

Violence Intervention Programme

**DIGITAL FAMILY VIOLENCE
DATA OPPORTUNITIES
SCOPING PROJECT**

2025–2026



CENTRE FOR INTERDISCIPLINARY
TRAUMA RESEARCH



AUT

Violence Intervention Programme

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Health New Zealand | Te Whatu Ora (Health NZ) commissioned this report. The views expressed in this report are those of the authors and do not necessarily represent the views of Health NZ.

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BACKGROUND

A nationally standardised digital family violence information system is essential for generating meaningful insights into the delivery and effectiveness of the Violence Intervention Programme (VIP), particularly for women and children.

Currently, VIP accountability and quality improvement rely on data from repeated manual clinical record audits. See Appendix A for the eligibility criteria and data element definitions that have guided VIP Snapshot clinical audits.^a The manual clinical audit process is resource-intensive and based on limited sampling, restricting the robustness and generalisability of findings. For example, the current sampling approach does not provide the consistency or depth needed to incorporate a clear and coherent narrative on impact and relevance specific to Māori. This limits our ability to reflect the experiences and needs of whānau Māori and other equity priority populations. To generate actionable insights at the local, regional and national levels – and across specific services – we need more complete, standardised datasets. This is especially important for understanding and improving outcomes for equity priority populations, including Māori and Pacific peoples.

Digital data can help us:

- Identify what is working and where improvement is needed
- Support more responsive and equitable services
- Contribute to improved outcomes for Māori, PACIFIC peoples, LGBTQI+ communities, and other priority populations

There is the opportunity to improve how we collect and use digital data about family violence responsiveness in health services. Located within Health NZ Population Health – Starting Well Planning, Funding and Outcomes, the longer-term aim is to develop a nationally standardised digital family violence data plan. As a first step, this project examined the current landscape, including what VIP data are being electronically collected and how they are used.

The terms **digital**, **electronic** and **analogue** are used in various contexts in relationship to health data.

For this project:

- **Digital data** refer to structured electronic data consisting of discrete, computer-readable values that can be consistently analysed
- **Structured digital data fields** restrict data entry choices and may include dropdown lists, check boxes, numeric fields, dates or other defined response options
- **Native digital health data** is captured in an entirely electronic format at its origin during a clinical encounter and can be immediately shared, accessed, and acted upon for clinical decision-making
- Handwritten notes and electronic free-text notes are treated as unstructured or analogue data sources because their content has not been separated into standardised, computer-readable values
- Scanned documents, including forms, emails or free-text notes are digitised records but are not treated as natively structured digital data
- Information manually abstracted from health records and entered into spreadsheets is treated as manually derived data rather than data digitally captured at the point of care

^a See the Violence Intervention programme evaluation 2020–2024 report available at: <http://hdl.handle.net/10292/20094>

METHODS

This enquiry sought to explore the family violence data pathway from clinical encounter to the collection and use of digital data. The enquiry was limited to data relating to services covered by the Violence Intervention Programme, as outlined in the 2016 guidelines.² Data collected by Plunket, Oranga Tamariki, lead maternity carer databases (such as Expect), primary care (such as MedTech, Indici) and others are therefore outside the scope of this project.

These exclusions highlight the existence of important family violence and intimate partner violence data sources beyond the Violence Intervention Programme that were not captured in this review. Furthermore, the 2016 guidelines predate Te Aorerekura and reflect a particular model of care. Future models of care may more fully address hauora for all those impacted by family violence, with implications for the nature and scope of data collected.

Data collection proceeded in two phases. The first was a survey distributed by Health NZ using Survey Monkey. The second was a semi-structured interview conducted during selected district evaluation site visits.

Phase One

A survey was distributed by Te Whatu Ora (Kathy Phillips) via Survey Monkey to all districts in October 2025. The survey aimed to identify:

- Where digital data were already being collected
- What data were being captured
- Which services were involved

Table 1. Phase One district digital survey responses		
No. of districts		
No digital data	4	South Canterbury, Te Tai Tokerau (X2), Waikato, Whanganui (X2)
Both IPV & CP	4	Bay of Plenty, Canterbury (X2), Te Toka Tumai (X2), Wairarapa
IPV only	4	Capital & Coast (Hutt Valley), Nelson Marlborough, Southern (X2) Hawke's Bay, Lakes, Taranaki, Te Tai o Poutini West Coast
CP only	3	Capital & Coast (Hutt Valley), Nelson Marlborough, Southern (X2)
Did not respond	5	Capital & Coast (Wellington), Counties Manukau, MidCentral, Tairāwhiti, Waitemata

Note: 'X2' indicates two responses were received from the same district. The number column reports unique districts rather than individual survey responses.

Twenty responses were received from 15/20 districts (see Table 1). Districts generally noted structured drop down box options. In some districts, electronic documentation confirming that a child protection (CP) checklist was completed (for children under 2 years of age) is a mandatory field prior to discharge from the service. When electronic documentation data fields are not mandatory, VIP teams reported significant missing data. In some cases, districts reported collection of digital IPV and CP data, while the accompanying explanations were not consistent with native digital data collection. This was further explored during Phase Two district site visits.

Districts cited a range of data platforms for collecting family violence data (Table 2). In many cases, family violence digital data collection was understood to be ‘coming in the future’.

Phase Two

In Phase Two we further explored the presence of digital family violence data across the districts. After confirming whether a district had family violence digital data based on their responses to the Phase One survey, we supplemented site visits (conducted to measure system infrastructure) with a semi-structured interview to discuss family violence digital data.

Phase Two interviews were conducted face to face and facilitated by the external evaluator, Jane Koziol-McLain. The Digital Health Partner, Kelsey Schwynn, was invited to participate remotely through Microsoft Teams. Districts were also asked to invite the business intelligence person(s) who provides support to the VIP team for the collection and reporting of family violence data. Twelve district site visits included a family violence digital data interview.

The interview schedule (Appendix B) addressed the pathway of family violence data from clinical encounter to digital collection and reporting. Site visit digital interviews occurred between February and June 2026 and ranged from 30 to 90 minutes. Descriptive categories were developed from the interview notes, consistent with a qualitative descriptive approach,³ which provided a flexible method for organising and interpreting the findings. Interpretation was also informed by the evaluation team’s clinical, programme, and research experience. Photographs were taken, where appropriate, to document variation in data fields and definitions. Image quality varied because the photographs were collected during site visits for illustrative rather than publication purposes. Relevant photographs are presented in Appendix C. The Health NZ Digital Health Partner reviewed the draft for technical and contextual accuracy and contributed to the organisation of the findings.

