, *choose one a-b and answer c-d)*:	13 (52%)	20 (80%)	24 (89%)	25 (93%)	25 (93%)	**26 (96%)**
	a) A trained victim advocate provides services during certain hours.	7 (28%)	8 (32%)	7 (26%)	17 (63%)	7 (26%)	**7 (26%)**
	b) A trained victim advocate provides service at all times.	6 (24%)	12 (48%)	17 (63%)	8 (30%)	18 (67%)	**19 (70%)**
	c) is a Māori advocate is available on-site for Māori victims?	8 (32%)	14 (56%)	20 (74%)	27 (100%)	27 (100%)	**27 (100%)**
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite?	3 (12%)	6 (24%)	9 (33%)	9 (33%)	15 (56%)	**24 (89%)**
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose one*)	14 (56%)	15 (60%)	20 (74%)	21 (78%)	23 (85%)	**26 (96%)**
	a) available, when indicated?	8 (32%)	13 (52%)	17 (63%)	17 (63%)	8 (30%)	**0 (0%)**
	b) performed routinely?	6 (24%)	2 (8%)	3 (11%)	4 (15%)	15 (56%)	**26 (96%)**
7.4	Is transportation provided for victims, if needed?	3 (12%)	6 (24%)	6 (22%)	20 (74%)	15 (56%)	**18 (67%)**
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment?	11 (44%)	14 (56%)	12 (44%)	13 (48%)	20 (74%)	**19 (70%)**
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims?	13 (52%)	12 (48%)	12 (44%)	7 (26%)	13 (48%)	**23 (85%)**
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims?	15 (60%)	17 (68%)	23 (85%)	21 (78%)	23 (85%)	**26 (96%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
7.8	Is there evidence of coordination between the hospital partner abuse programme and sexual assault, mental health and substance abuse screening and treatment?	8 (32%)	13 (52%)	19 (70%)	15 (56%)	26 (96%)	**26 (96%)**
CATEGORY 8. EVALUATION ACTIVITIES							
8.1	Are any formal evaluation procedures in place to monitor the quality of the partner abuse programme? If yes:	8 (32%)	8 (32%)	15 (56%)	17 (63%)	21 (78%)	**27 (100%)**
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening?	2 (8%)	3 (12%)	9 (33%)	16 (59%)	18 (67%)	**22 (82%)**
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse?	2 (8%)	5 (20%)	6 (22%)	13 (48%)	19 (70%)	**23 (85%)**
8.2	Do health care providers receive standardized feedback on their performance and on patients?	1 (4%)	3 (12%)	7 (26%)	10 (37%)	13 (48%)	**15 (56%)**
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme?	2 (4%)	1 (4%)	4 (15%)	6 (22%)	14 (52%)	**17 (63%)**
8.4	Is a quality framework (such as Whanau Ora) used to evaluate whether services are effective for Māori?	2 (8%)	1 (4%)	3 (11%)	4 (15%)	4 (15%)	**10 (37%)**
CATEGORY 9. COLLABORATION							
9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	22 (88%)	24 (96%)	24 (89%)	26 (96%)	27 (100%)	**27 (100%)**
	a) which types of collaboration apply:						
	i) collaboration with training?	9 (36%)	15 (60%)	15 (55%)	21 (78%)	24 (89%)	**26 (96%)**
	ii) collaboration on policy and procedure development?	11 (44%)	17 (68%)	20 (74%)	21 (78%)	27 (100%)	**27 (100%)**
	iii) collaboration on partner abuse working group?	6 (24%)	18 (72%)	21 (78%)	21 (78%)	24 (89%)	**25 (93%)**
	iv) collaboration on site service provision?	10 (40%)	18 (72%)	21 (78%)	24 (89%)	21 (78%)	**26 (96%)**
	b) is collaboration with						
	i) Māori provider(s) or representative(s)?	18 (72%)	23 (92%)	23 (85%)	25 (93%)	27 (100%)	**27 (100%)**
	iii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	4 (16%)	9 (36%)	12 (44%)	14 (52%)	22 (82%)	**24 (89%)**
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes:	16 (64%)	20 (80%)	20 (74%)	26 (96%)	26 (96%)	**27 (100%)**
	a) collaboration with training?	4 (16%)	12 (48%)	14 (52%)	22 (82%)	20 (74%)	**25 (93%)**
	b) collaboration on policy and procedure development?	5 (20%)	14 (56%)	16 (59%)	23 (85%)	25 (93%)	**27 (100%)**
	c) collaboration on partner abuse working group?	3 (12%)	18 (72%)	19 (70%)	22 (82%)	21 (78%)	**24 (89%)**
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	21 (84%)	22 (88%)	24 (89%)	26 (96%)	27 (100%)	**27 (100%)**
	a) within the same health care system?	13 (52%)	19 (76%)	22 (82%)	26 (96%)	27 (100%)	**27 (100%)**
