CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH

AUT

Health Response to Family Violence

VIOLENCE INTERVENTION PROGRAMME EVALUATION

2020–2024

AUT Evaluation Team Members

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We are also indebted to Deepika Sonia who contributed to the analysis and creation of the Power BI dashboard; Eric Wei who provided administrative support; and James Case, the Snapshot software engineer.

Acknowledgements

The evaluation team would like to thank all Violence Intervention Programme (VIP) coordinators, managers, champions and staff who facilitate and support the VIP evaluation process. We are grateful for the hospitality and engagement in learning shown during evaluation team site visits to hospitals in 2022 and 2023. We give our appreciation to members of the VIP national team including Miranda Ritchie and Kati Wilson (VIP management Health Networks) and Rachel Williams and Rebecca Webster (SHINE, national trainers). We are also indebted to Kathy Phillips and Abbie Taylor from the Health New Zealand | Te Whatu Ora Family Violence Whānau Wellbeing team for their leadership and support. Over time, many have contributed to the development of the violence intervention programme evaluation. These include Nathan Henry (data manager), Chris Cowley (researcher), Diane Koti (Māori health responsiveness), and Zoe Tip (Māori health responsiveness).

Ethics

The Multi-Region Ethics Committee (AKY/03/09/218/AM11) approved the evaluation project for meeting ethical standards. Most recent approval by the Northern A Health and Disability Ethics Committee on 25 April 2025 (2025PR1293). Text from previous Health Response to Family Violence reports is included with permission. For more information visit www.aut.ac.nz/vipevaluation.

Disclaimer

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

Citation: Koziol-McLain, J., Herbert, S., Garrett, N., Lowe, K., Ngawati, S., Pukeuke, T. (2025). Health response to family violence: Violence Intervention programme evaluation 2020-2024. (Report No. 20). Centre for Interdisciplinary Trauma Research, Auckland University of Technology. https://citr.aut.ac.nz/

Health Response to Family Violence

VIOLENCE INTERVENTION PROGRAMME EVALUATION

2020–2024

All people in Aotearoa New Zealand are thriving; their wellbeing is enhanced and sustained because they are safe and supported to live their lives free from family violence and sexual violence.

Te Aorerekura The National Strategy to Eliminate Famly Violence and Sexual Violence, 2021, p.6

EXECUTIVE SUMMARY

The moemoeā on the previous page reflects the vision framing the transformative change called for in Te Aorerekura, the Aotearoa New Zealand National Strategy to Eliminate Family Violence and Sexual Violence (2021). The strategy puts forth the responsibility for Health New Zealand | Te Whatu Ora to deliver safe, integrated, co-ordinated actions that are easy to access, understand and navigate, and, that those impacted by family violence and sexual violence can lead their own healing pathway.

This national evaluation report presents findings from the Violence Intervention Programme (VIP) across Aotearoa New Zealand's health system from 2020 to 2024. The evaluation draws on qualitative interviews, infrastructure audits, site visits, and clinical audit data to assess the health sector's response to intimate partner violence against women and child abuse and neglect for children under two years of age, with a particular focus on equity for Māori.

Key Findings

- Family violence remains a critical public health issue in Aotearoa, with significant and disproportionate impacts on Māori women and children.
- System infrastructure is variable, with a median Delphi (audit tool) score of 57/100 across districts. High-performing domains included documentation and policy, while cultural responsiveness, leadership, and VIP practices lagged.
- Service delivery across districts and audited services is inconsistent. Only 20% of services met or nearly met targets for both assessment and identification of intimate partner violence against women and child protection concerns for children under two years of age. Community-based services outperformed acute hospital services.
- Māori experience higher rates of violence disclosure and concern, yet lower rates of assessment – highlighting systemic barriers and unmet need.
- COVID-19 exposed vulnerabilities but also catalysed innovation, with VIP teams demonstrating resilience and adaptability.
- Infrastructure and clinical performance are weakly correlated, suggesting that system improvements alone are insufficient without leadership and cultural change.

Implications

- The current family violence health response is under-resourced and lacks consistent leadership, leaving coordinators and managers with an overwhelming burden.
- Te Aorerekura calls for transformation—requiring health sector accountability, culturally grounded services, and survivor-centred care, findings from this report suggest that is yet to be realised.
- A digital data strategy is urgently needed to support surveillance, equity monitoring, and, system and service improvement.
- Achieving Māori health equity must be prioritised and can be supported through Māori leadership, Te Ao Māori and kaupapa Māori solutions, and Māori data sovereignty.

The evaluation team proposes a vision where

- Family violence is recognised as a critical health issue.
- The health system is adequately resourced and culturally safe and responsive to all impacted by family violence.
- Community engagement and Māori leadership are central.
- Innovation and flexibility are fostered.
- A digital data plan informs equity-focused action.

Alongside this report is a dashboard that summarises the data collected across the 20 district Violence Intervention Programmes. This includes information on the rates of family violence (intimate partner violence, and child abuse and neglect) assessment, disclosure of intimate partner violence or identification of a child protection concern, and any referrals or specialist consultations. The dashboard presents rates at each district and across the targeted acute and community services. Māori compared to non-Māori analyses are also summarised.

Violence Intervention Programme Evaluation Dashboard (2025)
https://app.powerbi.com/

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INTRODUCTION

In Aotearoa New Zealand, family violence is both common, and a cause of substantial harm to individuals, whānau and communities (Mellar et al., 2023). Family violence is a human rights violation with significant social, economic, justice, health and wellbeing consequences (Gulliver & Fanslow, 2016). Family violence is defined in Aotearoa New Zealand legislation as violence inflicted against any person with whom the person is, or has been, in a family relationship with (Family Violence Act 2018). It includes a pattern of behaviour that is made up of acts of physical, sexual or psychological abuse and serves to control or coerce the person and may cause cumulative harm. Family violence may occur across the life course and includes intimate partner violence (relating to current or past partners), intrafamilial violence, child abuse and neglect, and elder abuse and neglect.

There exists a substantial and consistent body of evidence that documents family violence as a significant public health problem. Given the unacceptable prevalence and harm caused by family violence, there are numerous international instruments such as the 1989 Convention on the Rights of the Child, the 1993 Declaration on the Elimination of Violence against Women, the 1995 Beijing Platform for Action and the 2007 Declaration on the Rights of Indigenous Peoples (Article 22) that call for countries to take action to prevent and respond to family violence. More recently, the United Nations (2015) Sustainable Development Goal 5.2 set a target to "Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation" (p. 20).

If we are to work towards eliminating all forms of family violence from Aotearoa society, it will require a collaborative and comprehensive effort across whānau, communities, health and social services as well as effective public services designed to support the health and wellbeing of the entire population in Aotearoa. This may require culturally responsive and targeted approaches and solutions for various groups in the population. Eliminating family violence requires addressing the diverse social determinants of health and wellbeing that contribute to it, including socioeconomic deprivation, limited access to quality education, unsafe or unstable employment, insecure housing, inadequate transportation, weak social support networks, and exposure to racism and discrimination. Family violence must be understood within the wider societal context in which it occurs.

Importantly, consideration must also be given to the ways in which social determinants inequitably impact groups in the population. For example, Māori experience disproportionate harms as a result of family violence, while acknowledging the role of the social determinants of health, it is important to also acknowledge the root causes including historic and ongoing impacts of colonisation which have resulted in significant loss of political power for Māori, marginalisation of Māori language and culture, extensive land alienation, and, intergenerational deprivation and disadvantage including extensive economic impoverishment (Moewaka Barnes & McCreanor, 2019; Pihama et al., 2019; Reid et al., 2019).

Collectively, these harms not only influence how social determinants of health may impact Māori but also directly contribute to health inequities, including disproportionate harms from family violence which are experienced by Māori. As noted in a recent family violence death review, the three year IPV homicide rate (2000–2022) was 0.28 for non-Māori females compared to 1.40 for Māori females (per 100,000 population of women aged 15 years and older) (He Mutunga Kore | National Mortality Review Committee, 2025b). Further, the disparities in the rates of Māori women and child (female) homicide compared with non-Māori women and children (female) disproportionately increased between 2018 and 2020. Solutions for addressing family violence among whānau Māori must include system and structural changes that enable kaupapa Māori approaches and Te Ao Māori solutions (He Mutunga Kore | National Mortality Review Committee, 2025a; Wilson, 2023).

Over a decade ago, the World Health Assembly (2014) urged member nations "to strengthen the role of their health systems in addressing violence, in particular against women and girls, and against children, to ensure that all people at risk and or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination, to strengthen their contribution to prevention programmes and to support WHO's work related to this resolution" (p.4).

Aotearoa New Zealand health policy includes a Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence (The Guidelines). The Guidelines were first published in 2002, then revised in 2016 (Fanslow, 2002; Fanslow & Kelly, 2016). To support implementation of The Guidelines, the Ministry of Health provided funding for the Family Violence Health Intervention Pilot Project beginning in 2001. The 2007 relaunched Violence Intervention Programme (VIP) is now funded by Health New Zealand | Te Whatu Ora (Health NZ)[a]. The VIP provides a systems approach to support best practice, aligned with The Guidelines. The VIP system includes three tiers: national, district and service tiers (see Appendix A). This report communicates findings of the VIP system support for 'evaluation and monitoring' and 'quality improvement'.

[a] For an explanation of the Violence Intervention Programme access: www.tewhatuora.govt.nz/health-services-and-programmes/family-violence-and-sexual-violence/establishing-a-violence-intervention-programme-vip

Violence Intervention Programme Evaluation and Monitoring

This report addresses evaluation activities providing accountability and improvement data. Our intent is to present evidence to inform policy and practice. We recognise, however, that while important, our evaluation data is limited by the approach set out in The Guidelines, the Violence Intervention Programme and the available evaluation resources. This evaluative framework focuses on the crisis response to family violence within a limited number of acute and community health care services. Further programme development and evaluation is needed to realise the system transformations called for in the national Te Aorerekura strategy (Te Aorerekura The National Strategy to Eliminate Famly Violence and Sexual Violence, 2021) and the 'duty to care' called for in Family Violence Death Review reports (Family Violence Death Review Committee, 2022). In addition, we recognise further work is needed in developing an inclusive framework for learning and monitoring progress toward safe and supported lives free from family violence and sexual violence (Te Aorerekura The National Strategy to Eliminate Famly Violence and Sexual Violence, 2021)(p. 69). There is also a critical need for a monitoring and measurement framework conceptualised by and for Māori (Wilson, 2023).

Programme Context

This report covers evaluation activities conducted between 2021 and 2024, a period of significant upheaval. Health workforce shortages exacerbated by COVID-19, health restructuring, chronic health underspend and increasing health system demand all contribute to a stressed health system (Willing et al., 2024). The Aotearoa New Zealand health system restructure involved merging 28 district and regional organisations to a single health entity alongside the establishment of localities (2021) and Te Aka Whai Ora (2022) and subsequent disestablishment of Te Aka Whai Ora in 2024 and implementation of localities delayed. The Pae Ora Act [2022] heralded significant changes in health priorities, targets and budget as well as accountabilities of the health system. Changes in leadership and organisational instability became the norm.

The implications of these stresses on the health system response to those impacted by family violence are notable, including workforce impacts such as insufficient backup to release clinical staff for VIP training and to serve in clinical champion roles, attrition of experienced staff across service areas, prolonged delays in recruitment to vacant family violence intervention coordinator positions and coordinators not being released to attend regional or National meetings.

Despite the many challenges, the resilience of coordinators and clinical staff providing a sensitive, caring VIP service must be commended. The passion and dedication to pursuing best practice in responding to intimate partner violence and child protection concerns often requires working against prevailing norms (Family Violence Death Review Committee, 2022, p. 7). It is important to highlight that this evaluation monitors the extent to which the system provides support for a safe and effective response to family violence.

Evaluation Team Uaratanga

In November 2024 the National Evaluation team participated in a wānanga to determine the uaratanga (values) and tikanga (actions) that guide our mahi. The uaratanga that inform our collective thinking, processes and decision making are outlined in Figure 1.

Figure 1. Vip Evaluation Team Uaratanga (2024)

Evaluation Team Tikanga

We sought to apply our uaratanga to our practice via our identified tikanga; which guides how we work as a team, how we interact with all those who are involved in VIP and how we interpret and report data. Examples include:

- Utilising attentive, caring, empathetic communication styles
- Relying on strengths-based narratives, while simultaneously avoiding deficit narratives and victim blaming explanations when seeking to understand the impact and context of family violence among whānau Māori
- Having an appreciation of the various contributions and challenges faced by coordinators, managers, and kaimahi involved across VIP
- Promoting innovative responses that encourage both individual and team growth and opportunity for improvement in our VIP mahi
- Positive role modelling
- Sharing data-informed and evidence-based insights to substantiate our findings
- Tuakana-Teina modelling to build evaluation capability and capacity both within our team and more broadly across the Violence Intervention Programme
- Socialising our kaupapa to engage and encourage partnership, engagement and contribution among all those involved in VIP
- Striving for practical and innovative solutions that are applicable in real world contexts

Evaluation Team Commitment to Te Tiriti o Waitangi

In addition to identifying our guiding uaratanga and tikanga, we also sought to operationalise our commitment to Te Tiriti o Waitangi and Māori health rights. As an evaluation team, we chose an accountability tool to guide our reflection and actions. The Tiriti o Waitangi Accountability Tool questions were informed by Whakamaua: Māori Health Action Plan 2020-2025 (Manatū Hauora, 2020) and the Waitangi Tribunals Hauora Report [WAI2575]. Specifically, we drew on the four key Tiriti principles (equity, options, partnership and active protection) as well as Māori rights to Tino Rangatiratanga to help operationalise our obligations and commitment. The tool informed how we analysed, interpreted and reported evaluation data as well as being a living document for our ongoing mahi as evident in Appendix B.

The benefits we identified in utilising the Te Tiriti accountability tool include:

- Strengthening the National VIP Evaluation teams' awareness of, and commitment to, Te Tiriti o Waitangi and Māori health rights
- Supporting Te Tiriti o Waitangi and Māori health capacity and capability development among the evaluation team
- Valuing and holding space for Māori voice to inform the work of the evaluation mahi and our engagement across the VIP
- Identifying and implementing practical solutions that assist us to ensure we are working towards being more responsive to Māori
- Supporting Māori health gains and prioritization of Māori health equity considerations within the VIP programme.

Evaluation questions

Over the period 2021 to 2024, evaluation activities sought to answer the following questions:

1. What was the influence and what lessons were learnt about delivering VIP services through the first year of the COVID-19 pandemic?
2. What is the extent of institutional health system support (infrastructure) for family violence responsiveness?
3. What is the rate of VIP service delivery across health services and districts?
4. How many women and children are estimated to have received VIP assessment and intervention?
5. What inequities are evident in VIP evaluation findings?
6. Does greater infrastructure lead to improved clinical performance?

Image on page 11: Waitangi Treaty Grounds (Te Whare Rūnanga). Mathew/stock.adobe.com

METHODS

The VIP national leadership team recognised the pressures of the on-going COVID-19 pandemic, health reforms and workforce turnover and shortages on health services and staff during the 2021 to 2024 period covered by this report. Evaluation activities were therefore modified to address the impact of the pandemic as well as reduce evaluation burden on programmes. Key evaluation activities during the period included the following:

2020	• Self-audit of system infrastructure – Quality Improvement Domain only • Snapshot clinical audits of service delivery limited to three service (IPV in ED, IPV in Community Mental Health, Child protection in ED)
2021	• A qualitative descriptive study to explore how the VIP program was impacted during the first year of the COVID-19 pandemic, • District option to choose a single evaluation activity to support programme recovery
2022	• A stocktake of system infrastructure using the Delphi audit tool (external site assessments occurred in 2023)
2024	• Snapshot clinical audits of service delivery during the April-June 2024 quarter

Impact of COVID-19 on implementation of the VIP: A Qualitative Inquiry (2021)

A qualitative inquiry was conducted to answer the research question, 'What was the influence and what lessons were learnt about delivering VIP services through the first year of the COVID-19 pandemic?' Forty-one VIP coordinators and managers representing 15 of the 20 Districts and the National VIP Leadership Team shared their experiences during the first year of the COVID-19 pandemic (Koziol-McLain et al., 2023). Twelve focus groups and eight individual interviews were convened between 16 June and 3 December 2021. Participants were asked (a) how the role of VIP team members was impacted by the pandemic; (b) how the pandemic impacted the health response to family violence (service delivery), particularly for Māori and others that experience inequities; (c) what adaptations or innovations occurred in response to the challenges; and (d) recommendations for improvements to support the health response to family violence given the continuing challenges of the pandemic.

A team of four analysed the transcripts over a series of meetings guided by reflexive thematic analysis tools (Braun & Clarke, 2006, 2021) and oversight of Māori data by the Māori researcher (Te Mana Raraunga, 2018). Additional details of the study methods are available here (Koziol-McLain et al., 2023). The results of this study are included in the Findings section of this report.

System Infrastructure: The Delphi Audit (2022)

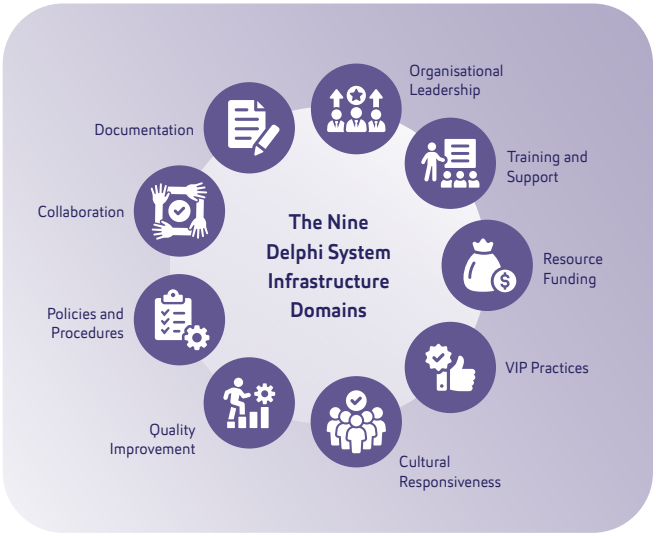
A quality, sustainable health response to family violence is reliant on quality systems. In a qualitative meta-synthesis of health practitioner readiness to address intimate partner violence, the most common theme impacting readiness was 'when the provider intention and actions were supported by a strong health system equipped to manage family violence' (Hegarty et al., 2020).

To determine 'What is the extent of institutional health system support (infrastructure) for family violence responsiveness' we applied the Delphi tool. The Delphi tool measures health system infrastructure supporting the development of a consistent and quality response to family violence. The tool reflects the VIP systems approach integrating intimate partner violence (IPV) and child abuse and neglect (CAN) responsiveness and is aligned to the Ministry of Health's 2016 Family Violence Assessment and Intervention Guideline (Fanslow & Kelly, 2016). The Delphi tool, revised in 2017[b], is aspirational, highlighting areas for development and improvement.

The relevant evaluation period for this Delphi round was the 2022 calendar year. Quantitative Delphi scores for 2022 provide a stocktake of programme infrastructure post the various restrictions imposed by the COVID-19 pandemic and the ongoing health system reforms.

Across nine domains (see Figure 2), the tool includes 56 items indicative of an ideal programme, rather than being all inclusive. Indicators are not scored unless fully attained, with evidence of process and implementation. Each Delphi domain score is standardised, resulting in a possible score from 0 to 100 with higher scores indicating greater levels of programme development. An overall score may range from 0 to 100 and is generated using a weighting scheme (Appendix C).

Figure 2. The Nine Delphi System Infrastructure Domains



[b] Language was changed from Ministry of Health and District Health Boards in the 2022 Delphi tool due to health system reforms.

