HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

48 MONTH FOLLOW-UP EVALUATION REPORT

MINISTRY OF HEALTH
MANATŪ HAUORA

Interdisciplinary Trauma Research Unit
Te wairere au noa

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HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:
48 MONTH FOLLOW-UP EVALUATION REPORT

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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.

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EXECUTIVE SUMMARY

BACKGROUND

The Ministry of Health's Violence Intervention Programme (VIP) in District Health Boards (DHBs) 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 to the multi-agency approach to reduce family violence and child abuse in New Zealand led by Government's *Taskforce for Action on Violence within Families*.

In 2002, the Ministry of Health published *Family Violence Intervention Guidelines: Child and Partner Abuse* to support health professionals in identifying and responding effectively to cases of family violence. In 2007, the Ministry funded Family Violence Intervention Coordinator (FVIC) appointments to expand the significant progress made by DHBs during the VIP pilot phase. These appointments have proved vital to the continued progress and sustainability of family violence intervention programmes. Local programmes are also being supported by individual hospital evaluation reports, national programme coordination and health professional training, all funded by the Ministry of Health.

2008 AUDIT

An external evaluation project provides information to DHBs and the Ministry about the implementation of family violence programmes. This report documents four rounds of hospital audits 2004 to 2008, summarising the development of DHB family violence systems responses. The quantitative data are the result of applying an audit tool to measure system indicators during 27 hospital site visits in the 21 DHBs.
The evaluation seeks to answer the following two 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?

KEY RESULTS

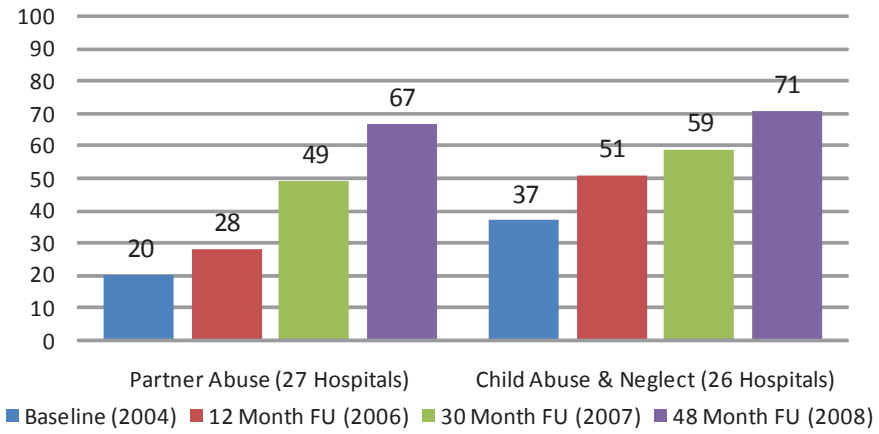
Forty-eight month follow-up audit findings reflect considerable family violence programme development since the baseline audit in 2004. The median Partner Abuse Intervention Programme score has more than tripled, from 20 to 67. The median Child Abuse and Neglect Intervention Programme score has almost doubled, from 37 to 71. Evaluation results are strongly linked to support and resources provided by the Ministry and DHBs.

Programme scores are steadily increasing:

13 (48%) hospitals have reached the target score of 70 [a]

[a] The minimal achievement threshold (target score) was set in 2004 based on international and New Zealand baseline data.

MEDIAN HOSPITAL VIP PROGRAMME SCORES[a] 2004-2008



SUMMARY

Increasing evaluation scores over time demonstrate that programme maturation, Family Violence Intervention Coordinator stability, ongoing health provider training, national programme coordination and other efforts can successfully create sustainable institutional change.

[a] Programme scores may range from 0 to 100, with higher scores indicating greater development.

BACKGROUND

Family violence (FV) is recognised to have significant social, economic, and health tolls internationally and in Aotearoa New Zealand.[1-9] With the identification of family violence as a preventable public health problem,[10] the Ministry of Health began a Family Violence Health Intervention Project in 2001 (see Appendix A). An explanation of the Project is included in earlier reports.[11-14] 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 and child abuse in New Zealand led by Government's *Taskforce for Action on Violence within Families*.

In 2002, the Ministry of Health published *Family Violence Intervention Guidelines: Child and Partner Abuse*[6] to support health professionals in identifying and responding effectively to cases of family violence. In 2007, the Ministry funded Family Violence Intervention Coordinator (FVIC) appointments to expand the significant progress made by DHBs during the VIP pilot phase. Local programmes are also being supported by individual hospital evaluation reports, national programme coordination and health professional training, all funded by the Ministry of Health. Also in 2007, the Ministry published *Family violence Intervention Guidelines: Elder Abuse and Neglect*.[15]

An external evaluation project operating since 2003 provides information to DHBs and the Ministry about the implementation of family violence programmes[a] . This 48 month follow-up report documents the development of DHB family violence systems response based on four rounds of hospital audits 2004 to 2008. The 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 during 27 hospital site visits in the 21 DHBs

The evaluation seeks to answer the following two 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?

METHODS

SETTING

The evaluation was conducted nationwide across Aotearoa New Zealand. The 27 acute secondary and tertiary public hospitals (located within the 21 DHBs) from earlier audit rounds were invited to participate in this fourth (48 month follow-up) audit (see Appendix B). Among the 27 hospitals, 26 participated fully and one hospital participated in the Partner Abuse Intervention Programme evaluation only. The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal).

AUDIT TOOL

Quantitative audit data were collected applying the modified *Delphi Instrument for Hospital-Based Domestic Violence Programmes*[16] during hospital site visits. The original 'Delphi' tool was developed to monitor primary indicators of hospital family violence programme quality. As described in the baseline report,[12] the original tool was modified for the purpose of this Aotearoa New Zealand evaluation project. The modified audit tool (Partner Abuse and Child Abuse and Neglect) includes performance measures categorised into nine domains for Partner Abuse and eight for Child Abuse and Neglect. The domains are described in Table 1.

Each domain 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 C for domain weights) .

[a] For the full series of evaluation reports go to: http://trauma-research.info/fv_evaluation.htm#reports

TABLE 1: AUDIT TOOL DOMAINS

DOMAINS	BRIEF DESCRIPTION
Policies & Procedures	Policies and procedures outline the assessment and treatment of family violence victims, mandate routine screening and direct sustainability.
Physical Environment	Attention to the physical environment (posters and brochures) lets patients and visitors know that it is OK to talk about and seek help for family violence.
Institutional Culture	Institutional culture indicators herald recognition of family violence as an important issue for the hospital and maturation of a family violence programme.
Training of Staff	A formal plan should be in place to train hospital staff to identify persons exposed to family violence and how to respond appropriately.
Screening & Safety Assessment	Standardised partner abuse screening and safety assessment instruments are available. Eligible patients are screened for violence.
Documentation	Standardised family violence documentation forms are used with attention to forensic details.
Intervention Services	Intervention checklists are available, with attention to co-occurrence of partner violence and child abuse.
Evaluation Activities	Evaluation activities monitor whether a programme is working efficiently and achieving its goal of system change.
Collaboration	Family violence programmes call for collaboration throughout their processes, from policy and procedure writing to monitoring programme effectiveness. Partnerships within the hospital as well as with external stakeholders such as Women's Refuge are important.
Safety & Security	*(New domain in Revised Child Abuse and Neglect Tool)* All children and young people are assessed for safety. Safety risks are identified and security plans implemented and attend to all children in a family.

REVISED CHILD ABUSE AND NEGLECT TOOL

The Child Abuse and Neglect (CAN) tool was revised to improve content validity in 2007, led by Dr Denise Wilson[17]. The Child Abuse and Neglect tool used to evaluate child abuse and neglect programs from 2004 to 2008 was recognised to not adequately measure the scope of an ideal child protection programme. A Delphi process, with an expert panel, was used to revise the modified CAN instrument to improve its validity and effectiveness for evaluation. Twenty-four New Zealand experts participated in four Delphi rounds, including one face-to-face meeting.

The expert panel agreed to extend the focus of the instrument from the hospital setting to include community settings. What was missing in the previous instrument was the need for assessing institutional support and promotion of the child abuse and neglect component within a violence intervention programme. There was also a need for greater collaboration between agencies and the various disciplines, which extended to the development of policies and procedures, access to information, alert systems, and ensuring the safety and security of children identified at risk. The panellists all stressed the need for everyone to work towards the welfare of children at risk of abuse and neglect rather than being bound by current system barriers. It was recognised that for many programmes attainment of the measurement items within the audit instrument will be a work in progress.

Strong participant agreement regarding the importance of current child abuse and neglect items was evident and existing domains were strengthened with the addition of one new domain (Safety and Security) and a number of new items. The revised instrument contains nine domains with 64 items. The Revised CAN instrument is intended to assess existing programmes against the criteria for an ideal programme given the current knowledge and expertise available in the area of child abuse and neglect, and child protection.

The 48 month follow-up audit made use of both the original and revised Child Abuse and Neglect tools in order to allow scores to be compared over time. The results of the Revised Child Abuse and Neglect tool were included in DHB reports as an addendum along with suggestions for improvement to support DHB programme development in anticipation of the next round of audits.

INTERACTIVE AUDIT TOOLS

In 2008 interactive excel files for the audit tools were developed.The excel format allows users to enter their indicator data and be provided score results. The form also provides 'tool-tips' for the user which outline the criteria necessary to achieve the indicator score. These interactive excel files effectively allow users to complete a self-audit in preparation for the external auditor. The excel files can be viewed at:
www.trauma-research.info/fv_evaluation.htm.

PROCEDURES

Audit procedures for the 48 month site visit mirrored those of the baseline, 12 and 30 month site visits as described below:

1. A letter of introduction was sent to each DHB CEO alerting them that the follow-up audit was due.
2. The person identified to act as a FV Liaison (either a Family Violence Intervention Coordinator (FVIC) or a person identified by the manager) was contacted, after which the general audit process and scheduling of the audit was arranged by e-mail and telephone.
3. Confirmation of the audit date and a detailed checklist of documents that needed to be collated for the audit were sent to the FV Liaison.
4. The FV liaison was asked to coordinate the involvement of others (such as the child protection coordinator) in the site visit as appropriate.
5. A few days prior to the audit, contact was made with the liaison to answer any outstanding questions about the audit.

Forty-eight month follow-up audits were conducted by Selu Ma'asi, a trained member of the research team, and Professor Jane Koziol-McLain. Claire Gear participated in resolving scoring dilemmas by team consensus. Each audit was conducted during a site visit lasting approximately 6 hours.

In addition to the DHB FV liaison person, partner abuse and child protection coordinators; social workers; representatives from the paediatric, maternity and emergency wards; as well as hospital management often contributed to the audit.

On completion of each site visit an audit report was provided to the DHB liaison person, usually within two weeks, to confirm the accuracy of the audit report. Once confirmed, the finalised hospital report was sent to the DHB CEO, with a copy sent to the FV liaison.

TIMEFRAME

Forty-eight month follow-up hospital audits were conducted between March and December 2008. The average time between the baseline and 48 month follow-up audit was 53 months (see Table 2).

TABLE 2: HOSPITAL AUDIT SCHEDULES

No. of Hospitals	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
Baseline Nov 03-Jul04	1	3	4	8	5	0	1	1	1	25
12 Month FU Nov 04-Jul05	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

[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.

ANALYSIS PLAN

DESCRIPTIVE ANALYSIS

Hospital characteristics and Delphi scores were analysed using SPSS (Version 15). In this report we present the distribution of overall Partner Abuse, Child Abuse and Neglect and Revised Child Abuse and Neglect scores in graphs and tables. Baseline, 12, 30 and 48 month follow-up scores are presented for each individual domain and overall Delphi scores. Box plots are used to examine the distribution of scores (see Appendix C: *How to Interpret Box Plots*). Both domain and overall scores may range from 0-100, with higher scores reflecting a greater level of programme development. The reader should note that both mean (mathematical average) and median (middle) scores are used.

In 2004 the 'minimal achievement threshold' (target score) was set at 70 based on international[18] and baseline New Zealand data[12].

TREND ANALYSIS

We tested whether scores changed significantly (statistically) over time. The 25 hospitals that were included in the baseline audit are the focus of this trend analysis. In cases of missing programme data, previous scores were carried forward based on the knowledge of unchanged Family Violence Intervention Coordinator status or other significant change indicators (see Table 3).

Using SAS (version 9; www.sas.com), repeated measures ANOVA models examined main effects (that is, whether the factor impacted on the audit score) and interaction effects for time (whether the factor had different impacts over time). Interaction effects by time were tested for the following factors: hospital size, rural/urban location, programme maturation, Family Violence Coordinator, Coordinator dual role (with Partner Abuse and Child Abuse and Neglect Programme responsibilities) and Coordinator FTE. The magnitudes and differentials presented utilised the estimated least squares means adjusting for subject, interaction and main effects and standard errors of the estimates. Model tables are included in Appendix H.

TABLE 3: AUDIT SCORE IMPUTING FOR TREND ANALYSIS

Baseline	• 25 hospitals with PA & CAN
12 Month Follow-Up	• 25 hospitals with PA & CAN • 1 hospital with PA only, had CAN scores carried over • 1 hospital had PA & CAN scores carried over
30 Month Follow-Up	• 22 hospitals with PA & CAN • 1 hospital with CAN, had PA scores carried over • 1 hospital with PA, had CAN scores carried over • 1 hospital with PA & CAN scores carried over
48 Month Follow-Up	• 26 hospitals with PA & CAN • 1 hospital with PA only

Note: PA=partner abuse programme; CAN=child abuse and neglect programme; two hospitals participating for the first time at the 30 and 48 month follow-up audits were not included in the trend analysis.

FINDINGS

PARTNER ABUSE AUDIT FINDINGS

13 hospitals reached the target score of 70, compared to 5 at the 30 month follow-up audit.

At 48 month follow-up, the partner abuse programme score ranged from 11 to 95, with 67 being the typical (median) score.

The median partner abuse programme score increased from 20 at baseline, to 28 at 12 month follow-up, to 49 at 30 month follow-up, to 67 at 48 month follow-up.

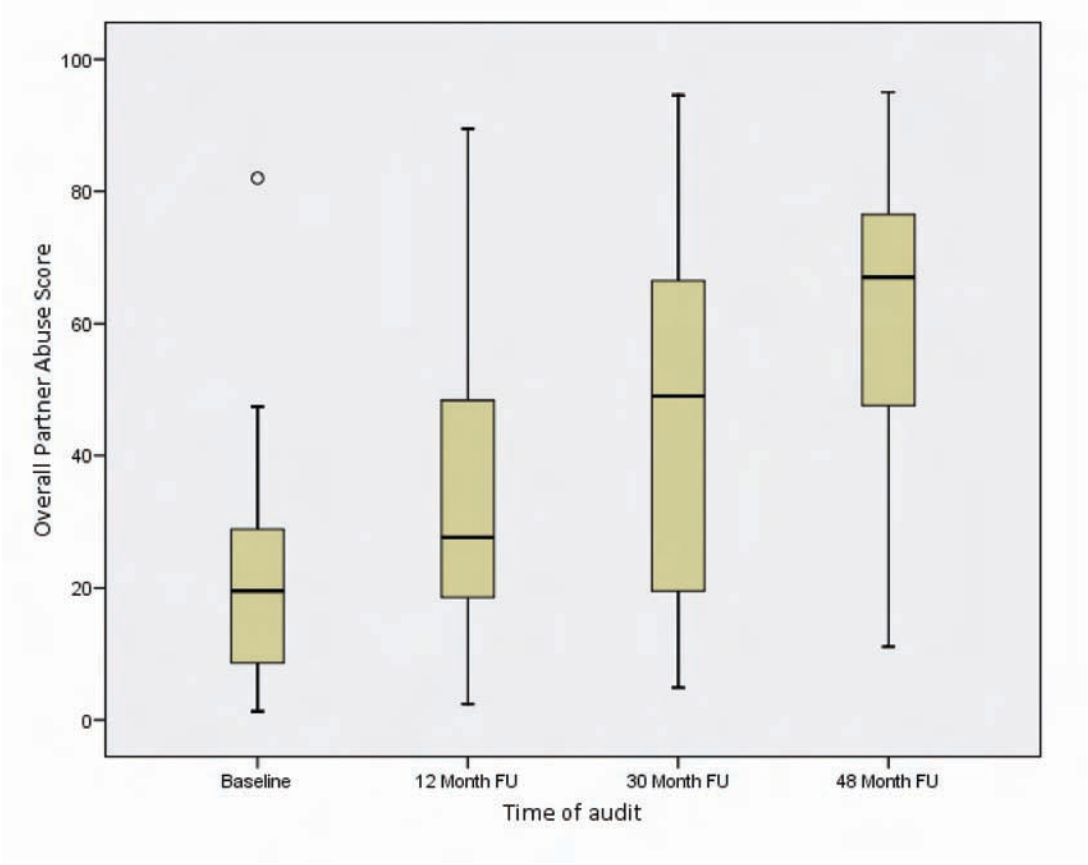
Results of the 48 month follow-up audit indicate significant progress continues to be made in programme development for responding to partner abuse. Key programme indicator highlights are listed below.

KEY PROGRAMME INDICATORS

- 21 (78%) hospitals employ an identifiable partner violence intervention programme coordinator.
- 19 (70%) hospitals have instituted partner violence screening in one or more inpatient or outpatient units.
- 21 (78%) hospitals have implemented official policies regarding the assessment and treatment of victims of partner abuse.
- 18 (67%) hospitals have a formal partner violence response staff training plan.
- 16 (59%) hospitals conduct formal written assessments of staff knowledge and attitudes about partner abuse.
- 17 (63%) hospitals had conducted quality improvement activities evaluating their partner abuse intervention programme since the last audit.
- 14 (52%) hospitals monitored their partner violence screening effort, with 6 (22%) hospitals screening at least 25% of eligible women.
- 5 (19%) hospitals set aside family violence funding specifically for Māori programmes and initiatives.