	If yes, with a Māori health unit?	12 (48%)	18 (72%)	21 (78%)	25 (93%)	27 (100%)	**27 (100%)**
	b) with other systems in the region?	18 (72%)	21 (21%)	19 (70%)	26 (96%)	26 (96%)	**27 (100%)**
	If yes, with a Māori health provider?	2 (8%)	13 (52%)	19 (70%)	25 (93%)	25 (93%)	**26 (96%)**

APPENDIX H. Child Abuse and Neglect Baseline and Follow-Up Scores

	Mean						*Median*						*Hospitals Achieving Target Score ≥70*					
	B	***F_{12}***	***F_{30}***	***F_{48}***	***F_{60}***	***F_{84}***	***B***	***F_{12}***	***F_{30}***	***F_{48}***	***F_{60}***	***F_{84}***	***B***	***F_{12}***	***F_{30}***[b]	***F_{48}***	***F_{60}***	***F_{84}***
Overall Score	40.6	49.5	56.5	72.62	77.8	**85.3**	36.7	50.8	59.3	74.5	80.9	**86.5**	2 (8%)	3 (12%)	4 (15%)	17 (65%)	21 (78%)	**25 (93%)**
Standard Deviation	*19.4*	*18.4*	*16.6*	*12.4*	*11.1*	***8.5***												
Domain Scores																		
Policies and Procedures	44.6	51.1	58.5	78.9	78.4	**88.7**	42.5	50.0	59.7	81.0	84.0	**92.0**	3 (12%)	5 (20%)	8 (29%)	23 (89%)	19 (70%)	**26 (96%)**
Safety & Security	-	-	-	75.0	71.9	**80.4**	-	-	-	77.0	72.0	**82.0**	-	-	-	17 (65%)	17 (63%)	**23 (85%)**
Collaboration	45.1	70.4	78.3	81.5	86.8	**90.3**	46.5	70.8	85.4	82.5	91.0	**94.0**	5 (20%)	15 (60%)	20 (74%)	21 (81%)	25 (93%)	**26 (96%)**
Institutional Culture	40.9	46.2	55.0	73.8	76.3	**83.4**	41.5	43.4	56.6	80.0	82.0	**86.0**	3 (12%)	5 (20%)	6 (22%)	18 (69%)	20 (74%)	**25 (93%)**
Training of Providers	36.8	51.5	58.4	78.4	86.3	**94.3**	39.7	49.4	66.7	92.5	96.0	**98.0**	2 (8%)	9 (36%)	14 (52%)	19 (73%)	22 (82%)	**26 (96%)**
Intervention Services	62.4	67.7	70.0	77.8	81.5	**87.4**	65.4	70.4	72.8	82.0	84.0	**89.0**	12 48%)	13 (52%)	15 (56%)	21 (81%)	22 (82%)	**27 (100%)**
Documentation	30.9	35.6	49.1	79.9	80.0	**82.9**	19.0	28.6	58.4	83.5	83.0	**87.0**	5 (20%)	5 (20%)	8 (29%)	22 (85%)	19 (70%)	**22 (82%)**
Evaluation Activities	31.9	35.1	37.7	34.6	49.1	**64.4**	35.1	36.6	36.6	29.8	58.5	**72.0**	1 (4%)	1 (4%)	5 (19%)	3 (12%)	7 (26%)	**14 (52%)**
Physical Environment	23.2	30.6	39.5	68.6	88.3	**95.1**	23.0	28.0	35.6	68.0	91.0	**100.0**	1 (4%)	2 (5%)	2 (7%)	12 (46%)	26 (96%)	**27 (100%)**

Notes: ***B*** =Baseline; ***F_{12}*** =12 month follow-up; ***F_{30}*** = 30 month follow-up; ***F_{48}*** = 48 month follow-up; ***F_{60}*** = 60 month follow-up; ***F_{84}*** = 84 month follow-up; 70 is selected benchmark score

[b] 30 month follow-up percentages corrected.

APPENDIX I: Revised Child Abuse and Neglect Delphi Tool Item Analysis

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
CATEGORY 1. POLICIES AND PROCEDURES							
1.1	Are there official, written DHB policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If so, do the policies:	23 (92%)	24 (96%)	27 (100%)	24 (92%)	26 (96%)	**26 (96%)**
	a) Define child abuse and neglect?	17 (68%)	21 (84%)	26 (96%)	24 (92%)	25 (93%)	**27 (100%)**
	b) Mandate training on child abuse and neglect for staff?	8 (32%)	8 (32%)	21 (78%)	22 (85%)	22 (82%)	**26 (96%)**
	c) Outline age-appropriate protocols for risk assessment?	5 (20%)	5 (20%)	11 (41%)	12 (46%)	12 (44%)	**20 (74%)**
	d) Define who is responsible for risk assessment?	19 (76%)	22 (88%)	25 (93%)	20 (77%)	21 (78%)	**27 (100%)**
	e) Address the issue of contamination during interviewing?	11 (44%)	16 (64%)	20 (74%)	17 (65%)	17 (63%)	**24 (89%)**
	f) Address documentation?	21 (84%)	23 (92%)	26 (96%)	24 (92%)	26 (96%)	**27 (100%)**
	g) Address referrals for children and their families?	22 (88%)	24 (96%)	27 (100%)	23 (89%)	26 (96%)	**27 (100%)**
	h) Address child protection reporting requirements?	19 (76%)	19 (76%)	26 (96%)	24 (92%)	26 (96%)	**27 (100%)**
	i) Address the responsibilities to, and needs of, Māori?	14 (56%)	16 (64%)	23 (85%)	18 (69%)	22 (82%)	**27 (100%)**
	j) Address other cultural and/or ethnic groups?	12 (48%)	15 (60%)	15 (56%)	18 (69%)	16 (59%)	**27 (100%)**