The evaluation process included firstly, the 20 districts submitting completed interactive Excel Delphi workbook self-assessment data to the evaluation team. Resources available for completing the tool included a short instructional video, an Information Pack, tool measurement notes and evaluation support from the evaluation team[c]. Instructions highlighted the evaluation activity as a learning opportunity for the VIP team, with specific items to be completed by the VIP senior manager or sponsor. The interactive excel file allowed users to view measurement notes, input indicator data and instantly see their overall and domain scores in real time, supporting targeted improvement planning. Districts were expected to submit the completed self-assessment by 31 January 2023.

Self-assessments were received between December 2022 and July 2023 (eight districts provided their self-audits by the due date of 31 January). Following receipt of a district's self-assessment, a site visit was scheduled to conduct an external, independent assessment. An evaluation team member(s) visited districts to review the Delphi indicator evidence, review progress and discuss solutions and action plans. Site visits took place at the 20 districts across Aotearoa New Zealand between March and November of 2023. The one-day site visits included a final verbal summary report. All districts received individualised reports documenting their results with analysis and recommendations by December 2023.

In this report, we present overall and domain scores and call attention to specific individual indicators and areas in which systems are high performing as well as areas requiring additional support. Historic (pre-COVID-19) self-audit Delphi data using the current tool is available for all districts for 2018 and 2019, with only the Quality Improvement domain required in 2020.

Clinical Service Delivery: Snapshot Audit (2024)

The rate of VIP service delivery across health services and districts is measured using Snapshot clinical audits. Audits focus on The Guideline mandatory (routine) services rather than those that are indicated due to presentation (case finding). The audits, therefore, address intimate partner violence routine enquiry and response for women, and child protection assessment and response for children under two years of age. Snapshot data allows national estimates of the number of women and children who have received VIP assessment and intervention.

The snapshot clinical audits aim to collect 'accountability data that matter to external parties' (Solberg et al., 1997) and monitor service delivery to inform performance improvements (Langley et al., 2009). Snapshot audits use a nationally standardised reporting process to provide estimates of: (a) VIP outputs – women and children assessed for violence and abuse and (b) VIP outcomes – women and children with a violence concern who received specialist assistance. Specialist assistance includes both active and passive referrals. Active referrals generate timely access to support from a family violence trained specialist, such as a social worker, family violence advocate or police.

The family violence assessment measures align with The Guideline (2016). For example, documentation of an IPV assessment is based on the four routine enquiry questions and the child protection assessment is based on a clinical assessment that includes a seven-item child protection checklist (Appendix D).

The audits cover a random sample of district records between 1st April and 30th June 2024 in seven targeted services identified by Health New Zealand | Te Whatu Ora. The services measuring intimate partner violence and child abuse and neglect response are as follows:

Intimate partner violence service audits for women 16 years of age and over in:

- Emergency Department
- Postnatal Maternity in-patient
- Child health in-patient (female caregivers)
- Community Mental Health
- Alcohol & Drug
- Sexual Health

Child abuse and neglect service audits for children under 2 years of age presenting to

- Emergency department (for any reason).

A range of resources to support consistent quality data entry were provided. These included Snapshot Instructions available on the evaluation website (www.aut.ac.nz/vipevaluation), a series of five Snapshot zoom webinars between the 10th of April to the 1st of May, with the recordings available on our website and on the CITR YouTube channel and individual support from the evaluation team. How to achieve a random sample, eligibility criteria and variable definitions are included in the instructions document available in Appendix E. In addition, we implemented tuakana–teina peer support between willing VIP coordinators and newer VIP coordinators engaging with the Snapshot clinical audits.

[c] Delphi resources available at www.aut.ac.nz/vipevaluation

Tuakana-Teina support

In recognition of the substantial number of FVIC being asked to be involved in completing the Snapshot clinical audits for the first time, the evaluation team implemented a tuakana-teina model.

Tuakana-teina is a Māori relational concept that highlights a reciprocal mentoring relationship in which both parties bring unique skills, knowledge and experience which is mutually beneficial (Oetzel et al., 2024). The relationship is focused on building collegial support and providing access to supports by bridging and fostering relationships and connections. Essential to this concept is the understanding of mutuality. Western models of mentoring often emphasise an expert working with a subordinate, in contrast our tuakana-teina model exemplifies an inter-relational and holistic approach which interweaves learning and supports. Both parties receive benefit through engagement with each other. While there are other established support systems, the VIP evaluation team chose to champion a tuakana-teina model as part of our commitment to being good Tiriti partners.

Thirteen VIP coordinators were identified who had been in their roles less than a year and had not participated in a previous audit. Three evaluation team members who had served in the role of coordinator (SN, TP, KL) served as tuakana. The intent was to offer support as a 'buddy' or 'peer' rather than an expert with the answers. They reached out to the new coordinators, firstly 'checking in' then asking on the status of the Snapshot audit, with a handover to appropriate supports. This holistic cultural approach exempflied our commitment to fostering an ongoing, mutually beneficial and supportive relationship.

A brief survey was distributed to teina in October 2024 asking whether the tuakana contact was valuable and whether they would recommend it be continued for new coordinators. Members of the evaluation team also led a kōrero about the model at the Violence Interventional Programme Coordinators meeting in November 2024. Participant feedback is included in the Findings chapter.

Clinical Audit Process

The Snapshot sampling process begins with identifying the population (sampling frame) of eligible visits during the three-month period (1 April – 30 June) within each district, for each designated service. Then, from the sampling frame, a random sample of 25 records are selected for review. Programmes were advised to seek assistance in eligibility and sampling processes from their Quality or Business Intelligence units. Once records are retrieved (electronic or hard copy), VIP staff or delegates (e.g., service champions) retrospectively reviewed the selected records and entered the de-identified data in the secure Snapshot website.

The published due date for submission of audit data was the 1st of September 2024. Across 20 districts, with between five and seven services offered in each district, there was a potential of 130 services reporting Snapshot data. For acute care services, most districts report data for their 'main' (tertiary hospital site) unless otherwise noted.

Interpretation

Consistent with improvement literature, system reliability is considered achieved when a standard action occurs at least 80% of the time (Nolan et al., 2004). Therefore, VIP aims to achieve IPV and CAN assessment rates (routine enquiry and child protection checklist respectively) ≥80%. With regard to disclosure of IPV, Aotearoa New Zealand and Australian research demonstrates that the quality of IPV routine enquiry (screening) influences women's decision whether or not to disclose IPV to a health worker (Fiolet et al., 2022; Koziol-McLain et al., 2008; Spangaro et al., 2020; Spangaro et al., 2016). IPV disclosure, therefore, is an indicator of underlying prevalence as well as the quality of the care and cultural responsiveness demonstrated when talking about family violence.

The minimum disclosure rate based on estimated Aotearoa New Zealand population past year (12 month) IPV prevalence rate among women is ≈ 5%. This is based on 2019 survey data summaries of physical, sexual and psychological IPV among ever-partnered women (2.4% physical IPV; 0.9% sexual IPV; 4.7% psychological abuse) (Fanslow, Hashemi, et al., 2021; Fanslow, Malihi, et al., 2021). The prevalence of IPV reported by women receiving health care services, however, is higher than the population prevalence in both international and Aotearoa New Zealand research (Ansara & Hindin, 2010; Bonomi et al., 2009; Koziol-McLain et al., 2004; Koziol-McLain et al., 2007). This is not surprising given the negative impact of IPV on health (Mellar et al., 2023).

We set IPV disclosure rate targets in 2019 informed by research literature and historical snapshot data, rounding of the 70th percentile (allowing for diversity in social determinants of health among populations) among those reporting at least a 30% assessment rate (Table 1). Based on the prevalence of CAN indicators (such as CAN alerts), VIP expects the rate of child protection concern identification to be ≥5%.

The electronic VIP snapshot reporting system provides service results and a graph on completion of the input for each service, providing timely feedback to services. An overview of tentative VIP snapshot data was provided to VIP leadership team in August 2024 to review data interpretation and inform national VIP planning. Tentative findings were also shared with VIP teams in an evaluation update distributed in November 2024.

Table 1. Disclosure And Concern Rate Targets

IPV Disclosure Rates	Target
Postnatal maternity	5%
Child health in-pit	10%
Emergency department	15%
Sexual health	15%
Alcohol and drug	25%
Community mental health	25%
CAN Concern Rates	**Target**
Emergency department	15%

Snapshot Analysis

2024 data files were downloaded from the VIP Snapshot digital platform in CSV format. Data cleaning (addressing missing values, duplicates and inconsistencies), data transformation and preliminary analyses were conducted in MS Excel. We then employed Power BI to create interactive dashboards and visualizations, facilitating deeper insights and data-driven decision-making.

Power BI DAX functions calculated routine enquiry, disclosure and referral rates. Disclosure rates were calculated as disclosures among those who had a documented routine enquiry. Referral rates were among those who had an IPV disclosure. Similarly, child protection concerns were among those who had a documented child protection checklist and consultations among those who had a documented concern.

National mean assessment rates and 95% confidence intervals were calculated using individual district rates weighted by the number of eligible visits or clients presenting to each VIP service during the audit period. Data were then extrapolated to provide national estimates of the number of health clients who received VIP assessment during the quarter. Identification of child protection concern and disclosure of IPV, along with consultation and referral rates were calculated similarly.

Snapshot data were first collected in 2014 for three services, with the current seven services in place since 2016[d]. This allows examination for trends in service delivery over time. While the data has been collected annually, this was modified to reduce evaluation activity burden for VIP coordinators during the COVID-19 pandemic. Prior VIP Evaluation Reports are available online.

Data is available (based on the April-June quarter):

- Annually between 2016 and 2019 for all seven services,
- In 2020 limited to three services: Emergency Department (IPV), Community Mental Health (IPV) and Emergency Department (Child protection concern for children under 2 years of age),
- In 2021, districts were able to select the audit activities that were judged most valuable. Snapshot clinical audits, therefore, were voluntary. A self-selected group of 9 districts reported snapshot data. Data are not nationally representative, and confidence intervals are wide, and
- In 2024 for all seven services.

Māori health inequities have been extensively documented (Reid et al., 2019; Reid & Robson, 2007; Wilson, 2023). In keeping with Ministry of Health's HISO ethnicity data protocols (Ministry of Health, 2017), using the NZ census question, multiple ethnicities were able to be entered in the Snapshot database for each case. We adopted a prioritisation output method to allow a Māori v. non-Māori analysis. Māori data interpretation was governed by the Māori evaluation team members.

While comparisons between Māori and non-Māori groups can yield valuable insights, it is important to acknowledge that the non-Māori comparison group aggregates all other ethnic groups, potentially obscuring heightened inequities within subgroups of the non-Māori population. In addition, the prioritised Māori non-Māori analysis does not account for ethnicity combinations (such as Māori/Pacific Peoples). Due to limited sample sizes in the Snapshot audit, more robust and granular analyses are not currently feasible.

To cautiously explore additional ethnicities, we applied the Ministry of Health's 'total response output' method (Ministry of Health, 2017). The total response, or overlapping, method counts individuals in each ethnic group as reported. Ethnic groups (level 1 codes) were included only when the denominator reached a minimum of six, ensuring anonymity. Despite small sample sizes across multiple ethnicities, we calculated total assessment rates and disclosed/concern rates for the available data. Population weighting was not applied, as the small number of patients per ethnic group by service and hospital would introduce significant uncertainty.

Anonymity

All Snapshot data is input into the web-based Snapshot system without unique identifiers (name or NHI). In the past we have reported disaggregated district information either naming districts or alternatively using an assigned pseudonym. Pseudonyms were the selected option when there was a new evaluation tool to allow districts time to implement the new tool. In our 2020 report we only named districts when they had achieved, or were close to achieving, set targets. For this report, neither the Delphi nor Snapshot were in an early implementation phase. Therefore, the decision was made to identify districts for both the infrastructure (Delphi) and clinical audit (Snapshot) reporting. This increases transparency across the sector, allowing districts to easily compare themselves to other like districts (for example, either geographically, in population size or similar ethnic diversity). Providing transparency allows individuals to consider their local context and use the data in meaningful ways, such as reflecting on community strengths and resources to guide VIP improvements that are appropriately resourced and address priority populations.

We recognise, however, that there are risks in identifying districts. Foremost is the risk that individuals (such as family violence intervention coordinators) rather than systems will be held accountable and 'blamed' for poor performance. The infrastructure and clinical practice data reflect a complex health system, and improvements are a shared responsibility. To mitigate this risk, we continue, in our strengths-based reporting, to highlight locations of achievement as they provide a window on the conditions that support good practice to occur. Another risk is to have a short-term focus rather than understanding that the reported data is referent to a point in time.

Combining Infrastructure and Practice Data

Finally, using the Spearman's rank correlation coefficient, we examined the data for an association between the overall infrastructure Delphi score (2022) and the overall family violence assessment (IPV routine enquiry and child protection checklist) and disclosure/concern rates (2024). This tests whether locations with stronger health system infrastructure had higher rates of VIP service delivery.

Data Visualisation

To accompany this report, we provide an interactive data visualisation dashboard. This was developed using Microsoft Power BI to enable sharing of information to inform decision making. The 2024 Snapshot data dashboard provides service assessment, disclosure and referral summary data across national, regional and district levels. The dashboard also includes 2022 Delphi data overall and domain scores.

[d] In 2014 Snapshot data began in post-natal maternity (IPV), child health inpatient (IPV) and emergency department (CAN); in 2015 sexual health (IPV) and emergency department (IPV) services added; in 2016 alcohol and drug and community mental health services added.

FINDINGS

Impact of COVID-19 Pandemic on VIP (2021)

A consequence of the COVID-19 pandemic was an increase in frequency and severity of violence against women and children alongside unprecedented upheaval in the delivery of health and social services (Boxall & Morgan, 2021; Piquero et al., 2021; UN Women, 2020). We conducted a qualitative study to identify the influence and lessons learnt about delivering VIP services through the first year of the COVID-19 pandemic. Forty-one VIP coordinators, managers and national team members shared their challenges and innovative solutions in navigating systems to support frontline health provider responsiveness to people impacted by family violence during the first year of the pandemic.

From our analysis we generated the following three themes: responding to the moment, valuing relationships and reflecting on the status quo. We present a selection of quotes that provide insights to the shifting landscape and innovation responses. The following sections are abstracted from the full report available at: https://doi.org/10.1177/00469580221146832.

Responding to the Moment

As the health system was trying to understand the impact of the pandemic and translate that into a national response, VIP coordinators who participated in the study talked about how despite the 'shifting goalposts', team members worked to be visible, communicate and provide resources to front-line health providers. They did this while they themselves were challenged to work in new ways, such as video conferencing, and to adapt how they could raise awareness and respond to family wellbeing and safeguarding needs while the health system prioritised the health impact of the infectious COVID-19.

> Initially when the pandemic hit, we didn't know what that was going to look like and so we automatically had to start thinking of different ways of doing things.

> I think it's really good that there was a bit of a shakeup in terms of making us think about how we can do things differently because we all get stuck in that rut of we just do this because it is how it is and it is how it's been for years when actually there is always so much that we could do differently or better and I think that was a good chance to start thinking about some of that stuff.

> We're feeling like the posts move every day, how are they (frontline staff) feeling? So we developed a FAQ resource for them that went out.

Valuing Relationships

VIP team members found energy and support from engaging in whakawhanaungatanga across sectors and maintaining contacts with their regional colleagues. The primary connections noted were 'communicating quite a lot with the police and Oranga Tamariki'. Working from home during lockdown, however, had a personal toll.

> That's when we changed it to a Zoom meeting once a day... for 15 minutes and it was around identifying really quickly those high-risk families. Where, because the police were obviously our outreach arm and had the capacity to go out if needed so that's changed.

> We were working from home for about 5 weeks... and I'm bringing all this stuff into my home environment which is my, supposedly peaceful place. And I don't like that, I don't like it.

Reflecting on the status quo

Coordinators spoke of the programme being viewed as an 'add on' and 'not a priority'. They reflected on a lack of culturally responsive services.

> It was a little challenging on the engagement factor with our own Māori services because they were really busy but I don't know if it was just a COVID thing I think generally they're stretched anyway.

> I'd say, there's still the issue of not having management support for the programme. Where we've done really well is where charge nurses have been on board and we see good rates of routine enquiry.

> The challenges are the same whether COVID's there or not... everyone sort of wonders if there have been more IPV reports identified or more reports of concern... that hasn't changed in my services. They still perform poorly. They still don't actually screen routinely.

Workers leading the health response to IPV and CAN demonstrated resilience and agility. They took the opportunity to interrogate routinized systems and create alternative approaches.

Overall, COVID-19 lockdown was an opportunity for VIP members from coordinators to national body, to take stock of what was working and what changes needed to be made to ensure the programme continued to be delivered in the hospital and community settings. While participants demonstrated innovation and resilience, they also experienced frustration and questioned their role.

Limitations

The kōrero shared here reflects the VIP workforce which is primarily female and NZ European, with underrepresentation of indigenous Māori and Pacific Peoples. By design of the current VIP, our findings are limited to hospital and several community services. How people impacted by family violence experienced health services during all phases of the pandemic represents a critical gap.

Conclusions

Lessons from the experience of the first year of the COVID-19 pandemic suggests a resilient health system response to family violence across future challenges will have:

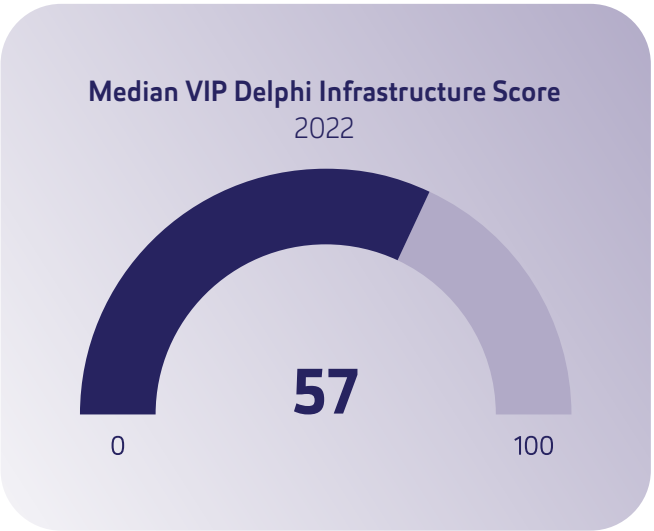
- Community engagement at its core
- Embrace uncertainty
- Meaningful, collaborative and reciprocol partnerships with māori to inform culturally responsive VIP services
- Normalise adapting to shocks

During the unprecedented time of the COVID-19 pandemic, key workers leading the health response to intimate partner violence and child abuse and neglect demonstrated resilience and agility. They took the opportunity to interrogate routinized systems and create alternative approaches. In emergency health care planning, it is vital to communicate the provision of services for responding to violence against women and children as an essential service. Local knowledge and networks and routinely coping with uncertainty will strengthen our systems to minimize risk of harm during emergencies.

System Infrastructure (2022)

Evaluating the 2022 calendar year, independent external auditor overall Delphi scores ranged from a low of 34 to a high of 87. The median overall score was 57 (Figure 3).

Figure 3.



Across the nine Delphi domains, the median score ranged from 36 to 100 (Appendix F). High achieving domains (Figure 4) included Documentation (100) and Policies and Procedures (100). Low performing domains included Organisational Leadership (50), Cultural Responsiveness (46), Quality Improvement (45) and VIP Practices (36). The districts with overall Delphi scores above the median included Whanganui, Hauora a Toi Bay of Plenty, Southern, Counties Manukau, Te Tai o Poutini West Coast, Te Pae Hauora o Ruahine o Tararua Mid Central, Taranaki, Waikato, Wairarapa and Capital and Coast.