Phase Two aimed to identify family violence data challenges and opportunities to inform the development of a nationally standardised digital family violence data plan. Stakeholder discussions about the collection and reporting of family violence service data revealed several recurring issues that have implications for data quality, consistency, and system-wide reporting.

Table 2. Platforms reported as containing or expected to contain family violence assessment and intervention data

Platform	Explanation
3M	Coding
BadgerNet	Maternity clinical information system
Centrik	Digitised clinical notes
Cortex	Electronic care documentation
EDIS	Emergency department information system
eNotes	Bedside electronic documentation; see also centric
e-Prosafe	Family harm documentation (Canterbury developed)
HCC	Health care community
HCS	Health connect south
Indici EHR	Electronic health record (primarily primary care)
iPM	Patient manager
MyWai	Portal for individuals, whānau and services (Northland developed)
NCPHISS	National Child Protection Health Information Sharing System for flagging child protection concerns within health
Qlik	Healthcare analytics
RCP	Regional clinical portal
SCP	South clinical portal

FINDINGS

Although districts reported collecting digital family violence data, much of the information originated in paper or unstructured records, was manually transcribed, or was held across disconnected systems. Variation in data fields, definitions, demographic information, analytical capability, and system maintenance limited confidence in the quality and comparability of the resulting data. At the same time, local dashboards, electronic fields, flags (previously referred to as ‘alerts’), and specialist platforms demonstrated opportunities that could inform a nationally standardised digital family violence data plan. In the following sections we outline six overarching key issues from data capture to data meaning to equity to systems to capability to use.

1. Reliance on paper records and manually transcribed data

In many services, family violence information continued to be recorded on paper or within unstructured clinical notes. Monitoring therefore depended on manual chart review, followed in some cases by transcription into Excel spreadsheets, patient portals, or clinical platforms. Consequently, the presence of information in an electronic system did not necessarily mean that it had been digitally captured at the point of care. These pathways obscured data provenance (source), including whether information had been captured directly during clinical care, transcribed from paper, retrospectively abstracted from unstructured notes, or derived from a secondary administrative process.

Paper and unstructured clinical records

In many sites, health notes continued to be paper-based, requiring manual chart review for quality monitoring and improvement (see Appendix C, Figure A).

Electronic data derived from analogue sources

Site visits revealed that districts’ reports of having digital data in the Phase One survey did not necessarily indicate that data collection was digital. Data were often based on manual record review and subsequently entered into Excel spreadsheets. In some cases, textual health information was abstracted from unstructured records and entered into patient portals by administrative staff. While manually transcribed data may appear digital, they retain the limitations of analogue data, including delayed availability, transcription burden, incomplete information, and restricted opportunities for automated analysis.

BadgerNet maternity IPV enquiry data represents analogue data. The pathway for IPV enquiry data during antenatal care is that lead maternity carers, predominantly midwives, submit a hand-completed hospital admission form to Health NZ before the expected birth. The form includes information about IPV enquiry, which a registration administrator subsequently enters into BadgerNet. The resulting electronic data are therefore transcribed from an analogue source rather than digitally captured at the point of care. In the majority of districts, VIP team members had little confidence in the reliability of the data. One setting reported supporting hospital district staff to enter VIP IPV routine enquiry results directly into BadgerNet.

Manual collation of identified-case information

VIP teams generally had an automated process for receiving copies of submitted Reports of Concern (ROCs) and IPV risk assessment forms. At a minimum, most received a notification that could be followed up for quality-monitoring purposes. Some districts manually transferred information from these documents into spreadsheets. Administrative support was valuable in undertaking this work. However, these documents describe secondary assessment and intervention following case identification and do not provide the primary-assessment denominator required for service-level reporting.

2. Inconsistent fields limit comparability

There was considerable variation in how IPV assessment and response were documented across districts and services. Some fields combined more than one concept, such as whether routine enquiry had occurred and the outcome of that enquiry. This created potential for inconsistent interpretation and documentation by clinicians.

Documentation also differed across stages of the clinical pathway:

- Primary assessment: whether routine enquiry was indicated, offered, completed, declined, or not undertaken.
- Case identification: whether family violence was identified and whether it related to a current partner, former partner, or past history.
- Secondary assessment: whether a risk assessment was initiated or completed.
- Intervention and referral: whether a Report of Concern, referral, safety response, or other intervention occurred.

Current IPV fields also do not align consistently with epidemiological measures such as one-year and lifetime prevalence. Although diagnostic coding could potentially support population-level reporting, equity analysis, and examination of outcomes, the validity of family violence coding has not been established in the New Zealand context.

Intimate Partner Violence Digital Fields

Across the site visits, discussions of data relating to intimate partner violence (IPV) assessment and response revealed significant variation in service delivery documentation. Along with variation across districts, there were instances of data fields interpreted and documented differently by clinicians. For example, a single field to capture both whether IPV routine enquiry (RE) was completed and what the response was, could easily cause confusion for the clinician. Table 3 lists the range of data elements in the clinical care pathway and what we learned about their measurement. The value options are based on the data being collected in some locations along with our clinical and programme experience. They are not our recommendations, nor should they be interpreted as a proposed minimum dataset; rather, they illustrate options for further consideration, consultation, and testing.

The field review also identified access and visibility as important design considerations. This included the need to determine whether specific family violence information should be visible through patient-facing portals and whether access to sensitive modules should be recorded through an audit log. These issues require explicit national decisions rather than variable local configuration.