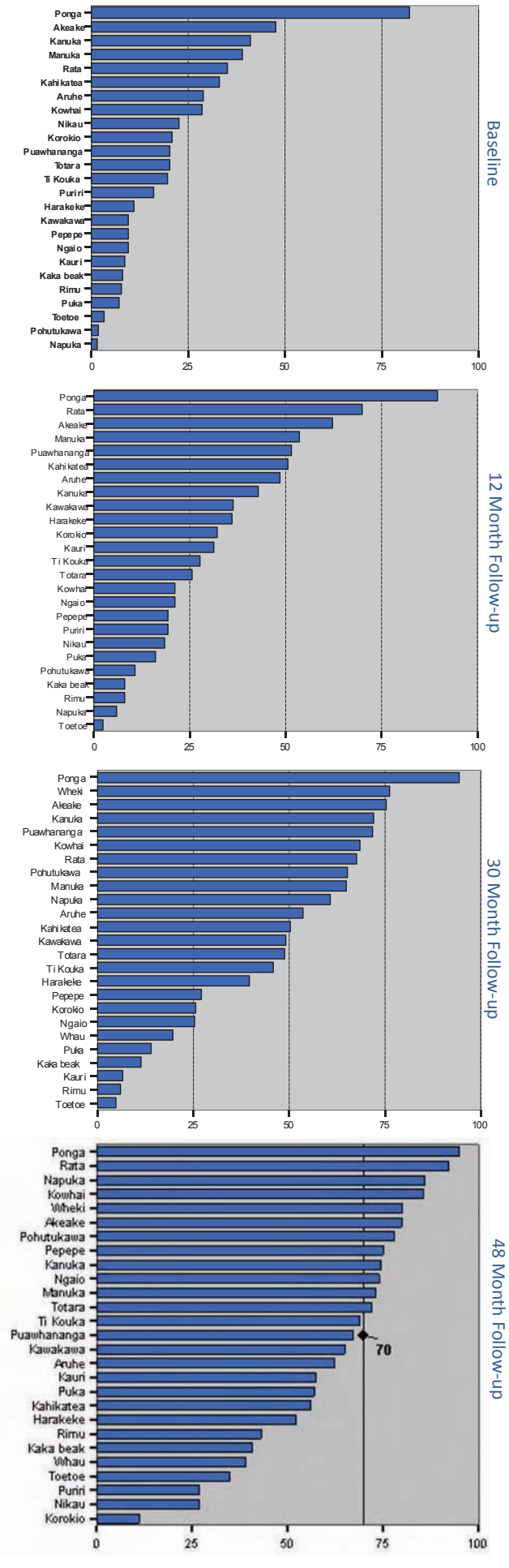
In Figure 2, box plots display the change in partner abuse scores over time; hospital league tables (anonymised) are provided in Figure 3; and median domain scores over time are provided in Figure 4. Table 4 provides the data supporting the displays/figures. Frequencies for individual Partner Abuse Programme Delphi items are provided in Appendix E.

FIGURE 2: OVERALL PARTNER ABUSE SCORE DISTRIBUTIONS OVER TIME



- The median Partner Abuse domain scores (see Figure 4 and Table 4) all increased between the 30 and 48 month follow-up audits.
- 'Physical Environment', 'Documentation' and 'Screening & Safety Assessment' domains all increased appreciably.
- 'Collaboration' continues to be the domain with the highest achievement, with 85% of hospitals scoring ≥ 70.
- All domains have achieved or are nearing the minimal achievement score (70) with the exception of 'Evaluation Activities'.
- Only 22% of hospitals scored ≥ 70 in the 'Evaluation Activities' domain and the median score was almost half that of the next lowest domain.

FIGURE 3: PARTNER ABUSE INTERVENTION HOSPITAL LEAGUE TABLES[1]



[1] Note Hospitals have been randomly allocated code names from a selection of native Aotearoa New Zealand plants to protect confidentiality during this period of programme development.

FIGURE 4: PARTNER ABUSE DOMAIN MEDIAN SCORES

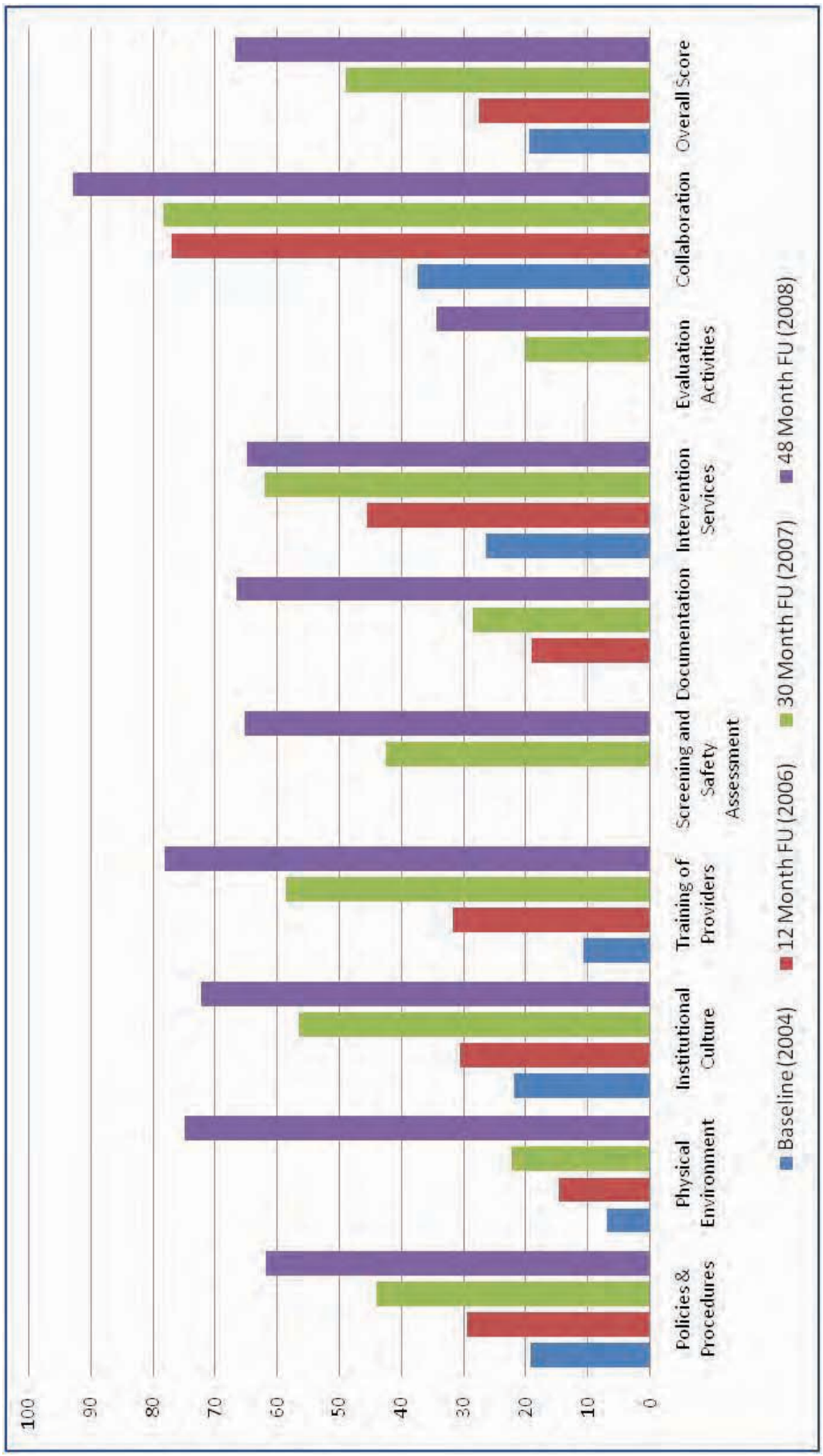


TABLE 4: PARTNER ABUSE BASELINE AND FOLLOW-UP SCORES

	Mean				*Median*				*Hospitals Achieving Score ≥ 70*			
	B	F_{12}	F_{30}	F_{48}	B	F_{12}	F_{30}	F_{48}	B	F_{12}	F_{30}	F_{48}
OVERALL SCORE	21.2	32.3	45.9	**61.9**	19.6	27.6	49.2	**66.9**	1 (4%)	2 (8%)	5 (20%)	**13[a] (48%)**
Domain Scores												
Policies & Procedures	22.3	31.5	47.0	**59.3**	19.4	29.5	48.8	**62.0**	1 (4%)	2 (8%)	7 (28%)	**11 (41%)**
Physical Environment	10.2	20.6	36.6	**68.2**	7.1	14.7	23.1	**75.0**	0	1 (4%)	4 (16%)	**16 (59%)**
Institutional Culture	27.9	35.3	51.3	**63.9**	22.1	30.7	59.0	**72.4**	2 (8%)	5 (20%)	8 (32%)	**15 (56%)**
Training of Providers	23.7	37.0	46.9	**64.6**	10.9	31.9	58.7	**78.2**	1 (4%)	2 (8%)	5 (20%)	**15 (56%)**
Screening & Safety Assessment	14.3	17.1	34.5	**55.8**	0.0	0.0	42.5	**65.3**	**1 (4%)**	2 (8%)	5 (20%)	**13 (48%)**
Documentation	6.5	18.9	35.2	**62.2**	0.0	19.1	28.6	**66.6**	0	0	2 (8%)	**12 (44%)**
Intervention Services	33.6	46.3	57.1	**62.1**	26.4	45.7	62.1	**65.0**	4 (16%)	6 (24%)	9 (36%)	**11 (41%)**
Evaluation Activities	11.5	14.3	30.0	**40.2**	0.0	0.0	20.0	**34.4**	1 (4%)	1 (4%)	4 (16%)	**6 (22%)**
Collaboration	35.4	66.3	71.6	**84.6**	37.5	77.1	78.5	**93.0**	1 (4%)	15 (60%)	19 (76%)	**23 (85%)**

Notes: B =Baseline; F_{12} =12 month follow-up; F_{30} = 30 month follow-up; F_{48} = 48 month follow-up; 70 is selected benchmark score based on international and New Zealand data

[a] Includes one hospital score which was rounded up during analysis.

UNIVARIATE TREND RESULTS

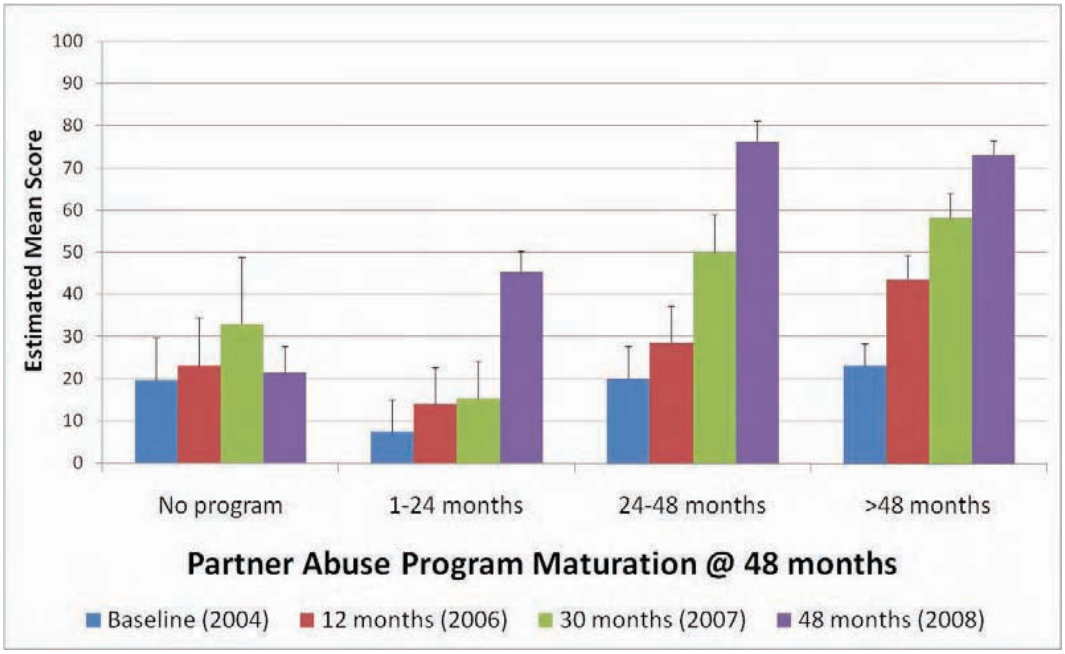
As demonstrated by Figure 5, Partner Abuse Intervention Programme scores increased significantly over time (p<.001). There are no statistically significant additional differences for either urban/rural (p=0.42) or hospital size measures (p=0.054). [a]

Three factors demonstrated strongly significant associations with audit score, and audit score over time. [b] These included the following:

- Programme maturation (time programme had been in place at the time of the 48 month audit)
- Presence of a Partner Abuse Intervention Programme Coordinator
- Coordinator in a dual role (with partner abuse and child abuse and neglect responsibilities).

Figure 5 demonstrates that hospitals with no Partner Abuse Intervention Programme at 48 months have shown no change in scores over time, whereas all other groups show increases over time. Hospitals with 1-24 month maturation rapidly catch up with those with 24-48 maturation, whereas those with >48 months maturation have remained consistently ahead of all other hospitals up to the most recent audit.

FIGURE 5: PROGRAMME MATURATION



[a] Appendix H presents the estimated mean scores and standard errors for these factors.

[b] Table 2 in Appendix H presents the ANOVA results.

Hospitals without a Partner Abuse Intervention Coordinator had consistently low scores. This compared to those with a part time coordinator, which steadily increased over time, and those with a full time coordinator, which reached a plateau after 12 months (Figure 6).

FIGURE 6: PRESENCE OF COORDINATOR [a]

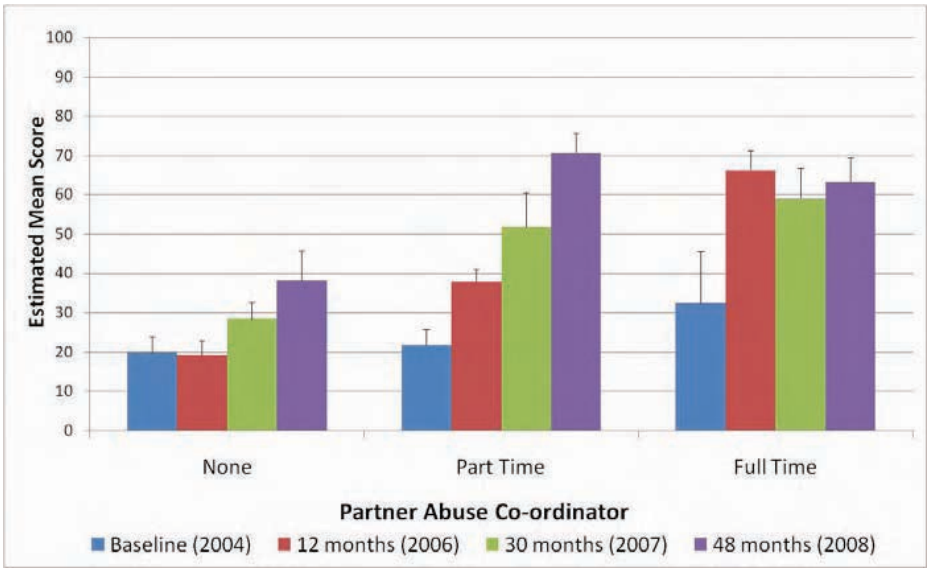
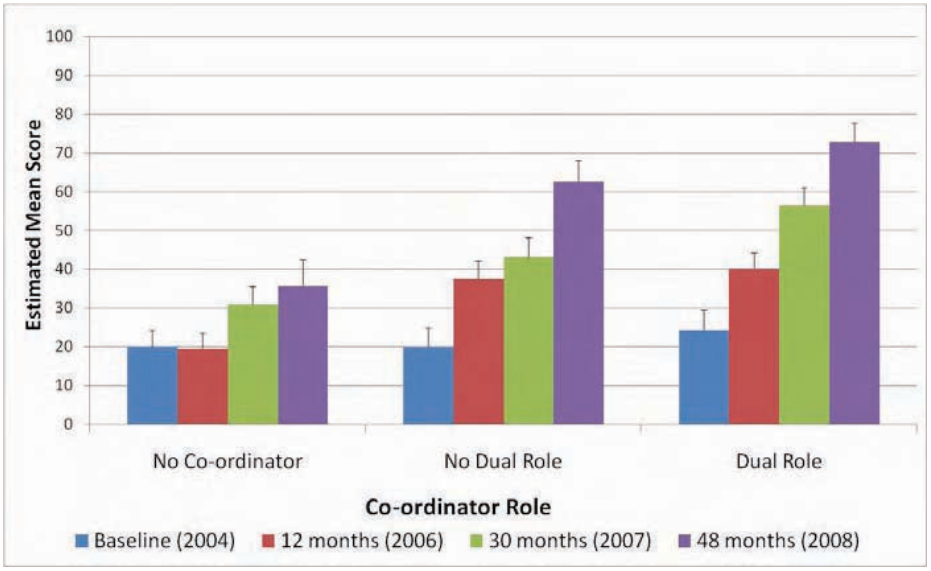


Figure 7 shows an advantage at 48 months to having a dual role coordinator (with programme responsibility for partner violence and child abuse and neglect).

FIGURE 7: DUAL ROLE COORDINATOR



[a] Analysis allows for changing presence of a coordinator in a hospital over time.