Of note, the VIP Practices domain sets a visionary benchmark for service delivery. For instance, one of its seven indicators calls for meeting the target of at least 80% of women receiving IPV routine inquiry in each of the designated services. While there are pockets of achievement, no district met this target across all services. Detailed results for each Delphi indicator are provided in Appendix F.

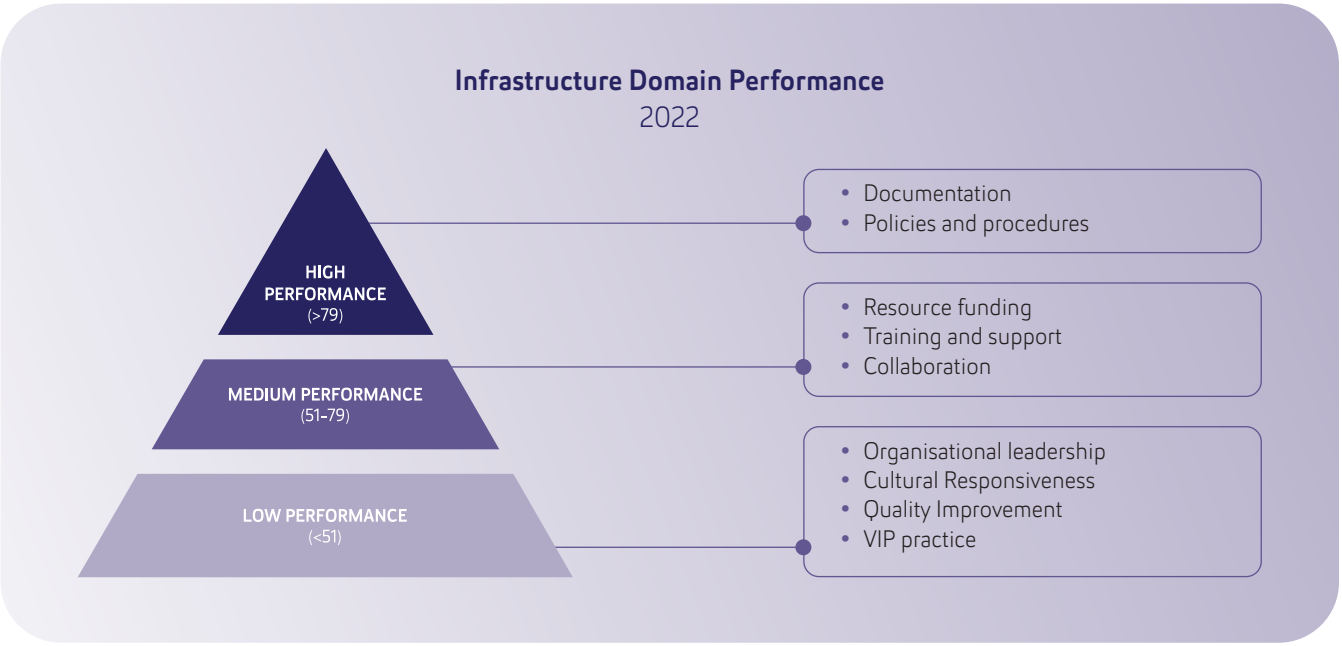
Individual indicators also evidenced the difficulty in sustaining infrastructure to support VIP practice following a pandemic and amid health system restructures. For example, in Organisational Leadership, while 95% of districts had an active Governance Group with a strategic VIP leadership role in 2019, only half had evidence of this in 2022. Similarly, half of the districts reported services implementing and monitoring VIP key performance indicators (KPIs) in 2019, reducing to 25% in 2022.

There was also difficulty in retaining and hiring people in the role of family violence intervention programme coordinator. Having someone in the position (covering both child protection and intimate partner violence, either independent or shared roles) for the previous 12 months had historically been met by 70% of districts, dropping to 45% in 2022. Only 15% of districts had the role filled at the time of the 2022 Delphi site visit. While not measured, we are also aware of difficulty in maintaining continuity in VIP managers in many districts.

Importantly, all districts (100%) in 2022 evidenced availability of support services for staff who have experienced/are experiencing family violence (including perpetrator and victim). This need was highlighted by coordinators during the pandemic restrictions (Koziol-McLain et al., 2023).

With the establishment of Te Aka Whai Ora in July 2022 and the subsequent shifting of many Māori health roles, responsibilities, functions and personnel, coordinators shared their experience of uncertainty. Coordinators sought clarity on who to engage and how to build and maintain relationships with Māori health staff to support

Figure 4. Infrastructure Domain Performance 2022



both the role and function of the VIP, as well as support to drive system improvements aimed at better outcomes for Māori. At times, this uncertainty was compounded by an apparent lack of Māori capacity and capability available to support coordinators in the VIP mahi and broader system response. Critical equity indicators in 2022 that address essential steps in ensuring services meet the needs of Māori include, for example:

15%

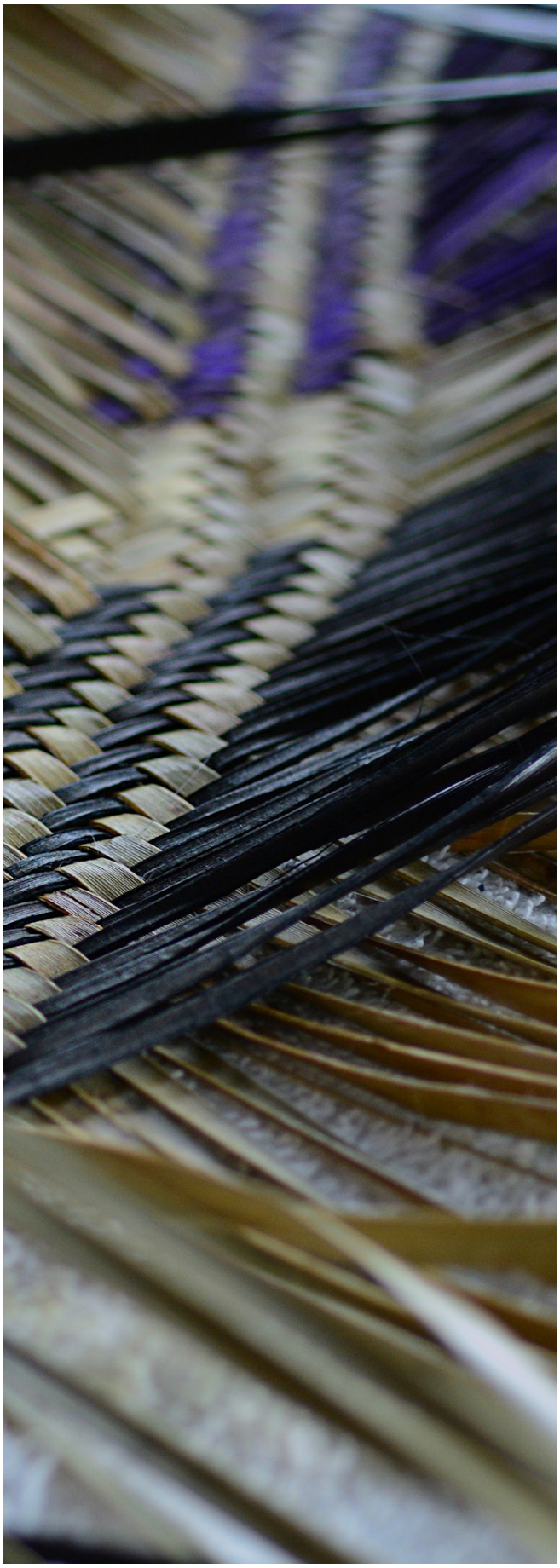
Within the Cultural Responsiveness domain, three districts had actively sought feedback from Māori engaging with the VIP service regarding its cultural responsiveness.

5%

Within the Quality Improvement domain, one district reported using a Māori quality framework to evaluate service effectiveness for Māori.

This highlights a disconnect between VIP services, Māori engagement and input, and Māori experiences of the service. Moreover, it raises questions about the degree with which Hospital and Specialist Services, as part of the broader health system, prioritised Māori engagement and input across their services – including VIP services. Without the necessary systemic and structural supports, Māori capacity and capability is often diminished, not available, or, has limited impact which has flow on effects to staff working to deliver services to the communities and people they serve.

The 2022 audit of district infrastructure with the revised Delphi tool (2017) was the first occasion involving independent external assessment. On average, external scores were 11 lower than internal scores. The overall score differences between self- and external- audit ranged from –52 (external score lower than internal) to 5 (external audit higher than internal). Large differences were commonly due to external evaluators not recording achievement for example, when there were governance group terms of reference available and a training package, but the governance group had not met, and no training had been delivered during the 12-month referent period.



Snapshot clinical audits (2024)

Snapshot data was completed for 128 out of 130 services across the 20 districts that have implemented VIP, indicating a high level of data collection coverage. The Snapshot data provides evidence for three of our evaluation questions: (1) What is the rate of VIP service delivery across health services and districts? (2) How many women and children are estimated to have received VIP assessment and intervention? and (3) What inequities are evident in VIP evaluation findings?

Some data collection anomalies in 2024 are important to be aware of when interpreting the data. For example, in 2024, the Southern district data was collected in Southland Hospital, so Dunedin Hospital is not represented. In another district, Waitematā, Snapshot audits were submitted from both North Shore Hospital and Waitākere Hospital (the district sample size is therefore 50 rather than 25).
A summary of Snapshot data follows. An interactive dashboard that allows you to drill down by service and location is available at www.aut.ac.nz/vipevaluation under 'Evaluation Reports'.

Rates of VIP Service Delivery across services and districts

Across the 130 locations of target services in districts, 8 (6%) achieved a consistent rate of assessment (≥80%) and the designated service identification (IPV disclosure or CP concern) rate (Table 2). An additional 18 (14%) locations 'nearly' achieved (assessment rate 60–80% and disclosure/concern a rate ≥5%). These 26 sites (20%) evidence that it is possible, given the right conditions, to provide a consistent quality violence intervention programme. Overall, community sexual health services were most likely to achieve the target of ≥80% women receiving routine IPV enquiry and ≥15% disclosing experience of IPV (33% of districts achieved; 5/15). Evidence of good practice was most evident in Te Tai o Poutini West Coast and Taranaki districts. Across the 130 locations, however, in the random sample of 25 health records in a service, there were 8 (6%) instances of no IPV or CP assessment in their random sample of 25. While there may be family violence assessments – and disclosures/concerns – occurring in these services, the practice is rare, estimated to occur for less than 1 in 100 women/children.

Consistent with Snapshot data trends observed since 2015, the 2024 findings continue to highlight variation in service delivery across both services and districts. While the 2024 average rate of intimate partner violence (IPV) assessments — referred to as routine enquiry — was 38%, this figure masks significant differences. IPV assessment rates ranged from a high of 76% in community sexual health services to a low of 24% in postnatal maternity services and 25% in emergency services, underscoring the uneven implementation of IPV routine enquiry practice. Among those who received an IPV assessment, the average IPV disclosure rate was 15%, varying between 29% in Community Mental Health to 2.2% in Child Health Inpatient.

Interpreting IPV disclosure rates when routine enquiry is ad hoc is fraught, for example, if the snapshot random sample of 25 in a service shows two routine enquiries, one of whom discloses IPV, the disclosure rate would be 50%.

A pattern of variation was also evident in 2024 child protection assessments (child protection checklist). The concern rate varied between 0% and 100% (achieved by Southland Hospital). The sole location that achieved the child protection target of assessment ≥80% and identifying a concern ≥5% was Te Tai o Poutini West Coast.

In 2024, for the Snapshot sample of 561 emergency department visits by children under 2 years of age, 283 (50%) children had a documented child protection assessment. Among the children with a completed assessment, a child protection concern was documented in 5 children (2%). Among the 5, a specialist consultation was documented for 4 (80%). The cases with an identified concern occurred in only three of the 20 districts. Caution is needed in interpreting this data. For example, the 2% rate of concern reflects the probability that a concern will be noted following the completion of a child protection assessment. It does not reflect the number of Reports of Concern made to Oranga Tamariki within a district.

Table 2. District Services Achieving Family Violence Assessment and Identification Target Rates Based on Snapshot Data (April – June 2024)

	IPV Acute services (women ≥16 years)			IPV Community services (women ≥16 years)			Child Protection (<2 years)
District	**Postnatal Maternity**	**Child Health In-Patient**	**Emergency Department**	**Sexual Health**	**Mental Health**	**Alcohol and Drug**	**Emergency Department**
Service Disclosure/Concern target	**5%**	**10%**	**15%**	**15%**	**25%**	**25%**	**5%**
Te Toka Tumai Auckland						NA	
Hauora a Toi Bay of Plenty							
Waitaha Canterbury							
Capital and Coast				NA			
Counties Manukau				NA		NA	
Te Matau a Māui, Hawke's Bay							
Hutt Valley				NA		NA	
Lakes					NS	NA	
Te Pae Hauora o Ruahine o Tararua MidCentral							
Nelson Marlborough							
Te Tai Tokerau							
South Canterbury							
Southern							
Tairāwhiti							
Taranaki							
Waikato							
Wairarapa				NA		NA	
Waitematā				NA			
Te Tai o Poutini West Coast		NA					
Whanganui							

Table notes: Southern data represents only Southland Hospital. Waitematā provided data for both North Shore Hospital and Waitākere Hospital. Waitematā was near the target in postnatal maternity limited to Waitākere Hospital.

	Dark purple cells indicate both ≥80% assessment and ≥ service specific disclosure/concern rate achieved
	Lavender cells indicate 'near target' with ≥60% assessment and ≥ population rate of 5% disclosure/concern rate achieved
NA	= not applicable (no designated ward, regional or contracted out service)
NS	= data not submitted
	A blank cell indicates neither target nor 'near target' met

Change Over Time

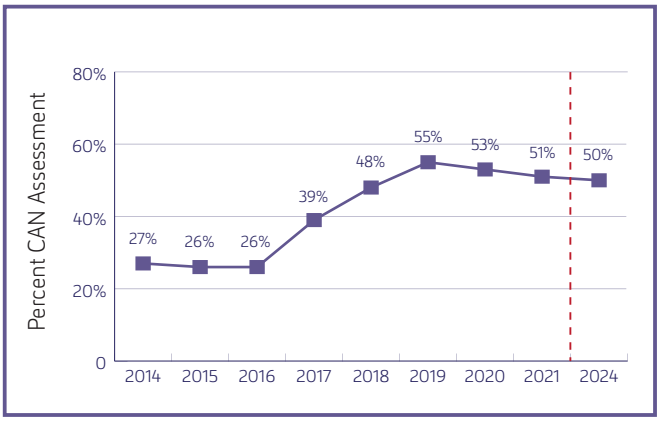
The systematic collection of clinical audit data in selected services began in 2014, with the additional services added 2015 and 2016. Longitudinal summary data are provided in Appendix G (CAN) and Appendix H (IPV). The following figures graph service rates over time for each service, firstly for child protection (Figure 5), followed community services (Figure 6) and hospital acute services (Figure 7).

The graphs for child abuse and neglect assessment (child protection checklist) and concern are provided in Figure 5. They demonstrate:

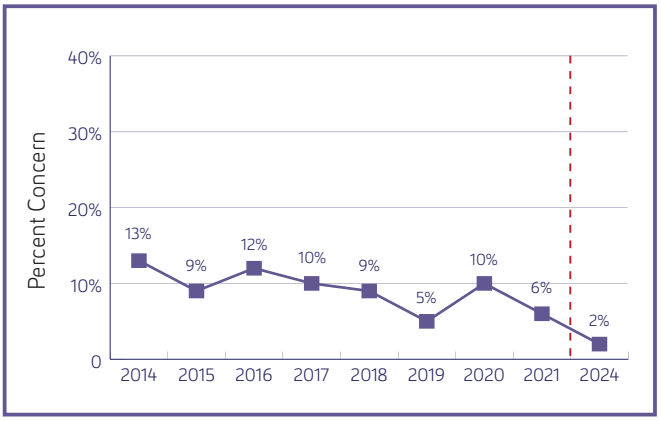
- The rate of child protection assessment increased from approximately 1 in 4 children having a child protection assessment 2014 to 2016, to a rate of 1 in 2 achieved across the last five audit periods (2018–2024).
- In 2024, the proportion of children with a completed child protection checklist who had a concern identified dropped significantly. Only 2% of these children were flagged for concern, indicating a notable decrease compared to previous years.

Figure 5. National Rates of Child Protection Assessment and Concern 2014– 2024 (April–June Quarter)

a. Child Protection Checklist



b. Child Protection Concern



Notes: Assessment of child protection (checklist completed) for children under 2 years of age presenting to the emergency department for any reason; Concern rate among children with a completed assessment; weighted means based on eligible population; with evaluation activity a choice in 2021, 2021 Snapshot data includes 9 districts; dotted red line represents time series interruption; 95% confidence intervals provided in Appendix G.

Image: Janice/stock.adobe.com

The data for IPV routine enquiry and disclosure for women ≥16 years of age in community health services are provided in Appendix H and Figure 6. They demonstrate:

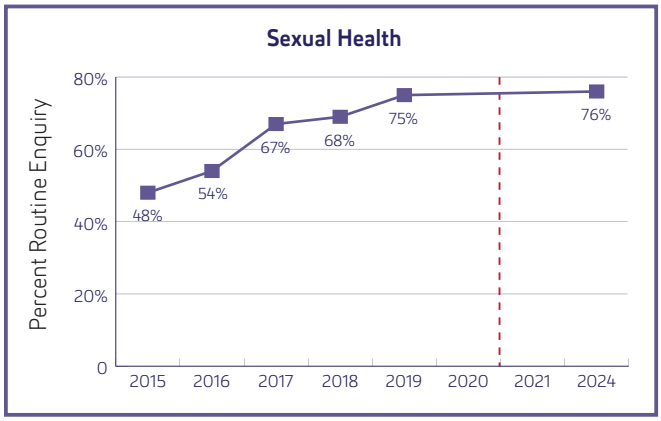
- Sexual health services is the sole VIP service area that is nearing the IPV target assessment rate of 80%. The 95% CI has included the target of 80% routine enquiry rate consistently across the most recent three audit periods 2018 – 2024.
- The sexual health service IPV disclosure rate has varied between 10% and 20%. The expected disclosure rate of 15% has been achieved most years (included in 95% CI in all years except 2018).
- Historically, the completed IPV routine enquiry rate within the intake assessment for women and young women 16 years of age and older presenting as a new client to community mental health services hovered around 46%. In 2024, however, the rate dropped to 37%, indicating a notable decline in routine screening practices.
- IPV disclosure rates in community mental health services have been maintained over time at the expected rate of 25%.
- Approximately one in every two women referred to alcohol and drug services is assessed for IPV. While the rate dropped to 49% in 2024, it was still within the margin of error.

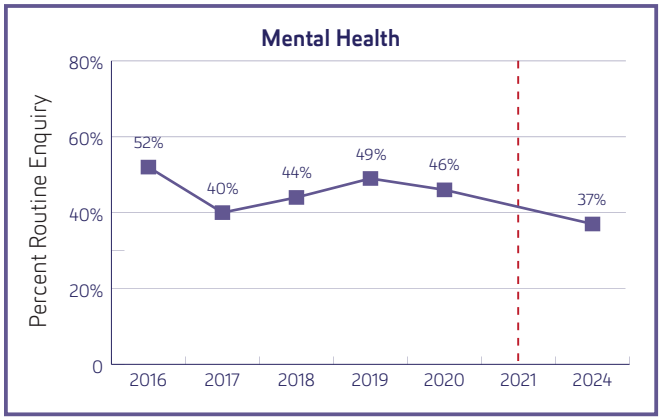
IPV disclosure rates in alcohol and drug services have been maintained over time at the expected rate of 25%.