Table 3. Intimate partner violence digital field issues and options for national standardisation

Clinical Concept	Measurement Issue	Value Options
Enquiry Trigger	The IPV enquiry trigger is not currently collected. There are a range of circumstances that will trigger an IPV assessment across a range of health setting and presentations. The ‘crisis presentation’ is common in the emergency department. One district provided ‘presentation after assault’ (Appendix C, Figure C) and another noted when disclosure was ‘voluntary’ (Appendix C, Figure G). Some reported that there can be a ‘crisis presentation’ where a risk assessment is completed and referrals provided, but the IPV routine enquiry is not ‘ticked’. ‘Indicator-based’ is consistent with WHO guidelines and would apply to health settings broadly.	• Routine enquiry • Routine antenatal • Indicator-based • Crisis presentation
Safe to Ask	In some districts, the ‘reason’ for not asking about IPV is documented. In some settings a single field collects both whether RE was conducted and the RE ‘result’ (see Appendix C, Figure G)	• Yes → go to screen result • No → (reason for not asking) partner present / child present / patient declined
Enquiry Result	For the New Zealand guideline IPV routine enquiry, a ‘yes’ to any of the four questions is considered ‘positive’. The questions, however, inquire about exposure to abusive acts, they are not tied to the relationship with the person causing harm. There are discrepancies in how people document the result if the person using the violence is not a current or past partner. See ‘person using harm’ below. The NZ guideline questions refer to the previous 12 months (though the ‘control you’ question is worded ‘did anyone EVER...’).	• Yes → go to person using violence • No
Types of Harm	Some districts include a tick box for each of the four assessment questions, allowing ‘tick all that apply’. All abusive behaviours operate as forms of coercive control because of their intent and context. Other behaviours may include technology-facilitated abuse, reproductive coercion, and financial abuse.	• Physical • Psychological/emotional (scare or threaten) • Sexual • Coercive Control (control you, make you feel bad about yourself)

Table 3. ... continued		
Clinical Concept	Measurement Issue	Value Options
Case Identification	This provides an option to collect current (confirmed), suspected and past harm. This will be based on the conversation around IPV assessment. Some districts provide the opportunity to document 'suspected' harm (Appendix C, Figure E); others allow documentation of 'past history' (Appendix C, Figure F). If 'past history' is not an option, health providers might choose to document family harm as present. Unclear how reports of abuse as a child would be documented. Note the language is not consistent nationally, IPV, family harm, family violence. Given the health impact of violence exposure, best practice would include assessment of abuse across the lifespan, particularly in mental health. Documentation of both current and past abuse is preferred.	• Suspected family harm • Confirmed family harm • Past history of family harm
Person using violence	As the IPV assessment questions are not tied to the person causing the harm, this field would collect the relationship. A few districts will use the IPV documentation template for intra-familial harm. In one known case, there is a field for whether routine enquiry was for partner or intra-familial violence. Participants noted that some people experience harm from multiple individuals, highlighting the need for a 'tick all that apply' option. (Appendix C, Figure E).	• Current partner • Ex-partner • Parent • Adult child • Caregiver • Other
Clinical coding mapping	The relationship between locally documented family violence information and standard clinical terminology or diagnostic codes was unclear. SNOMED CT ICD-10-AM (Twelfth Edition)	Examples: • At increased risk of domestic violence • 706893006 Victim of intimate partner abuse • 397940009 Victim of child abuse • T74 Adult and child abuse, neglect and other maltreatment • Z63 Problems in relationship with spouse or partner impacting health

Table 3. ... continued

Clinical Concept	Measurement Issue	Value Options
Immediate safety status		• Immediate danger • Safe to discharge home
Safety plan established		• Yes • No
Referrals	Tick all that apply. Potential fields include the organisation referred to and the date and time of referral. Several participants noted that what services people had used in the past and whether they were helpful is key to considering referral pathways.	• Specialist family violence agency • Police • Oranga Tamariki • Social Work • Kaupapa Māori service • Other
Audit log	This design issue emerged during discussion of how an IPV risk assessment may be updated over time by several health professionals, such as the primary nurse and social worker. An audit log would record who accessed or amended the information and when.	• user ID • date • time
Patient portal visibility	Participants raised questions about whether family violence information should be visible through patient-facing applications or portals. This was particularly complex when IPV enquiry concerning a female caregiver was documented in the record of a child admitted to hospital.	• Yes • No

Secondary Assessment (risk assessment)

Our interview schedule focused on documentation of routine enquiry and case identification rather than on the subsequent secondary assessment (risk assessment). IPV risk assessment forms are generally scanned with a notation or 'flag' in their record (either local or national) indicating there is a completed risk assessment form available. The e-Prosafe platform includes check boxes for risk assessment questions.

Alignment with epidemiological measures of IPV

The most common epidemiological measures of IPV are one-year period prevalence, often described as current IPV, and lifetime prevalence. A positive enquiry result, together with confirmed family harm involving a current or former partner, could potentially indicate IPV within the previous year. Lifetime IPV would require information about both recent and previous exposure. However, lifetime exposure is not adequately captured by the current brief enquiry items, which primarily refer to the previous 12 months.

Denominator Data

Reports of Concern and IPV risk assessment forms primarily document activity following identification. They do not establish how many eligible patients were assessed and therefore cannot independently provide the denominator needed to calculate enquiry, identification, or response rates.

Diagnostic Coding

While health diagnostic coding would be useful for population surveillance and examination of equity and outcomes, there has not been a validation exercise in New Zealand for family violence diagnostic coding (e.g. ICD-10 or SNOMED CT).

Limited validation and quality assurance

Few examples were identified of systematic validation of family violence data fields, extraction logic, or generated reports. Concerns about denominator accuracy, differing clinical interpretation, manual transcription, and uncertainty about the provenance of electronically held data reduced confidence in reported measures. Diagnostic coding for family violence has also not been validated for surveillance or population reporting in Aotearoa New Zealand.

3. Incomplete demographic data constrain equity monitoring

District reporting varied in the demographic variables included and in the way those variables were recorded.

Multiple ethnicity reporting

In some cases, only one ethnicity was captured, limiting the ability to undertake meaningful equity analysis.

Disability, gender and at risk groups

Information relating to disability, gender, and other groups at increased risk was also difficult to examine while family violence information remained dependent on paper records and manually constructed datasets.

Participants' accounts indicated the potential value of drawing demographic information from, or linking it with, the most reliable available source where appropriate and permitted, rather than repeatedly transcribing it into separate family violence datasets.

These limitations constrain more than the ability to disaggregate results. They restrict examination of whether people and whānau from different communities have equitable access to enquiry, identification, assessment, referral, and support. However, differences in recorded rates would need careful interpretation because they may reflect variation in service access, clinical practice, documentation, missing data, or exposure to harm.

4. Fragmented platforms and variable confidence in electronic systems

Existing platforms demonstrate that digital collection and information sharing are possible, but they do not currently constitute a consistent national family violence information system. Their usefulness depended on appropriate design, consistent implementation, maintenance, user understanding, and governance.