MULTIVARIATE TREND RESULTS

The multivariate analysis identified that the following factors best explain the changes in Partner Abuse Intervention Programme audit scores (Table 5):

- Time
- Programme maturation
- Programme maturation interaction with time
- Presence of Partner Abuse Coordinator
- Presence of Partner Abuse Coordinator interaction with time

The significant programme maturation interaction with time indicates that hospitals which began Partner Abuse Intervention Programmes more recently have been able to achieve rapid growth compared to programmes that began before VIP commenced. This rapid growth is likely due to the available resources that are now in place to support VIP in the DHBs, such as materials on the VIP web site, health professional training support, the Family Violence Intervention Coordinator (FVIC) networking group and the National VIP Manager for DHBs.

TABLE 5: MULTIVARIATE MODEL

	df	F	p-value
Time	3,21	12.48	< 0.0001
Maturation	3,21	3.14	0.05
Maturation x Time	9,21	3.98	0.004
Partner Abuse Coordinator	2,21	14.12	0.0001
Partner Abuse Coordinator x Time	6,21	5.92	0.001

CHILD ABUSE AND NEGLECT AUDIT FINDINGS

Results of the 48 month follow-up audit indicate that significant progress continues to be made in programme development for responding to child abuse and neglect. Key programme indicator highlights are listed below.

13 hospitals reached the target score of 70, compared to 4 at the 30 month follow-up audit.

At 48 month follow-up, the child abuse and neglect intervention programme score ranged from 40 to 97, with 71 being the median score.

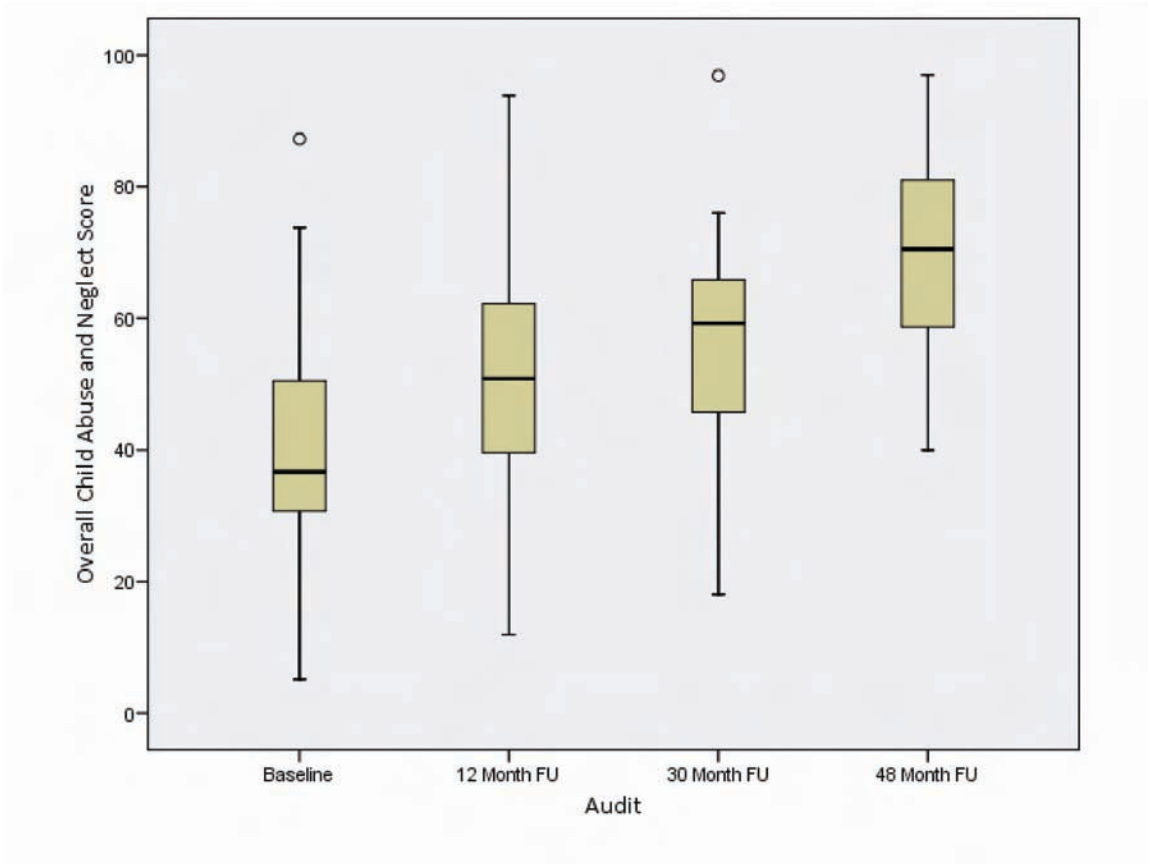
The median child abuse and neglect intervention programme score increased from 37 at baseline, to 51 at 12 month follow-up, to 59 at 30 month follow-up, to 71 at 48 month follow-up.

KEY CHILD ABUSE & NEGLECT PROGRAMME INDICATORS

- 23 (88%) hospitals employ an identifiable child protection programme coordinator.
- 25 (96%) hospitals have a clinical assessment policy for identifying signs and symptoms of child abuse & neglect and for identifying children at risk.
- 24 (92%) hospitals have implemented official policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children.
- 19 (73%) hospitals have a formal child abuse & neglect response staff training plan.
- 11 (42%) hospitals conduct formal written assessments of staff knowledge and attitudes about child abuse and neglect.
- 13 (50%) hospitals used quality improvement activities to evaluate their child protection programme.

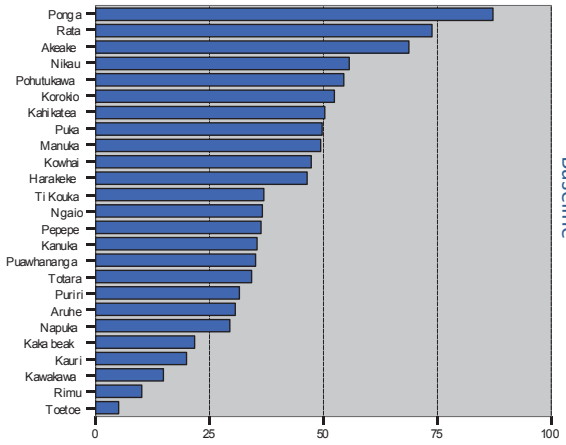
In Figure 8, box plots display the change in Child Abuse and Neglect scores over time; hospital league tables are provided in Figure 9; and median domain scores over time are provided in Figure 10. Table 6 provides the data supporting the figures. Frequencies for individual Delphi items are provided in Appendix F.

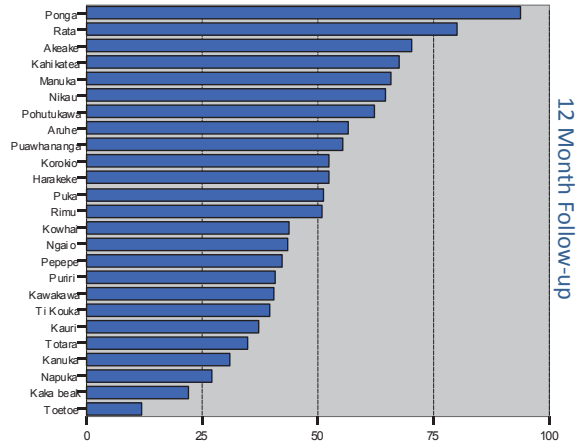
FIGURE 8: CHILD ABUSE AND NEGLECT PROGRAMME SCORES

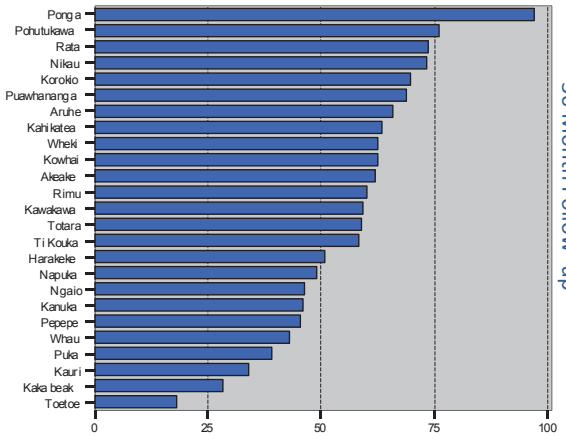


- The median Child Abuse and Neglect domain scores (see Figure 10 and Table 6) all increased between the 30 and 48 month follow-up audits with the exception of 'Evaluation Activities'.
- 'Physical Environment' and 'Documentation' domains increased appreciably.
- 'Collaboration' continues to be the domain with the highest achievement, with 96% of hospitals scoring ≥ 70.
- All domains have achieved or are nearing the minimal achievement score (70) with the exception of 'Evaluation Activities'.
- Only 11% of hospitals scored ≥ 70 in the 'Evaluation Activities' domain with a median score of 32. The next lowest domain was 'Institutional Culture'.

FIGURE 9: CHILD ABUSE AND NEGLECT HOSPITAL LEAGUE TABLES







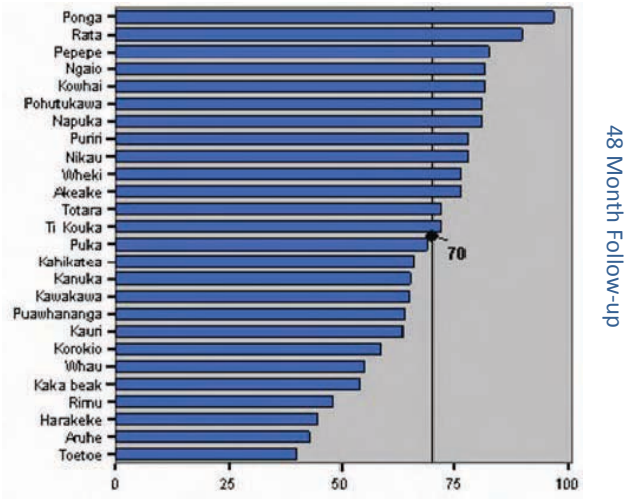


FIGURE 10: CHILD ABUSE AND NEGLECT DOMAIN SCORES (MEDIAN SCORE)

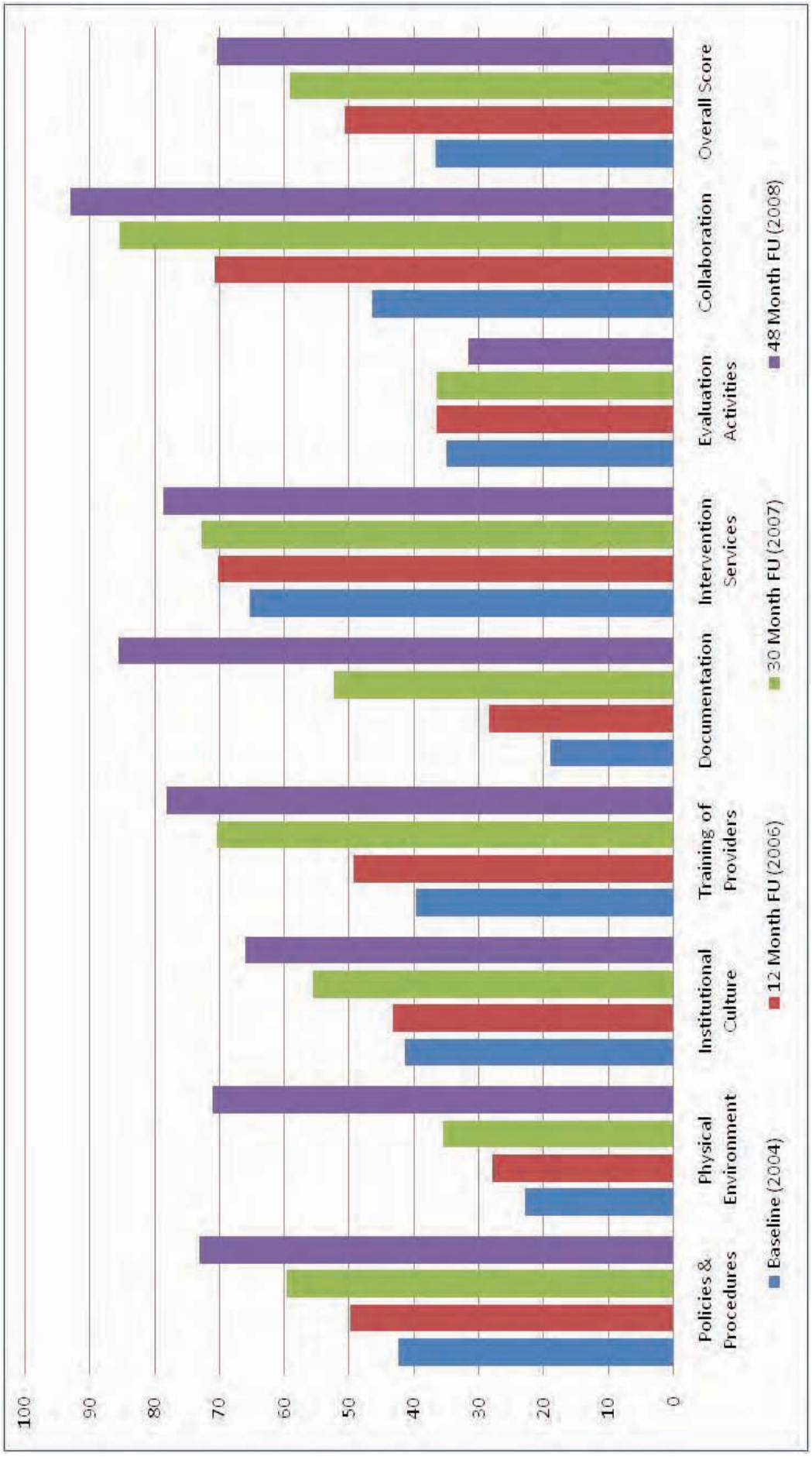


TABLE 6: CHILD ABUSE AND NEGLECT PROGRAMME SCORES

	Mean				*Median*				*Hospitals Achieving Score ≥ 70*			
	B	*F^{12}*	*F^{30}*	*F^{48}*	*B*	*F^{12}*	*F^{30}*	*F^{48}*	*B*	*F^{12}*	*F^{30}*	*F^{48}*
Overall Score	40.6	49.5	56.5	**69.2**	36.7	50.8	59.3	**70.5**	2 (8%)	3 (12%)	4 (16%)	**13 (48%)**
Domain Scores												
Policies & Procedures	44.6	51.1	58.5	**72.1**	42.5	50.0	59.7	**73.1**	3 (12%)	5 (20%)	7 (28%)	**16 (59%)**
Physical Environment	23.2	30.6	39.5	**69.5**	23.0	28.0	35.6	**71.0**	1 (4%)	2 (5%)	2 (8%)	**14 (52%)**
Institutional Culture	40.9	46.2	55.0	**67.2**	41.5	43.4	56.6	**66.0**	3 (12%)	5 (20%)	6 (24%)	**10 (37%)**
Training of Providers	36.8	51.5	58.4	**73.6**	39.7	49.4	66.7	**78.2**	2 (8%)	9 (36%)	12 (48%)	**16 (59%)**
Documentation	30.9	35.6	49.1	**68.5**	19.0	28.6	58.4	**85.7**	5 (20%)	5 (20%)	7 (28%)	**17 (63%)**
Intervention Services	62.4	67.7	70.0	**73.7**	65.4	70.4	72.8	**78.7**	12 (48%)	13 (52%)	13 (52%)	**17 (63%)**
Evaluation Activities	31.9	35.1	37.7	**33.8**	35.1	36.6	36.6	**31.6**	1 (4%)	1 (4%)	5 (20%)	**3 (11%)**
Collaboration	45.1	70.4	78.3	**93.0**	46.5	70.8	85.4	**93.0**	5 (20%)	15 (60%)	20 (80%)	**25 (93%)**

Notes: B =Baseline; F^{12} =12 month follow-up; F^{30} = 30 month follow-up; F^{48} = 48 month follow-up; 70 is selected benchmark score based on international and New Zealand data.

UNIVARIATE TREND RESULTS

Child Abuse and Neglect Intervention Programme scores were significantly associated with the following factors:

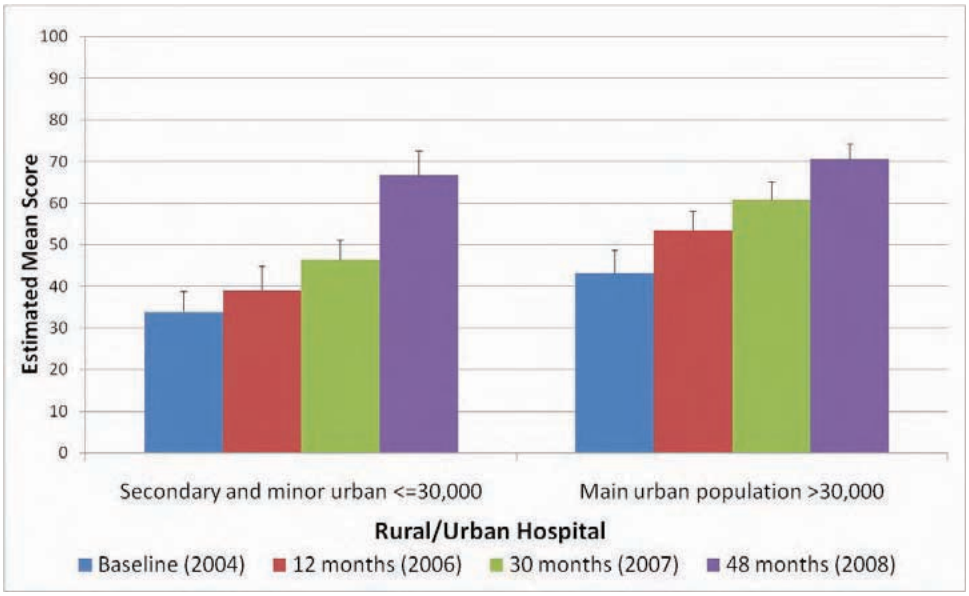
- Time
- Programme maturation (at the 48 month audit)
- Presence of a Child Abuse and Neglect Intervention Programme Coordinator
- Dual role of the coordinator

There are no statistically significant additional differences for either urban/rural (p=0.10) or hospital size measures (p=0.10). This is in contrast to earlier audit rounds where hospitals with more than 100 beds and those located in main urban areas had significantly higher scores compared to smaller rural hospitals. This is likely due to secondary, provincial hospitals benefiting from DHB-wide programme elements such as policies and procedures, access to Family Violence Intervention Coordinators and health professional training.