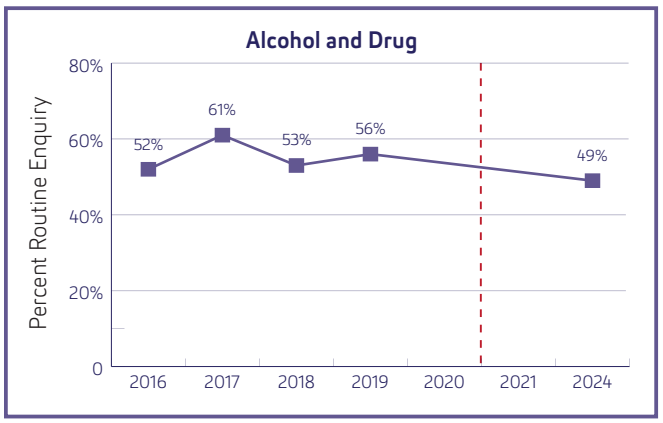
Image: Cathedral Cave. Michael/stock.adobe.com

Figure 6. National Rates of IPV Routine Enquiry and Disclosure in Community Sexual Health, Mental Health and Alcohol & Drug Services 2015–2024 (April–June Quarter)

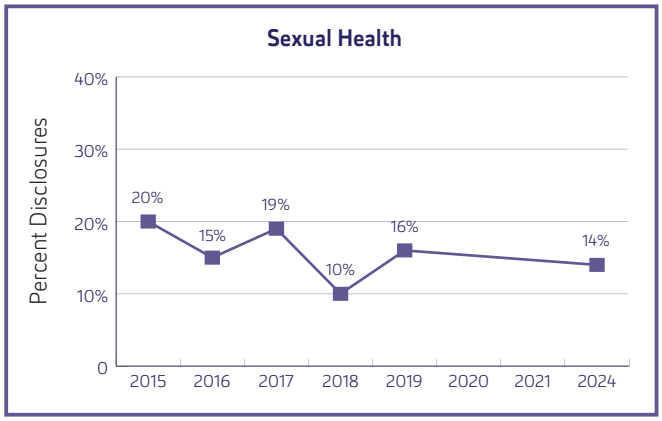
a. Routine Enquiry Rates

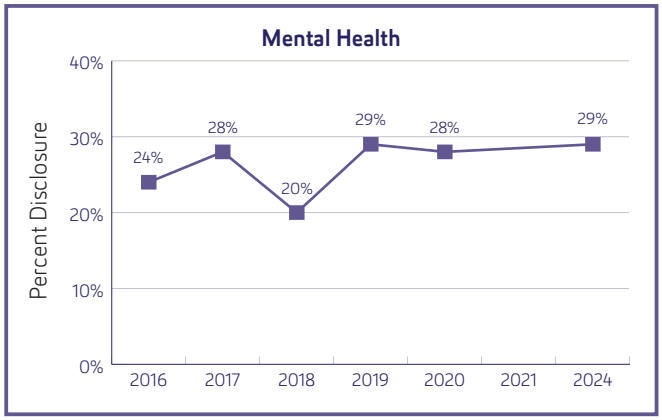


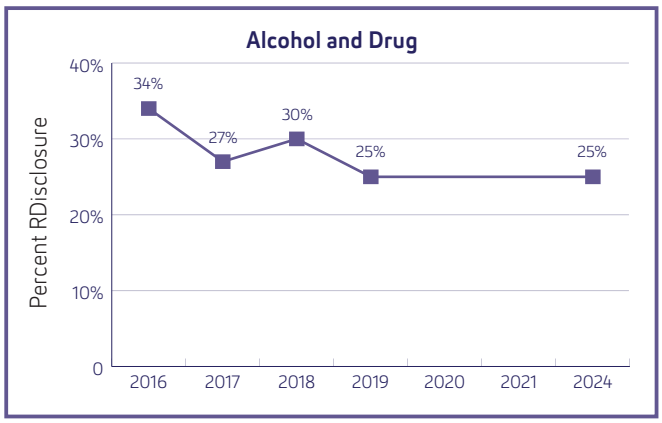




b. Disclosure Rates







Notes: For women ≥16 years of age; weighted means based on eligble population; disclosure rates among women with a completed assessment; 2021 data for service included if > 5 districts reporting; dotted red line represents time series interruption. See Appendix E for specific eligibility criteria and Appendix G for tabular data including 95% confidence intervals.

The data for IPV routine enquiry and disclosure for women ≥16 years of age in acute health services are provided in Appendix H and Figure 7.

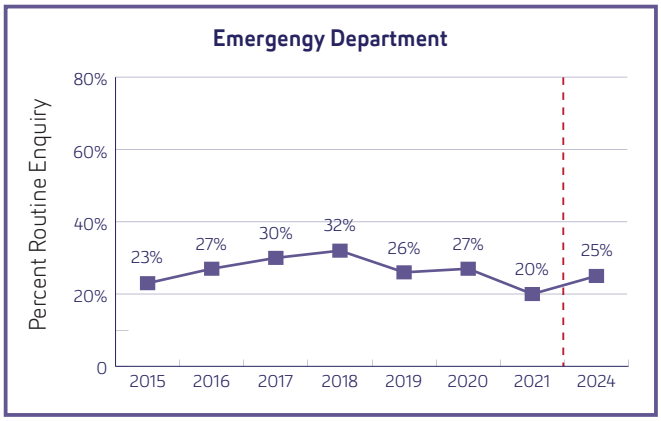
- Approximately one in every four women 16 years of age and older presenting to the emergency department receive an IPV assessment. While there was a promising increase in the assessment rate each year 2015 to 2018, the trend did not continue.
- Since 2019, fewer than 1 in 10 women asked about intimate partner violence (IPV) during an emergency department visit disclosed abuse. These rates are similar to the rate of disclosure in 2015, the first year of routine enquiry implementation in the emergency department and well below the 15% expected rate of disclosure.
- The trend of increasing rates of IPV routine enquiry for women admitted to hospital post-natal maternity services from 2015 peaked in 2018 at 62%, followed by three audits of decreasing rates. In the most recent audit (2024), the rate of IPV assessment fell to one in four women (24%).
- Among women admitted to post-natal maternity who were asked about IPV, between 2% and 8% disclosed over time. The disclosure rate dropped sharply in 2021 (to 2% for the 7 reporting districts) disclosure rebounded to 8% in 2024.
- During child health hospital admissions, one three women caregivers receive an IPV assessment for IPV. The proportion of women asked in 2024 is similar to the proportion screened ten years ago, in 2015.
- Of concern, among the women who were assessed for IPV the disclosure rate dropped to 2% in 2024. This is the lowest disclosure rate since clinical audits began and well below the 11% rate achieved in 2018 and 2019.

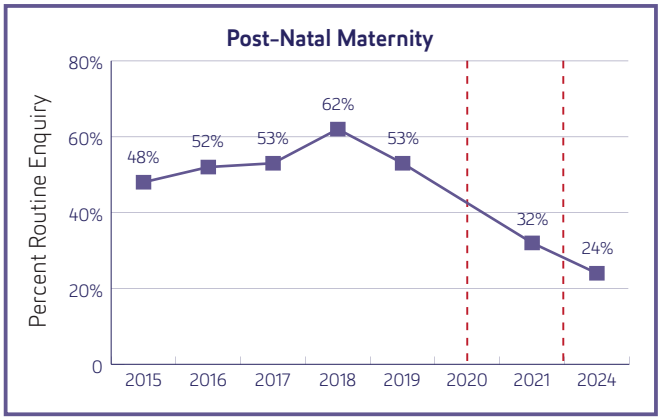
Among women who disclose IPV across the six services, 69% received a referral to a specialist service. Referrals are categorised as either active (on-site) or passive (off-site). Among all referrals, the proportion active ranged from 70% in sexual health services to 33% in the emergency department (Figure 8). The low rate of active referrals in the emergency department indicates a need for increased hospital-based services that can be offered by social workers or through contracts with community services.

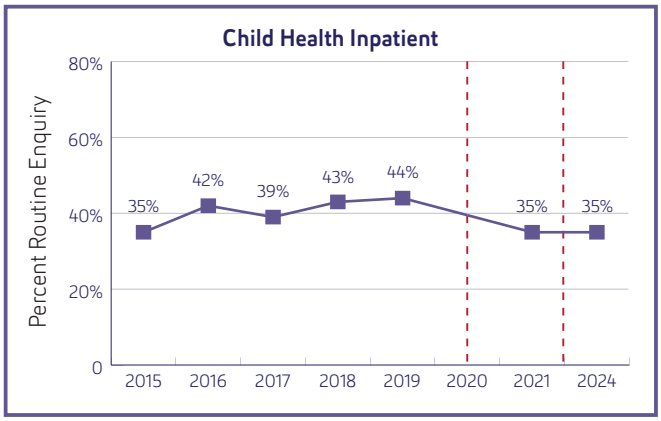
Image: Dragana Gordic/stock.adobe.com

Figure 7. National Rates of IPV Routine Enquiry and Disclosure in Acute Hospital Services (Emergency Department, Post-Natal Maternity, Child Health) 2015–2024 (April–June Quarter)

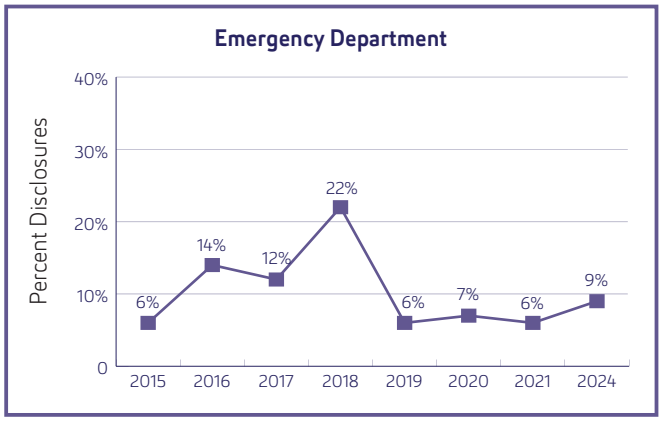
a. Routine Enquiry Rates

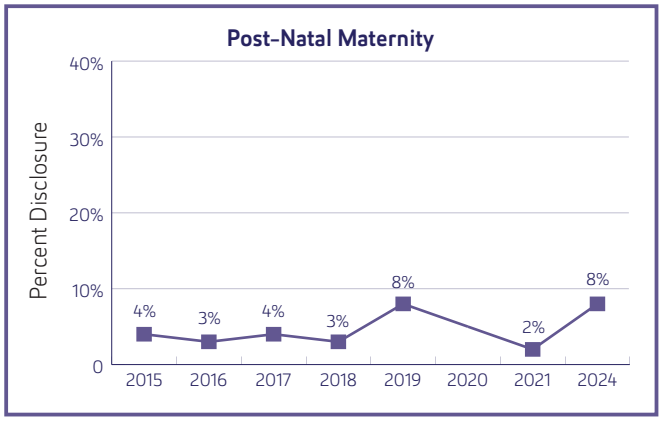


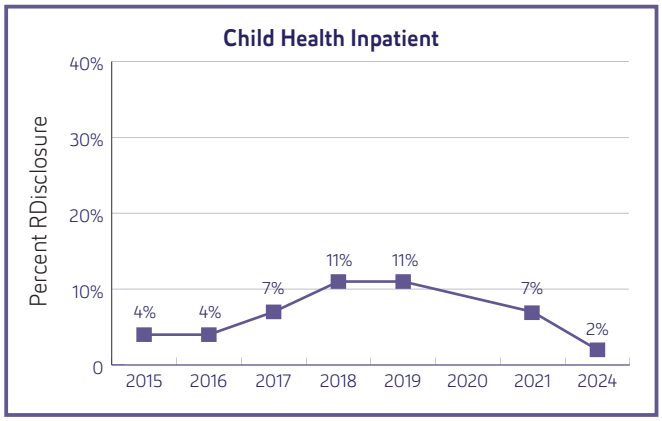




b. Disclosure Rates

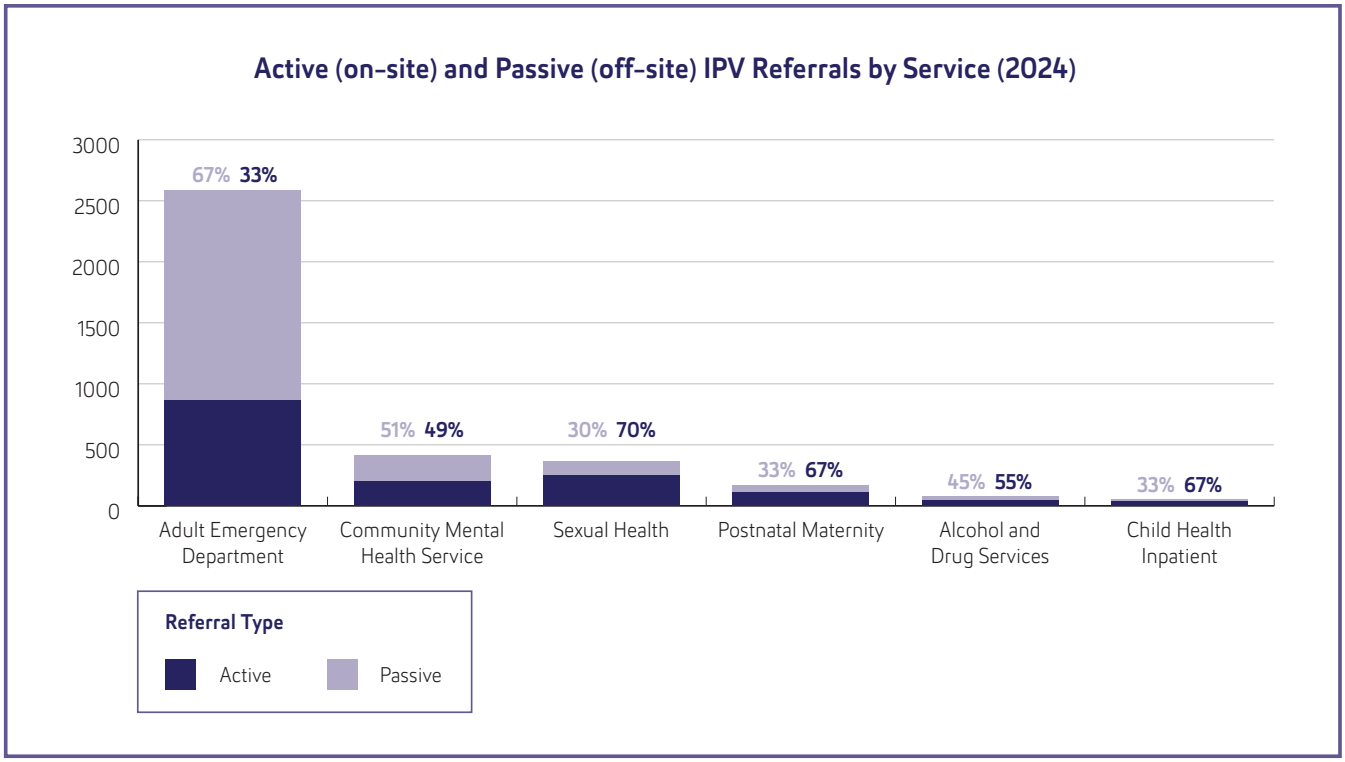






Notes: For women ≥16 years of age; weighted means based on eligible population; disclosure rates; disclosure rates among women with a completed assessment; 2021 data for service included if > 5 districts reporting; dotted red line represents time series interruption. See Appendix E for specific eligibility criteria and Appendix H for tabular data and 95% confidence intervals.

Figure 8. Active (On-Site) And Passive (Off-Site) Ipv Referrals By Service (2024)



Estimates of the number of people receiving VIP service nationally

Extrapolating from the random sample of clinical record audits, we provide the following national estimates of VIP service delivery for the three-month period (April – June 2024).

Nationally, we estimate that a total of 10,757 emergency department visits by children under 2 years of age during the period included documented assessments for child protection concerns (Appendix G). Of these:

- 190 visits involved a child protection concern.
- 152 visits resulted in a specialist consultation.

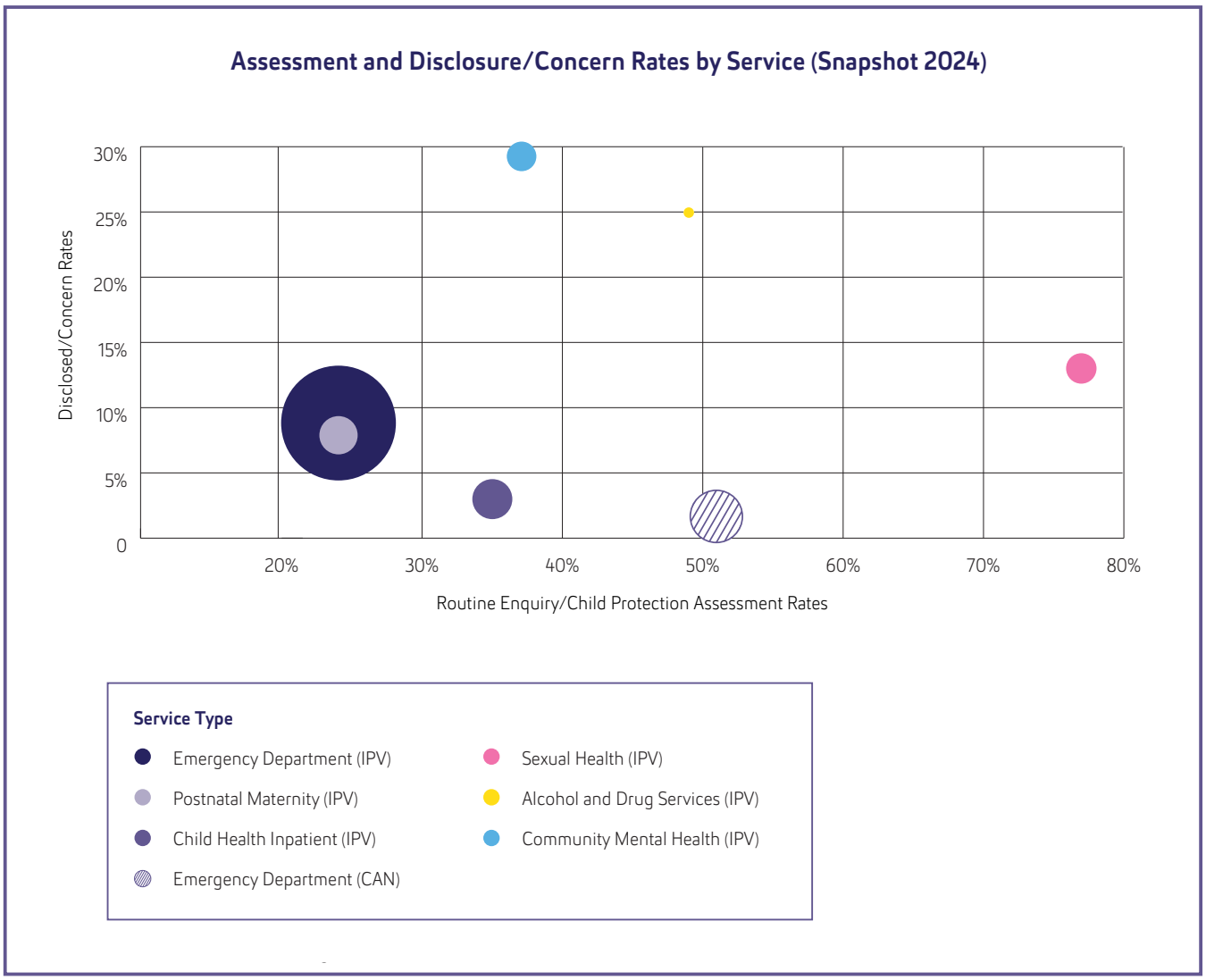
Nationally, we estimate that a total of 59,415 visits by women aged 16 years and older included documented assessments for intimate partner violence (IPV) within one of the six services implementing the VIP programme (Appendix H). Of these:

- 8,937 visits involved women disclosing experiences of IPV; an important step toward receiving help.
- 6,174 visits resulted in connecting a woman with specialist support services.