BadgerNet

As described in Finding 1, BadgerNet IPV information may be transcribed from a handwritten form. In addition to this data source issue, participants reported limited capability to query the data and low confidence in the accuracy of available reports. Not all districts have access to BadgerNet. Among those that do, only one reported competence in querying IPV data from the platform. In this one district, the VIP manager was on a BadgerNet advisory board and had expert knowledge of the data pathway and platform. Many noted that the platform was built for the UK rather than New Zealand.

e-Prosafe

e-Prosafe supported whānau information sharing, particularly in Canterbury, but its use was largely concentrated in the South Island. Participants reported that the platform required maintenance and lacked dedicated support.

Child protection information sharing

All districts participate in the National Child Protection Health Information Sharing System (NCPHISS), formerly the National Child Protection Alert System. We defer to the specifications provided in the recent National Child Protection Health Information Sharing System Protocol.⁴ The system provides for a ‘child protection flag’ in the National Health Index Medical Warning System.

Local IPV alerts

Some districts used a local family violence alert to indicate that an IPV risk assessment had been initiated. The purpose and interpretation of these alerts differed from national child protection alerts.

Child protection checklist fields

Child protection checklist fields were common in electronic emergency department records, but their configuration varied. In some settings completion was mandatory before discharge, while elsewhere participants described barriers to obtaining approval to make the field mandatory.

5. Insufficient analytical capability and unclear data stewardship

Responsibility for maintaining platforms, assuring data quality, documenting report logic, approving access, and updating family violence fields was not always apparent. In some settings, capability depended on an individual with specialist knowledge of the platform and data pathway. Participants also reported that e-Prosafe had lacked dedicated maintenance support for an extended period. These findings indicate vulnerability in both analytical capacity and ongoing data stewardship.

Insufficient Business Intelligence Resource

A working relationship between a business intelligence (BI) or Decision Support Unit (DSU) analyst and collection and reporting of family violence data was rare. Many mentioned that district BI analyst roles had been lost with the health restructure. When there was a BI resource, it was often limited to a particular service, such as mental health. During interviews it was often the case that interview queries raised issues about data collection and quality that were not previously considered. Given the preponderance of manual record review, the lack of digital data literacy is not unexpected. However, many VIP team members raised the issue of a lack of robust ‘denominator’ data.

6. Constraints on actionable service, workforce and equity reporting

Reporting needs differed by purpose. Clinical quality reporting required information about adherence to the care pathway; programme reporting required timely service-level information for improvement; workforce reporting required linkage between training completion and current staff denominators; and national equity or population reporting required validated, standardised, and demographically complete data. Existing data sources did not support all four purposes equally. Stakeholder accounts identified a need for more timely and accessible information.

Manual quality monitoring of identified cases

VIP teams generally received Reports of Concern and IPV risk assessment forms, or notifications of their submission, for quality-monitoring purposes. Some districts manually transferred information from these documents into spreadsheets to monitor activity and trends. These data describe secondary assessment and intervention following case identification. Importantly, they do not provide the primary-assessment denominator required to calculate routine enquiry or identification rates.

Insufficient denominators for clinical-service monitoring

Available data did not consistently identify the population eligible for family violence assessment, the number offered or completing routine enquiry, or the reasons enquiry was not completed. Reports of Concern and IPV risk assessment forms provide information about activity following case identification, but do not provide the primary-assessment denominator needed to calculate routine enquiry, identification, secondary assessment, or response rates. Participants also raised concerns about the accuracy of denominator data in reports generated from existing electronic platforms.

Delayed access to data and reports

VIP programme leaders reported delays in obtaining requested data and reports. These delays were attributed to reduced local BI capacity and, in some

cases, requirements for senior leadership approval before data could be extracted. This limited teams' ability to use data responsively for programme monitoring and quality improvement. Participants also described regional approval processes as a barrier to introducing changes to local electronic documentation, such as making the child protection checklist mandatory.

Local dashboards as an emerging reporting opportunity

In a small number of districts, locally developed dashboards provided an example of how programme information could be presented, although the underlying data were still often manually collected or transcribed. These dashboards therefore illustrate the desired reporting function rather than the full benefits of structured data captured digitally at the point of care.

Insufficient workforce information for training accountability

In Aotearoa New Zealand, HealthLearn and Ko Awatea support the management of VIP training registration and completion records. HealthLearn generally covers the South Island districts and Ko Awatea the North Island (though not exclusively). While training registration was helpful, reports did not consistently include attendees' service locations or link completion data with the current eligible workforce. Managers therefore could not readily determine the proportion of current staff who had completed required core or refresher training.

Need for qualitative information alongside numeric reporting

Participants noted that structured numeric measures could not fully represent the complexity of family violence conversations, historical or intra-familial violence, or the clinical work involved in supporting safety and hauora. Many identified a need for qualitative information to complement standardised measures and provide context for interpreting service data.

DISCUSSION

Taken together, the findings indicate that the principal challenge is not simply the absence of digital family violence records. Family violence information is generated through a combination of paper records, unstructured clinical notes, manual abstraction, locally configured fields, and disconnected platforms. Inconsistent definitions and limited denominator and demographic data restrict comparison across services and analysis of equity. These limitations are compounded by insufficient analytical capability, dependence on individual expertise, delays in accessing reports, and unclear responsibility for maintaining some specialist platforms. Locally developed dashboards and electronic tools nevertheless demonstrate the potential for more accessible and actionable information.

The range of platforms identified in this study reflects the ‘fragmented, old and complex digital landscape’ described in the 2025 Health New Zealand | Te Whatu Ora Health Digital Investment Plan (HDIP).¹ Some regionally developed systems had not been maintained and were reported to be approaching or at the end of their useful life. Digital records are not, in themselves, the solution to current family violence documentation challenges. Rather, they provide essential infrastructure for a nationally consistent and culturally responsive approach, supported by agreed documentation standards, safe information governance, effective clinical pathways, and sufficient workforce and analytical capability.