While there were univariate associations, no factors had changing associations with audit score over time (no interaction effects with time). [a] There were, however, still strong time effects as is demonstrated in the following figures.

Figure 11 shows the steady increase of audit scores with the secondary or minor urban hospitals lagging below the major urban hospitals. However the gap is no longer significantly different at the 48 month audit.

FIGURE 11: RURAL OR URBAN CATCHMENT



[a] Appendix H presents the estimated mean scores and standard errors for these effects.

As would be expected, the hospital size follows the trends seen between the rural and urban settings, with increases in the smaller hospitals lagging behind the larger hospitals, but catching up at the 48 month audit (Figure 12).

FIGURE 12: HOSPITAL SIZE (NUMBER OF BEDS)

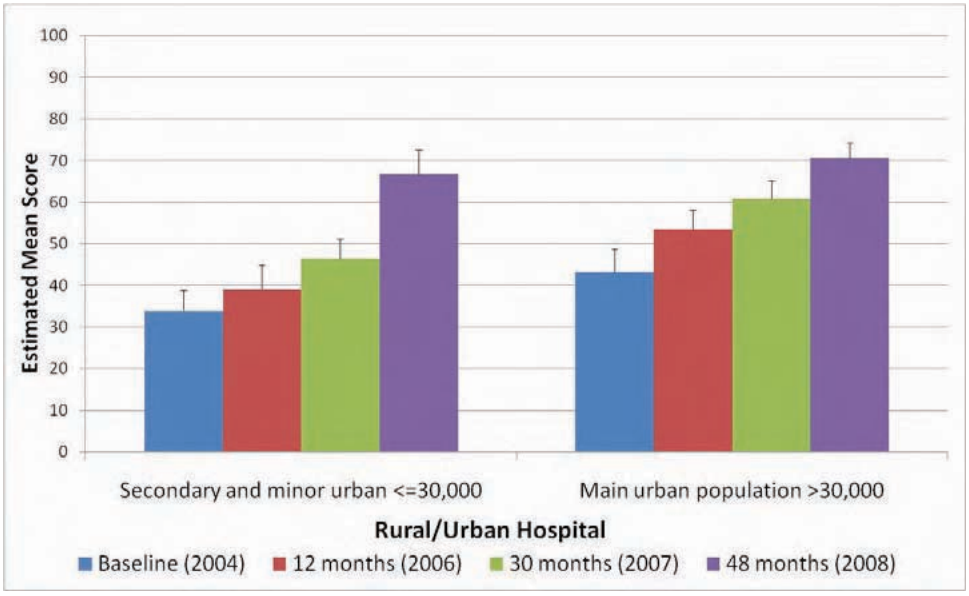


Figure 13 demonstrates that audit scores increased with increasing age of the programme.

FIGURE 13: PROGRAMME MATURATION

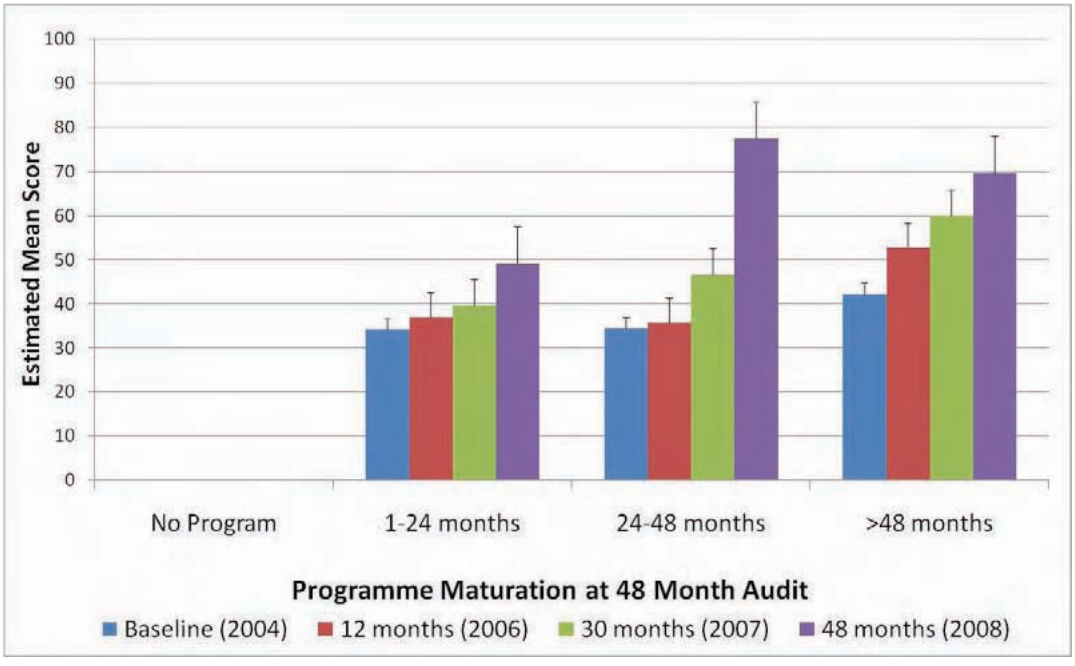


Figure 14 demonstrates the impact of the presence of Child Abuse and Neglect Intervention Coordinators. While their effect is not as strong as was seen for Partner Abuse Coordinators, scores are incrementally higher in programmes with part-time and full-time coordinators.

FIGURE 14: PRESENCE OF CHILD ABUSE AND NEGLECT COORDINAOR

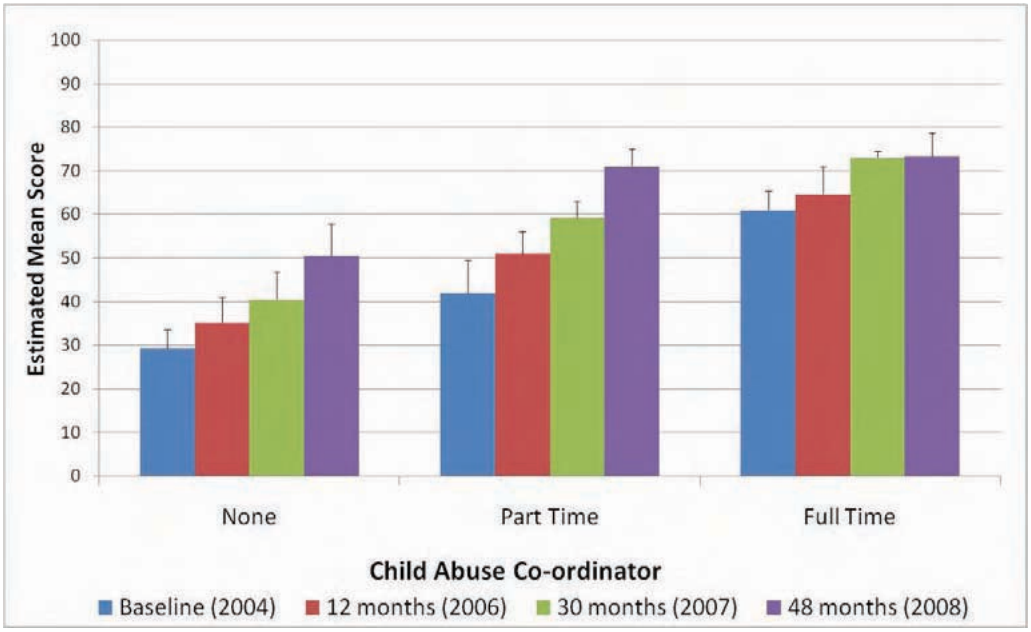
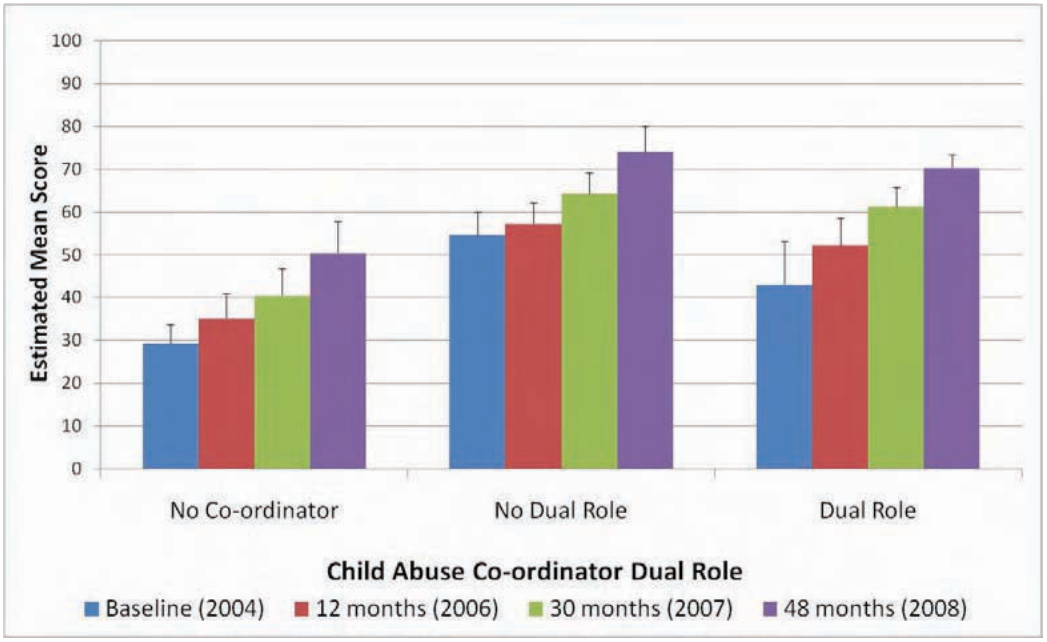


Figure 15 demonstrates a small advantage to having a Child Abuse and Neglect Intervention Programme Coordinator without Partner Abuse Intervention Programme responsibilities.

FIGURE 15: DUAL ROLE OF COORDINATOR



UNIVARIATE TREND RESULTS

The multivariate analysis identified that the following factors best explain the changes in audit scores (Table 7):

- Time
- Programme maturation
- Child Abuse and Neglect Intervention Programme Coordinator

TABLE 7: MULTIVARIATE MODEL

	df	F	p-value
Time	3,21	22.58	<0.0001
Maturation	2,21	4.20	0.03
Child Abuse Coordinator	2,21	13.24	0.0002

REVISED CHILD ABUSE AND NEGLECT AUDIT FINDINGS

The Revised Child Abuse and Neglect tool was administered concurrently with the prior tool during the 48 month follow-up audits. Hospital scores are relatively similar between the original and the revised tools, and overall share the same mean score of 67. The most significant difference in scores was reflected in the 'Evaluation Activities' domain illustrating the need for continued improvement in this area. The results of the Revised Child Abuse and Neglect tool were included in the audit reports submitted to each DHB along with suggestions for improvement. This was to support DHB programme development in anticipation of the next round of audits in 2009.

FIGURE 16: REVISED VS. CURRENT CHILD ABUSE AND NEGLECT AUDIT SCORES

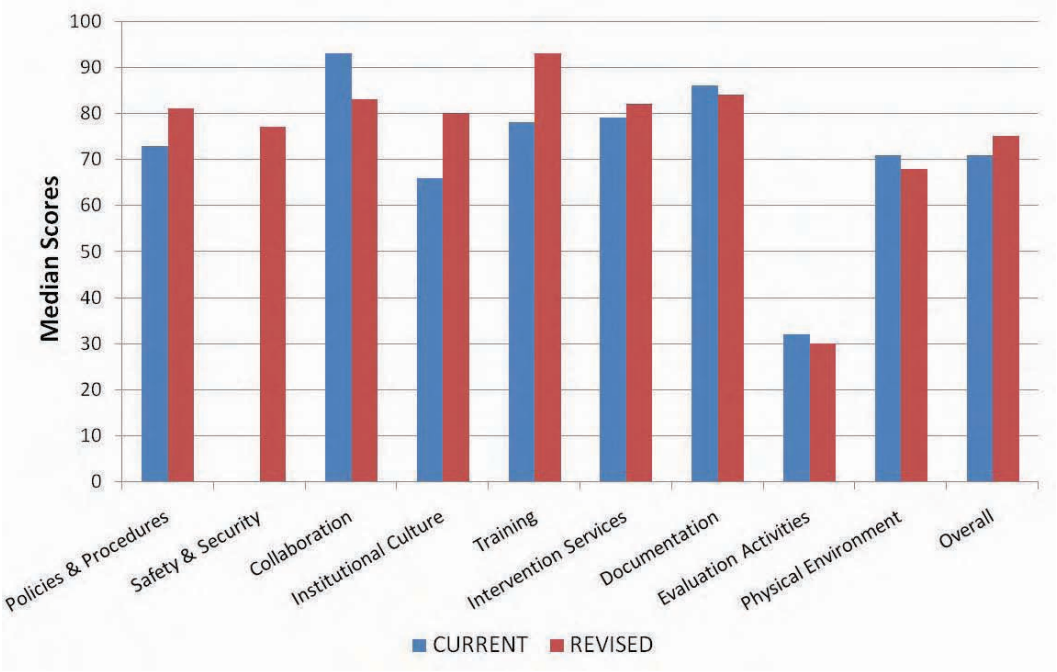


TABLE 8: 48 MONTH FOLLOW-UP REVISED CHILD ABUSE AND NEGLECT PROGRAMME SCORES

	Mean	*Median*	*Hospitals Achieving ≥70*
Overall Score	69.2	70.5	17 (65%)
Domain Scores			
Policies & Procedures	78.9	81.0	23 (89%)
Safety & Security	75.0	77.0	17 (65%)
Collaboration	81.5	82.5	21 (81%)
Institutional Culture	73.8	80	18 (69%)
Training	78.4	92.5	19 (73%)
Intervention Services	77.8	82	21 (78%)
Documentation	79.9	83.5	22 (85%)
Evaluation Activities	34.6	29.8	3 (11%)
Physical Environment	68.6	68	12 (46%)

KEY CHILD ABUSE & NEGLECT PROGRAMME INDICATORS

- 25 (96%) hospitals have materials such as flow charts and cue cards to facilitate the application of policy and procedures.
- 15 (58%) hospitals have a protocol for collaborative safety planning with the primary sector for children at high risk.
- 16 (62%) hospitals have a local alert system in acute care and 8 (31%) have clear criteria for identifying levels of risk and processes that guide the use of the alert system.
- 21 (81%) hospitals have relevant staff membership on the CYF Care and Protection Resource Panel.
- 16 (62%) hospitals have DHB strategic plans that address child protection.
- 18 (69%) hospitals have a strategic plan for training.
- 20 (77%) hospitals include dual assessment for partner violence in their hospital child abuse and neglect training.
- 3 (12%) hospitals provide a 24 hour social work service.
- 16 (62%) hospitals record, collate and report to the DHB, child abuse and neglect assessments, identifications, referrals and alert status data.
- 7 (27%) hospitals provide health workers with standardised feedback on their performance and on notifications to CYF.
- 8 (31%) hospitals measure community satisfaction with the Child Abuse and Neglect programme

DISCUSSION

Results of the 48 month follow-up audits indicate that significant progress continues to be made across New Zealand DHB health care systems in responding to both partner abuse and child abuse and neglect.

- From 2004 to 2008, the number of hospitals achieving the recommended minimal achievement threshold has risen from 1 to 13 for both Partner Abuse and Child Abuse and Neglect Intervention Programmes.
- In 2004 only 2 hospitals reported monitoring partner violence screening effort. In 2008, 14 hospitals monitored their screening effort, with 6 hospitals screening at least 25% of eligible women.
- An effective, sustainable health sector response to women, children and families at risk for family violence is possible with the will and effort of many, both within and outside of the health sector.
- Increasing audit scores over time demonstrate that programme maturation, Family Violence Intervention Coordinator stability, ongoing health provider training, national programme coordination and other efforts are successful in creating sustainable institutional change.

Partner Abuse and Child Abuse & Neglect Intervention Programmes have made steady progress between 2004 and 2008 across all of the measured domains. Evidenced by the high 'Collaboration' domain scores, local programmes have collaborated internally and externally to support a multi-agency approach to responding to women and children at risk for family violence. The sole domain that remains under-developed is 'Evaluation Activities'. To support development of internal programme evaluation, the Ministry of Health is currently funding the development of a quality improvement resource toolkit.

In the 2008 audit round we found the difficulty in developing programmes in small, secondary hospitals has diminished, indicating diffusion of resources across DHBs. This may suggest that in future evaluation reports the unit of analysis could be DHB rather than hospital. In addition, hospitals which had recently begun Family Violence Programmes had been able to make significant gains in a short time period. National programme support resourcing that includes Family Violence Intervention Coordinators, VIP website, a National VIP Manager for DHBs, and twice yearly coordinator meetings have likely contributed to this. The system development in responding to partner abuse and child abuse and neglect is expected to serve as a platform to expand DHB services to include implementation of the recently published Elder Abuse and Neglect Guidelines .[15] At the 48 month follow-up audit, 18 (67%) hospitals reported having elder abuse and neglect intervention policy.