These numbers reflect the current scale of the programme's reach across selected health services. When VIP services are delivered, they provide an opportunity for children and families at risk to receive the attention and support they need and for women to step towards safety and support.

Figure 9 demonstrates the average IPV assessment and disclosure by service. The figure references the size of the eligible population for each service. While women seeking care in sexual health services are more likely to receive an IPV assessment (77%) compared to women in emergency services (29%), the population size is vastly different (approximately 25K vs 538K respectively). Improvements in emergency services, therefore, have the potential to support a large number of women.

Figure 9. Assessment and Disclosure/Concern Rates by Service (Snapshot 2024

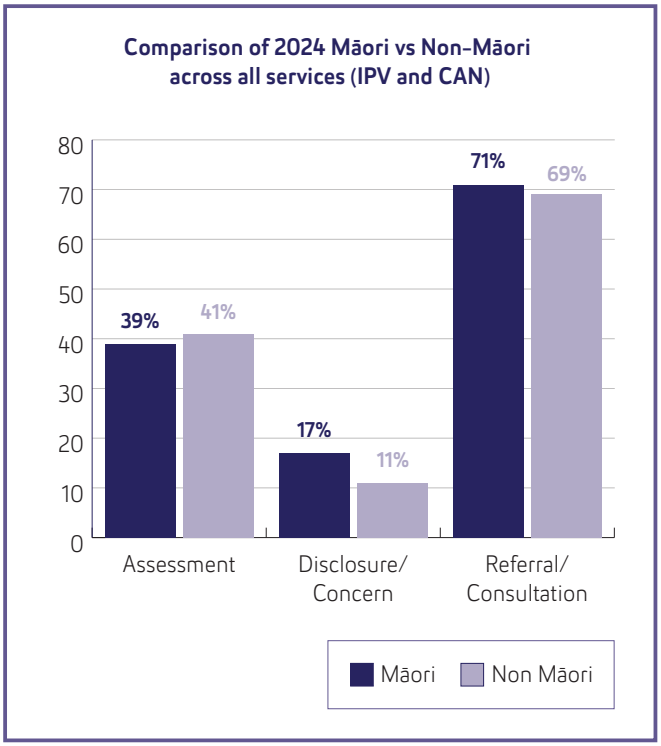


Notes: Bubble size represents eligible population for each service. Samples include women ≥ 16 years or children < 2 years (child protection ED).

Service delivery by Māori and non-Māori

Māori (prioritised ethnicity) accounted for 28.6% (975/3413) of the total Snapshot sample in 2024. The 2024 aggregated data across services demonstrates similar assessment (39% v 41%) and referral rates (71% v 69%) for Māori and non-Māori (Figure 10). Family violence identification rates, however, are higher for Māori compared to non-Māori presenting to the targeted health services (17% v 11%).

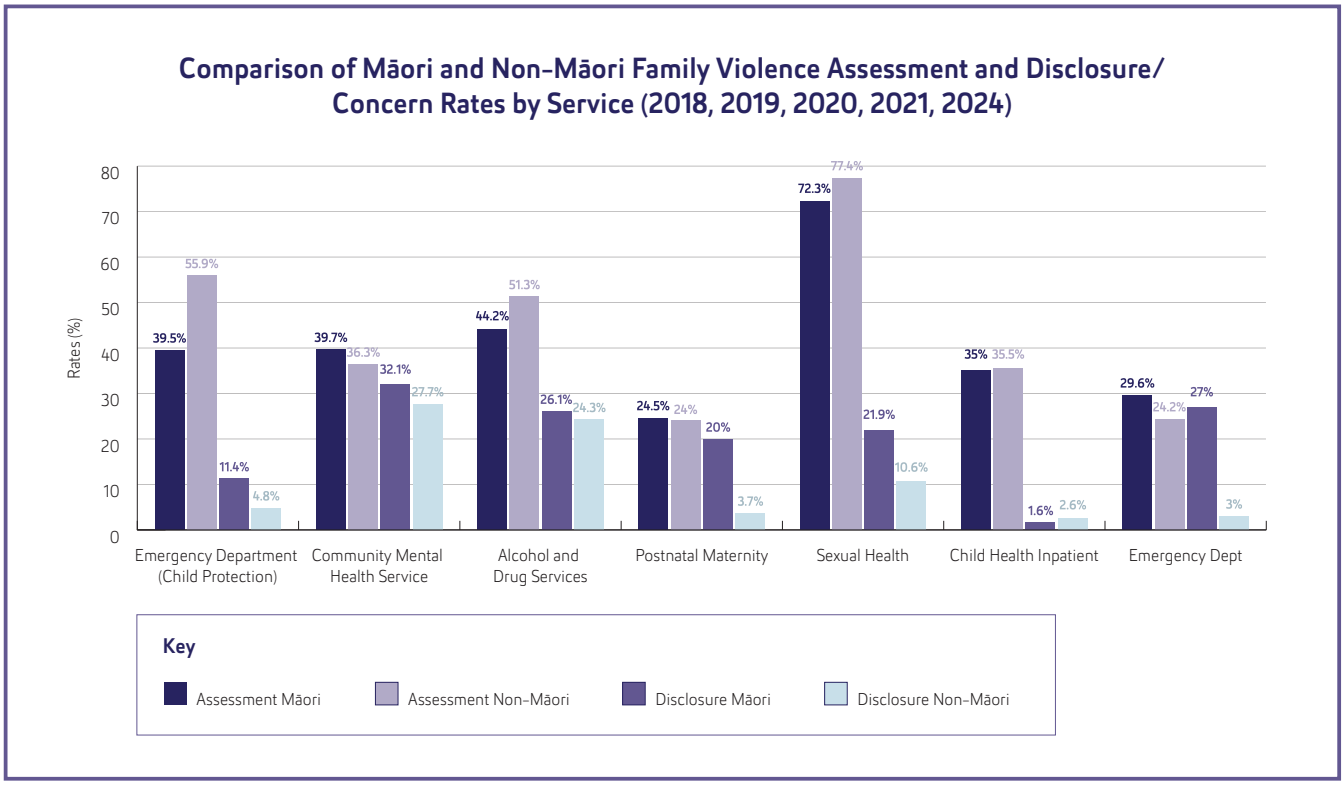
Figure 10. Comparison of 2024 Māori vs Non-Māori across all services (IPV and CAN)



Disaggregated service-level sample sizes were inadequate to provide robust estimates for 2024 data. We therefore combined service-level data across five snapshot audits (2018, 2019, 2020, 2021 and 2024). Data for all locations was available in four of the five years. All services were included in three of the years (2018, 2019, 2024). Data reveals several important disparities in family violence assessment practices between Māori and non-Māori (Figure 11, Table 3):

- Child protection assessment in the emergency department shows the largest disparity in assessment rates. Only 40% of Māori children under 2 years were assessed using the child protection checklist, compared to 56% of non-Māori—an absolute difference of 16 percentage points.
- Routine enquiry for intimate partner violence (IPV) was also lower for Māori in:
  - Alcohol and Drug services (44% Māori vs 51% non-Māori; 7-point difference)
  - Sexual Health services (72% Māori vs 77% non-Māori; 5-point difference)
- In contrast, Māori had higher IPV enquiry rates in the Emergency Department (30% Māori vs 24% non-Māori; 6-point difference), suggesting variability in practice across settings.
- Sexual Health was the only service where both Māori and non-Māori approached the target IPV enquiry rate of 80%, with 72% for Māori and 77% for non-Māori.
- There were notable differences in family violence identification between Māori and non-Māori, with higher identification for Māori in 6 out of the 7 services.
- In the emergency department, a child protection concern was identified in 11% of visits by Māori children, compared to 5% for non-Māori – more than double the rate. Importantly, this disparity exists alongside the disparity in family violence assessment, where Māori children under 2 years old were less likely to be assessed (40%) compared to non-Māori (56%) children.
- The greatest differential rates of intimate partner violence disclosure occurred in:
  - Emergency department: 27% Māori vs 3% non-Māori (24-point difference)
  - Post-natal maternity: 20% Māori vs 4% non-Māori (16-point difference)
- Specialist consultation and referral rate estimates for Māori compared to non-Māori should be interpreted with caution due to limited case numbers in which family violence was both assessed and identified. These estimates are therefore considered tentative (Table 2).
- Among child visits where a child protection concern was identified, all Māori children received specialist consultation, compared to 75% of non-Māori—suggesting a more consistent response for Māori in this context.
- Among women who disclosed intimate partner violence, Māori caregivers of hospitalised children were more likely to receive a specialist referral than non-Māori (100% vs 67%), indicating a potential disparity in follow-up support.

Figure 11. Comparison of Māori and Non-Māori Family Violence Assessment and Disclosure / Concern Rates by Service (2018, 2019, 2020, 2021, 2024)



Notes: Intimate partner violence for women ≥16 years of age; child protection for children <2 years of age. Only partial data was available for 2020 (only IPV in ED and CMH and Child Protection in ED required) and 2021 (locations self-selected participation in snapshot).

Table 3. Comparison Of Māori And Non-Māori Family Violence Assessment, Disclosure/Concern, Consultation/Referral Rates And Absolute Difference By Service (2018, 2019, 2020, 2021, 2024)

Service	Child Protection Emergency Dept	Community Mental Health	Alcohol and drug	Postnatal Maternity	Sexual Health	Child Health Inpatient	Emergency Department	IPV (All services)
Assessment								
Māori	39.5%	39.7%	44.2%	24.5%	72.3%	35%	29.6%	39.1%
Non-Māori	55.9%	36.3%	51.3%	24%	77.4%	35.5%	24.2%	37.8%
Absolute Difference	-16.4%	3.4%	-7.1%	0.5%	-5.1%	-0.5%	5.4%	1.3%
Concern/Disclosure								
Māori	11.4%	32.1%	26.1%	20%	21.9%	1.6%	27%	20.7%
Non-Māori	4.8%	27.7%	24.3%	3.7%	10.6%	2.6%	3%	12.8%
Absolute Difference	6.6%	4.4%	1.8%	16.3%	11.3%	-1%	24%	7.9%
Consultation/Referral								
Māori	100%	61.1%	66.7%	85.7%	62.5%	100%	90%	70.3%
Non-Māori	75%	73.7%	69.7%	75%	50%	66.7%	100%	68.3%
Absolute Difference	25%	-12.6%	-3%	10.7%	12.5%	33.3%	-10%	2%

Notes: Intimate partner violence for women ≥16 years of age; child protection for children <2 years of age. Only partial data was available for 2020 (only IPV in ED and CMH and Child Protection in ED required) and 2021 (locations self-selected participation in snapshot). Data referent to the April – June quarter in each of the years.

Service delivery by Ethnicity

The VIP intimate partner violence service for women ≥16 years presenting to the six target services using a total response ethnicity analysis (women included in each ethnic group reported) is shown in Figure 12. Data met our threshold (sample of >5) for New Zealand European, Māori, Pacific Peoples, Asian and Other Ethnicity. We acknowledge ethnicity coding at level 1 masks the heterogeneity of ethnicities within a category, so our conclusions are muted. In addition, we report raw rather than weighted population adjusted rates, due to lack of eligible population sizes by ethnicity.

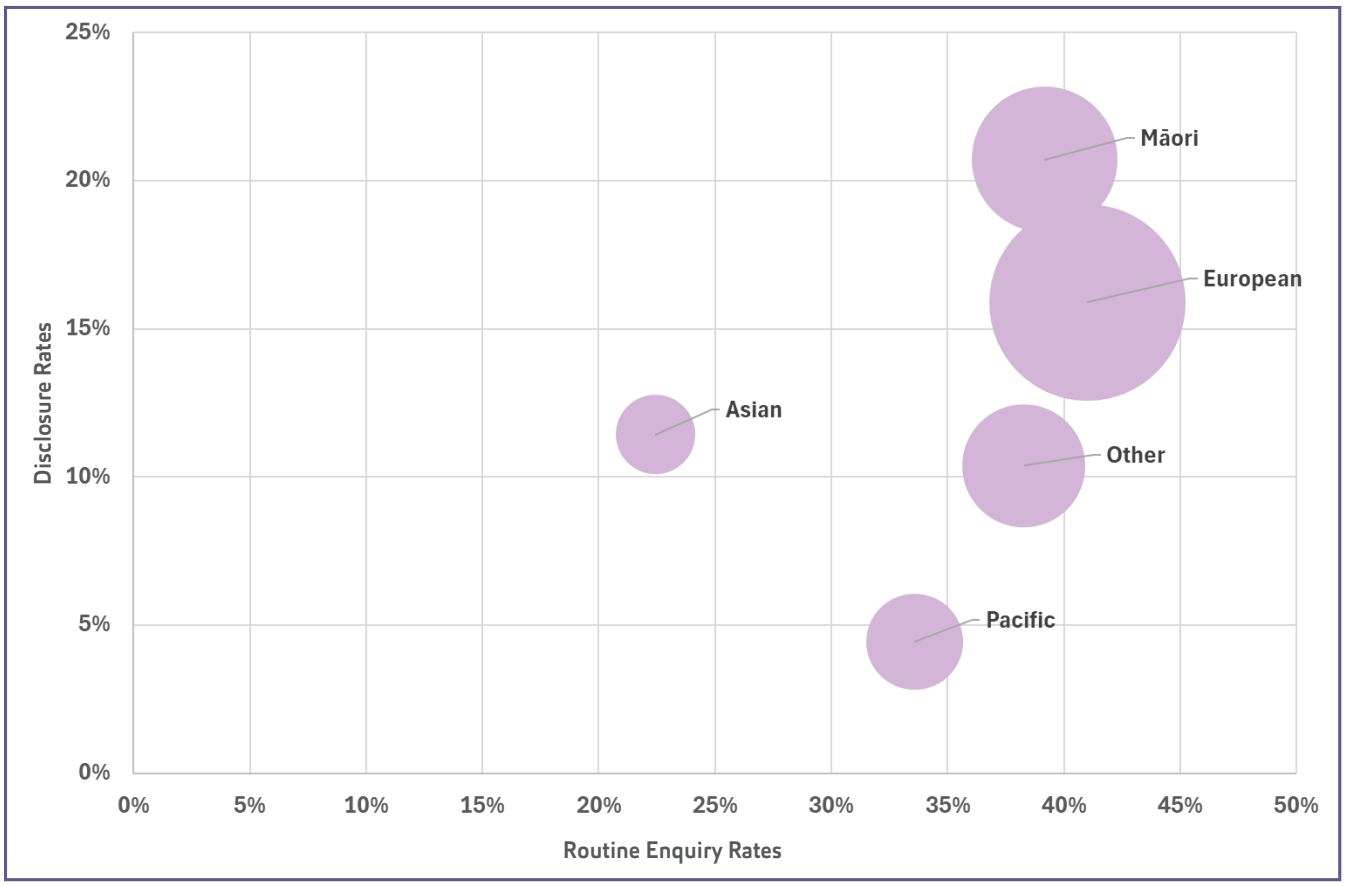
Average routine enquiry rates were highest for European women, followed by Māori women, women of 'other' ethnicity, Pacific women and Asian women. Average disclosure rates among women were highest for Māori, followed by European, Asian, 'Other' ethnicity and Pacific.

The small sample sizes by ethnicity for 2024 child protection data prohibited confidence in estimates and are therefore not presented.

Tuakana-Teina model feedback

The tuakana-teina approach between evaluation team members and VIP coordinators embodied the concept of ako: offering rich exchanges of collective ideas, building on both the coordinators and evaluation team members knowledge and experience, while strengthening collegiality and relationships. Through these relationships, the evaluation team gained insights into localised resources and innovative approaches that had the potential to benefit other coordinators and the VIP more widely. Creative strategies for enhancing effectiveness when working with Māori were also explored. We found ourselves in our growth zone—challenging our thinking, embracing curiosity, and questioning what we know (or think we know)—unlocking new potential for strengthening VIP, particularly when considering how to translate the knowledge shared within the tuakana–teina framework into meaningful actions to strengthen the role and presence of VIP in acute care settings. Teina feedback identified the connection with tuakana was useful and they recommended that the model be continued for new coordinators. They also wanted the opportunity in future audits to comment on their local context, opportunities for innovative approaches, and what influences their audit results.

Figure 12. Intimate Partner Violence Assessment And Disclosure By Ethnicity (2024)



Infrastructure and Clinical Performance Associations

Our final evaluation question sought to examine the degree, or if, greater infrastructure led to improved clinical performance. We examined associations (spearman correlations) between the total Delphi infrastructure scores from 2022 and snapshot assessment and concern/disclosure rates from 2024.

For child abuse and neglect, the correlation between the total Delphi score and the rate of child protection assessment is 0.21, which is not statistically different from 0 (p=0.39). The correlation, however, between the total Delphi score and child protection concern rates is 0.46, a moderate correlation which is statistically different from 0 (p=0.036). In both cases, the correlation was in the expected direction, with higher infrastructure scores associated with higher child protection assessment and concern rates.

For intimate partner violence, the correlation between the total Delphi score and routine IPV enquiry is –0.005, which is not statistically different from 0 (p=0.98). The correlation between total Delphi score and IPV disclosure rates is 0.16, which is not statistically different from 0 (p=0.50).

Lack of correlation could be due to changes in time between the Delphi audit in 2022 and the Snapshot audit in 2024.

DISCUSSION

COVID-19 Pandemic Response

VIP teams demonstrated resilience and adaptability during the unprecedented period of the pandemic, successfully navigating typically rigid health system bureaucracies. Rather than relying solely on mandated, manualised approaches—which, while designed to minimise risk, may inadvertently increase it if lacking flexibility—the teams revitalised systems, approaches, and services. Their capacity to routinely manage uncertainty and innovate in response to evolving needs represented a significant and valuable contribution to service delivery. In some cases, innovation has been sustained post-pandemic, such as virtual interagency meetings, where the pandemic signalled a crash course for VIP teams in Zoom and Microsoft Teams. In many ways however, there has been a pull to the pre-pandemic status quo, raising the question of how we sustain flexibility and innovation. Herzlinger et al (2023) in 'Maintaining health care innovations after the pandemic' referenced a quote attributed to Winston Churchill, 'we should never let a good crisis go to waste'. This report is an opportunity to reflect on our systems and how flexibility and innovation are needed to move forward in improving health responsiveness to family violence.

System Infrastructure

Although the infrastructure Delphi tool is intentionally aspirational, the 2022 median score of 57 (possible range 0–100) is notable, given over a decade of VIP development and implementation. This score is lower than the median of 63 observed in Victorian hospitals' similar SAFE tool administered during the early stages (first two years) of their Strengthening Hospital Responses to Family Violence initiative (Kyei-Nimakoh et al., 2025; McKay et al., 2021)[f]. These findings suggest that despite sustained efforts, there remains significant room for growth in embedding robust infrastructure to support family violence responses.

Low scores in organisational leadership and governance – evident in both Aotearoa New Zealand and Victoria – underscore a shared challenge. Reflecting findings from Victoria, we reinforce the urgent need for a cohesive strategy that actively engages senior leadership in health to take ownership and drive the success of family violence programmes (Kyei-Nimakoh et al., 2025). Without senior health system leadership and resourcing, those working within the Violence Intervention Programme are largely constrained in their ability to effect meaningful and positive change in violence intervention work (Eppel et al., 2025).