National reporting would need to distinguish between clinical quality, programme implementation, workforce accountability, equity monitoring, and population surveillance. Each measure should have a clearly defined purpose, numerator, denominator, inclusion and exclusion criteria, data source, provenance, missing-data rules, disaggregation requirements, and limitations. Data-quality information, including completeness, timeliness, consistency, and whether information was captured directly at the point of care

or manually transcribed, should be reported alongside results. These distinctions are important because information collected to support individual clinical care may not be sufficiently complete, representative, or validated for performance assessment or population surveillance.

There are also important limitations to standardised numeric measures that must be considered in developing a digital family violence data plan. The current health response model and the measures derived from it tend to conceptualise family violence as a discrete event involving enquiry, identification, assessment and referral. However, family violence may occur across the life course and its effects on health, wellbeing and equity can be cumulative and long-term. An event-focused model may therefore fail to recognise historical or intra-familial violence, changing patterns of risk and the ongoing clinical work involved in supporting safety and hauora. Structured performance data can indicate whether particular steps in the clinical pathway were documented but cannot fully convey the complexity of discussing family violence, responding to the circumstances of patients and whānau, or sustaining support over time.

During site visits, many participants identified a need for qualitative information to complement standardised measures. Frustration arose particularly where data fields did not reflect the clinical care pathway or the realities encountered in practice. For example, current documentation templates may not adequately capture a disclosure of intra-familial violence, a history of violence, or a clinically significant conversation that does not result in identification of a current IPV event. Digital development should not therefore simply reproduce the limitations of the current model in electronic form. Rather, it provides an opportunity to reconsider how the model of care, clinical pathway, documentation, and measurement can better reflect family violence across the life course. The World Health Organization similarly emphasises needs-led

digital development, informed use of data, equitable access to quality care, and purposeful, safe, role-based and governed information sharing across digital systems.⁵

How change is implemented will also be important. VIP programme leaders anticipated that nationally standardised digital data could improve monitoring and quality improvement, but described delays in obtaining reports, reduced access to local business intelligence support, and regional barriers to modifying clinical documentation. Data elements, definitions, response options, and reporting measures will need to be tested with clinicians to ensure that they reflect clinical practice, support safe care and do not create unnecessary documentation burden. Implementation will also require clear data protocols, workforce training, technical support, platform maintenance, and ongoing data stewardship.

Implications and Recommendations

Recognising family violence as a critical determinant of health, wellbeing, and health inequities in Aotearoa New Zealand, we recommend investment in a nationally consistent, integrated, and culturally responsive approach to digital family violence information. Although this report focused on the VIP clinical data pathway, a national approach would also recognise and, where appropriate, enable the safe use of relevant information from the wider health data ecosystem to understand associated health needs, service use, responses, and outcomes.

A national digital family violence data plan would contribute directly to Te Aorerekura outcome of improving the quality and use of information for evidence-based practice, policy, and investment.⁶ The national Outcomes and Measurement Framework⁷ also emphasises alignment with data standards and representation of populations disproportionately affected by family violence and sexual violence.

As a scoping study, this report identifies the problems to be addressed and the requirements of a national approach, rather than prescribing a final dataset, platform, technical architecture, or implementation model. Health NZ would lead the next phase through its established digital health, clinical and information governance, privacy, security, and implementation processes. This work would incorporate Te Tiriti o Waitangi, Māori data governance,⁸ clinicians' experience of care pathways and information systems, family violence clinical and programme expertise, and the perspectives of people and communities affected by family violence. Future models of care, for example, may more fully address hauora for all those impacted by family violence, with implications for the nature and scope of data collected.

The immediate priority is a nationally governed digital family violence data plan that embeds equity across data collection, governance, analysis, interpretation, reporting, and use. The plan would establish a minimum dataset and data dictionary across the clinical pathway, enable structured capture at the point of care, and specify requirements for privacy, safety, access, system maintenance, analytical capability, and reporting. Data pathways, platforms, fields, and measures would require validation before use in national performance, equity, or population reporting. The data elements and value options identified in this report provide a starting point, but data pathways, platforms, fields, and measures will require further specification, consultation, testing, and validation before national adoption or use in performance, equity, or population reporting. The breadth and complexity of the considerations involved are illustrated in the figure on the following page.

Figure. Key Considerations for a Nationally Governed Digital Family Violence Data Plan

Delivery will require a substantial, sustained, multi-year programme, supported by national leadership, investment, specialist expertise, collaboration, and the secure exchange and use of data across health information systems. Progress will need to be staged and refined over time. Ultimately, this digital foundation would support safer, more equitable and coordinated care, better-informed service improvement, and greater accountability to people and communities impacted by family violence.

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APPENDICES

Appendix A. VIP Clinical Snapshot Audit Specification (2024)

1. Introduction

The VIP Snapshot clinical audit's primary purpose is to provide measurement data of VIP Intimate Partner Violence (IPV) and Child Abuse and Neglect (CAN) assessment and intervention delivery in selected health services. The audits are nationally standardised to measure service delivery and inform improvements in the services to vulnerable children and women, whānau and families. Aside from accountability, the Snapshot findings provide an opportunity to learn about your system and identify areas for improvements.

You can use the secure VIP Snapshot system for either 'official' or 'ad hoc' audits. Official audits are directed by Te Whatu Ora and follow a standardised process that is outlined in this document. You can also use the system to enter VIP data for ad hoc audits at any time during the year. Ad hoc audits may have variable sample sizes, time periods and sampling methods (such as a certain number of consecutive cases). Ad hoc audits are useful for measuring whether change actions result in service improvement, particularly as part of a improvement plan-do-study-act cycle.

All collected VIP clinical audit data is de-identified. The VIP evaluation project is approved by the Health and Disability Ethics Committee (AKY/03/09/218/AM12 with latest approval 08 March 2024).

What data are required?

We recommend you advise your Quality Manager, Clinical Records or technology (intelligence) support as soon as possible of the audit requirements for each of services you will be auditing. They will need to identify the eligible population, then draw retrospective random samples of 25 patient health records from the 3-month review period (1 April to 30 June).

What services are included?

Seven Te Whatu Ora health services are available in the VIP Snapshot audits as follows:

Intimate Partner Violence (IPV) services:

1. Postnatal Maternity inpatient
2. Emergency Department
3. Child Health inpatient (aged 0–16 years) – female guardians, parents or caregivers assessed for IPV
4. Sexual Health
5. Community Mental Health
6. Alcohol & Drug

Child Abuse and Neglect service:

1. Emergency Department: All children aged under two presenting to Emergency Department for any reason

Which sites should I audit?