Trend analysis indicated that having a designated Family Violence Intervention Coordinator (partner abuse and child abuse and neglect), programme maturation and time (audit round) all predicted higher family violence programme scores. While significant improvements have been made, it is a concern that several hospitals have yet to begin developing a system response to family violence, indicated by low scores and the absence of a Family Violence Intervention Coordinator. Hospitals which have employed Family Violence Intervention Coordinators (FVIC) consistently score higher than those which do not. Similarly, scores were consistently lower for hospitals that did not have an identifiable FVIC, even if they had had a FVIC in the past. Maintenance and development of family violence programmes, therefore, relies on the stability of the coordinator position. With dedicated District Health Board and Ministry of Health resourcing, family violence programme process indicators are likely to continue steady improvement towards sustainability.

STRENGTHS AND LIMITATIONS

This family violence evaluation project contributes evidence informing healthcare system programme development for addressing family violence, a significant – preventable - public health problem. Scores which are based on external auditing provide an advantage over self-report or internal audits alone. In addition, the series of audits allows the tracking of change over time. Indeed, this longitudinal series of four audits has successfully captured the implementation of programme planning across individual hospitals and DHBs across New Zealand.

The 48 month follow-up audit is improved from earlier audits in that programme elements identified by New Zealand experts were assessed in the Revised Child Abuse and Neglect Audit Tool. As well as improved content validity, the revised tool represented a change in scope, from hospital to DHB system, including acute and community (but not Primary Health Organisation) services.

While this audit report focuses on audit scores, it is important to appreciate the potential that the audit process served as a lever for system change. The evaluation procedures involved in the audit required active participation by stakeholders within hospitals, thus increasing the likelihood that evaluation findings would result in further programme development. Through the audit process many hospitals learned the important elements of a family violence programme.

The limitations that have been noted in earlier reports remain[12,13,19]. For example, the audit scores represent a snap shot of systems and services in place at the time of the audit, rather than those under development. We also caution the reader that the hospital audit process focused on system indicators rather than quality of services provided. It is important that the results of the audit tool are balanced with outcome based measures. Finally, with the audit limited to a single one-day site visit, there is likely to be some measurement error. This is especially true as development progresses and measurement criteria become more explicit over time.

CONCLUSIONS

Healthcare system family violence process indicators have steadily improved over the past 48 months, evidenced by four rounds of hospital audit data. Collaboration with community agencies, staff training and intervention services are now present across the majority of hospitals for both partner abuse and child abuse and neglect. With continued family violence programme resourcing and time we expect that the number of hospitals achieving the benchmark score of 70 will grow in the coming years. The healthcare system is making significant progress in responding to the high prevalence of family violence in our society, potentially reducing both acute and long-term health effects. While this evaluation provides important information to guide and monitor further system development, it is important to stress that it is only one aspect of an effective healthcare family violence strategy. Community healthcare responsiveness and research evidence of intervention effectiveness are other elements that will be necessary to achieve family violence prevention targets.

REFERENCES

1. 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

2. World Health Organisation. Preventing child maltreatment: *a guide to taking action and generating evidence*. Geneva, Switzerland: WHO; 2006.

3. Balzer R, Haimona D, Henare M, Matchitt V. *Maori Family Violence in Aotearoa*. Wellington, New Zealand: Te Puni Kokiri (Ministry of Maori Affairs); 1997.

4. Fanslow J, Robinson E. Violence against women in New Zealand: prevalence and health consequences. *N Z Med J*. 2004;117(1206):U1173.

5. Morris A, Reilly J, Berry S, Ransom R. *New Zealand National Survey of Crime Victims 2001*. Wellington, New Zealand: Ministry of Justice; 2003.

6. Fanslow J. *Family Violence Intervention Guidelines: Child and Partner Abuse*. Wellington, New Zealand: Ministry of Health; 2002.

7. Morris A. *Women's Safety Survey* 1996. Wellington, New Zealand: Victimisation Survey Committee; 1997.

8. Young W, Morris A, Cameron N, Haslett S. *New Zealand National Survey of Crime Victims 1996*. Wellington, New Zealand: Victimisation Survey Committee; 1997.

9. Hau'alofa'ia Koloto A. *The Needs of Pacific Peoples When They Are Victims of Crime*. Wellington, New Zealand: Ministry of Justice; 2003.

10. Ministry of Health. *The New Zealand Health Strategy*. Wellington, New Zealand: Ministry of Health; 2000.

11. Ministry of Health. *Family Violence: Guidelines for Health Sector Providers to Develop Practice Protocols*. Wellington, New Zealand: Ministry of Health; 1998.

12. Koziol-McLain J, Adams J, Neitzert E, et al. *Hospital Responsiveness to Family Violence: Baseline Audit Findings*. Auckland: Auckland University of Technology; 2004. Commissioned by the New Zealand Ministry of Health.

13. Koziol-McLain J, Adams J, Davies E, Balzer R, Harvey S, Coben J. *Hospital Responsiveness to Family Violence: 12 Month Follow-up Evaluation*. Auckland: Auckland University of Technology; 2006 Commissioned by the New Zealand Ministry of Health.

14. Koziol-McLain J, Adams J, Garrett N, Sharma P. *Hospital responsiveness to family violence: 30 month follow-up evaluation* Auckland: Interdisciplinary Trauma Research Unit, Auckland University of Technology; 2007

15. Glasgow K, Fanslow J. *Family Violence Intervention Guidelines: Elder Abuse and Neglect*. Wellington: Ministry of Health; 2006.

16. Agency for Health Care Research and Quality. Evaluating Domestic Violence Programs.

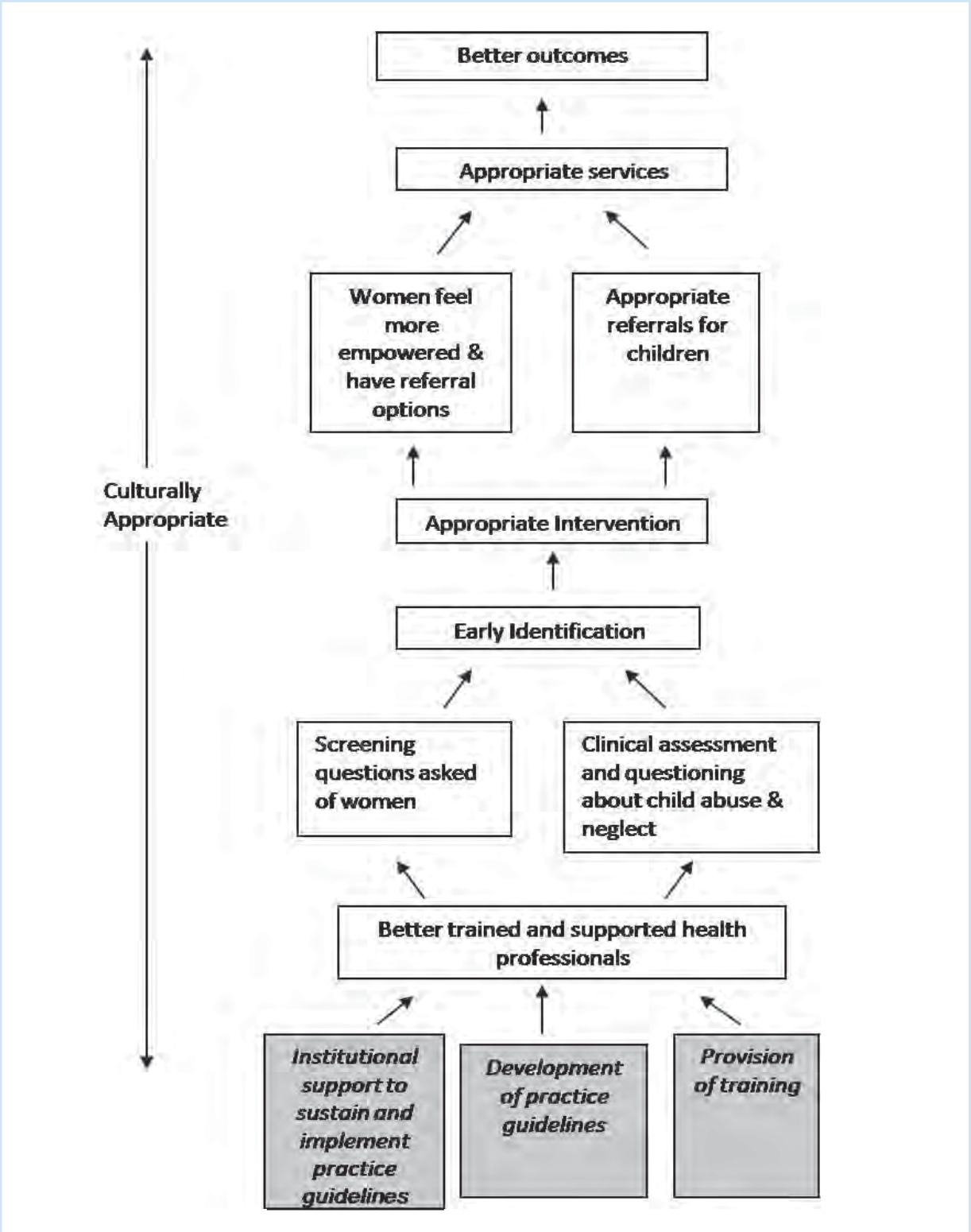
17. Wilson D. Monitoring the quality of health-based child abuse prevention and intervention programs. 2007, Auckland.

18. Coben J. Measuring the quality of hospital-based domestic violence programs. *Acad Emerg Med*. 2002;9(11):1176-1183.

19. Koziol-McLain J, Neitzert E, Coben J, Davies E, Balzer R, Harvey S. Measuring Hospital Institutional Culture: The Delphi Instrument New Zealand. Paper presented at: 2004 National Conference on Health Care and Domestic Violence: Health Consequences Over the Lifespan, 2004; Boston.

APPENDICES

APPENDIX A: FAMILY VIOLENCE PROJECT PROGRAMME LOGIC [a]



[a] 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		S
	Whangarei	S
Waitemata	North Shore	S
	Waitakere	S
Auckland	Auckland/Starship	T
Counties Manukau	Middlemore	T
Waikato	Hamilton	T
	Thames	S
Bay of Plenty	Tauranga	S
	Whakatane	S
Lakes District	Rotorua	S
Tairawhiti	Gisborne	S
Taranaki	New Plymouth	S
Hawkes Bay	Hawkes Bay	S
Whanganui	Wanganui	S
Midcentral	Palmerston North	S
Capital and Coast	Wellington	T
Wairarapa	Masterton	S
Hutt Valley	Lower Hutt	S
Nelson-Marlborough	Nelson	S
	Wairau	S
Canterbury	Christchurch	T
	Ashburton	S
West Coast	Greymouth	S
South Canterbury	Timaru	S
Otago	Dunedin	T
Southland	Invercargill	S

S = secondary service, T = tertiary

Links to DHB Maps:

http://www.moh.govt.nz/dhbmaps

APPENDIX C: DELPHI SCORING WEIGHTS

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

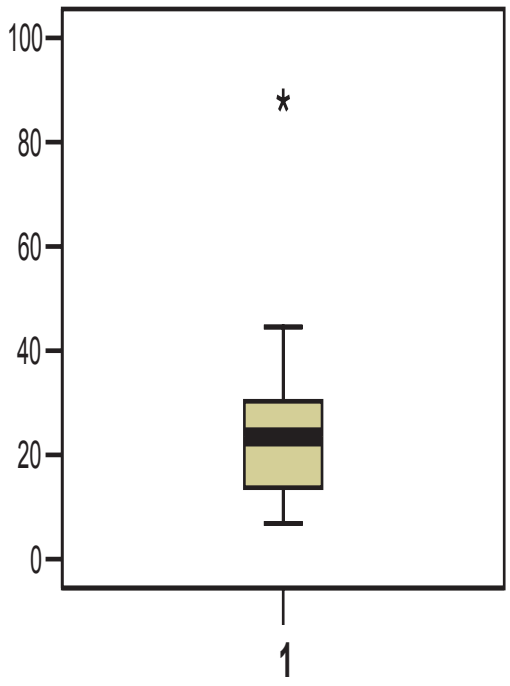
The weightings used for this study are provided below.

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 D: 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 E: PARTNER ABUSE ITEM ANALYSIS

CATEGORY 1. HOSPITAL POLICIES AND PROCEDURES [a]

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
1.1	Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do these policies:	10 40%	9 36%	21 78%	**21** **78%**
	a) define partner abuse?	8 32%	9 36%	20 74%	**21** **78%**
	b) mandate training on partner abuse for any staff?	4 16%	5 20%	18 67%	**19** **70%**
	c) advocate universal screening for women anywhere in the hospital?	4 16%	6 24%	16 59%	**20** **74%**
	d) define who is responsible for screening?	3 12%	4 16%	17 63%	**20** **74%**
	e) address documentation?	7 28%	8 32%	19 70%	**20** **74%**
	f) address referral of victims?	8 32%	8 30%	21 78%	**20** **74%**
	g) address legal reporting requirements?	5 20%	6 24%	16 60%	**19** **70%**
	h) address the responsibilities to, and needs of, Māori?	3 12%	6 24%	18 67%	**17** **63%**
	i) address the needs of other cultural and/or ethnic groups?	3 12%	5 20%	17 63%	**12** **44%**
	k) address the needs of LGBT (lesbian, gay, bisexual, transgendered) clients?	2 8%	2 8%	8 30%	**11** **41%**
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the working group:	15 60%	19 76%	19 70%	**26** **96%**
	a) meet at least every month?	12 48%	14 56%	16 59%	**22** **82%**
	b) include representative(s) from more than two departments?	15 60%	19 76%	18 67%	**26** **96%**
	c) include representative(s) from the security department?	0 0%	7 28%	7 26%	**15** **56%**
	d) include physician(s) from the medical staff?	12 48%	16 64%	16 59%	**24** **89%**
	e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?	4 16%	9 36%	14 52%	**21** **78%**
	f) include representative(s) from hospital administration?	13 52%	16 64%	17 63%	**21** **78%**
	g) include Māori representative(s)?	12 48%	17 68%	19 70%	**24** **89%**
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%**
	a) < $5000/year	1	1	1	**0**

[a] The number of participating hospitals over time are: baseline (25), 12 month (25), 30 month (27), 48 month (27).

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
		4%	4%	4%	**0%**
	b) $5000-$10,000/year	3 12%	3 12%	0 0%	**1** **4%**
	c) > $10,000/year	10 40%	14 56%	17 63%	**20** **74%**
1.3 a	Is funding set aside specifically for Māori programmes and initiatives? If yes, how much annual funding? (*Choose one):*	**1** **4%**	**1** **4%**	2 8%	**5** **19%**
	a) < $5000/year	1 4%	1 4%	1 4%	**0** **0%**
	b) > $5000/year	0 0%	0 0%	1 4%	**5** **19%**
1.4	Is there a mandatory universal screening policy in place? If yes, does the policy require screening of all women: (*choose one*)	5 20%	6 24%	9 33%	**19** **70%**
	a) in the emergency department (ED) or any other out-patient area?	0 0%	3 12%	1 4%	**0** **0%**
	b) in in-patient units only?	0 0%	0 0%	0 0%	**0** **0%**
	c) in more than one out-patient area?	0 0%	1 4%	8 30%	**1** **4%**
	d) in both in-patient and out-patient areas?	5 20%	2 8%	10 37%	**18** **67%**
1.5	Are there quality assurance procedures in place to ensure partner abuse screening? If yes, are there:	5 20%	6 24%	10 37%	**16** **59%**
	a) regular chart audits to assess screening?	2 8%	3 12%	10 37%	**15** **56%**
	b) positive reinforcers to promote screening?	2 8%	3 12%	5 19%	**9** **33%**
	c) is there regular supervision?	3 12%	6 24%	11 40%	**14** **52%**
1.6	Are there procedures for security measures to be taken when victims of partner abuse are identified? If yes, are there:	11 44%	12 48%	10 37%	**12** **44%**
	a) written procedures that outline the security department's role in working with victims and perpetrators?	3 12%	8 32%	11 40%	**10** **37%**
	b) procedures that include name/phone block for victims admitted to hospital?	3 12%	6 24%	8 30%	**12** **44%**
	c) procedures that include provisions for safe transport from the hospital to shelter?	1 4%	4 16%	7 26%	**13** **48%**
	d) do these procedures take into account the needs of Māori?	3 12%	4 16%	6 22%	**9** **33%**
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%**
	a) part time position or included in responsibilities of someone with other responsibilities?	11 44%	15 68%	15 56%	**14** **52%**
	b) full-time position with no other responsibilities?	1 4%	1 4%	2 7%	**7** **26%**