Despite significant evidence linking family violence to long-term physical and mental health outcomes, its role as a critical social determinant of health is often overlooked in national policy. This lack of recognition is apparent in our national Te Aorerekura strategy, where the contribution of the health system to family violence prevention, healing and responsiveness could be strengthened. While the Health and Disability Services Standards include 'I am protected from abuse and revictimization' and 'My service provider shall have effective safeguards to protect me from abuse and revictimization' (standard 1.5 and 1.5.2 (Ngā Paerewa Health and Disability Services Standard, 2021)), we are not aware of remedial structural actions despite repeatedly not being achieved.

The need for senior health leadership attention was reflected in our COVID-19 interviews, as one participant noted:

> "There's actually some real systemic issues within the organisation that are problematic and hinder progress and traction and probably stems right from the top, lack of priority given to VIP.

[f] The Strengthening Hospital Responses to Family Violence (SHRFV) is a system-wide approach aimed at enhancing the health sector's response to family violence in Victorian hospitals (McKay et al., 2021). Adapting the Delphi infrastructure tool for their context, they reported data across two administrations of the System Audit Family Violence Evaluation (SAFE) tool as they implemented their programme (Kyei-Nimakoh et al., 2025; McKay et al., 2021). In the second administration (2023-2025), sites had an option to participate in the SAFE – Lite tool (n=9; which did not include clinical audit data) or SAFE (n=11; included clinical audit of IPV routine enquiry, disclosure and referral). Overall, SAFE tool scores in the second administration were 71 (SAFE Lite tool without patient clinical audit) and 63 (SAFE tool including patient clinical audit – similar to the New Zealand Delphi tool).

Service Delivery

With the current system infrastructure, the 2024 average assessment rate was 38% for intimate partner violence (IPV), with the Māori and non-Māori rates similar (39% and 41% respectively). This suggests that while a significant number of women are being assessed and given the opportunity to disclose abuse, many more, both Māori and non-Māori, are missing critical opportunities for early identification and support during healthcare encounters. Average IPV assessment rates ranged from three out of every four women in community sexual health services, to one out of every four women in postnatal maternity and emergency services, evidencing ad hoc, inconsistent service delivery.

Despite over a decade of efforts to improve family violence responsiveness in targeted services, the IPV routine enquiry target rate of ≥80% was achieved in only 15% of service locations across Aotearoa New Zealand in 2024. This compares to 45% of sites with mandatory IPV screening in the Victorian evaluation[9] achieving the same target, for a programme that began in 2021 (Kyei-Nimakoh et al., 2025). Māori assessment rates were also disproportionately lower in comparison to non-Māori for child protection assessment within emergency departments and intimate partner violence assessment in alcohol and drug services. In the 2024 Aotearoa New Zealand clinical snapshot audit, sexual health service was the only service in which 50% of the districts achieved a routine enquiry rate ≥80 for both Māori and non-Māori.

Disparities in family violence health responsiveness can stem from multiple and complex factors, including provider bias and systemic mechanisms. For instance, non-Māori health providers may feel more confident assessing non-Māori patients for family violence, influenced by a bias that people like themselves are less likely to be affected. This expectation of a negative disclosure may inadvertently reduce the likelihood of inquiry with Māori patients. To address these inequities, conducting Kaupapa Māori research and over-sampling Māori are two approaches that may deepen our understanding of the extent and how personal and systemic biases influence practice .

In the 2024 Snapshot period, the average child protection assessment rate for children under two years of age presenting to the emergency department was 50%—somewhat higher than the rate for intimate partner violence (IPV) assessments (38%). Among the children assessed – approximately one in every two – only 2% had a concern identified. This marked the lowest recorded concern rate since Snapshot audits began in 2014. This is despite Aotearoa New Zealand police family harm call outs increasing by 49% from 2017 to 2022/2023 (New Zealand Police, 2023), with one or more children present at nearly two-thirds of family harm call outs. The Snapshot data highlights a significant gap in the identification and assessment of child safety concerns. It also reflects a missed opportunity to engage with families and whānau in a way that is both sensitive and supportive, with the potential to strengthen protective factors and promote wellbeing.

The nationwide estimated IPV disclosure rate is 15% across the six services. This rate, however, is influenced by the community-based services. Higher disclosure rates of intimate partner violence (IPV) within sexual health, mental health, and alcohol and drug services compared to the acute care services are likely to reflect firstly, the strong association between family violence and poor sexual, mental, and substance-related health outcomes and secondly, the settings' culture of wholistic assessment offering a supportive context in which women may disclose abuse. These services represent critical priority settings for family violence intervention and support. The largest impact on improved service delivery, however, would occur for the emergency department, being the service with the largest volume of women presenting for care.

Examining the average rate of family violence service delivery across all services and districts, there has been minimal change over time. This stagnation is concerning, as we should expect a consistent and sustainable increase year-on-year. This highlights widespread underperformance across most regions, particularly in the acute hospital services. As a participant commented about the impact of the COVID-19 pandemic, 'The challenges are the same whether COVID's there or not... everyone sort of wonders if there have been more IPV reports identified or more reports of concern... that hasn't changed in my services. They still perform poorly. They still don't actually screen routinely' (Koziol-McLain et al., 2023, p. 9). We note that the resources allocated to the VIP have remained constant over time and family violence responsiveness has not been a priority within health strategies or leading health policy. We do not have a health target for family violence assessment and response, and we do not have the necessary measurement tools for nationwide surveillance.

More consistent implementation of family violence assessment and response protocols are urgently needed to ensure consistent, sensitive and quality care across all health service areas. Without health leadership declaring family violence a critical determinant of ill health, change in service delivery is unlikely and the human, social and economic costs of family violence will continue.

[9] Clinical audit data from the Victorian SAFE tool application in 2023-2025 Kyei-Nimakoh, M., Hegarty, K., Morris, A., and McLindon, E. (2025). The System Audit Family Violence Evaluation (SAFE) Project Expanded.

Māori health Equity

The family violence assessment data reveals that both Māori and non-Māori women and children are underserved. However, the disproportionately higher rates of IPV disclosure among Māori women and concern for Māori children under 2 years of age, coupled with low assessment rates, highlight a significant and unmet need. This disparity signals systemic barriers that work to prevent Māori from receiving timely and appropriate support, resulting in missed opportunities for essential services and the underserving of whānau Māori in the context of family violence intervention. The urgency of this issue is amplified by the disproportionate increase in familial homicide rates among Māori compared to non-Māori women and girls between 2018 and 2020 (He Mutunga Kore | National Mortality Review Committee, 2025a). For children under the age of 4 years, the rate of Māori children killed was four times higher compared to the rate of non-Māori children killed between 2009-2015 (Family Violence Death Review Committee, 2017). The unmet need, produced by the health system, among Māori experiencing family violence sits alongside multiple barriers in accessing affordable, available and appropriate health services in general, including mental health services (Te Hiringa Mahara, 2024).

The inequities reflected in clinical snapshot data, the limited engagement with Māori highlighted in qualitative findings from the COVID-19 pandemic, and the low cultural responsiveness scores in the Delphi infrastructure audit collectively point to a troubling lack of resources, and lack of capacity and capability within the health system to ensure culturally safe and responsive VIP services. These findings underscore the urgent need for systemic change to uphold Māori health rights; including the right to access culturally safe, timely and appropriate health care services as well as the right to equitable health service access and health outcomes as part of ensuring a Tititi-compliant health system. The current systemic inequities require targeted strategies to ensure culturally responsive and accessible assessment pathways. To counter the systemic entrapment of unhelpful services for Māori, Wilson et al advocate - among other strategies – for a shift away from deficit based narratives about Māori women, towards recognising and valuing their inherent strengths, capabilities and potential (Wilson et al., 2019, p. 65). There is a need to strengthen how we attract Māori to engage in the development of culturally safe and responsive VIP services as well as how we enable a partnered approach to addressing the systemic issues, all of which requires a review of current resource and funding models.

Measurement Issues

The World Health Organization identifies a clear role for the health sector in addressing violence against women and children, including surveillance and health information system evidence (World Health Organization, 2024). The Aotearoa VIP snapshot clinical audits Guideline-informed intimate partner violence 12 month period prevalence indicator (Appendix D) is aligned with the Sustainable Development Goal indicator 'Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months' (United Nations General Assembly, 2017). While we have critical population data (Mellar et al., 2023), we are limited in health to the VIP snapshot data for surveillance due to the high burden of manual medical record review.

There is a critical need for development of a national health digital data plan for collecting family violence assessment, intervention and outcomes. While there are family violence related ICD codes (Rebbe et al., 2023), they are only available for people admitted to hospital and there has not been an improvement project to prioritise family violence coding in Aotearoa New Zealand that we are aware of. Accurate surveillance data over time is needed to respond to the problem of family violence as a critical determinant of ill health. As noted by the WHO (Krug et al., 2002, p. 247):

> "Establishing or enhancing national capacity to collect and analyse data covering the scope, causes and consequences of violence ...is necessary in order to set priorities, guide program design, and monitor the progress of the action plan.

To ensure robust and scientifically accurate data, it is essential to understand the data pathway – from clinical encounter to data platform – and to collect digital data routinely in a standardised manner.

Accurate family violence digital data included in minimum datasets, however, will not allow for comprehensive understanding of the influence of family violence assessment and support for those accessing health services. Alternative enquiry methods are needed, approaches that more accurately reflect people's realities and values. There is a pressing need for measurement that capture trends relevant to Māori and which uphold the integrity of Māori experiences, ensuring that data collection supports tino rangatiratanga (Te Mana Raraunga, 2018) and culturally grounded insights. Both Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples affirm Māori data sovereignty as an inherent right (Kukutai et al., 2023; Te Mana Raraunga, 2018). Māori authority over Māori data provides an opportunity for family violence data in health systems to meet Māori information needs, to more clearly understand and monitor inequities, and ultimately, to better support thriving Māori whānau, hapū and iwi.

Limitations

There are important limitations to be aware of when interpreting the data presented in this report. The scope of the evaluation is limited by the scope of the VIP. This means that we do not have evidence of service delivery beyond the six targeted services of VIP, which are largely urban, public tertiary acute care district hospital and community services. There are private health services as well as services provided in rural locations that are not represented in the snapshot data. Bias is likely introduced in excluding rural regions that have unique population characteristics and face unique challenges. In addition, the data is reliant on the rigour involved in identifying random samples and manual medical record review. Obtaining a list of random NHIs for audit from all eligible visits proved difficult in 2024 due to implementing the National Data Platform centralising health data. In addition, while some locations may have access to digital data, it is not standardised, with varying definitions and coding.

Our snapshot monitoring of clinical service delivery is limited by the sample size of 25 health records per service per location. This means that our current systems and processes for capturing and monitoring data and insights lack the robustness required to consistently incorporate a clear and coherent Māori narrative across all insights. Specifying actionable insights at the granular local or district level as well as across specific services, particularly for priority populations (e.g., Māori, Pacific, LGBTQI+), would require more complete datasets.

Finally, this evaluation did not integrate data from the National Child Protection Alert System (NCPAS). The health system's NCPAS provides an electronic flag to share information about a child protection concern. The system includes multi-disciplinary team (MDT) review and quarterly auditing (Kelly et al., 2020). Our de-identified Snapshot data does not provide information on the link between a child protection concern identified in the emergency department checklist (for children under two years of age), a Report of Concern to Oranga Tamariki (statutory child protection agency) and an NCPAS child protection alert.

Going Forward

VIP represents a health system model for responding to family violence that includes the structures reported in the literature to enable health practitioner best practice. These include, for example, policies and procedures, training, referral pathways, collaboration with community services and clinical champions (Garcia-Moreno et al., 2015; Hudspeth et al., 2022). Similar structures are attributed to VIP in the second Te Aorerekura Action Plan (2024), contributing to strengthening the workforce, "training to the tertiary health workforce to identify family violence, assess health and risk, and refer victims of abuse by developing training programmes, practice protocols, standardised documentation, support processes, posters, monitoring and evaluation" (Te Aorerekura: Action Plan 2025-2030, 2024, p. 30).

Our findings, however, identify that the current structures are insufficient to ensure an equitable, consistent, quality response to those impacted by family violence as they engage with the health system. While the opportunity for support from the health system is great, given peoples frequent engagement with health and the large health workforce, evaluation data suggests this opportunity is not being realised. While there is evidence of pockets of quality VIP service delivery, there remains unmet needs for women and children impacted by family violence. Further investigation into the conditions for success is needed. For example, how do practitioner characteristics such as commitment to addressing the issue of family violence (Hegarty et al., 2020) interact with system characteristics?

VIP is a programme that focuses on responding to family violence: identifying intimate partner violence and child abuse and neglect to provide a pathway for support and specialist services. Te Aorerekura, however, advocates that all three dimensions of the Tokotoru Model are necessary: responding, healing, and strengthening (Te Aorerekura The National Strategy to Eliminate Famly Violence and Sexual Violence, 2021, p. 34). This shift would signify a shift to best practice that is whānau centred, with a duty to care for all who are impacted by family violence across the life cycle while working closely with communities.

The learning from our COVID-19 qualitative interviews, Delphi infrastructure audit, site visits, and clinical Snapshot data informs a vision where:

- Family violence is recognised as a critical health issue by government and health professional leaders, with clear expectations for action.
- The health system response is adequately resourced to meet the scale and complexity of need.
- Culturally responsive VIP services are shaped through meaningful, collaborative, and reciprocal partnerships with Māori, Pacific peoples, and other communities.
- Community engagement is central to service design, delivery, and evaluation.
- Māori governance is actively supported and embedded across all levels of decision-making.
- There is no 'wrong door' across the health system—all services are equipped to provide appropriate support for those impacted by family violence.
- Innovation and flexibility are fostered, recognising the uncertainty and complexity inherent in systems change.
- Health services respond holistically, addressing immediate needs, strengthening protective factors, and supporting healing for all impacted.
- A digital family violence data plan is in place, providing insights to identify and remedy inequities.

Conclusion

The current health sector response to family violence in Aotearoa New Zealand reflects the efforts of many committed individuals. While there are notable examples of excellence, these remain unevenly distributed, and too many women and children—particularly Māori—continue to experience unmet needs and systemic inequities. The health burden of family violence is profound (Fanslow et al., 2024), and the status quo is insufficient.

Te Aorerekura outlines a transformative vision grounded in the voices of communities and experts. Realising this vision demands sustained health leadership, strategic investment, and institutional accountability. Yet, family violence intervention coordinators and their managers are often left to shoulder this responsibility with limited support—an effort akin to the mythologic Greek King Sisyphus endlessly pushing a boulder uphill.

As UN Women (2025, p. 5) emphasise, workforce training alone is not enough. A truly effective response must be coordinated, culturally grounded, age-appropriate, and survivor-centred. It must be embedded within systems that are accountable and collaborative. Without this, the promise of equity and safety for all remains out of reach.

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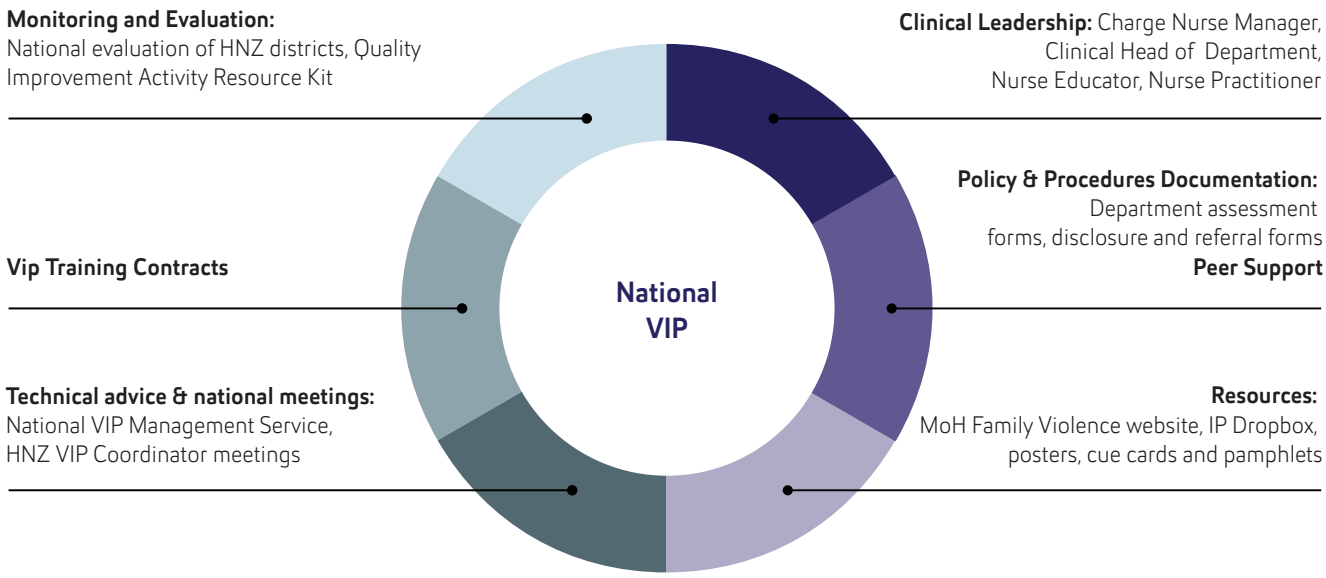
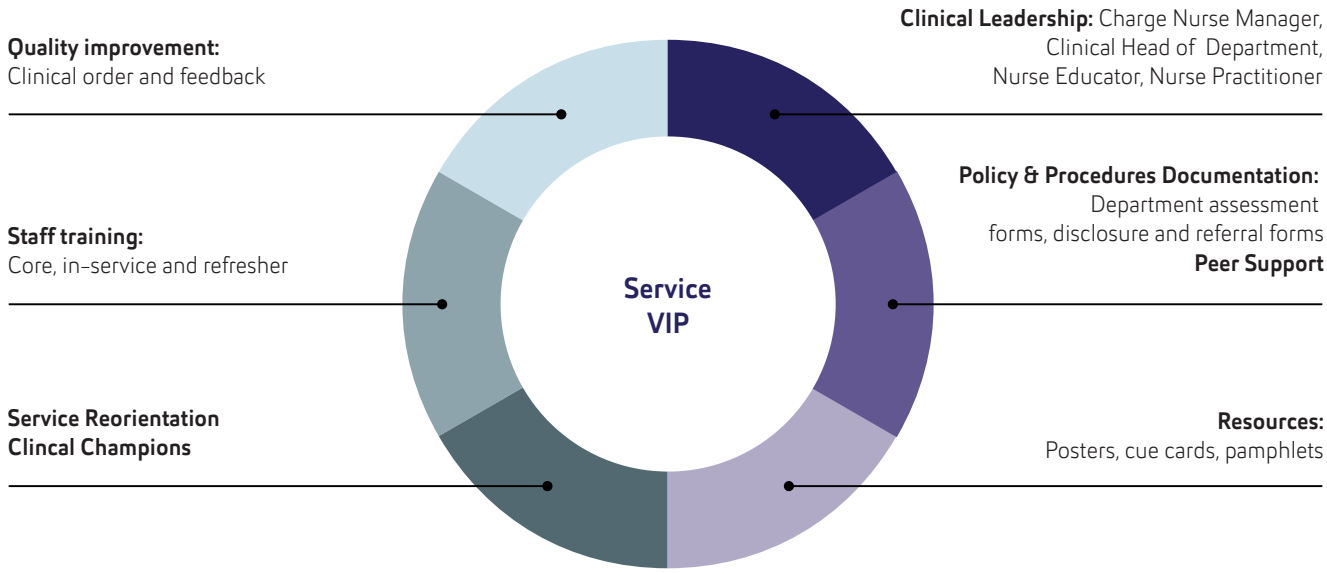
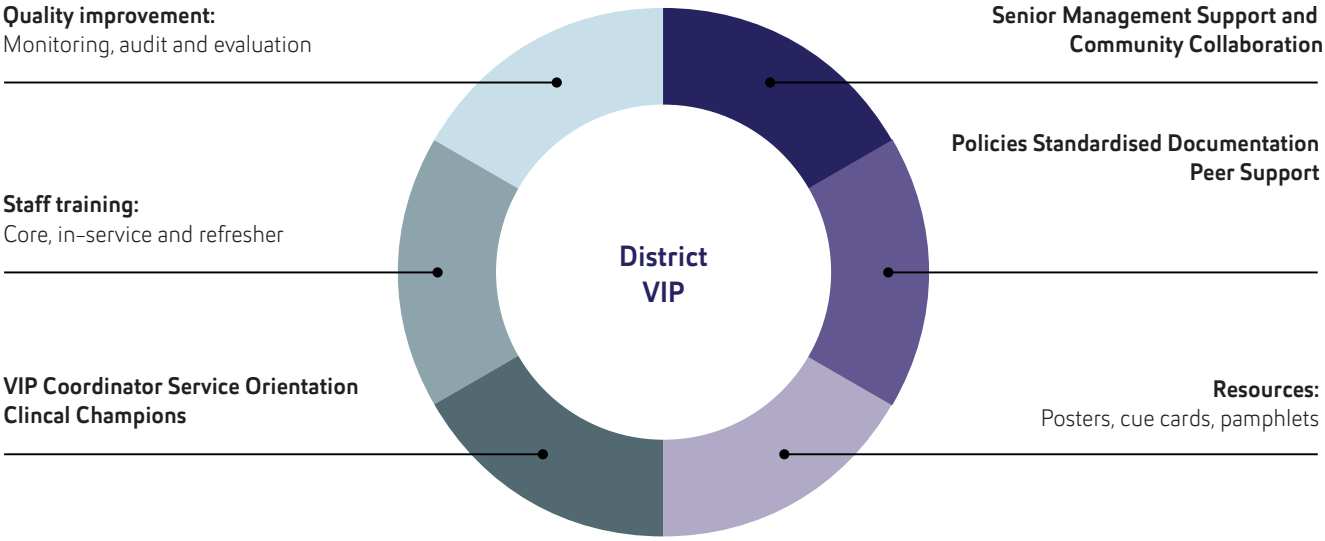
APENDICES

Appendix A. VIP System Tiers

Source: https://www.tewhatuora.govt.nz/health-services-and-programmes/family-violence-and-sexual-violence/establishing-a-violence-intervention-programme-vip and National VIP Management Service, Miranda Ritchie Miranda@healtnetworks.co.nz.
Note: Developed pre-health system restructure.