For the Snapshot official audits, only main hospitals are required to be audited.

Overtime, districts with two main sites have either:

- (a) collected a random sample of 25 from among all eligible patients seen in both sites; or
- (b) collected a random sample of 25 for each site.

Being consistent year to year provides the best measurement of change over time. Satellite sites may be audited as ad hoc audits.

What is the time period for the audit?

The 3-month Snapshot audit period for each year is from **1 April to 30 June**.

2. Completing a Snapshot audit

Accessing the Snapshot URL

Access the Snapshot system at <https://vipsnapshot.aut.ac.nz>

- If you are a new user, or a current user and have forgotten your password, please log in using your work username – your work email address – and select 'Forgot password'. The system will automatically send you an email with a temporary password. On logging in with the temporary password, you will be prompted to create a new password and click 'reset'.
- If you are unable to progress, please email Eric: vip-eval@aut.ac.nz to confirm registration access and troubleshoot with you.
- Users will be able to save and edit data and receive their audit results in real time.

Selecting a random sample

The first step in selecting a random sample is to identify all eligible persons during the three month review period (1 April – 30 June) for each of the audited services. You will be asked to enter this total number of eligible women/children by service in each audit. In research terms, this is the 'sampling frame'. From those eligible, random samples of 25 patient health records are to be retrospectively selected for each service. A sample of 25 is the minimum, should a district want more precision in their results, they may elect to audit a larger number of cases (should be identified a priori and still be a random sample process).

The Quality Manager, Clinical Records or IT Help should be involved in identifying the number of eligible persons and selecting the random sample. Refer to the VIP Tool Kit document 'How to select an audit sample' (available in the VIP Dropbox or upon request we can mail this to you).

Starting a new Snapshot audit

1. Click on the + New Audit button.
2. Click whether an Official (random sample of clients between 01 April–30 June) or ad hoc (other time period, variable sample size) audit.
3. Select your DHB from the drop-down list (DHBs are ordered north to south).
4. Enter the percent of current staff who have completed VIP core training by profession (e.g. doctor, nurse, midwife, social worker). You will have reported this in your most recent report to the Ministry of Health.
5. Enter the total number of eligible women/children who were admitted during the audit period.
 - a. Please see definition of 'eligible women/children' in the detailed definitions (it is not the sample number of 25 patients).
 - b. It is from the 'eligible women/children' number that 25 patients should be randomly selected.
6. Click 'save' to advance to patient data entry.

Entering patient data

1. Ethnicities
 - a. Select ethnicity or ethnicities as recorded in the patient file (can enter multiple ethnicities).
2. IPV Screen (Routine Enquiry) / Child Protection Screen (Risk Assessment)
 - a. Select for the patient 'Yes' or 'No'
 - i. If tick 'No', save and move on to next patient file.
 - ii. If tick 'Yes', go to IPV Disclosed / Child Protection Concern
3. If tick 'No', save and move onto next patient file
4. 2. If tick 'Yes', go to IPV Referral /CAN Consultation
 - a. Tick 'Yes' or 'No', save and move onto next patient.
5. The number of files entered and saved appears on the right side of the screen. Twentyfive (25) patients' data are to be entered for each service.
6. The 'Official' audit may need to be manually switched over by clicking the 'In Progress' button to 'DONE' when complete. This is the same process as for the 'ad hoc' audits.
7. Data can be entered in one or more sittings. The system will keep track of how many patients you have entered. Please save your results at the end of each sitting.
8. If you are entering a smaller number of cases for an 'ad hoc' audit you may click the 'In Progress' button to change to 'DONE'.

Your results

The system will provide the results:

- IPV routine enquiry, disclosure and referrals
- CAN assessment, concern and consultation

Document your results for each service in your next report to Te Whatu Ora.

3. Service specifications and definitions

Generic questions

- 'VIP Core Training'
 - Enter the percent of current staff who have completed VIP Core Training in designated service
- 'Ethnicity'
 - Select ethnicities as indicated in patient file (you may enter multiple ethnicities)
- 'Total number eligible'
 - Total number of women (or children) who meet eligibility criteria for the specific service during audit period. See specific service below for criteria.

IPV definitions

Was the woman asked routine enquiry questions about IPV occurring in the past 12 months?

IPV Routine Enquiry

NO	- There is no documentation that the woman was asked routine enquiry questions. If there is documentation regarding a reason for not asking routine enquiry questions (such as 'with partner'), this is still a 'NO'. Note: In Child Health inpatients, the female parent, guardian or caregiver is assessed for IPV. If no female caregiver, the IPV routine enquiry is a 'NO'.
YES	- There is documentation that the woman was asked routine enquiry questions about IPV occurring within the past 12 months or the woman self-disclosed IPV. - This would include asking the woman three or more routine enquiry questions about IPV. The FVAIG (2016) recommend four routine enquiry questions should be asked and the rationale for this is explained (MoH FVAIG P53-54). - We recognise that some IPV case identification occurs by referral sources (e.g. brought to ED by police with IPV related injuries). In these cases, we assume there is an assessment re the disclosure and therefore routine enquiry should be ticked as a 'YES'.

Did the woman disclose IPV?

IPV Disclosure

NO	Woman did not disclose IPV. If a woman was asked routine enquiry questions about IPV, but there is no documentation regarding disclosure, this is a 'NO'.
YES	Woman disclosed abuse occurring within the past 12 months. If woman disclosed abuse before being asked routine enquiry questions about IPV, it would still be a 'YES'.

Were appropriate referrals made?

IPV Referral

NO	No identification in notes that referrals were discussed, or notes indicate referrals were made, but do not specify to whom, or appear incomplete. If documented that a woman refused a referral, this is also a 'NO'.
YES (Active)	Direct referral to timely access for support by a family violence trained specialist who can provide the victim with danger assessment, safety planning and access to community services. (The trained specialist may include for example, police, social worker, or family violence advocate.)
YES (Passive)	Evidence in notes of appropriate referrals to specialised family violence support. This would include, for example, providing the woman with a brochure with contact information.