CATEGORY 2. HOSPITAL PHYSICAL ENVIRONMENT

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
2.1	Are there posters and/or brochures related to partner abuse on public display in the hospital?	20 80%	25 100%	26 96%	**27** **100%**
	If yes, total number of *locations* (up to 35): 0	5 20%	0 0%	1 4%	**0** **0%**
	1-5	11 44%	14 56%	4 15%	**2** **7%**
	6-10	7 28%	6 24%	10 37%	**3** **11%**
	11-20	1 4%	3 12%	6 22%	**3** **11%**
	21-35	1 4%	2 8%	6 22%	**19** **70%**
	Are there Māori images related to partner abuse on public display in the hospital?	9 36%	17 68%	23 85%	**27** **100%**
	If yes, total number *locations (up to 17)* 0	16 64%	8 32%	4 15%	**0** **0%**
	1-5	9 36%	13 50	8 30%	**6** **22%**
	6-10	0 0%	2 8%	6 22%	**6** **22%**
	11-17	0 0%	2 8%	7 26%	**15** **56%**
2.2	Is there referral information (eg., local or national phone numbers) related to partner abuse services on public display in the hospital? (Can be included on the posters/brochure noted above).	20 80%	24 96%	26 96%	**27** **100%**
	If yes, total number *locations* (up to 35): 0	5 20%	1 4%	1 4%	**0** **0%**
	1-4	14 56%	12 48%	3 11%	**3** **11%**
	5-10	4 16%	8 32%	10 38%	**2** **7%**
	11-20	2 8%	2 8%	8 30%	**5** **19%**
	21-35	0 0%	2 8%	5 19%	**17** **63%**
	Is there referral information related to Māori providers of partner abuse services on public display in the hospital?	8 32%	20 80%	24 89%	**24** **89%**
	If yes, total number *locations (up to 17)* 0	17 68%	5 20%	3 11%	**3** **11%**
	1-4	8 32%	12 48%	7 26%	**4** **15%**
	5-10	0 0%	6 24%	9 33%	**10** **37%**
	11-17	0 0%	2 8%	6 22%	**10** **37%**
	Is there referral information related to partner abuse services for particular ethnic or cultural group (other than Māori or Pakeha) on public display in the hospital?	4 16%	7 28%	13 48%	**23** **85%**
	If yes, total number *locations (up to 17)* 0	21 84%	18 72%	14 52%	**4** **15%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	1	4 16%	5 20%	6 22%	**0** **0%**
	2-6	0 0%	1 4%	4 15%	**9** **33%**
	7-17	0 0%	1 4%	3 11%	**14** **52%**
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%**
	a) Victims are permitted to stay in ED until placement is secured.	0 0%	1 4%	2 7%	**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%**
	c) In-patient beds are available for victims until placement is secured.	3 12%	4 16%	8 30%	**20** **74%**
	d) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	5 20%	6 24%	7 26%	**16** **59%**

CATEGORY 3: HOSPITAL INSTITUTIONAL CULTURE

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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?	5 20%	11 44%	13 48%	**16** **59%**
	a) nursing staff	5 20%	9 36%	13 48%	**16** **59%**
	b) medical staff	5 20%	7 28%	6 22%	**14** **52%**
	c) administration	4 16%	7 28%	7 26%	**13** **48%**
	d) other staff/employees	3 12%	8 32%	8 30%	**15** **56%**
	If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse?	1 4%	1 4%	1 4%	**6** **22%**
3.2	How long has the hospital's partner abuse programme been in existence? (*Choose one*):				
	a) 1-24 months	13 52%	15 60%	7 26%	**5** **19%**
	b) 24-48 months	2 8%	3 12%	9 33%	**5** **19%**
	c) >48 months	0 0%	1 4%	3 11%	**13** **48%**
3.3	Does the hospital have plans in place for responding to employees experiencing partner abuse? If yes:	15 60%	15 60%	16 59%	**21** **78%**
	a) Is there a hospital policy covering the topic of partner abuse in the workplace?	2 8%	1 4%	11 41%	**11** **41%**
	b) Does the Employee Assistance programme maintain specific policies and procedures for	9 36%	6 24%	13 48%	**5** **19%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	dealing with employees experiencing partner abuse?				
	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%**
3.4	Does the hospital's partner abuse programme address cultural competency issues? If yes:	24 96%	24 96%	25 93%	**22 82%**
	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%**
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	9 36%	10 40%	14 52%	**19 70%**
	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%**
	d) Are referral information and brochures related to partner abuse available in languages other than English?	5 20%	6 24%	11 41%	**23 85%**
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%**
	a) 1 programme in the last 12 months?	9 36%	5 20%	8 30%	**1 4%**
	b) >1 programme in the last 12 months?	5 20%	10 40%	12 44%	**22 82%**
	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%**

CATEGORY 4: TRAINING OF PROVIDERS

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
4.1	Has a formal training plan been developed for the institution? If yes:	5 20%	9 36%	16 59%	**18 67%**
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	4 16%	8 32%	15 56%	**19 70%**
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	2 8%	7 28%	15 56%	**14 52%**
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%**
	b) to members of the clinical staff via colloquia or other sessions?	5 20%	15 60%	17 63%	**22 82%**
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%**
	b) dynamics of partner abuse?	11 44%	14 56%	15 56%	**24 89%**
	c) epidemiology?	9 36%	13 52%	14 52%	**25 93%**
	d) health consequences?	9	13	14	**25**

		36%	52%	52%	**93%**
	e) strategies for screening?	9 36%	12 48%	12 44%	**18** **67%**
	f) risk assessment?	7 28%	11 44%	12 44%	**21** **78%**
	g) documentation?	10 40%	13 52%	12 44%	**23** **85%**
	h) intervention?	8 32%	13 52%	13 48%	**23** **85%**
	i) safety planning?	10 40%	9 36%	11 41%	**20** **74%**
	j) community resources?	5 20%	14 56%	12 44%	**24** **89%**
	k) reporting requirements?	6 24%	10 40%	12 44%	**22** **82%**
	l) legal issues?	6 24%	12 48%	12 44%	**19** **70%**
	m) confidentiality?	9 36%	12 48%	12 44%	**25** **93%**
	n) cultural competency?	7 28%	10 40%	10 37%	**21** **78%**
	o) clinical signs/symptoms?	9 36%	14 56%	14 52%	**22** **82%**
	p) Māori models of health?	3 12%	6 24%	7 26%	**17** **63%**
	q) risk assessment for children of victims?	6 24%	11 44%	12 44%	**24** **89%**
	r) the social, cultural, historic, and economic context in which Māori family violence occurs?	2 8%	5 20%	6 22%	**17** **63%**
	s) te Tiriti o Waitangi?	3 12%	5 20%	4 15%	**15** **56%**
	t) Māori service providers and community resources?	7 28%	13 52%	12 44%	**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%**
	v) partner abuse in same-sex relationships?	3 12%	5 20%	8 30%	**21** **78%**
	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%**
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%**
	b) a single individual?	2 8%	2 8%	8 30%	**3** **11%**
	c) a team of hospital employees only? List departments represented:	0 0%	1 4%	1 4%	**1** **4%**
	d) a team, including community expert(s)?	11 44%	11 44%	10 37%	**21** **78%**
	If provided by a team, does it include:				
	e) a Māori representative?	7 28%	10 40%	8 30%	**16** **59%**
	f) a representative(s) of other ethnic/cultural groups?	2 8%	2 8%	1 4%	**2** **7%**

CATEGORY 5: SCREENING AND SAFETY ASSESSMENT

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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%**
	a) included, as a separate form, in the clinical record?	0 0%	3 12%	5 19%	**2** **7%**
	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%**
	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%**
	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%**
5.2	What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area)?				
	a) Not done or not applicable	23 92%	22 88%	17 63%	**13** **48%**
	b) 0% - 10%	0 0%	0 0%	3 11%	**7** **26%**
	c) 11% - 25%	2 8%	0 0%	1 4%	**1** **4%**
	d) 26% - 50%	0 0%	1 4%	4 15%	**2** **7%**
	e) 51% - 75%	0 0%	1 8%	1 4%	**3** **11%**
	f) 76% - 100%	0 0%	0 0%	1 4%	**1** **4%**
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%**
	a) also assess the safety of any children in the victim's care?	7 28%	7 28%	14 52%	**20** **74%**

CATEGORY 6: DOCUMENTATION

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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%**
	a) information on the results of partner abuse screening?	1 4%	9 36%	14 52%	**19** **70%**
	b) the victim's description of current and/or past abuse?	2 8%	4 16%	9 33%	**15** **56%**
	c) the name of the alleged perpetrator and relationship to the victim?	1 4%	2 8%	10 37%	**17** **63%**
	d) a body map to document injuries?	3	6	10	**13**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
		12%	24%	37%	**48%**
	e) information documenting the referrals provided to the victim?	1 4%	4 16%	11 41%	**18 67%**
	f) in the case of Māori, information documenting whether the individual was offered a Māori advocate?	0 0%	3 12%	5 19%	**11 41%**
6.2	Is forensic photography incorporated in the documentation procedure? If yes:	8 32%	9 36%	10 37%	**16 59%**
	a) Is a fully operational camera with adequate film available in the treatment area?	1 4%	7 28%	11 41%	**23 85%**
	b) Do hospital staff receive on-going training on the use of the camera?	2 8%	2 8%	8 30%	**14 52%**
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	1 4%	1 4%	2 7%	**15 56%**
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	5 20%	12 48%	17 63%	**21 78%**
	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%**

CATEGORY 7: INTERVENTION SERVICES

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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%**
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%**
	a) A trained victim advocate provides services during certain hours.	7 28%	8 32%	7 26%	**17 63%**
	b) A trained victim advocate provides service at all times.	6 24%	12 48%	17 63%	**8 30%**
	c) is a Māori advocate is available "on-site" for Māori victims?	8 32%	14 56%	20 74%	**27 100%**
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori is available onsite? If yes, list ethnicity:	3 12%	6 24%	9 33%	**9 33%**
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%**
	a) available, when indicated?	8 32%	13 52%	17 63%	**17 63%**
	b) performed routinely?	6 24%	2 8%	3 11%	**4 15%**
7.4	Is transportation provided for victims, if needed?	3 12%	6 24%	6 22%	**20 74%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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%**
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%**
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%**
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%**

CATEGORY 8: EVALATION ACTIVITIES

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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%**
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening?	2 8%	3 12%	9 33%	**16 59%**
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse?	2 8%	5 20%	6 22%	**13 48%**
8.2	Do health care providers receive standardized feedback on their performance and on patients?	1 4%	3 12%	7 26%	**10 37%**
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%**
8.4	Is the quality framework *He Taura Tieke* (or an equivalent) used to evaluate whether services are effective for Māori?	2 8%	1 4%	3 11%	**4 15%**

CATEGORY 9: COLLABORATION

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	22 88%	24 96%	24 89%	**26 96%**
	a) which types of collaboration apply:				
	i) collaboration with training?	9 36%	15 60%	15 55%	**21 78%**
	ii) collaboration on policy and procedure development?	11 44%	17 68%	20 74%	**21 78%**

	iii) collaboration on partner abuse working group?	6 24%	18 72%	21 78%	**21** **78%**
	iv) collaboration on site service provision?	10 40%	18 72%	21 78%	**24** **89%**
	b) is collaboration with				
	i) Māori provider(s) or representative(s)?	18 72%	23 92%	23 85%	**25** **93%**
	iii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	4 16%	9 36%	12 44%	**14** **52%**
	c) List collaborating partner abuse programmes:				
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes, which types of collaboration apply:	16 64%	20 80%	20 74%	**26** **96%**
	a) collaboration with training?	4 16%	12 48%	14 52%	**22** **82%**
	b) collaboration on policy and procedure development?	5 20%	14 56%	16 59%	**23** **85%**
	c) collaboration on partner abuse working group?	3 12%	18 72%	19 70%	**22** **82%**
	c) List collaborating agencies (eg., police, courts):				
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	21 84%	22 88%	24 89%	**26** **96%**
	a) within the same health care system?	13 52%	19 76%	22 82%	**26** **96%**
	If yes, with a Māori health unit?	12 48%	18 72%	21 78%	**25** **93%**
	b) with other systems in the region?	18 72%	21 21%	19 70%	**26** **96%**
	If yes, with a Māori health provider?	2 8%	13 52%	19 70%	**25** **93%**

APPENDIX F: CHILD ABUSE AND NEGLECT TOOL ITEM ANALYSIS

CATEGORY 1: HOSPITAL POLICIES AND PROCEDURES [a]

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
1.1	Are there official, written hospital policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children?	23 92%	24 96%	27 100%	**24 92%**
	If yes, do these policies:				
	a) define child abuse and neglect?	17 68%	21 84%	26 96%	**24 92%**
	b) mandate training on child abuse and neglect for any staff?	8 32%	8 32%	21 78%	**22 85%**
	c) outline age-appropriate protocols for risk assessment?	5 20%	5 20%	11 41%	**12 46%**
	d) define who is responsible for risk assessment?	19 76%	22 88%	25 93%	**20 77%**
	e) address the issue of contamination?	11 44%	16 64%	20 74%	**17 65%**
	f) address documentation?	21 84%	23 92%	26 96%	**24 92%**
	g) address referrals for children and their families?	22 88%	24 96%	27 100%	**23 89%**
	h) address child protection reporting requirements?	19 76%	19 76%	26 96%	**24 92%**
	i) address the responsibilities to, and needs of, Māori?	14 56%	16 64%	23 85%	**18 69%**
	i) address the needs of other cultural and/or ethnic groups?	12 48%	15 60%	15 56%	**18 69%**
1.2	Is there evidence of a hospital-based child abuse and neglect working group?	12 48%	19 76%	24 89%	**25 96%**
	If yes, does the working group:				
	a) meet at least every month?	10 40%	15 60%	17 63%	**24 92%**
	b) include representatives from more than two departments?	12 48%	18 72%	24 89%	**25 96%**
	List represented departments:				
	c) include representative(s) from the security department?	2 8%	4 16%	6 22%	**10 38%**
	d) include physician(s) from the medical staff?	11 44%	17 68%	23 85%	**24 92%**
	e) include representative(s) from Child Youth and Family?	3 12%	8 32%	16 59%	**17 65%**
	f) include representative(s) from hospital administration?	11 44%	16 64%	19 70%	**20 77%**
	g) include representative(s) from an agency or programme involved in partner abuse advocacy?	2 8%	5 20%	12 44%	**19 73%**
	h) include representative(s) from community-based	1	7	14	**19**

[a] The total number of participating hospitals were: baseline (25), 12 month (25), 30 month (26) and 48 month (26).

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	children's services?	4%	28%	52%	**73%**
	i) include at least two youth representatives?	0 0%	1 4%	1 4%	**2** **8%**
	j) include Māori representative(s)?	10 40%	16 64%	18 67%	**21** **81%**
1.3	Does the hospital provide direct financial support for the child abuse and neglect programme? If yes, how much annual funding? (*Choose one of a-c and answer d*):	17 68%	19 76%	23 85%	**24** **92%**
	a) < $5000/year	2 8%	0 0%	1 4%	**2** **8%**
	b) $5000-$10,000/year	1 4%	3 12%	1 4%	**1** **4%**
	c) > $10,000/year	14 56%	16 64%	21 78%	**23** **89%**
	d) Is funding set aside specifically for Māori programmes and initiatives? If yes, how much annual funding?	5 20%	2 8%	4 15%	**8** **31%**
	i) < $5000/year	3 12%	1 4%	1 4%	**0** **0%**
	ii) > $5000/year	2 8%	1 4%	3 11%	**8** **31%**
1.4	Is there a clinical assessment policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? If yes, does the policy include children: (choose one)	23 92%	24 96%	24 89%	**25** **96%**
	a) in the emergency department (ED) or any other out-patient area?	1 4%	3 12%	3 11%	**2** **8%**
	b) in in-patient units only?	0 0%	0 0%	0 0%	**0** **0%**
	c) in more than one out-patient area?	1 4%	1 4%	1 4%	**0** **0%**
	d) in both in-patient and out-patient areas? List departments:	21 84%	20 80%	20 74%	**23** **89%**
1.5	Are there quality assurance procedures in place to ensure the clinical assessment policy for identifying child abuse and neglect is implemented? If yes:	18 72%	18 72%	13 48%	**20** **77%**
	a) are there regular chart audit to assess whether signs and symptoms of child abuse and neglect are investigated? List departments:	5 20%	6 24%	5 19%	**14** **54%**
	b) is there regular peer review? List departments:	12 48%	14 56%	13 48%	**22** **85%**
	c) is there regular supervision? List departments:	11 44%	11 44%	13 48%	**22** **85%**
	d) is there regular feedback from Child Youth and Family (CYF)?	18 72%	16 64%	21 78%	**20** **77%**
1.6	Are there procedures for security measures to be taken when suspected cases of child abuse and neglect are identified and the child is perceived to be at immediate risk? If yes, are there:	12 48%	12 48%	17 63%	**21** **81%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	a) written procedures that outline the security department's role in working with victims and their families and perpetrators?	4 16%	10 40%	13 48%	**21 81%**
	b) procedures that include name/phone block for children and their families admitted to hospital?	1 4%	3 12%	6 22%	**9 35%**
	c) procedures that include provisions for safe transport from the hospital to shelter?	2 8%	5 20%	3 11%	**12 46%**
	d) do these procedures take into account the needs of Māori?	2 8%	4 16%	7 26%	**15 58%**
1.7	Is there an identifiable child protection coordinator at the hospital? If yes is it a: (*choose one*)	14 56%	16 64%	19 70%	**23 89%**
	a) part time position or included in responsibilities of someone with other responsibilities?	9 36%	12 48%	15 56%	**15 58%**
	b) full-time position with no other responsibilities?	5 20%	4 16%	4 15%	**8 31%**

CATEGORY 2: HOSPITAL PHYSICAL ENVIRONMENT

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
2.1	Are posters and images that are of relevance to children and young people on public display in the hospital so as to create a 'child-friendly' environment?	25 100%	25 100%	27 100%	**26 100%**
	If yes, total number of *locations* (up to 35): 0	0 0%	0 0%	0 0%	**0 0%**
	1-5	11 44%	9 36%	3 11%	**0 0%**
	6-10	3 12%	7 28%	8 30%	**3 12%**
	11-20	9 36%	7 28%	12 44%	**7 27%**
	21-35	2 8%	2 8%	4 15%	**16 62%**
	Are there posters and/or brochures related to child abuse and neglect, including posters and/or brochures about children's rights, on public display in the hospital?	24 96%	25 100%	27 100%	**26 100%**
	If yes, total number of *locations* (up to 35): 0	1 4%	0 0%	0 0%	**0 0%**
	1-5	11 44%	10 40%	3 11%	**0 0%**
	6-10	10 40%	8 32%	7 26%	**6 23%**
	11-20	2 8%	4 16%	11 41%	**4 15%**
	21-35	1 4%	3 4%	6 22%	**16 62%**
	Are there Māori images related to child abuse and neglect on public display in the hospital?	18 72%	22 88%	26 96%	**26 100%**