Quality improvement:
Monitoring, audit and evaluation
Staff training:
Core, in-service and refresher
VIP Coordinator Service Orientation
Clincal Champions
Senior Management Support and
Community Collaboration
Policies Standardised Documentation
Peer Support
Resources:
Posters, cue cards, pamphlets
District
VIP

Appendix B. VIP Evaluation Team Te Tiriti o Waitangi Accountability

During a wānanga in April 2025, the national evaluation team met to discuss and conceptualise how we collectively understood tino rangatiratanga among Māori as well as the WAI2575 identified principles of Te Tiriti o Waitangi. Example excerpts are provided here based on our wānanga and current understandings of the principles.

Tino Rangatiratanga is about recognising Māori sovereignty, autonomy, and self-determination both across the health system and in terms of whānau, hapū, and iwi wellbeing aspirations. In the context of VIP our recognition of Māori tino rangatiratanga requires critical consideration of Māori experiences of engaging with VIP both as service users and as members of VIP service delivery, training and evaluation. Specifically, engaging with Māori rights to Tino Rangatiratanga in our evaluation work required us to think about how we supported the realisation of Māori (iwi, hapū, whānau) health and well-being realities and aspirations as well as how Māori autonomy, equal power sharing and shared decision making would be enabled across the mahi of the evaluation team. At a practical level we recognised the need to ensure Māori voice across the evaluation mahi as well as ensuring Māori are involved in governance (co-governance) and as co-designers of both the evaluation work and in shaping VIP training and delivery. We acknowledge that our perspectives shape just small parts of what is encapsulated within Tino Rangatiratanga among Māori in the context of the health system and VIP services.

Partnership acknowledges Māori rights to equal power sharing and decision making across the "governance, design, delivery and monitoring of health and disability services" (Manatū Hauora, 2020). Partnership is built upon meaningful and genuine engagement with Māori, particularly mana whenua when working at a local level. We recognise there is work to be done in this space, for example, strengthening partnerships across VIP with mana whenua, Māori health and social service providers and among Māori engaged in the delivery of VIP. Such partnerships would strengthen Māori cultural responsiveness of VIP by (ideally) enabling pathways between VIP and local Maōri led solutions and supports for whānau requiring these.

We have encouraged the building of relationships between VIP and Māori. Upon inspection, however, we fall short of ensuring comprehensive mana whenua engagement across VIP evaluation services. For example, the development of the 2022 Delphi tool included Māori in the working group and many indicators refer to engagement with Māori. However, this engagement was not among iwi representatives or with mana whenua specifically. Rather, it simply ensured Māori representation, and indicators generally reference engagement with a Māori Health Unit (pre-health restructure) or 'local Māori health services' rather than iwi or mana whenua specifically.

Further, we acknowledge the diversity of health and well-being aspirations held among iwi, hapū and whānau Māori as well as the measures and outcomes important to Māori. During our wānanga we became cognisant that we didn't have a strong understanding of what these aspirations, measures and outcomes are, in the context of family violence prevention and support (or living free from the harms of family violence). Resultingly, we identified future work by the evaluation team could seek to explore how VIP and the evaluation team may draw on Māori voice more strongly, to support iwi, hapū and whānau aspirations, measures and outcomes to be embedded in our understanding of VIP services more clearly. This requires us to build partnerships, and to learn about iwi, hapū, whānau perspectives in order to inform more culturally safe and responsive violence intervention programmes as well as our role in accomplishing this.

There has been research and consultation with Māori about their aspirations for health, well-being and safety. It is reliant on us to learn from what has been shared. For example, in Denise Wilson's recent literature review (Wilson, 2023) (p. 153) she states:

> Wilson et al. (Wilson et al., 2019) found that both wāhine Māori and tāne often wanted someone who understood their reality, had lived it, and had successfully made the change. In addition, they needed someone who had aroha, displayed manaakitanga, and knew how to navigate the plethora of government and non-government agencies they were required to engage with.

We wonder, what does a VIP look like that enables the aspirations of Māori? Is it in the practice guidelines, in training, in monitoring. What about at the coal face? Whānau-centred care? Relationships? How do we support Kaupapa Māori services that are available? How do we appreciate the diversity of Māori, including differently abled, takatāpui, multiple heritages?

Equity is about recognising the need for different approaches and solutions to support the advancement of hauora Māori as well as a commitment to mitigating the barriers preventing Māori from experiencing equitable access, experiences and outcomes in the context of VIP. Consideration of equity required us to be purposeful in how we sought to identify and convey Māori inequities as we explored the VIP data and insights. Importantly, the principle of equity required us to consider the limitations of our data. VIP data does not measure outcomes for Māori, it does not provide iwi specific perspectives, nor does it provide insight into whether women feel heard, or whether they gain knowledge about how to respond to or seek support for family violence. As a result of data limitations, it is challenging to identify and address Māori inequities within the context of VIP and family violence response. A key contribution we can make is to disaggregate our data by ethnicity to consider Māori specific insights as well as ensuring we adopt a strengths-based and mana enhancing narrative to understand what inequities exist for Māori within the context of VIP.

Active Protection recognises the need to act "to the fullest extent practicable, to achieve equitable health outcomes for Māori" (Manatū Hauora, 2020). A large component of our evaluation work is about advocacy, including advocating for the centring of Māori voice, knowledge and contribution across VIP and within our evaluation work specifically. It requires us to critically consider the impact VIP may, or may not, have on supporting Māori health advancement and the achievement of Māori health equity. More specifically, it meant we approached the task of evaluation with a mindset that VIP must be culturally safe and responsive to Māori. Where we identified opportunities to strengthen cultural safety and responsiveness, we sought to advocate for change. All parts of the system can contribute – evaluation, training, coordination, funding – to strengthen culturally safe and responsive health service for Māori.

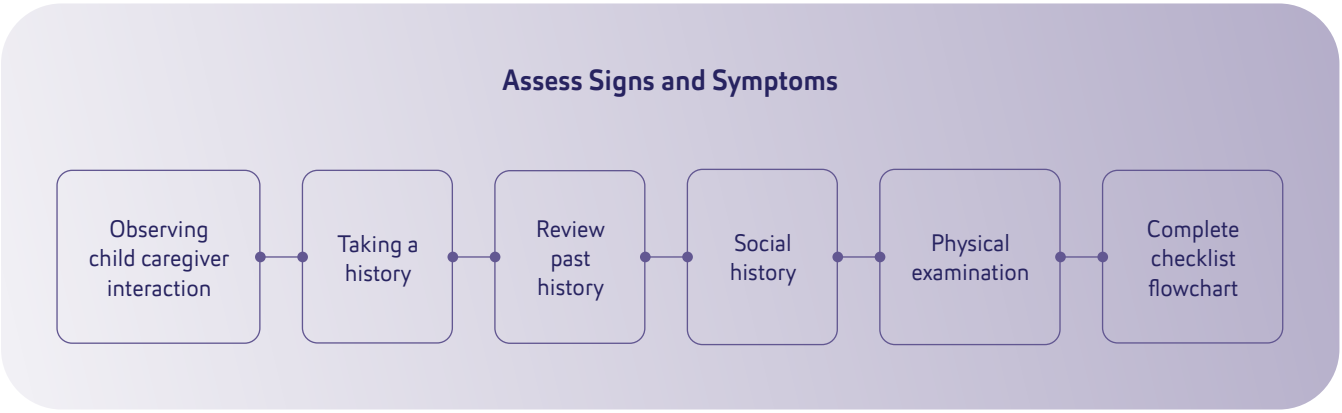
Options recognise Māori rights to accessing services that are culturally safe and responsive and which support Hauora Māori models of care. This requires the Crown to appropriately resource Kaupapa Māori health services. We recognise that transformation is needed in service design and delivery to enable whānau-centred, joined up services. We continue to reflect on the constraints within a transactional, individualistic colonial model that are preventing us from achieving that change. We advocate for building relationships with Māori and iwi organisations (reciprocity, authentic relationships), so that when family violence has been identified via VIP there is a pathway to support those individuals/whānau into an appropriate and responsive service.

Appendix C. VIP Delphi Tool Domains, Definitions and Scoring Weights

Domain (Number of items)	**Definition**	**Weight**
Organisational Leadership	Ownership, leadership and support evidenced through participation, communication and connection	14
Training and support (8)	Staff receive the appropriate training, reinforcement and support to effectively implement VIP	11.8
Resource funding (2)	VIP funding is fully allocated, supporting continuous and sustained coordinator(s), with dedicated cultural resources	11.5
VIP practices (7)	Intervention services follow the MoH Family Violence Assessment and Intervention Guideline procedures and are implemented at all levels of the DHB	11
Cultural Responsiveness (7)	Includes education, support and services informed by people's diverse needs: Māori, multicultural, disabled and gender identity when living with family violence	10.9
Quality improvement (9)	Strategic and continuous monitoring to ensure effective programme delivery	10.8
Policies and procedures (5)	Policies and procedures exist, are reviewed, aligned to guidelines and legislation, and are culturally responsive	10.6
Collaboration (6)	Internal and external collaboration throughout programme and practice	10.5
Documentation (3)	Standardised documentation tools are easily accessible, aligned with the MoH Guideline, and are used to record known or suspected cases of family violence	8.8
TOTAL (56)		**100**

Appendix D. Child Protection and Intimate Partner Violence Assessment Resources

A. Child Abuse and Neglect Assessment

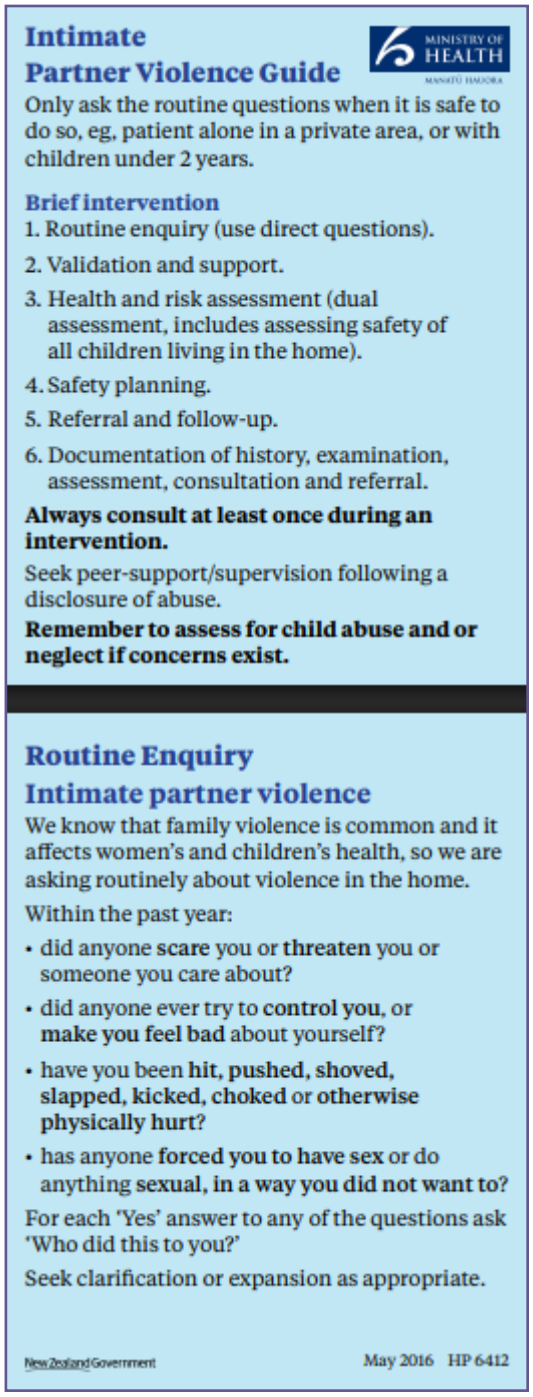


CHILD PROTECTION CHECKLIST

CHILD PROTECTION CHECKLIST to be completed for ALL children under the age of 2 presenting to ED				
COMPLETE a)–d) FOR **ALL PATIENTS UNDER 2 YEARS OF AGE**				
a) Is there any concern about the child and/or family's BEHAVIOUR?	☐	Yes	☐	No
b) Is there a past history of PREVIOUS INJURIES or does a CHILD PROTECTION ALERT exist?	☐	Yes	☐	No
c) On examination, does the child have any UNEXPLAINED INJURIES?	☐	Yes	☐	No
d) Any other concern?	☐	Yes	☐	No
ALSO COMPLETE e)–g) FOR **ALL PATIENTS UNDER 2 YEARS PRESENTING WITH AN INJURY**				
e) Has there been a DELAY between the injury and seeking medical advice, for which there is no satisfactory explanation?	☐	Yes	☐	No
f) Is the HISTORY INCONSISTENT with the injury and/or with the child's developmental level?	☐	Yes	☐	No
g) Is the child UNDER 12 MONTHS of age?	☐	Yes	☐	No
ANY SUSPICION OF NON-ACCIDENTAL INJURY (NAI)?				
☐ Uncertain or possible ("Yes") to any answer above → **Discuss with ED Senior Doctor** and ensure **routine enquiry for intimate partner violence** is completed				
☐ No suspicion of NAI				
Name:..... Signature:..... Date:.....				

Appendix D. Child Protection and Intimate Partner Violence Assessment Resources

B. Child Abuse and Neglect Assessment



Intimate Partner Violence Guide

MINISTRY OF HEALTH

Only ask the routine questions when it is safe to do so, eg, patient alone in a private area, or with children under 2 years.

Brief intervention

1. Routine enquiry (use direct questions).
2. Validation and support.
3. Health and risk assessment (dual assessment, includes assessing safety of all children living in the home).
4. Safety planning.
5. Referral and follow-up.
6. Documentation of history, examination, assessment, consultation and referral.

Always consult at least once during an intervention.

Seek peer-support/supervision following a disclosure of abuse.

Remember to assess for child abuse and or neglect if concerns exist.

Routine Enquiry

Intimate partner violence

We know that family violence is common and it affects women's and children's health, so we are asking routinely about violence in the home.

Within the past year:

- did anyone **scare** you or **threaten** you or someone you care about?
- did anyone ever try to **control you**, or **make you feel bad** about yourself?
- have you been **hit, pushed, shoved, slapped, kicked, choked** or **otherwise physically hurt?**
- has anyone **forced you to have sex** or do anything **sexual, in a way you did not want to?**

For each 'Yes' answer to any of the questions ask 'Who did this to you?'

Seek clarification or expansion as appropriate.

New Zealand Government

May 2016 HP 6412

Appendix E. VIP Evaluation Information: 2024 Snapshot Audits

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 three 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.

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 at eric.wei@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
1. If tick 'No', save and move onto next patient file
2. If tick 'Yes', go to IPV Referral /CAN Consultation
    a. Tick 'Yes' or 'No', save and move onto next patient.
3. The number of files entered and saved appears on the right side of the screen. Twenty– five (25) patients' data are to be entered for each service.
4. 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.
5. 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.
6. 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 Health New Zealand

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' o 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

IPV ROUTINE ENQUIRY

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

IPV DISCLOSURE

Did the woman disclose IPV?	
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'.

IPV REFERRAL

Did the woman disclose IPV?	
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.

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.

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
Age of child	Enter child's age at last birthday. Please enter '0' for children under 1 year
Ethnicity/Ethnicities	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 & 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 three 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.

CAN ASSESSMENT

Was a child protection assessment done?	
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).

CAN CONCERN

Was a child protection concern identified?	
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'.

CAN CONSULTATION

Were identified child protection concerns discussed?	
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.

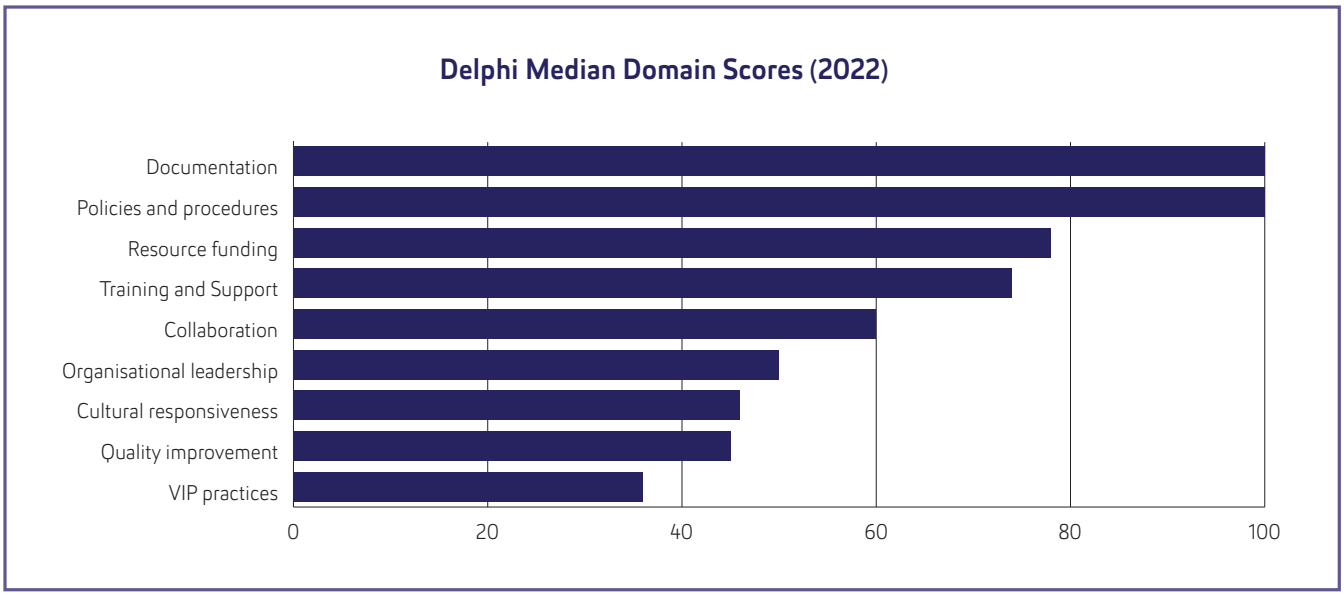
Please also feel free to get help from the evaluation team. Note their contact details below.