1.2	Who is consulted regarding child protection policies and procedures?						
	a) Is there evidence of consultation with agencies and groups listed below, which MUST include consultation with Māori and Pacific?				25 (96%)	25 (93%)	**26 (96%)**
	Maori and Pacific?				25 (6%)	25 (93%)	**26 (96%)**
	CYF?				25 (96%)	25 (93%)	**27 (100%)**
	Police?				25 (96%)	24 (89%)	**24 (89%)**
	Child abuse and neglect programme and Violence Intervention Programme staff?				26 (100%)	26 (96%)	**27 (100%)**
	Plus Other Agencies: such as Refuge; National Network of Stopping Violence Services (NNSVS); Office of the Children's Commissioner (OCC); Community Alcohol & Drug Service (CADS)				25 (96%)	25 (93%)	**25 (93%)**
1.3	Is there evidence of a DHB-based child abuse and neglect steering group? If yes, does the:						
	a) Steering group meet at least every three (3) months?				24 (92%)	24 (89%)	**25 (93%)**
	b) Include representatives from more than two departments?				25 (96%)	25 (93%)	**26 (96%)**
1.4	Does the DHB provide direct financial support for the child abuse and neglect programme? If yes, how much annual funding is allocated:	17 (68%)	19 (76%)	23 (85%)	23 (89%)	21 (78%)	**25 (93%)**
	a) No funding allocated?				3 (12%)	6 (22%)	**2 (7%)**
	b) <$5000 per year?	2 (8%)	0 (0%)	1 (4%)	0 (0%)	1 (4%)	**1 (4%)**
	c) $5000 to $10,000 per year?	1 (4%)	3 (12%)	1 (4%)	1 (4%)	0 (0%)	**1 (4%)**
	d) >$10,000 per year?	14 (56%)	16 (64%)	21 (78%)	23 (89%)	20 (74%)	**23 (85%)**
	e) Is funding set aside specifically for Māori programmes and initiatives (choose one):	5 (20%)	2 (8%)	4 (15%)	8 (31%)	8 (30%)	**13 (48%)**
	f) <$5000 per year?	3 (12%)	1 (4%)	1 (4%)	0 (0%)	1 (4%)	**2 (7%)**
	g) >$5000 per year?	2 (8%)	1 (4%)	3 (11%)	8 (31%)	7 (26%)	**11 (41%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
1.5	Is there a 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):	23 (92%)	24 (96%)	24 (89%)	26 (100%)	24 (89%)	**27 (100%)**
	a) In the Emergency Department or other outpatient area?	1 (4%)	3 (12%)	3 (11%)	3 (12%)	0 (0%)	**0 (0%)**
	b) Inpatient units only?	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**
	c) In more than one outpatient area?	1 (4%)	1 (4%)	1 (4%)	0 (0%)	0 (0%)	**0 (0%)**
	d) In both inpatient and outpatient areas?	21 (84%)	20 (80%)	20 (74%)	23 (89%)	24 (89%)	**27 (100%)**
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 the procedures:						
	a) written?	4 (16%)	10 (40%)	13 (48%)	21 (81%)	26 (96%)	**27 (100%)**
	b) include name/phone block?	1 (4%)	3 (12%)	6 (22%)	9 (35%)	12 (44%)	**17 (63%)**
	c) provide for safe transportation?	2 (8%)	5 (20%)	3 (11%)	12 (46%)	15 (56%)	**19 (70%)**
	d) account for the needs of Māori?	2 (8%)	4 (16%)	7 (26%)	15 (58%)	15 (56%)	**16 (59%)**
1.7	Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one):	14 (56%)	16 (64%)	19 (70%)	23 (89%)	22 (82%)	**26 (96%)**
	a) part-time <0.5 FTE				5 (19%)	2 (7%)	**1 (4%)**
	a) part-time ≥0.5 FTE?				11 (42%)	11 (41%)	**13 (48%)**
	b) full-time?	5 (20%)	4 (16%)	4 (15%)	7 (27%)	9 (33%)	**12 (44%)**
1.8	Are there policies that outline the minimum expectation for all staff:						
	a) to attend mandatory training?				20 (77%)	23 (85%)	**26 (96%)**
	b) to identification and referral children at risk?				24 (92%)	27 (100%)	**27 (100%)**
	c) to reporting child protection concerns?				24 (92%)	25 (93%)	**25 (93%)**
1.9	Do the child abuse and neglect policies and procedures indicate collaboration with government agencies and other relevant groups, such as the Police, CYF, refuge, and NNSVS ('men's programme provider')?						
	a) government agencies?				25 (96%)	27 (100%)	**27 (100%)**
	b) community groups?				22 (85%)	23 (85%)	**26 (96%)**
1.10	Are the DHB policies and procedures easily accessible and user-friendly? If yes, are				26 (100%)	25 (93%)	**27 (100%)**
	a) they available on the DHB intranet?				26 (100%)	25 (93%)	**27 (100%)**
	b) there supporting and reference documents appended to the appropriate policies and procedures?				24 (92%)	27 (100%)	**27 (100%)**
	c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms?				25 (96%)	27 (100%)	**27 (100%)**
1.11	Are the DHB policies and procedures cross-referenced to other forms of family violence, such as partner abuse and elder abuse?				20 (77%)	20 (74%)	**26 (96%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
CATEGORY 2. SAFETY & SECURITY							
2.1	Does the DHB have a policy in place that all children are assessed when signs and symptoms are suggestive of abuse and/or neglect?				24 (92%)	26 (96%)	**25 (93%)**
2.2	Does the DHB have a protocol for collaborative safety planning for children at high risk?						
	a) are safety plans available or used for children identified at risk? Which types of collaboration apply:				22 (85%)	21 (78%)	**26 (96%)**
	b) within the DHB?				23 (89%)	26 (96%)	**27 (100%)**
	c) with other groups and agencies in the region?				23 (89%)	25 (93%)	**26 (96%)**
	d) with Māori and Pacific health providers?				22 (85%)	23 (85%)	**24 (89%)**
	e) with other relevant ethnic/cultural groups?				13 (50%)	19 (70%)	**22 (82%)**
	f) with the primary health sector?				15 (58%)	11 (41%)	**11 (41%)**
2.3	Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect while in the DHB?				24 (92%)	25 (93%)	**27 (100%)**
	a) within the DHB alone?				24 (92%)	25 (93%)	**27 (100%)**
	b) with relevant primary health care providers as part of discharge planning?				16 (62%)	13 (48%)	**12 (44%)**
	c) by accessing necessary support services for the child and family to promote ongoing safety of the child?				23 (89%)	17 (63%)	**22 (82%)**
2.4	Do inpatient facilities have a security plan where people at risk of perpetrating abuse, or who have a protection order against them, can be denied entry?				22 (85%)	24 (89%)	**25 (93%)**
	a) 1-2 departments? OR				1 (4%)	0 (0%)	**0 (0%)**
	b) >3 departments?				21 (81%)	25 (93%)	**25 (93%)**
2.5	Do the DHB services have an alert system or a central database recording any concerns about children at risk of abuse and neglect in place?						