	"YES" responses		Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	If yes, total number *locations (up to 17)*	0	7 28%	3 12%	1 4%	**2 8%**
		1-2	11 44%	11 44%	5 19%	**1 4%**
		3-5	4 16%	4 16%	5 19%	**3 12%**
		6-10	2 8%	4 16%	6 22%	**9 35%**
		11-17	1 4%	3 12%	10 39%	**11 43%**
2.2	Is there referral information (local or national phone numbers) related to child advocacy and therapeutic services on public display in the hospital? (Can be included on the posters/brochure noted above).		21 84%	21 84%	26 96%	**26 100%**
	If yes, total number *locations* (up to 35):	0	4 16%	4 16%	1 4%	**0 0%**
		1-4	16 64%	13 52%	8 29%	**0 0%**
		5-10	3 12%	6 24%	8 30%	**5 19%**
		11-20	1 4%	1 4%	6 22%	**8 31%**
		20-35	1 4%	1 4%	4 15%	**13 50%**
	Is there referral information related to Māori providers of child advocacy services on public display in the hospital?		8 32%	9 36%	17 63%	**25 96%**
	If yes, list total number *locations (up to 17)* List number per department:	0	17 68%	16 64%	10 37%	**1 4%**
		1-2	5 8%	7 28%	6 22%	**1 4%**
		3-5	2 8%	1 4%	2 7%	**3 12%**
		6-10	0 0%	0 0%	5 19%	**12 46%**
		11-17	1 4%	1 4%	4 15%	**9 35%**
	Is there referral information related to child advocacy services for particular ethnic or cultural group (other than Māori or Pakeha) on public display in the hospital?		3 12%	3 12%	7 26%	**20 77%**
	If yes, total number *locations (up to 17)*	0	22 88%	22 88%	20 74%	**6 23%**
		1-2	2 8%	2 8%	4 15%	**1 4%**
		3-4	0 0%	0 0%	1 4%	**2 8%**
		5-10	1 4%	0 0%	0 0%	**10 38%**
		11-17	0 0%	1 4%	2 7%	**7 27%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	2.3 Does the hospital provide temporary (<24 hours) safe shelter for victims of child abuse and neglect and their families who cannot go home or cannot be placed in a community-based shelter? If yes: (*choose one a-c and answer d*)	15 60%	19 76%	17 63%	**26 100%**
	a) Children and their families are permitted to stay in ED until placement is secured.	1 4%	0 0%	0 0%	**3 12%**
	b) Children and their families are provided with safe respite room, separate from ED, until placement is secured.	0 0%	0 0%	0 0%	**1 4%**
	c) In-patient beds are available for children and their families until placement is secured.	14 56%	19 76%	17 63%	**22 85%**
	d) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	17 68%	17 68%	14 52%	**18 69%**

CATEGORY 3: INSTITUTIONAL CULTURE

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
3.1	In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about child abuse and neglect? If yes, which groups have been assessed?	6 24%	11 44%	11 41%	**11 42%**
	a) nursing staff	6 24%	10 40%	11 41%	**11 42%**
	b) medical staff	5 20%	7 28%	7 26%	**11 42%**
	c) administration	2 8%	8 32%	6 22%	**9 35%**
	d) other staff/employees	2 8%	9 36%	9 33%	**9 35%**
	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%**
3.2	How long has the hospital's child abuse and neglect programme been in existence? (*Choose one*):				
	a) 1-24 months	7 28%	5 20%	2 7%	**2 8%**
	b) 24-48 months	5 20%	7 28%	5 19%	**4 15%**
	c) >48 months	9 36%	13 52%	20 74%	**20 77%**
3.3	Does the hospital's child abuse and neglect programme address cultural competency issues? If yes:	23 92%	25 100%	27 100%	**24 92%**
	a) Does the hospital's policy specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background?	18 72%	18 72%	27 100%	**23 89%**
	b) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	17 68%	16 64%	19 70%	**21 81%**
	c) 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%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	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%**
3.4	Does the hospital participate in preventive outreach and public education activities on the topic of child abuse and neglect? If yes, is there documentation of: (*choose a or b and answer c)*	19 76%	15 60%	8 30%	**22 85%**
	a) 1 programme in the last 12 months?	9 36%	4 16%	9 33%	**0 0%**
	b) >1 programme in the last 12 months?	10 40%	11 44%	10 37%	**22 85%**
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	9 36%	9 36%	14 52%	**20 77%**

CATEGORY 4: TRAINING OF PROVIDERS

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
4.1	Has a formal training plan been developed for the institution? If yes:	5 20%	10 40%	17 63%	**19 73%**
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	5 20%	11 44%	17 63%	**20 77%**
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	2 8%	10 40%	15 56%	**16 62%**
4.2	During the past 12 months, has the hospital provided training on child abuse and neglect:				
	a) as part of the mandatory orientation for new staff?	7 28%	6 24%	15 56%	**19 73%**
	b) to members of the clinical staff via colloquia or other sessions?	8 32%	20 80%	23 85%	**21 81%**
4.3	Does the hospital's 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%**
	b) dynamics of child abuse and neglect?	16 64%	21 84%	21 78%	**24 92%**
	c) child advocacy	16 64%	20 80%	17 63%	**19 73%**
	d) child-focused interviewing	12 48%	17 68%	14 52%	**19 73%**
	e) issues of contamination	12 48%	18 72%	17 63%	**22 85%**
	f) ethical dilemmas?	11 44%	19 76%	20 74%	**23 89%**
	g) conflict of interest	11 44%	17 68%	18 67%	**21 81%**
	h) epidemiology?	15 60%	18 72%	20 74%	**23 89%**
	i) health consequences?	17 68%	20 80%	19 70%	**24 92%**
	j) identifying high risk indicators?	16 64%	21 84%	21 78%	**24 92%**
	k) physical signs and symptoms?	15	21	20	**24**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
		60%	84%	74%	**92%**
	l) documentation?	15 60%	20 80%	20 74%	**24** **92%**
	m) intervention?	16 64%	21 84%	20 74%	**24** **92%**
	n) safety planning?	13 52%	18 72%	14 52%	**24** **92%**
	o) community resources?	14 56%	19 76%	16 59%	**22** **85%**
	p) child protection reporting requirements?	17 68%	21 84%	18 67%	**24** **92%**
	q) linking with Child Youth and Family?	17 68%	21 84%	20 74%	**24** **92%**
	r) Confidentiality?	13 52%	18 72%	18 67%	**24** **92%**
	s) age appropriate assessment and intervention?	11 44%	18 72%	14 52%	**20** **77%**
	t) cultural competency?	11 44%	13 52%	13 48%	**22** **85%**
	u) link between partner violence and child abuse and neglect?	15 60%	19 76%	20 74%	**22** **85%**
	v) Māori models of health?	13 12%	6 24%	9 33%	**13** **50%**
	w) the social, cultural, historic, and economic context in which Māori family violence occurs?	3 24%	9 36%	8 30%	**12** **46%**
	x) te Tiriti o Waitangi?	6 20%	10 40%	7 26%	**14** **54%**
	y) Māori service providers and community resources?	5 36%	15 60%	14 52%	**21** **81%**
	z) Service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	9 20%	10 40%	8 30%	**15** **58%**
4.4	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%**
	b) a single individual?	5 16%	3 12%	6 22%	**0** **0%**
	c) a team of hospital employees only?	4 28%	5 20%	2 7%	**2** **8%**
	d) a team, including community expert(s)?	7 36%	14 56%	17 63%	**22** **85%**
	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%**
	f) a Māori representative?	10 40%	9 36%	15 56%	**18** **69%**
	g) a representative(s) of other ethnic/cultural groups?	4 16%	2 8%	1 4%	**5** **19%**

CATEGORY 5: DOCUMENTATION

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
5.1	Does the hospital use a standardized documentation instrument to record known or suspected cases of child abuse and neglect? If yes, does the form include:	13 52%	15 60%	21 78%	**24 92%**
	a) information generated by risk assessment?	7 28%	9 36%	15 56%	**21 81%**
	b) the victim or caregiver's description of current and/or past abuse?	8 32%	9 36%	13 48%	**21 81%**
	c) the name of the alleged perpetrator and relationship to the victim?	4 16%	5 20%	8 30%	**20 77%**
	d) a body map to document injuries?	11 40%	16 64%	20 74%	**19 73%**
	e) information documenting the referrals provided to the victim and their family?	9 36%	10 40%	17 63%	**21 81%**
	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%**
5.2	Is a standardised safety assessment performed for children? If yes:	10 40%	13 52%	17 63%	**17 65%**
	a) Does this also assess the safety of the child's mother?	6 24%	4 16%	9 33%	**14 54%**

CATEGORY 6: INTERVENTION SERVICES

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
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%**
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%**
	a) A member of the child protection team or social worker provides services during certain hours.	7 28%	12 48%	10 37%	**17 65%**
	b) A member of the child protection team or social worker provides service at all times.	16 64%	12 48%	16 59%	**9 35%**
	c) A Māori advocate or social worker is available "on-site" for Māori victims.	20 80%	21 84%	23 85%	**26 100%**
	d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite. If yes, list ethnicity:	9 36%	10 40%	12 44%	**9 35%**
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%	**26 100%**
	a) available, when indicated?	13 52%	16 64%	16 59%	**20 77%**
	b) performed routinely?	6 24%	4 16%	7 26%	**4 15%**
	c) age-appropriate?	19 76%	21 84%	23 85%	**21 81%**
6.4	Is transportation provided for victims and their families, if needed?	3 12%	9 36%	10 37%	**20 77%**
6.5	Does the hospital 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%**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
6.6	Does the hospital child abuse and neglect programme offer and provide on-site legal options counselling for the families of suspected child abuse and neglect victims?	19 76%	13 52%	10 37%	**7 27%**
6.7	Does the hospital child abuse and neglect programme offer and provide family violence intervention services for the families, and in particular mothers, of abused children?	8 32%	13 52%	16 59%	**23 88%**
6.8	Is there evidence of coordination between the hospital child abuse and neglect programme and the partner abuse and sexual assault programmes?	18 72%	20 80%	24 89%	**22 85%**
6.9	Is there evidence of coordination with CYF?	21 84%	22 88%	25 93%	**26 100%**

CATEGORY 7: EVALUATION ACTIVITIES

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
7.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:	15 60%	17 68%	18 67%	**13 50%**
	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%**
	b) Is the evaluation process standardised?	11 44%	10 40%	9 33%	**10 38%**
	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%**
7.2	Do health care providers receive standardized feedback on their performance and on patients from CYF?	14 56%	12 48%	12 44%	**8 31%**
7.3	Is there any measurement of client satisfaction and/or community satisfaction with the child abuse and neglect programme?	2 8%	1 4%	7 26%	**9 35%**
7.4	Is the quality framework *He Taura Tieke* (or an equivalent) used to evaluate whether services are effective for Māori?	2 8%	1 4%	2 7%	**3 12%**

CATEGORY 8: COLLABORATION

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
8.1	Does the hospital collaborate with NGO and CYF child advocacy and protection ? If yes,	23 92%	24 96%	27 100%	**24 92%**
	a) which types of collaboration apply:				
	i) collaboration with training?	15 60%	19 76%	21 78%	**24 92%**
	ii) collaboration on policy and procedure	17	17	23	**25**

	"YES" responses	Baseline n %	12 mo FU n %	30 mo FU n %	48 mo FU n %
	development?	68%	68%	85%	**96%**
	iii) collaboration on child abuse and neglect task force?	5 20%	19 76%	20 74%	**22 85%**
	iv) collaboration on site service provision?	16 64%	22 88%	22 82%	**25 96%**
	b) is collaboration with:				
	i) Māori provider(s) or representative(s)?	19 76%	21 84%	22 82%	**26 100%**
	ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	6 24%	8 32%	8 30%	**15 58%**
8.2	Does the hospital collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme?	23 92%	24 96%	25 93%	**26 100%**
	If yes, which types of collaboration apply:				
	a) collaboration with training?	5 20%	11 44%	17 63%	**24 92%**
	b) collaboration on policy and procedure development?	10 40%	11 44%	18 67%	**26 100%**
	c) collaboration on child abuse and neglect task force?	4 16%	18 72%	20 74%	**23 89%**
8.3	Is there collaboration with the child abuse and neglect programme of other health care facilities?	20 80%	21 84%	25 93%	**26 100%**
	If yes, which types of collaboration apply:				
	a) within the same health care system?	17 68%	23 92%	26 96%	**26 100%**
	If yes, with a Māori health unit?	11 44%	22 88%	23 85%	**26 100%**
	b) with other systems in the region?	20 80%	20 80%	21 78%	**26 100%**
	If yes, with a Māori health provider?	6 24%	17 68%	23 85%	**25 96%**

APPENDIX G: REVISED CHILD ABUSE AND NEGLECT DELPHI TOOL ITEM ANALYSIS

DOMAIN 1: POLICIES AND PROCEDURES

	'YES' RESPONSES	48 mo FU n %
1.1	Are there official, written hospital policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If yes, do these policies:	**24 92%**
	a) define child abuse and neglect?	**24 92%**
	b) mandate training on child abuse and neglect for any staff?	**22 85%**
	c) outline age-appropriate protocols for risk assessment?	**12 46%**
	d) define who is responsible for risk assessment?	**20 77%**
	e) address the issue of contamination?	**17 65%**
	f) address documentation?	**24 92%**
	g) address referrals for children and their families?	**23 89%**
	h) address child protection reporting requirements?	**24 92%**
	i) address the responsibilities to, and needs of, Māori?	**18 69%**
	i) address the needs of other cultural and/or ethnic groups?	**18 69%**
1.2	Who is consulted regarding child protection policies and procedures?	
	i) consultation with Māori and Pacific	**25 96%**
	ii) consultation with CYF	**25 96%**
	iii) consultation with Police	**25 96%**
	iv) consultation with CAN programme staff	**26 100%**
	v) consultation with other agency	**25 96%**
1.3	Is there evidence of a DHB-based child abuse and neglect working group? If yes, does the working group:	**25 96%**
	a) meet at every three months?	**24 92%**
	b) include representatives from more than two departments? List representatives:	**25 96%**
1.4	Does the DHB provide direct financial support for the child abuse and neglect programme? If yes, how much annual funding? (*Choose one of a-c and answer d*):	**23 89%**
	a) No funding allocated?	**3 12%**

	a) < $5000/year	**0 0%**
	b) $5000-$10,000/year	**1 4%**
	c) > $10,000/year	**23 89%**
	d) Is funding set aside specifically for Māori programmes and initiatives? If yes, how much annual funding?	**8 31%**
	i) < $5000/year	**0 0%**
	ii) > $5000/year	**8 31%**
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)	**26 100%**
	a) in the emergency department (ED) or any other out-patient area?	**3 12%**
	b) in in-patient units only?	**0 0%**
	c) in more than one out-patient area?	**0 0%**
	d) in both in-patient and out-patient areas? List departments:	**23 89%**
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:	**21 81%**
	a) written?	**21 81%**
	b) include name/phone block?	**9 35%**
	c) safe transportation?	**12 46%**
	d) account for the needs of Māori?	**15 58%**
1.7	Is there an identifiable child protection coordinator at the hospital? If yes is it a: (*choose one*)	**23 89%**
	a) part time <0.5 FTE	**5 19%**
	b) part time >0.5 FTE	**11 42%**
	c) full time?	**7 27%**
1.8	Are there policies that outline the minimum expectation for all staff:	
	a) to attend mandatory training?	**20 77%**
	b) to identify and refer children at risk?	**24 92%**
	c) to report child protection concerns	**24 92%**
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')? If yes, is there evidence of collaboration with:	

	a) government agencies?	**25 96%**
	b) community groups?	**22 85%**
1.10	Are the DHB policies and procedures easily available and user-friendly? If yes, are:	**26 100%**
	a) they available on the DHB intranet?	**26 100%**
	b) there supporting and reference documents appended to the appropriate policies and procedures?	**24 92%**
	c) there translation materials to facilitate the application	**25 96%**
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%**

DOMAIN 2: SAFETY AND SECURITY

	'YES' RESPONSES	**48 mo FU n %**
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%**
2.2	Does the DHB have a protocol for collaborative safety planning for children at high risk? If yes:	**22 85%**
	a) are safety plans available or used for children identified at risk?	**22 85%**
	Which types of collaboration apply? b) within the DHB?	**23 89%**
	c) with other groups and agencies in the region?	**23 89%**
	d) with Māori and Pacific health providers?	**22 85%**
	e) with other relevant ethnic/cultural groups?	**13 50%**
	f) with the primary sector?	**15 58%**
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? If yes, is safety promoted:	**24 92%**
	a) within the DHB alone?	**24 92%**
	b) with relevant primary healthcare providers as part of the discharge planning?	**16 62%**
	c) by accessing necessary support services for the child and family to promote ongoing safety of the child?	**23 89%**
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? If yes, how many departments have a security plan?	**22 85%**
	a) 1-2 departments	**1 4%**
	b) >3 departments	**21 81%**
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? There is:	**14 52%**
	a) no alert system in place	**9 35%**
	b) a local alert system in acute care setting	**16**

		62%
	c) a local alert system in community setting including PHO	**2 8%**
	d) a process for notification of alert placements to relevant providers	**9 35%**
	e) participation in a national alert system	**6 23%**
	f) clear criteria for identifying levels of risk, and process that guides the use of the alert system	**8 31%**
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? If yes, is there a:	**24 92%**
	a) process that includes the safety of other children in the home are considered?	**25 96%**
	b) process for notifying CYF and/or other agencies?	**25 96%**
	c) referral form that requires the documentation of the risk assessed for these children?	**22 85%**