IPV service specific information

Postnatal maternity

Eligibility criteria	Women who have given live birth and who have been admitted to postnatal maternity ward during audit period.
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Emergency Department

Eligibility criteria	The number of visits by women aged 16 years and over who presented to ED during the audit period.
Age	Age of woman
Triage	Select triage status 1, 2, 3, 4, or 5
Admitted to ICU, coronary care or high dependency unit	Select 'Yes' or 'No'

Sexual Health

Eligibility criteria	Women aged 16 years and over who present to Sexual Health Services during the audit period.
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Child Health Inpatient

Eligibility criteria	Child health admissions aged 16 years and under, admitted to a general paediatric inpatient ward (not a specialty setting) during the audit period
No female caregiver	Documentation states there is no female caregiver. If there is no female caregiver, the response to IPV routine enquiry question is 'NO'.
Age of child	Enter child's age at last birthday. Please enter '0' for children under 1 year
Ethnicity/s	Select as indicated in the child's file
IPV routine enquiry	Was the female caregiver (parent, guardian or caregiver) asked routine enquiry questions about IPV occurring in the past 12 months?

Community Alcohol and Drugs

Eligibility criteria	All new referrals of women aged 16 years and over to community alcohol & drug services, who completed at least one face -to-face contact, during the audit period. (For women with more than one referral during the 3-month audit period, only enter 1st visit.)
Record review	For randomly selected clients, record review to be conducted for the index visit and up to two subsequent visits if occurring within two months of the initial index visit. (For example, if client seen in April, review may extend through June; if client seen in June, review may extend through August).

Adult General Community Mental Health	
Service definition	- General adult community mental health services. This includes Kaupapa Māori, community, adult, non-residential mental health services. - Excluded are mental health residential services and mental health specialist services such as Community Adolescent Mental Health, Maternal Mental Health, Crisis Team and CAT (Crisis Assessment and Treatment).
Eligibility criteria	All new women clients (seen for the first time by the service) and previous woman clients (who have been discharged from and re-referred to the service (as if they were a new client), aged 16 years and over who presented to the adult general Community Mental Health Service and Kaupapa Māori Community Mental Health Services during the audit period.
Sampling	If fewer than 25 new clients during the 3-month audit period, include them all in the audit.
Record review	For randomly selected clients, record review to be conducted for the index visit and up to two subsequent visits if occurring within two months of the initial index visit. (For example, if client seen in April, review may extend through June; if client seen in June, review may extend through August).

CAN definitions and service specifications

Eligibility criteria

Children aged under 2 years presenting to the Emergency Department for any reason during the audit period.

Was a child protection assessment done?	
CAN Assessment	
NO	No evidence of a child protection checklist, screen or flowchart (i.e. no child injury checklist, child injury flowchart or equivalent in the notes, or documentation is present but is blank, or is partially completed).
YES	Evidence of a thorough child protection assessment (i.e. child protection checklist, child injury flowchart, or equivalent fully completed including legible signature).
Was a child protection concern identified?	
CAN Concern	
NO	No child protection concerns or risk factors of child abuse and neglect were documented; or documentation was not complete.
YES	A child protection concern (i.e. one or more risk factors) is identified in the notes. If documentation of a Report of Concern, suspected child maltreatment or child protection concern is included in the notes, this would be a 'YES'.

Were identified child protection concerns discussed?

CAN Consultation

NO	- No indication of discussion in the notes about child protection risk factors and assessment, or the plan appears inappropriate, unclear or misleading, or notes indicate clear plan but do not indicate who the case was discussed with. - If no CAN concern, this is a 'NO'.
YES	Evidence that child protection consultation occurred is in the notes with name and designation of person consulted. Child protection consultation may be with a Senior Consultant ED, Paediatrician, specialist social worker, Oranga Tamariki, or another member of the multidisciplinary child protection team. Discussion of the child protection risk factors, assessment of the level of risk and plan is recorded.

Support for your Snapshot audit

Evaluation support is available through various means. For your first point of contact, consider communicating with your regional family violence intervention coordinators. Evaluation documents including templates and past reports are available at www.aut.ac.nz/vipevaluation. If you do not have access to Dropbox, please contact us and we can email you any requested documents. We are also planning several webinars to cover the Snapshot process.

Appendix B. Phase Two Digital Interview Schedule

Do you currently enter any information relating to family violence responsiveness that is documented digitally? (See digital data matrix)

- Tell me about the variables that are collected
- Who enters the data
- Tell me about your confidence in the completeness of the data
- Tell me about your confidence in the accuracy of the data

What else is important for us to know about regarding the pathway from clinical encounter to digital data?

With regard to entering information relating to family violence responsiveness in a digital tool?

- Which tool (or tools) do you enter data into?
- If not you, who enters the data?

Walk me through how you enter the information

- Take note of what information is captured and how

Do you know who oversees or manages the tool/platform?

- Is it regionally/locally customised? Or managed centrally?

What happens with this data once it's entered?

- Who else has access to it?
- Who else takes actions based on it?

Do you view this information or take actions based on it?

- What information is most useful to you? (Take note of format and type)
- What data do you feel is missing from this flow? Or, what information might you need to make this data useful?

Is this the right platform/tool to be entering this data into?

- If not, what would be a better one? Why?
- What other tools do you use in your workflow?

If you could wave your magic wand and improve this digital system to make it better for the workflow, what would you do?

Digital Data Matrix			
Service	Yes/No	Digital Tool	Comments
IPV			
ED			
Postnatal Maternity			
Child Health Inpatient			
Comm Mental Health			
Alcohol and Drug			
Sexual Health			
CAN			
ED			

NA – district is not responsible for the service

Appendix C. Site Visit Photos

Notes: IPV = intimate partner violence; RE = IPV routine enquiry

Figure A. Paper-based documentation forms covering a back wall in an emergency department

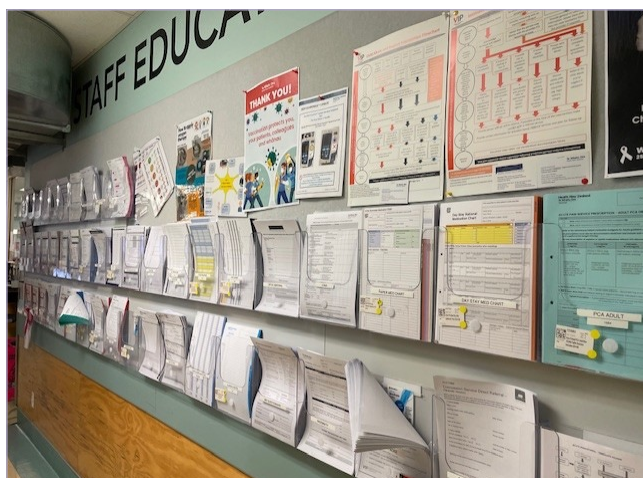


Figure B. Emergency Department Triage IPV RE

Isolation: ☐ Not screened ☐ Screened

Admitted/worked in overseas hospital or travelled overseas in past year: ☐ No ☐ Yes

MDRO in the past 3 years? ☐ No ☐ Yes

Mental Health Concerns: ☐ No ☐ Yes ☐ Not screened

Family Violence: ☐ No ☒ Yes ☐ Not screened

Printer: ED Reception (Canon)

Unclear re mandatory triage field and if tick 'not screened', is there a flag that RE should be completed later in their ED stay? And how would that be reflected in the data?