	b) a local alert system in acute care setting				16 (62%)	21 (78%)	**25 (93%)**
	c) a local alert system in community setting, including PHO				2 (8%)	2 (7%)	**8 (30%)**
	d) a process for notification of alert placements to relevant providers				9 (35%)	8 (30%)	**18 (67%)**
	e) participation in a national alert system				6 (23%)	3 (11%)	**8 (30%)**
	f) clear criteria for identifying levels of risk, and process that guides the use of the alert system				8 (31%)	6 (22%)	**18 (67%)**
2.6	Is there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children living in the house when child abuse and neglect or partner violence has been identified?				24 (92%)	26 (96%)	
	a) process that includes the safety of other children in the home are considered?				25 (96%)	26 (96%)	**27 (100%)**
	b) process for notifying CYF and/or other agencies?				25 (96%)	26 (96%)	**26 (96%)**
	c) referral form that requires the documentation of the risk assessed for these children?				22 (85%)	9 (33%)	**13 (48%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
	CATEGORY 3. COLLABORATION						
3.1	Does the DHB collaborate with CYF and NGO child advocacy and protection?	23 (92%)	24 (96%)	27 (100%)	26 (100%)	27 (100%)	**27 (100%)**
	a) which types of collaboration apply:						
	i) collaboration with training?	15(60%)	19 (76%)	21 (78%)	24 (92%)	26 (96%)	**27 (100%)**
	ii) collaboration on policy and procedure development?	17 (68%)	17 (68%)	23 (85%)	25 (96%)	25 (93%)	**27 (100%)**
	iii) collaboration on child abuse and neglect task force?	5 (20%)	19 (76%)	20 (74%)	22 (85%)	19(70%)	**27 (100%)**
	iv) collaboration on site service provision?	16 (64%)	22 (88%)	22 (82%)	25(96%)	27 (100%)	**27 (100%)**
	v) collaboration is two-way?				24 (92%)	26 (96%)	**27 (100%)**
	b) is collaboration with:						
	i) CYF?				26 (100%)	27 (100%)	**27 (100%)**
	ii) NGOs and other agencies such as Women's Refuge?				26 (100%)	26 (96%)	**27 (100%)**
	iii) Māori provider(s) or representative(s)?	19 (76%)	21 (84%)	22 (82%)	26 (100%)	26 (96%)	**27 (100%)**
	iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	6 (24%)	8 (32%)	8 (30%)	15 (58%)	23 (85%)	**25 (93%)**
	c) services, departments and between relevant staff within the DHB evident?				25 (96%)	27 (100%)	**27 (100%)**
3.2	Does the DHB collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply:	23 (92%)	24 (96%)	25 (93%)	26 (100%)	26 (96%)	**27 (100%)**
	a) collaboration with training?	5 (20%)	11 (44%)	17 (63%)	24 (92%)	25 (93%)	**27 (100%)**
	b) collaboration on policy and procedure development?	10 (40%)	11 (44%)	18 (67%)	26 (100%)	25 (93%)	**26 (96%)**
	c) collaboration on child abuse and neglect task force?	4 (16%)	18 (72%)	20 (74%)	23 (89%)	16 (59%)	**26 (96%)**
3.3	Is there collaboration of the child abuse and neglect programme with other health care facilities? If yes, which types of collaboration apply:	20 (80%)	21 (84%)	25 (93%)	26 (96%)	27 (100%)	**27 (100%)**
	a) within the DHB?	17 (68%)	23 (92%)	26 (96%)	26 (96%)	27 (100%)	**27 (100%)**
	b) with a Māori unit?	11 (44%)	22 (88%)	23 (85%)	26 (100%)	27 (100%)	**27 (100%)**
	c) with other groups and agencies in the region?	20 (80%)	20 (80%)	21 (78%)	26 (100%)	27 (100%)	**27 (100%)**
	d) with a Māori health provider?	6 (24%)	17 (68%)	23 (85%)	25 (96%)	26 (96%)	**24 (89%)**
	e) with the primary health care sector?				21 (81%)	27 (100%)	**25 (93%)**
	f) with national network of child protection and family violence coordinators?				26 (100%)	27 (100%)	**27 (100%)**
3.4	Do relevant staff have membership on, or attend:						
	a) the interdisciplinary child protection team?				22 (85%)	25 (93%)	**27 (100%)**
	b) Child abuse team meetings?				22 (85%)	23 (85%)	**27 (100%)**
	c) Sexual abuse team meetings?				16 (62%)	17 (63%)	**25 (93%)**
	d) CYF Care and Protection Resource Panel?				21 (81%)	24 (89%)	**24 (89%)**
	e) National Network of Family Violence Intervention Coordinators?				26 (100%)	27 (100%)	**27 (100%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
3.5	Does the DHB have a Memorandum of Understanding that enables the sharing of details of children at risk for entry on their database with the Police and/or CYF?				18 (69%)	24 (89%)	
	a) CYF?				18 (69%)	24 (89%)	**22 (82%)**
	b) the Police?				15 (58%)	22 (82%)	**20 (74%)**
3.6	Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support:				14 (54%)	15 (56%)	