DOMAIN 3: COLLABORATION

	'YES' RESPONSES	**48 mo FU n %**
3.1	Does the DHB collaborate with CYF and NGO child advocacy and protection? If yes,	**26 100%**
	a) which types of collaboration apply:	
	i) collaboration with training?	**24 92%**
	ii) collaboration on policy and procedure development?	**25 96%**
	iii) collaboration on child abuse and neglect task force?	**22 85%**
	iv) collaboration on site service provision?	**25 96%**
	v) collaboration is two-way?	**24 92%**
	b) is collaboration with:	
	i) CYF?	**26 100%**
	ii) NGOs and other agencies such as Women's Refuge?	**26 100%**
	iii) Māori provider(s) or representative(s)?	**26 100%**
	iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	**15 58%**
	v) services, departments and between relevant staff within the DHB evident?	**25 96%**
3.2	Does the hospital collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply:	**26 100%**
	a) collaboration with training?	**24 92%**
	b) collaboration on policy and procedure development?	**26**

		100%
	c) collaboration on child abuse and neglect task force?	**23 89%**
3.3	Is there collaboration with the child abuse and neglect programme with other health care facilities? If yes, which types of collaboration apply:	**26 96%**
	a) within the DHB?	**26 96%**
	b) with a Māori unit?	**26 100%**
	c) with other groups and agencies in the region?	**26 100%**
	d) with a Māori health provider?	**25 96%**
	e) with the primary health care sector?	**21 81%**
	f) with national network of child protection and family violence coordinators?	**26 100%**
3.4	Do relevant staff have membership on, or attend:	
	a) the interdisciplinary child protection team?	**22 85%**
	b) child abuse team meetings?	**22 85%**
	c) sexual abuse team meetings?	**16 62%**
	d) CYF Care and Protection Resource Panel	**21 81%**
	e) National Network of Family Violence Intervention Coordinators?	**26 100%**
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? If yes, is there a Memorandum of Understanding or written agreement with:	**18 69%**
	a) CYF?	**18 69%**
	b) the Police?	**15 58%**
3.6	Does the DHB have a Memorandum of Understanding of service agreement that enables timely medical examinations to support:	**14 54%**
	a) CYF?	**11 42%**
	b) Police?	**10 39%**
	c) DSAC?	**6 23%**

DOMAIN 4: INSTITUTIONAL CULTURE

	'YES' RESPONSES	**48 mo FU n %**
4.1	Does the DHB senior management support and promote the child abuse and neglect programme? If yes, does the evidence include:	**26 100%**
	a) child protection is in the DHB Strategic Plan?	**16 62%**

	b) child protection is in the DHB Annual Plan?	**18 69%**
	c) the child protection programme is adequately resourced, including dedicated programme staff?	**18 69%**
	d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator?	**22 85%**
	e) attendance at training as a key performance indicator (KPI) for staff?	**6 23%**
	f) roles of those in the child abuse and neglect working team are included in position descriptions?	**13 50%**
	g) DHB representation on the CYF Care and Protection Resource Panel?	**22 85%**
	h) the Child Protection Coordinator is suppored to attend the Violence Intervention Programme Coordinator Meetings?	**25 96%**
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? If yes, did it include:	**11 42%**
	a) nursing staff	**11 42%**
	b) medical staff	**11 42%**
	c) administration	**9 35%**
	d) other staff/employees	**9 35%**
	e) does the assessment address staff knowledge and attitude about Māori and child abuse and neglect?	**5 19%**
4.3	How long has the hospital's child abuse and neglect programme been in existence? (*Choose one*):	
	a) 1-24 months	**2 8%**
	b) 24-48 months	**4 15%**
	c) >48 months	**20 77%**
4.4	Does the DHB child abuse and neglect programme address cultural competency issues? If yes:	**24 92%**
	a) does the hospital's policy specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background?	**23 89%**
	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%**
	c) are cultural issues discussed in the hospital's child abuse and neglect training programme?	**21 81%**
	d) are translators/interpreters available for working with victims if English is not the victim's first language?	**26 100%**
	e) are referral information and brochures related to child abuse and neglect available in languages other than English?	**24 92%**
4.5	Does the DHB participate in preventive outreach and public education activities on the topic of child abuse and neglect? If yes, is there documentation of:	**22 85%**

	a) 1 programme in the last 12 months?	**0 0%**
	b) >1 programme in the last 12 months?	**22 85%**
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	**20 77%**
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%**
	a) is a list of supportive interventions available?	**14 54%**
	b) are staff aware of how to access support interventions available?	**19 73%**
4.7	Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes?	**26 100%**
	a) Is there a referral mechanism?	**26 100%**
4.8	Does the child protection policy require mandatory use of the DHB approved translators when English is not the victim's or caregiver's first language? If yes, is there evidence of:	**19 73%**
	a) DHB approved translators being used?	**22 85%**
	b) a list of translators is accessible?	**22 85%**
	c) translators used that are gender and age appropriate?	**16 62%**
4.9	Does the DHB support and promote child protection and intervention within the primary sector? If yes, is there evidence of:	**25 96%**
	a) involvement of primary health care providers in the planning and development of child abuse and neglect and child protection programmes?	**17 65%**
	b) access to child abuse and neglect training?	**24 92%**
	c) coordination of referral processes between the DHB and primary health care sectors?	**17 65%**
	d) ongoing relationships and activities that focus on prevention and promoting child protection?	**19 73%**

DOMAIN 5: TRAINING OF PROVIDERS

	'YES' RESPONSES	**48 mo FU n %**
5.1	Has a formal training plan been developed for the institution? If yes:	**19 73%**
	a) a strategic plan for training?	**18 69%**
	b) an operational plan that outlines the specifics of the programme of training?	**17 65%**
	a) a plan that includes the provision of regular, ongoing education for clinical staff?	**20 77%**
	b) a plan that includes the provision of regular, ongoing education for non-clinical staff?	**17 65%**
5.2	During the past 12 months, has the DHB provided training on child abuse and neglect:	**25 96%**

	a) as part of the mandatory orientation for new staff?	**19 73%**
	b) to members of the clinical staff via colloquia or other sessions?	**22 85%**
5.3	Does the hospital's training/education on child abuse and neglect include information about:	
	a) definitions of child abuse and neglect?	**24 92%**
	b) dynamics of child abuse and neglect?	**24 92%**
	c) child advocacy	**18 69%**
	d) child-focused interviewing	**19 73%**
	e) issues of contamination	**21 81%**
	f) ethical dilemmas?	**23 89%**
	g) conflict of interest	**21 81%**
	h) epidemiology?	**23 89%**
	i) health consequences?	**24 92%**
	j) identifying high risk indicators?	**24 92%**
	k) physical signs and symptoms?	**24 92%**
	l) dual assessment with partner violence?	**20 77%**
	m) documentation?	**24 92%**
	n) intervention?	**24 92%**
	o) safety planning?	**24 92%**
	p) community resources?	**22 85%**
	q) child protection reporting requirements?	**24 92%**
	r) linking with Police and Child Youth and Family?	**23 89%**
	s) confidentiality?	**24 92%**
	t) age appropriate assessment and intervention?	**19 73%**
	u) cultural competency?	**23 89%**
	v) link between partner violence and child abuse and neglect?	**22 85%**
	w) Māori models of health?	**12 46%**
	x) the social, cultural, historic, and economic context in which Māori family violence occurs?	**13 50%**
	y) te Tiriti o Waitangi?	**14 54%**
	z) Māori service providers and community resources?	**21 81%**

	aa) Service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	**15 58%**
	ab) if all sub-items are evident, bonus	**6 23%**
5.4	Is the child abuse and neglect training provided by:	
	a) no training provided	**2 8%**
	b) a single individual?	**0 0%**
	c) a team of DHB employees only?	**1 4%**
	d) a team, including community expert(s)?	**23 89%**
	If provided by a team, does it include:	
	e) a Child Youth and Family statutory social worker?	**24 92%**
	f) a Māori representative?	**18 69%**
	g) a representative(s) of other ethnic/cultural groups?	**5 19%**
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%**
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%**

DOMAIN 6: INTERVENTION SERVICES

	'YES' RESPONSES	**48 mo FU n %**
6.1	Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified?	**26 100%**
6.2	Are child protection services available "on-site"?	**26 100%**
	a) a member of the child protection team or social worker provides services during certain hours.	**17 65%**
	b) a member of the child protection team or social worker provides service at all times.	**9 35%**
	c) a Māori advocate or social worker is available "on-site" for Māori victims.	**26 100%**
	d) an advocate of ethnic and cultural background other Pakeha and Māori is available onsite. If yes, list ethnicity:	**9 35%**
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*)	**24 92%**
	a) available, when indicated?	**20 77%**
	b) performed routinely?	**4 15%**
	c) age-appropriate?	**21 81%**
6.4	Do the intervention services for child abuse and neglect include:	
	a) access to physical and sexual examination?	**26**

	aa) Service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	**15 58%**
	ab) if all sub-items are evident, bonus	**6 23%**
5.4	Is the child abuse and neglect training provided by:	
	a) no training provided	**2 8%**
	b) a single individual?	**0 0%**
	c) a team of DHB employees only?	**1 4%**
	d) a team, including community expert(s)?	**23 89%**
	If provided by a team, does it include:	
	e) a Child Youth and Family statutory social worker?	**24 92%**
	f) a Māori representative?	**18 69%**
	g) a representative(s) of other ethnic/cultural groups?	**5 19%**
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%**
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%**

DOMAIN 7: DOCUMENTATION

	'YES' RESPONSES	**48 mo FU n %**
6.1	Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified?	**26 100%**
6.2	Are child protection services available "on-site"?	**26 100%**
	a) a member of the child protection team or social worker provides services during certain hours.	**17 65%**
	b) a member of the child protection team or social worker provides service at all times.	**9 35%**
	c) a Māori advocate or social worker is available "on-site" for Māori victims.	**26 100%**
	d) an advocate of ethnic and cultural background other Pakeha and Māori is available onsite. If yes, list ethnicity:	**9 35%**
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*)	**24 92%**
	a) available, when indicated?	**20 77%**
	b) performed routinely?	**4 15%**
	c) age-appropriate?	**21 81%**
6.4	Do the intervention services for child abuse and neglect include:	
	a) access to physical and sexual examination?	**26**

		85%
	g) a social history, including living circumstances?	**21 81%**
	h) a injury assessment, including photographic evidence (if appropriate?)	**20 77%**
	i) the interventions undertaken?	**20 77%**
	f) information documenting the referrals provided to the victim and their family?	**21 81%**
	g) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate?	**15 58%**
7.2	Does the DHB have sexual abuse specific forms that include:	
	a) a genital diagram?	**17 65%**
	b) a consent form?	**21 81%**
7.3	Is there evidence of use of a standardised referral form and process for CYF and/or Police notification?	**23 85%**
	a) CYF notification?	**25 96%**
	b) Police notification?	**15 58%**
7.4	Are staff provided training on documentation for children regarding abuse and neglect?	**24 92%**

DOMAIN 8: EVALUATION ACTIVITIES

	'YES' RESPONSES	**48 mo FU n %**
8.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:	**15 58%**
	a) do evaluation activities include periodic monitoring of the implementation of the child abuse and neglect clinical assessment policy?	**11 42%**
	b) is the evaluation process standardised?	**10 39%**
	c) do evaluation activities measure outcomes, either for entire child abuse and neglect programme or components thereof?	**13 50%**
	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%**
	Monitoring trends re demographics, risk factors, and types of abuse?	**17 65%**
	Documentation?	**20 77%**
	Referrals to CYF and the Police?	**21 81%**
	Case reviews?	**16 62%**
	Critical incidents?	**17 65%**
	Mortality morbidity review?	**13**

		50%
	Policy and procedure reviews?	**23** **89%**
	e) Do the evaluation activities include:	**21** **81%**
	Multidisciplinary team members?	**21** **81%**
	The Police?	**21** **81%**
	CYF?	**21** **81%**
	Community agencies?	**21** **81%**
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%**
8.3	Do health care providers receive standardised feedback on their performance and on notifications to CYF?	**7** **27%**
8.4	Is there any measurement of client and community satisfaction with the child abuse and neglect programme?	**7** **27%**
	a) client satisfaction?	**3** **12%**
	b) community satisfaction?	**8** **31%**
8.5	Is a quality framework (or an equivalent) used to evaluate whether services are effective for Māori?	**3** **12%**
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%**
8.7	Is the child abuse and neglect programme evident in the DHB quality and risk programme?	**9** **35%**
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?	**1** **4%**

DOMAIN 9: PHYSICAL ENVIRONMENT

	'YES' RESPONSES	**48 mo FU** **n** **%**
9.1	Are posters and images that are of relevance of children and young people on public display, are they child-friendly, contain messages about child rights and safety, and contain Māori and other relevant cultural or ethnic images? If yes, are there:	**26** **100%**
	a) <10 posters or images	**0** **0%**
	b) 10-20 posters or images	**10** **39%**
	c) >20 posters or images	**16** **62%**

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).	**26 100%**
	a) <10 locations	**5 19%**
	b) 10-20 locations	**9 35%**
	c) >20 locations	**12 46%**
9.3	Are there designated private spaces available for interviewing?	**24 92%**
	a) 1-2 locations?	**13 50%**
	b) 2-4 locations?	**3 12%**
	a) > 4 locations?	**8 31%**
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? If yes, is:	**25 96%**
	a) 'Social admissions" mentioned in child abuse and neglect policies?	**20 77%**
	b) Temporary safe shelter is available?	**25 96%**

APPENDIX H: TREND ANALYSIS

TABLE 1: PARTNER ABUSE AUDIT TREND ANALYSIS

		No.	Estimated Mean Score	SE	p-value
Time	Baseline	25	21.19	3.63	
	12 months	25	32.28	4.37	
	30 months	25	43.25	5.20	
	48 months	25	62.16	4.33	<0.0001
Urban*	Main urban population >30,000	68 (17)	41.44	4.33	
	Secondary and minor urban ≤30,000	32 (8)	36.09	5.82	0.42
Bed-size*	> 100 beds	76 (19)	43.03	6.27	
	≤100 beds	24 (6)	29.43	4.03	0.054

*adjusted for time effect

TABLE 2: PARTNER ABUSE UNIVARIATE REPEATED MEASURE MODELS

	df	F	p-value
Time	3, 24	34.55	<0.0001
Maturation	3, 24	6.79	0.002
Maturation x Time	9, 24	3.79	0.006
Time	3, 24	14.68	<0.0001
Partner Abuse Coordinator	2, 24	24.63	<0.0001
Partner Abuse Coordinator x Time	6, 24	7.72	0.0001
Time	3, 24	24.99	<0.0001
Dual Role	2, 24	24.67	<0.0001
Dual Role x Time	6, 24	5.11	0.002

Note: Adjusted for subject, interaction and main effects and standard errors of the estimates

TABLE 3: PARTNER ABUSE ESTIMATED MEAN SCORES ADJUSTED FOR SUBJECT, TIME AND INTERACTION EFFECTS.

		Time	No.	Estimated Mean Score	SE
Programme Maturation at 48 months	No Programme	Baseline	3	19.71	10.08
		12 months	3	23.30	11.24
		30 months	3	33.07	15.78
		48 months	3	21.64	6.20
	1-24 months	Baseline	5	7.37	7.81
		12 months	5	14.09	8.71
		30 months	5	15.26	8.90
		48 months	5	45.46	4.80
	24-48 months	Baseline	5	20.02	7.81
		12 months	5	28.54	8.71
		30 months	5	50.07	8.90
		48 months	5	76.44	4.80
	>48 months	Baseline	12	23.30	5.04
		12 months	12	43.67	5.62
		30 months	12	58.20	5.75
		48 months	12	73.30	3.10
Partner Abuse Intervention Coordinator	None	Baseline	13	19.84	3.98
		12 months	9	19.29	3.68
		30 months	9	28.46	4.16
		48 months	5	38.23	7.56
	Part Time	Baseline	11	21.78	4.07
		12 months	15	37.81	3.38
		30 months	14	51.81	8.66
		48 months	13	70.77	4.90
	Full Time	Baseline	1	32.41	13.25
		12 months	1	66.28	4.84
		30 months	2	59.10	7.56
		48 months	7	63.26	6.26
Dual Role	No Coordinator	Baseline	13	20.21	4.02
		12 months	9	19.70	3.99
		30 months	9	31.00	4.68
		48 months	5	35.82	6.75
	Yes	Baseline	6	24.40	5.10
		12 months	10	40.34	3.98
		30 months	10	56.56	4.42
		48 months	12	72.80	4.82
	No	Baseline	6	20.13	4.98
		12 months	6	37.74	4.50
		30 months	6	43.17	4.99
		48 months	8	62.66	5.46

TABLE 4: CHILD ABUSE & NEGLECT AUDIT TREND ANALYSIS

		No.	Estimated Mean	SE	p-value
Time	Baseline	24	40.25	4.03	
	12 months	24	48.79	3.78	
	30 months	24	56.10	3.53	
	48 months	24	69.29	3.16	<0.0001
Urban	Main urban population >30,000	64 (16)	56.83	3.57	
	Secondary and minor urban ≤30,000	32 (8)	47.18	4.85	0.10
Bed-size	≤ 100 beds	24 (6)	45.98	5.51	
	> 100 beds	72 (18)	56.15	3.34	0.12
Programme Maturation at 48 months	No Program	-	-	-	-
	1-24 months	8 (2)	30.83	8.90	
	24-48 months	16 (4)	55.14	6.46	
	>48 months	72 (18)	55.80	3.48	0.04
Child Abuse Coordinator	None	25	43.10	3.16	
	Part-Time	37	55.33	2.90	
	Full-Time	13	64.18	4.20	<0.0001
Dual Role	No Coordinator	2	43.65	3.28	
	Yes	26	56.35	3.06	
	No	25	59.44	3.59	0.0002