Figure C. Case identification source

This form is to document the first hand victim account of violence. It must be

<https://waitemataadhb.hnz.health.nz/Page>

How did ED become aware of the family/partner violence?

☒ Voluntary ☐ Spontaneous disclosure

☐ Presentation after assault ☐ During routine enquiry

☐ Brought in by ambulance ☐ Brought in by police

In this setting, case identification source noted as either voluntary or crisis post assault:

Voluntary

- Spontaneous disclosure
- During RE

Presentation after assault

- Brought in by ambulance
- Brought in by police

Figure D. Range of responses for documenting routine IPV enquiry

*FVSQ:

☒ Negative

☐ Positive

☐ Positive - suspected

☐ Not asked

☐ Declined to answer

Assume select only one, therefore, collects both whether an IPV assessment was conducted (safe to ask) and RE results (negative, positive, positive-suspected)

Figure E. Including family member 'screening' and historical abuse disclosure

Screen relates to * ☒ Intimate Partner | ☐ Family Member

Disclosure

☐ Negative Disclosure (reporting no violence)

☒ Negative - Suspected

☐ Positive Disclosure - Yes

☐ Positive Disclosure - Historical

Top line provides differentiating RE 'relates to': intimate partner or family member (the RE questions are the same, relates to if discloses, what is the relationship to the person causing harm).

- Provides a response option for
- Negative disclosure
- Negative – suspected (note in Figure D example 'suspected' is listed as 'positive')
- Positive disclosure – Yes
- Positive disclosure – Historical

Figure F. Another example with RE result including past history of family harm

Routine Enquiry Code Guide –

Y	Yes, Routine Enquiry has been delivered
U	Unable to deliver Routine Enquiry (please include this in your handover so that Routine Enquiry can be delivered during the next safe/appropriate opportunity)
+	Positive disclosure of violence and harm
-	Negative disclosure of violence and harm
PH	Past History of violence, harm and/or trauma (more than 12 months ago)

Examples of Routine Enquiry Documentation –

Routine Enquiry

☒ Y ☐ U ☒ + ☐ - ☐ PH

Routine Enquiry was delivered, and the patient has disclosed experiences of violence and harm within the last 12 months

Routine Enquiry

☒ Y ☐ U ☐ + ☐ - ☒ PH

Routine Enquiry was delivered, and the patient has disclosed experiences of violence and harm MORE than 12 months ago

Collects whether an IPV assessment was conducted (safe to ask) and RE results. Can select more than one in this example. Results Include:

- Negative
- Positive
- Past History

Figure G. An example of five IPV RE items

Routine Enquiry for Family Violence - Violence Intervention Programme (VIP)

Criteria for completing routine enquiry with patients/clients:

- All females aged 16+
- Anyone aged 12+ on suspicion of abuse
- Parents/caregivers of patients who are under the age of 18 and do not fit the above criteria

Q1: Have you completed routine enquiry for family violence?

☐ Yes (proceed to Q2)

☐ No

Q1a: If you did not complete routine enquiry, please select the reason why:

☐ Unable to get person on their own

☐ Person declined to answer or did not want to be asked

☐ They did not fit the criteria for routine enquiry and neither did their parent/caregiver

☐ They were in pain or distress

☐ Another reason

Q2: Was the person a client/patient?

☐ Yes

☐ No*

*Tick if the person concerned is a parent/caregiver of the patient

Note: Parents/caregivers should only be asked if the patient is a child that does not fit the criteria for completing routine enquiry

Q3: Was a disclosure made (includes disclosures where the patient has volunteered information without being asked)?

☐ Yes (complete Q3a)

☐ No (ignore Q3a, form complete)

Q3a: Has a referral been made (for example, to an external agency, social worker or by giving a This is Not Love brochure)?

☐ Yes

☐ No

For all disclosures of family violence, please complete an IPV Risk Assessment Form

- Q1. IPV RE completed
- Q1a. Reasons for not completing IPV RE
- Q2. Reference to IPV RE of child caregiver
- Q3. IPV RE result (note that 'where patient volunteered information without being asked' is a 'Yes'; Yes No rather than positive negative)
- Q3a. Referral (yes/no)

Figure H. e-Prosafe IPV risk assessment

ePROSAFE Te Whatu Ora **PROD**

Health New Zealand

Source: CMSS Clinical Nurse Specialist Service: Child and Family Safety Service Referral Date:

Referred By: Cookson, Natalie Allocated To: Natalie Cookson Confidentiality

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PERSONAL DETAILS **FAMILY VIOLENCE** **PARTIAL DISCLOSURE** **KEY ISSUES/REASON** **ATTACHMENT** **ACTION TAKEN**

Family Violence

☒ PV + (Positive) ☒ PV (Signs/Symptoms?) ☒ Patient/Client Pregnant?

1. Assess Patient/Client Safety:

Details of Person(s) Who Disclosed Info:

NHI	Name of Person(s)	Relationship to Patient/Client	DOB	Age	DOD	NHI
No Record found.						

Add New

Details of Alleged

Is the alleged abuser present? ☐ Yes ☐ No

Is patient/client afraid of alleged abuser? ☐ Yes ☐ No

Is patient/client afraid to go/stay home? ☐ Yes ☐ No

Has the violence increase in severity? ☐ Yes ☐ No

Specify type of violence: ☐ Physical ☐ Sexual ☐ Psychological

2. Was there an immediate need for help?

Threats of homicide? (if 'yes', by whom) ☐ Yes ☐ No