	a) CYF?				11 (42%)	15 (56%)	**15 (56%)**
	b) Police?				10 (39%)	12 (44%)	**16 (59%)**
	c) DSAC?				6 (23%)	12 (44%)	**14 (52%)**
CATEGORY 4. INSTITUTIONAL CULTURE							
4.1	Does the DHB senior management support and promote the child abuse and neglect programme?						
	a) child protection is in the DHB Strategic Plan?				16 (62%)	20 (74%)	**20 (74%)**
	b) child protection is in the DHB Annual Plan?				18 (69%)	21 (78%)	**23 (85%)**
	c) the chid protection programme is adequately resourced, including dedicated programme staff?				18 (69%)	6 (22%)	**12 (44%)**
	d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator?				22 (85%)	27 (100%)	**27 (100%)**
	e) attendance at training as a key performance indicator (KPI) for staff?				6 (23%)	9 (33%)	**13 (48%)**
	f) roles of those in the child abuse and neglect working team are included in position descriptions?				13 (50%)	12 (44%)	**19 (70%)**
	g) DHB representation on the CYF Care and Protection Resource Panel?				22 (85%)	25 (93%)	**25 (93%)**
	h) the Child Protection Coordinator is supported to attend the Violence Intervention Programme Coordinator Meetings?				25 (96%)	25 (93%)	**27 (100%)**
4.2	In the last 3 years, has there been a formal (written) assessment of the DHB staff's knowledge and attitude about child abuse and neglect?	6 (24%)	11 (44%)	11 (41%)	11 (42%)	17 (63%)	**26 (96%)**
	a) nursing staff	6 (24%)	10 (40%)	11 (41%)	11 (42%)	16 (59%)	**26 (96%)**
	b) medical staff	5 (20%)	7 (28%)	7 (26%)	11 (42%)	15 (56%)	**20 (74%)**
	c) administration	2 (8%)	8 (32%)	6 (22%)	9 (35%)	12 (44%)	**17 (63%)**
	d) other staff/employees	2 (8%)	9 (36%)	9 (33%)	9 (35%)	16 (59%)	**24 (84%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and child abuse and neglect?	0 (0%)	1 (4%)	1 (4%)	5 (19%)	8 (30%)	**15 (56%)**
4.3	How long has the hospital's child abuse and neglect programme been in existence?						
	a) 1-24 months	7 (28%)	5 (20%)	2 (7%)	2 (8%)	3 (11%)	**0 (0%)**
	b) 24-48 months	5 (20%)	7 (28%)	5 (19%)	4 (15%)	4 (15%)	**2 (7%)**
	c) >48 months	9 (36%)	13 (52%)	20 (74%)	20 (77%)	20 (74%)	**25 (93%)**
4.4	Does the DHB's child abuse and neglect programme address cultural issues?	23 (92%)	25 (100%)	27 (100%)	24 (92%)	27 (100%)	**27 (100%)**
	a) does the DHBs policies specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background?	18 (72%)	18 (72%)	27 (100%)	23 (89%)	25 (93%)	**27 (100%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
	b) does the child protection coordinator and the steering group work with the Māori health unit and other cultural/ethnic groups relevant to the DHBs demographics?				25 (96%)	27 (100%)	**27 (100%)**
	b) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	17 (68%)	16 (64%)	19 (70%)	21 (81%)	27 (100%)	**27 (100%)**
	d) are translators/interpreters available for working with victims if English is not the victim's first language?	23 (92%)	25 (100%)	27 (100%)	26 (100%)	27 (100%)	**27 (100%)**
	d) Are referral information and brochures related to child abuse and neglect available in languages other than English?	8 (32%)	8 (32%)	12 (44%)	24 (92%)	25 (93%)	**26 (96%)**
4.5	Does the DHB participate in prevention outreach and public education activities on the topic of child abuse and neglect?	19 (76%)	15 (60%)	8 (30%)	22 (85%)	21 (78%)	**27 (100%)**
	a) 1 programme in the last 12 months?	9 (36%)	4 (16%)	9 (33%)	0 (0%)	1 (4%)	**3 (11%)**
	b) >1 programme in the last 12 months?	10 (40%)	11 (44%)	10 (37%)	22 (85%)	20 (74%)	**24 (89%)**
	c) Does the DHB collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities?	9 (36%)	9 (36%)	14 (52%)	20 (77%)	19 (70%)	**25 (93%)**
4.6	Do policies and procedures indicate the availability of supportive interventions for staff who have experienced abuse and neglect, or who are perpetrators of abuse and neglect?				15 (58%)	20 (74%)	**23 (85%)**
	b) is a list of supportive interventions available?				14 (54%)	23 (85%)	**20 (74%)**
	c) are staff aware of how to access support and interventions available?				19 (73%)	24 (89%)	**23 (85%)**
4.7	Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes?				26 (100%)	27 (100%)	**27 (100%)**
	b) is there is a referral mechanism?				26 (100%)	27 (100%)	**26 (96%)**
4.8	Does the child protection policy require mandatory use of DHB approved translators when English is not the victim's or caregiver's first language?						
	a) DHB approved translators being used?				22 (85%)	23 (85%)	**21 (78%)**
	b) a list of translators is accessible?				22 (85%)	24 (89%)	**26 (96%)**
	c) translators used that are gender and age appropriate?				16 (62%)	12 (44%)	**16 (59%)**
4.9	Does the DHB support and promote child protection and intervention within the primary sector.						
	a) involvement of primary health care providers in the planning and development of child abuse and neglect and child protection programmes?				17 (65%)	20 (74%)	**19 (70%)**
	b) access to child abuse and neglect training?				24 (92%)	23 (85%)	**22 (82%)**
	c) coordination of referral processes between the DHB and primary health care sectors?				17 (65%)	14 (52%)	**13 (48%)**
	d) ongoing relationships and activities that focus on prevention and promoting child protection?				19 (73%)	19 (70%)	**23 (85%)**
CATEGORY 5. TRAINING OF PROVIDERS							
5.1	Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical staff?						
	a) a strategic plan for training?				18 (69%)	21 (78%)	**25 (93%)**
	b) an operational plan that outlines the specifics of the programme of training?				17 (65%)	20 (74%)	**25 (93%)**
	c) Does the plan include the provision of regular, ongoing education for clinical staff?	5 (20%)	11 (44%)	17 (63%)	20 (77%)	21 (78%)	**25 (93%)**
	d) Does the plan include the provision of regular, ongoing education for non-clinical staff?	2 (8%)	10 (40%)	15 (56%)	17 (65%)	17 (63%)	**22 (82%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
5.2	During the past 12 months, has the DHB provided training on child abuse and neglect?						
	a) as part of the mandatory orientation for new staff?	7 (28%)	6 (24%)	15 (56%)	19 (73%)	23 (85%)	**27 (100%)**
	b) to members of the clinical staff via colloquia or other sessions?	8 (32%)	20 (80%)	23 (85%)	22 (85%)	27 (100%)	**27 (100%)**
5.3	Does the training/education on child abuse and neglect include information about:						
	a) definitions of child abuse and neglect?	17 (68%)	21 (84%)	22 (82%)	24 (92%)	25 (93%)	**27 (100%)**
	b) dynamics of child abuse and neglect?	16 (64%)	21 (84%)	21 (78%)	24 (92%)	26 (96%)	**27 (100%)**
	c) child advocacy?	16 (64%)	20 (80%)	17 (63%)	18 (69%)	25 (93%)	**25 (93%)**
	d) appropriate child-centred interviewing?	12 (48%)	17 (68%)	14 (52%)	19 (73%)	22 (82%)	**26 (96%)**
	e) issues of contamination?	12 (48%)	18 (72%)	17 (63%)	21 (81%)	26 (96%)	**27 (100%)**
	f) ethical dilemmas?	11 (44%)	19 (76%)	20 (74%)	23 (89%)	26 (96%)	**26 (96%)**
	g) conflict of interest?	11 (44%)	17 (68%)	18 (67%)	21 (81%)	25 (93%)	**25 (93%)**
	h) epidemiology?	15 (60%)	18 (72%)	20 (74%)	23 (89%)	26 (96%)	**27 (100%)**
	i) health consequences?	17 (68%)	20 (80%)	19 (70%)	24 (92%)	26 (96%)	**26 (96%)**
	j) identifying high risk indicators?	16 (64%)	21 (84%)	21 (78%)	24 (92%)	26 (96%)	**27 (100%)**
	k) physical signs and symptoms?	15 (60%)	21 (84%)	20 (74%)	24 (92%)	26 (96%)	**27 (100%)**
	l) dual assessment with partner violence?				20 (77%)	21 (78%)	**26 (96%)**
	m) documentation?	15 (60%)	20 (80%)	20 (74%)	24 (92%)	26 (96%)	**27 (100%)**
	n) intervention?	16 (64%)	21 (84%)	20 (74%)	24 (92%)	26 (96%)	**27 (100%)**
	o) safety planning?	13 (52%)	18 (72%)	14 (52%)	24 (92%)	25 (93%)	**26 (96%)**
	p) community resources?	14 (56%)	19 (76%)	16 (59%)	22 (85%)	25 (93%)	**26 (96%)**
	q) child protection reporting requirements?	17 (68%)	21 (84%)	18 (67%)	24 (92%)	26 (96%)	**27 (100%)**
	r) linking with the police and child youth and family?	17 (68%)	21 (84%)	20 (74%)	23 (89%)	26 (96%)	**27 (100%)**
	s) limits of confidentiality?	13 (52%)	18 (72%)	18 (67%)	24 (92%)	25 (93%)	**27 (100%)**
	t) age appropriate assessment and intervention?	11 (44%)	18 (72%)	14 (52%)	19 (73%)	23 (85%)	**25 (93%)**
	u) cultural issues?	11 (44%)	13 (52%)	13 (48%)	23 (89%)	26 (96%)	**26 (96%)**
	v) link between partner violence and child abuse and neglect?	15 (60%)	19 (76%)	20 (74%)	22 (85%)	26 (96%)	**27 (100%)**
	w) Māori models of health?	13 (12%)	6 (24%)	9 (33%)	12 (46%)	17 (63%)	**21 (78%)**
	x) the social, cultural, historic, and economic context in which Māori family violence occurs?	3 (24%)	9 (36%)	8 (30%)	13 (50%)	16 (59%)	**22 (82%)**
	y) Te Tiriti o Waitangi?	6 (20%)	10 (40%)	7 (26%)	14 (54%)	22 (82%)	**23 (85%)**
	z) Māori service providers and community resources?	5 (36%)	15 (60%)	14 (52%)	21 (81%)	23 (85%)	**25 (93%)**
	aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori?	9 (20%)	10 (40%)	8 (30%)	15(58%)	19(70%)	**23 (85%)**
	ab) If all sub-items are evident, bonus 1.5				6 (23%)	11 (41%)	**18 (67%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
5.4	Is the child abuse and neglect training provided by: (*choose one of a-d and answer e-f)*						
	a) no training provided	5 (20%)	3 (12%)	2 (7%)	2 (8%)	0 (0%)	**0 (0%)**
	b) a single individual?	5 (16%)	3 (12%)	6 (22%)	0 (0%)	0 (0%)	**0 (0%)**
	c) a team of DHB employees only?	4 (28%)	5 (20%)	2 (7%)	1 (4%)	3 (11%)	**1 (4%)**
	d) a team, including community expert(s)?	7 (36%)	14 (56%)	17 (63%)	23 (89%)	24 (89%)	**26 (96%)**
	If provided by a team, does it include:						
	e) a Child Youth and Family statutory social worker?	12 (48%)	15 (60%)	18 (67%)	24 (92%)	22 (82%)	**26 (96%)**
	f) a Māori representative?	10 (40%)	9 (36%)	15 (56%)	18 (69%)	17 (63%)	**26 (96%)**
	g) a representative(s) of other ethnic/cultural groups?	4 (16%)	2 (8%)	1 (4%)	5 (19%)	12 (44%)	**16 (59%)**
5.5	Is the training delivered in collaboration with various disciplines, and providers of child protection services, such as CYF, Police and community agencies?				22 (85%)	26 (96%)	**26 (96%)**
5.6	Does the plan include a range of teaching and learning approaches used to deliver the training on child abuse and neglect?				23 (89%)	26 (96%)	**26 (96%)**
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?	17 (68%)	21 (84%)	27 (100%)	26 (100%)	26 (96%)	**27 (100%)**
6.2	Are child protection services available "on-site"? If yes, *choose one of a-b and answer c-d*:	23 (92%)	24 (96%)	26 (96%)	26 (100%)	26 (96%)	**27 (100%)**
	a) A member of the child protection team or social worker provides services during certain hours.	7 (28%)	12 (48%)	10 (37%)	17 (65%)	0 (0%)	**5 (19%)**
	b) A member of the child protection team or social worker provides service at all times.	16 (64%)	12 (48%)	16 (59%)	9 (35%)	26 (96%)	**22 (82%)**
	c) A Māori advocate or social worker is available "on-site" for Māori victims.	20 (80%)	21 (84%)	23 (85%)	26 (100%)	26 (96%)	**27 (100%)**
	d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite.	9 (36%)	10 (40%)	12 (44%)	9 (35%)	10 (37%)	**17 (63%)**
6.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose a or b and answer c*)	19 (76%)	20 (80%)	23 (85%)	24 (92%)	26 (96%)	**27 (100%)**
	a) available, when indicated?	13 (52%)	16 (64%)	16 (59%)	20 (77%)	20 (74%)	**18 (67%)**
	b) performed routinely?	6 (24%)	4 (16%)	7 (26%)	4 (15%)	7 (26%)	**9 (33%)**
	c) age-appropriate?	19 (76%)	21 (84%)	23 (85%)	21 (81%)	23 (85%)	**26 (96%)**
6.4	Do the intervention services for child abuse and neglect include:						
	a) access to physical and sexual examination?				26 (100%)	27 (100%)	**27 (100%)**
	b) access to specialised sexual abuse services?				25 (96%)	27 (100%)	**27 (100%)**
	c) family focused interventions?				24 (92%)	25 (93%)	**24 (89%)**
	d) support services that include relevant NGOs, or acute crisis counsellors/support?				22 (85%)	27 (100%)	**27 (100%)**
	e) culturally appropriate advocacy and support?				24 (92%)	26 (96%)	**27 (100%)**
6.5	Are Social Workers available?				26 (100%)	27 (100%)	**27 (100%)**
	a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours?				20 (77%)	17 (63%)	**15 (56%)**
	b) 0n-call after 4 pm and at weekends?				3 (12%)	4 (15%)	**3 (11%)**
	c) as a 24 hour service?				3 (12%)	6 (22%)	**9 (33%)**
6.6	Is there a current list of relevant services available to support child and family safety?				24 (92%)	23 (85%)	**25 (93%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
6.7	Is provision made for transport for victims and their families, if needed?	3 (12%)	9 (36%)	10 (37%)	20 (77%)	22 (82%)	**23 (85%)**
6.8	Does the DHB child abuse and neglect programme include follow-up contact and counselling with victims after the initial assessment?	17 (68%)	20 (80%)	20 (74%)	17 (65%)	18 (67%)	**22 (82%)**
6.9	Does the child abuse and neglect programme assess and provide family violence intervention services and appropriate referral for:						
	a) the mother				23 (89%)	20 (74%)	**26 (96%)**
	b) siblings				23 (89%)	26 (96%)	**27 (100%)**
6.10	Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect?				26 (100%)	27 (100%)	**27 (100%)**
CATEGORY 7. DOCUMENTATION							
7.1	Is there evidence of use of a standardised documentation form to record known or suspected cases of child abuse and neglect, and safety assessments? If yes, does the form include:	13 (52%)	15 (60%)	21 (78%)	24 (92%)	27 (100%)	**27 (100%)**
	a) Reason for presentation?				22 (85%)	27 (100%)	**27 (100%)**
	a) information generated by risk assessment?	7 (28%)	9 (36%)	15 (56%)	21 (81%)	20 (74%)	**21 (78%)**
	b) the victim or caregiver's description of current and/or past abuse?	8 (32%)	9 (36%)	13 (48%)	21 (81%)	23 (85%)	**22 (82%)**
	c) the name of the alleged perpetrator and relationship to the victim?	4 (16%)	5 (20%)	8 (30%)	20 (77%)	10 (37%)	**13 (48%)**
	d) a body map to document injuries?	11 (40%)	16 (64%)	20 (74%)	21 (81%)	19 (70%)	**19 (70%)**
	f) Past medical history?				22 (85%)	22 (82%)	**19 (70%)**
	g) A social history, including living circumstances?				21 (81%)	23 (85%)	**13 (48%)**
	h) An injury assessment, including photographic evidence (if appropriate)?				20 (77%)	20 (74%)	**19 (70%)**
	i) The interventions undertaken?				10 (77%)	19 (70%)	**19 (70%)**
	e) information documenting the referrals provided to the victim and their family?	9 (36%)	10 (40%)	17 (63%)	21 (81%)	20 (74%)	**19 (70%)**
	f) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate?	4 (16%)	4 (16%)	4 (15%)	15 (58%)	9 (33%)	**12 (44%)**
7.2	Does the DHB have sexual abuse specific forms that include:						
	a) a genital diagram?				17 (65%)	21 (78%)	**24 (89%)**
	b) a consent form?				21 (81%)	23 (85%)	**23 (85%)**
7.3	Is there evidence of use of a standardised referral form and process for CYF and/or Police notification? If yes, is a referral form and process available for:				23 (89%)	27 (100%)	**27 (100%)**
	a) CYF notification?				25 (96%)	27 (100%)	**27 (100%)**
	b) Police notification?				15 (56%)	15 (56%)	**17 (63%)**
7.4	Are staff provided training on documentation for children regarding abuse and neglect?				24 (92%)	26 (96%)	**27 (100%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
CATEGORY 8. EVALUATION ACTIVTIES							
8.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:						
	a) Do evaluation activities include periodic monitoring of the implementation of the child abuse and neglect clinical assessment policy?	6 (24%)	12 (48%)	9 (33%)	11 (42%)	19 (70%)	**26 (96%)**
	b) Is the evaluation process standardised?	11 (44%)	10 (40%)	9 (33%)	10 (39%)	17 (63%)	**22 (82%)**
	c) Do evaluation activities measure outcomes, either for entire child abuse and neglect programme or components thereof?	7 (28%)	9 (36%)	14 (52%)	13 (50%)	18 (67%)	**26 (96%)**
	d) Does the evaluation of the child abuse and neglect programme include relevant review/audit of the following activities:						
	Identification, risk assessment, admissions and referral activities?				16 (62%)	21 (78%)	**18 (67%)**
	Monitoring trends re demographics, risk factors, and types of abuse?				17 (65%)	19 (70%)	**14 (52%)**
	Documentation?				20 (77%)	15 (56%)	**20 (74%)**
	Referrals to CYF and the Police?				21 (81%)	21 (78%)	**21 (78%)**
	Case reviews?				16 (62%)	17 (63%)	**23 (85%)**
	Critical incidents?				17 (65%)	17 (63%)	**20 (74%)**
	Mortality morbidity review?				13 (50%)	18 (67%)	**20 (74%)**
	Policy and procedure reviews?				23 (89%)	23 (85%)	**26 (96%)**
	e) Do the evaluation activities include:						
	Multidisciplinary team members?				21 (81%)	23 (85%)	**26 (96%)**
	The Police?				21 (81%)	11 (41%)	**22 (82%)**
	CYF?				21 (81%)	20 (74%)	**26 (96%)**
	Community agencies?				21 (81%)	11 (41%)	**20 (74%)**
8.2	Is there evidence of feedback on the child abuse and neglect programme from community agencies and government services providers, such as CYF, the Police, refuge, and well child providers?				16 (62%)	15 (56%)	**24 (89%)**
8.3	Do health care providers receive standardized feedback on their performance and on patients from CYF?	14 (56%)	12 (48%)	12 (44%)	7 (27%)	20 (74%)	**18 (67%)**
8.4	Is there any measurement of client satisfaction and community satisfaction with the child abuse and neglect programme?						
	a) client satisfaction?				3 (12%)	1 (4%)	**7 (26%)**
	b) community satisfaction?				8 (31%)	13 (48%)	**17 (63%)**
8.5	Is a quality framework used to evaluate whether services are effective for Māori?	2 (8%)	1 (4%)	2 (7%)	3 (12%)	4 (15%)	**8 (30%)**
8.6	Are data related to child abuse and neglect assessments, identifications, referrals and alert status recorded, collated and reported on to the DHB?				16 (62%)	21 (78%)	**20 (74%)**
8.7	Is the child abuse and neglect programme evident in the DHB quality and risk programme?				9 (35%)	7 (26%)	**16 (59%)**

	"YES" responses	Baseline n (%)	12 mo FU n (%)	30 mo FU n (%)	48 mo FU n (%)	60 mo FU n (%)	84 mo FU n (%)
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?				1 (4%)	14 (52%)	**17 (63%)**
CATEGORY 9. PHYSICAL ENVIRONMENT							
9.1	Are posters and images that are of relevance of children and young people on public display which are they child-friendly, contain messages about child rights and safety, and contain Māori and other relevant cultural or ethnic images?	25 (100%)	25 (100%)	27 (100%)	26 (100%)	27 (100%)	**27 (100%)**
	a) <10 posters or images				0 (0%)	0 (0%)	**0 (0%)**
	b) 10-20 posters or images				10 (39%)	2 (7%)	**2 (7%)**
	c) >20 posters or images				16 (62%)	25 (93%)	**25 (93%)**
9.2	Is there referral information (local or national phone numbers) related to child advocacy and relevant services on public display in the DHB? (Can be included on the posters/brochure noted above).	21 (84%)	21 (84%)	26 (96%)	26 (100%)	27 (100%)	**27 (100%)**
	a) <10 locations				5 (19%)	3 (11%)	**2 (7%)**
	b) 10-20 locations				9 (35%)	7 (26%)	**2 (7%)**
	c) >20 locations				12 (46%)	17 (63%)	**23 (85%)**
9.3	Are there designated private spaces available for interviewing?				24 (92%)	27 (100%)	
	a) 1-2 locations?				13 (50%)	2 (7%)	**0 (0%)**
	b) 2-4 locations?				3 (12%)	3 (11%)	**0 (0%)**
	c) > 4 locations?				8 (31%)	22 (82%)	**27 (100%)**
9.4	Does the DHB 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 until CYF or a refuge intervene?	15 (60%)	19 (76%)	17 (63%)	25 (96%)	26 (96%)	**25 (93%)**
	a) 'Social admissions" mentioned in child abuse and neglect policies?				20 (77%)	23 (85%)	**23 (85%)**
	b) Temporary safe shelter is available?				25 (96%)	25 (93%)	**25 (93%)**

APPENDIX J: Self Audit Missing Indicators[a]

Variable	Indicators	No. Hospitals
PARTNER ABUSE PROGRAMME AUDIT TOOL		
2.1a	Posters and/or brochures related to partner abuse on public display in clinical settings? (number of locations)	3
2.1b	Are Māori images included in posters/brochures? (number of locations)	3
2.2a	Is there referral information (e.g. local or national phone numbers) related to partner abuse services on public display? (number of locations)	2
2.2c	Is there referral information related to partner abuse services for non-Maori non-Pakeha clients on display? (number of locations)	3
3.5	Does the partner abuse programme participate in preventive outreach and public education activities on the topic of partner abuse? (1 or >1 programme in last 12 months)	2
9.1aiv	Does the programme collaborate with local partner abuse programmes in on-site service provision?	3
CHILD ABUSE AND NEGLECT PROGRAMME AUDIT TOOL		
1.3b	Does the DHB-based child abuse and neglect steering group includes representatives from more than two departments?	2
2.2	Does the DHB collaborate on safety planning for children at high risk c) With other groups and agencies in the region?	2
2.3	Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect: a) Within the DHB?	2
2.5	Do DHB services have an alert system recording concerns about children at risk of abuse and neglect: d) Including a process for notification of alert placements to relevant providers?	2
4.4e	Are referral information and brochures related to child abuse and neglect available in languages other than English?	2
5.3ab	If all training sub-items are evident, bonus 0.5 points.	2
5.4g	Does the training team include a non-Māori, non-Pakeha representative?	2
8.1c	Do evaluation activities measure outcomes, either for the entire child abuse and neglect programme or components thereof?	2
8.1d	Does the evaluation of the child abuse and neglect programme include relevant review/audit of:	
	i) identification, risk assessment, admissions and referral activities?	2
	ii) monitoring trends such as demographics, risk factors and types of abuse?	2
	iii) Documentation?	2
	iv) Referrals to CYF and Police?	3
8.1e	Do evaluation activities include	
	ii) Police?	2
	iv) Community agencies?	2
8.4a	Is there measurement of client satisfaction with the programme?	2
8.5	Is a quality framework used to evaluate whether services are effective for Māori?	3
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?	2

[a] Limited to indicators not completed by 2 or more hospitals