- For queries on accessing the Snapshot website – Eric Wei
- For concerns regarding the process of the audit – Jane Koziol-McLain or Kathy Lowe
- For concerns regarding Māori responsiveness and Te Tiriti o Waitangi – Sarah Herbert
- Follow up issues with data entry – Nathan Henry
- Conduct of the audit and relationship to Te Whatu Ora – Kathy Phillips

For general queries you may email: vip-eval@aut.ac.nz

Appendix f. Infrastructure (Delphi) Domain and Indicator Scores

2022 Delphi Domain Score Distribution (external auditor scores; N=20)					
	Minimum	**Maximum**	**Median**	**Mean**	**Std. Deviation**
Documentation	43	100	100	84	20.2
Policies and Procedures	0	100	100	82	26
Resource Funding	4	100	78	71	23.39
Training and Support	37	100	74	68	19.17
Collaboration	42	100	60	63	14.58
Organisational Leadership	13	76	50	46	21.35
Cultural Responsiveness	17	100	46	50	18.11
Quality Improvement	10	90	45	49	23.3
VIP Practice	0	71	36	33	23.07
OVERALL	34	87	57	59	13



The Delphi Indicator Table follows on pages 55 – 65. Cells are highlighted when indicators were met by ≥80% of the districts; Only Quality Improvement Domain was required from all districts in 2020; The Delphi for 2021 was optional, therefore data not included due to low sample size (n = 6); 2018–2021 reflect internal self-audit scores while 2022 scores include both internal self-audit (I), and independent external audit (E) scores based on site visits. FV = family violence.

Item	Domain: Organisational Leadership (1)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	There is a governance group with clearly defined roles and responsibilities for strategic leadership of the Violence Intervention Programme (VIP).	17 (85%)	19 (95%)	N/A	13 (65%)	10 (50%)
2	The following people with family violence understanding are active participants in the VIP governance group:					
2.1	At least one member of the district Executive Leadership Team (the most senior tier of managers who report to the CEO or COO).	16 (80%)	19 (95%)	N/A	14 (70%)	12 (60%)
2.2	At least one professional leader of the core disciplines (e.g. Director of Nursing, Director of Midwifery, Chief Medical Officer, Director of Allied Health).	16 (80%)	19 (95%)	N/A	13 (65%)	11 (55%)
2.3	At least one directorate leader (or equivalent) from corporate services (e.g. Quality and Risk, Funding & Planning).	11 (55%)	14 (70%)	N/A	11 (55%)	9 (45%)
2.4	A Māori leader within the district or community.	15 (75%)	18 (90%)	N/A	12 (60%)	12 (60%)
2.5	Senior manager(s) responsible for services implementing VIP.	17 (85%)	20 (100%)	N/A	16 (80%)	12 (60%)
2.6	VIP team member (sponsor, manager or coordinator).	18 (90%)	20 (100%)	N/A	16 (80%)	11 (55%)
3	There is a two-way communication pathway between the governance group and the VIP team (includes VIP sponsor, VIP manager(s) and family violence intervention programme coordinator (FVIPC)).	16 (80%)	19 (95%)	N/A	13 (65%)	12 (60%)
4	Consistent with interagency Memorandum of Understanding (MOU), there are at least biannual meetings at the senior leadership level on family violence between the district with Police and Oranga Tamariki [both Police and Oranga Tamariki]	11 (55%)	14 (70%)	N/A	15 (75%)	13 (65%)
5	Executive leadership of VIP demonstrated by:					
5.1	District Annual Plan/Strategic Plan specifies VIP.	14 (70%)	16 (80%)	N/A	17 (85%)	18 (90%)
5.2	VIP status reporting to the DHB Board at least annually.	10 (50%)	12 (60%)	N/A	9 (45%)	9 (45%)
5.3	Quarterly agenda item for DHB Board or a designated Advisory Committee to the Board regarding VIP contract deliverables and KPIs.	7 (35%)	11 (55%)	N/A	6 (30%)	6 (30%)
5.4	Current, endorsed DHB policy that includes compulsory 8-hour VIP core training for all clinical staff in designated services.	20 (100%)	20 (100%)	N/A	20 (100%)	11 (55%)
5.5	Implementing and monitoring the key performance indicators (KPIs) reporting by services.	10 (50%)	11 (55%)	N/A	12 (60%)	5 (25%)

5.6	Evidence of acting on non-attained KPI(s), noting recommendations for improvement, necessary resourcing and follow up.	8 (40%)	9 (45%)	N/A	7 (35%)	6 (30%)
6	Senior clinical leaders communicate the expected VIP standard of clinical practice to their professional group(s)					
6.1	Clinical Director (Chief Medical Officer)	8 (40%)	7 (35%)	N/A	6 (30%)	3 (15%)
6.2	Director of Nursing	8 (40%)	11 (55%)	N/A	9 (45%)	6 (30%)
6.3	Director of Midwifery	13 (65%)	13 (65%)	N/A	10 (50%)	4 (20%)
6.4	Director of Allied Health	11 (55%)	12 (60%)	N/A	8 (40%)	6 (30%)
7	Service Leaders report on the following key performance indicators (KPIs) to their senior managers at least quarterly.					
7a	Please indicate how many of the six designated services the DHB provides.					
7.1	How many of these services report on the proportion of staff trained in VIP? (Average)	2.3	1.71	N/A	1.64	0.69
7.2	How many of these services report on the number of VIP clinical champions? (Average)	2.45	1.71	N/A	1.48	0.10
7.3	How many of these services report on assessment and intervention compliance with policy? (Average)	1.25	1.43	N/A	1.13	0.41
7.4	How many of these services report on actions taken to address any non-compliance? (Average)	1.3	1.24	N/A	0.65	0.08
8	The implications of DHB initiatives on VIP service delivery where relevant are considered (e.g. design, documentation forms, alert systems).	16 (80%)	15 (75%)	N/A	17 (85%)	15 (75%)
9	At least 80% of senior executives/leadership team members (including the VIP sponsor) and senior service level managers have received training in VIP in the past two years.	0 (0%)	0 (0%)	N/A	2 (10%)	2 (10%)

Item	Domain: Training and Support (2)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	The DHB VIP core training package and any updates have been signed off by the national training provider.	20 (100%)	19 (95%)	N/A	15 (75%)	13 (65%)
2	The DHB training programme has been observed by the national training provider in the past two years with a report sent back with feedback and recommendations.	14 (70%)	16 (80%)		12 (60%)	12 (60%)
3	There are positive reinforcement practices in place (e.g. inclusion in staff review process) to encourage staff in designated services to conduct routine enquiry for family violence.	18 (90%)	19 (95%)	N/A	18 (90%)	16 (80%)
4	Follow-up support occurs within one week of training.	12 (60%)	13 (65%)	N/A	14 (70%)	13 (65%)
5	Information about the VIP (including DHB policy) is provided at the orientation for service staff appointed to the DHB.	16 (80%)	17 (85%)	N/A	13 (65%)	12 (60%)
6	The family violence training programme includes dealing with difference, i.e. bicultural (as informed by Māori Health Unit), multicultural, disability, gender identity and sexual orientation.	19 (95%)	19 (95%)	N/A	20 (100%)	19 (95%)
7	Staff are evaluated/surveyed on their knowledge and attitude to family violence and its impact on Māori.	15 (75%)	16 (80%)	N/A	12 (60%)	4 (20%)
8	There are support services available for DHB staff who have experienced/are experiencing family violence (including perpetrator and victim)	19 (95%)	20 (100%)	N/A	20 (100%)	20 (100%)

Item	Domain: Resource Funding (3)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	The DHB funding and any extra funding for VIP is spent on the programme and not diverted elsewhere.	20 (100%)	20 (100%)	N/A	20 (100%)	18 (90%)
1.1	There is extra funding provided for people and resources specifically to reduce the impact of family violence on Māori.	7 (35%)	11 (55%)	N/A	10 (50%)	7 (35%)
1.2	There is allocated administrative resources and support for the VIP.	15 (75%)	15 (75%)	N/A	17 (85%)	16 (80%)
2	The family violence intervention programme coordinator (FVIPC) roles for IPV and CAN are currently filled [someone in place for both roles/independent or shared]	18 (90%)	18 (90%)	N/A	15 (75%)	14 (70%)
2.1	How many months in the past 12 months has the coordinator role been filled? Please enter a number between 0 and 12 [districts with role(s) filled for 12 months]	14 (70%)	18 (90%)	N/A	14 (70%)	9 (45%)

Item	Domain: VIP Practices (4)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	At least 80% of women receive routine inquiry for IPV in each designated service.	1 (5%)	0 (0%)	N/A	0 (0%)	0 (0%)
2	At least 5% of women who receive a routine inquiry disclose IPV in each designated service	4 (20%)	4 (20%)	N/A	4 (20%)	3 (15%)
3	All women who disclose IPV are offered a referral to a specialised service or agency.	14 (70%)	15 (75%)	N/A	16 (80%)	8 (40%)
4	A Child Protection Checklist is completed for at least 95% children under the age of two presenting in an Emergency Department.	3 (15%)	3 (15%)	N/A	2 (10%)	2 (10%)
5	There is evidence of consultation with someone who has child protection specialist knowledge for all cases when child protection concerns are identified.	14 (70%)	15 (75%)	N/A	17 (85%)	11 (55%)
6	For all Reports of Concern (ROC) made to Oranga Tamariki, child protection concerns are identified, and safety plans are documented.	12 (60%)	13 (65%)	N/A	15 (75%)	12 (60%)
7	Assessments of the safety of children in the care of all persons disclosing IPV occurs, evident in the most recent quarterly chart audit or electronic record report.	12 (60%)	14 (70%)	N/A	14 (70%)	10 (50%)

Item	Domain: Cultural Responsiveness (5)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	Knowledge of family violence dynamics that address personal and whānau needs for specific groups are embedded in the VIP policy:					
1.1	Māori	20 (100%)	20 (100%)	N/A	20 (100%)	16 (80%)
1.2	Other cultures	20 (100%)	20 (100%)	N/A	19 (95%)	15 (75%)
1.3	Disabled	16 (80%)	17 (85%)	N/A	17 (85%)	8 (40%)
1.4	Gender identity	17 (85%)	18 (90%)	N/A	18 (90%)	14 (70%)
2	The DHB ensures delivery of a culturally competent VIP service, and cultural competency of its staff, particularly for Māori. Please list some ways that this is evident.					
2.1	Cultural competency of the service is evident in VIP policy.	19 (95%)	19 (95%)	N/A	19 (95%)	16 (80%)
2.2	Cultural competency is included in VIP training.	19 (95%)	19 (95%)	N/A	17 (85%)	20 (100%)
2.3	Cultural competency of staff is assessed through staff surveys of attitudes and understanding or family violence and its impact for Māori.	11 (55%)	12 (60%)	N/A	13 (65%)	5 (25%)
2.4	Feedback is sought from Māori who interact with the VIP service that specifically addresses the cultural responsiveness of the service.	6 (30%)	8 (40%)	N/A	7 (35%)	3 (15%)
3	A whānau-centred response is followed when working with victims of family violence. "Māori and their whānau remain the central focus of health professionals' activities, involving them in planning and decision-making activities and when deciding which services are needed to achieve their goals. Identifies both the collective and individual whānau members." (Wepa, 2015, p.242)	10 (50%)	13 (65%)	N/A	14 (70%)	6 (30%)
	Please provide examples to support rating:					
4	There are culturally inclusive family violence pathways and services available in the community.	20 (100%)	19 (95%)	N/A	19 (95%)	18 (90%)
	Provide examples:					
5	The delivery of the service for Māori is evaluated by Māori in a way that is culturally appropriate and safe.	1 (5%)	4 (20%)	N/A	4 (20%)	4 (20%)
6	Trained and approved health care interpreters with family violence training are available for translating for individuals and family if English is not their first language.	16 (80%)	15 (75%)	N/A	11 (55%)	4 (20%)

7	Information is available, relevant, and on display in Te Reo.	16 (80%)	16 (80%)	N/A	17 (85%)	16 (80%)
7.1	Information is available or on display in other languages (not including English) that reflects the DHB's catchment demographic if needed. List the languages that should be available (i.e. reflect demographic):	12 (60%)	15 (75%)	N/A	16 (80%)	16 (80%)
	List languages:					

Item	Domain: Quality Improvement (6)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	VIP is included in the DHB quality and risk strategic plan.	6 (30%)	8 (40%)	10 (53%)	8 (40%)	8 (40%)
2	There is a formal VIP quality improvement plan.	11 (55%)	13 (65%)	13 (68%)	10 (50%)	9 (45%)
3	Responsibility for acting on quality improvement findings is clearly outlined in VIP policy and formal strategic (family violence and child protection) quality improvement process plan.	10 (50%)	12 (60%)	15 (79%)	13 (65%)	10 (50%)
4	There is a regular formal process whereby the VIP evaluation and quality improvement findings are discussed, reviewed and acted on with respective services.	12 (60%)	14 (70%)	16 (84%)	14 (70%)	10 (50%)
5	Evaluation includes health care providers receiving feedback relevant to their involvement with the VIP.	18 (90%)	18 (90%)	18 (95%)	17 (85%)	18 (90%)
6	Patient/client or community agency feedback regarding VIP service delivery is gathered and analysed on a regular basis (at least annually).	7 (35%)	10 (50%)	10 (53%)	9 (45%)	6 (30%)
7	Staff in designated services where VIP is implemented are asked to provide feedback including ideas for programme enhancement in their services every two years.	14 (70%)	16 (80%)	15 (53%)	13 (65%)	15 (75%)
8	A Māori quality framework (such as Whānau Ora) is used by DHB leadership to evaluate whether services are effective for Māori.	6 (30%)	10 (50%)	11 (58%)	7 (35%)	1 (5%)
8.1	This process includes Māori Health Unit review of feedback and recommendations for improving the VIP effectiveness for Māori.	6 (30%)	9 (45%)	11 (58%)	8 (40%)	4 (20%)
8.2	Please provide examples of how the service's effectiveness for Māori is evaluated?					
9	There is evidence that changes have been made to the VIP on the basis of staff, community or user feedback, or audit findings, in the past 12 months.	19 (95%)	20 (100%)	18 (95%)	15 (75%)	8 (40%)
9.1	If no changes please explain why (e.g. feedback positive, no budget). If changes, please summarise what the feedback was, how it was sourced and what the changes were.					

Item	Domain: Policies and Procedures (7)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	The DHB has documented policies and procedures on intimate partner violence and child protection that are current and align with the Ministry of Health guideline	20 (100%)	20 (100%)	N/A	20 (100%)	16 (80%)
2	The DHB family violence policies and procedures are aligned with current legislation and relevant national policy initiatives (e.g. MOUs)	20 (100%)	19 (95%)	N/A	19 (95%)	17 (85%)
3	The policies and procedures are readily available to staff on the intranet (within three clicks).	19 (95%)	20 (100%)	N/A	19 (95%)	17 (85%)
4	The Māori Health Unit participate in policy review and endorse all DHB family violence policy and procedure.	16 (80%)	15 (75%)	N/A	15 (75%)	17 (85%)
5	Additional safety and security measures are specified for suspected cases of child abuse and neglect with perceived immediate risk, and for adults who are identified as high risk or in imminent threat.	20 (100%)	20 (100%)	N/A	19 (95%)	15 (75%)

Item	Domain: Collaboration (8)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	There is clear evidence that a MOU between the district AND Oranga Tamariki AND Police for FV responses has been operationalised by:					
1.1	Signing of MOU	20 (100%)	20 (100%)	N/A	19 (95%)	19 (95%)
1.2	Regular meetings at service level with actions and accountability (at least biannual)	12 (60%)	13 (65%)	N/A	15 (75%)	16 (80%)
1.3	Interagency review of cases	14 (70%)	14 (70%)	N/A	14 (70%)	15 (75%)
1.4	Participation in or initiation of interagency training	15 (75%)	18 (90%)	N/A	13 (65%)	13 (65%)
2	There is evidence of Service Level Agreements (SLA) between DHB and family violence services with regards to referrals and how on-site services will be provided.	12 (60%)	16 (80%)	N/A	12 (60%)	7 (35%)
3	Ongoing partnership between the DHB and Māori service agencies or health providers, and/or local Iwi or Urban Māori Authority evidenced by:					
3.1	Participation in, or initiation, of training (e.g. involvement in the VIP training at the DHB) [one or more partnership]	10 (50%)	10 (50%)	N/A	16 (80%)	16 (80%)
3.2	Policy review [one or more partnership]	8 (40%)	11 (55%)	N/A	11 (55%)	6 (30%)
3.3	Representation on the VIP governance group [one or more partnership]	9 (45%)	9 (45%)	N/A	11 (55%)	7 (35%)
4	There is evidence of engagement and collaboration with external FV services agencies at a senior management and operational VIP level					
4.1	Senior management level (provide examples)	17 (85%)	19 (95%)	N/A	14 (70%)	13 (65%)
4.2	Operational VIP level (provide examples)	18 (90%)	19 (95%)	N/A	20 (100%)	18 (90%)
5	There is an MOU or SLA with the following agencies regarding the service delivery for victims of sexual assault (adults, adolescents and children).					
5.1	Police	18 (90%)	19 (95%)	N/A	16 (80%)	14 (70%)
5.2	ACC	16 (80%)	17 (85%)	N/A	15 (75%)	16 (80%)
5.3	Oranga Tamariki	15 (75%)	17 (85%)	N/A	17 (85%)	15 (75%)

5.4	District policies specify the pathway for service delivery including acute response and referral for sexual assault or suspected/alleged sexual abuse of a child.	18 (90%)	19 (95%)	N/A	19 (95%)	15 (75%)
6	≥ 2 multiagency case reviews (one for IPV and one for CAN) have been undertaken in the last 12 months that evaluate health actions within family violence response.		11 (55%)	N/A		
6.1	At least 1 review for IPV?	11 (55%)	14 (70%)	N/A	11 (55%)	11 (55%)
6.2	At least 1 review for CAN?	15 (75%)	20 (100%)	N/A	12 (60%)	17 (85%)
6.3	How have findings been shared with DHB services?					
6.4	How have recommendations been actioned?					

Item	Domain: Documentation (9)	Response YES				
		2018 - I N = 20	2019 - I N = 20	2020 - I N = 19	2022 – I N = 20	2022 - E N = 20
1	Standardised documentation instruments /templates are aligned with the Ministry of Health FVAIG are used to record known or suspected cases of family violence.	19 (95%)	20 (100%)	N/A	20 (100%)	20 (100%)
1.1	All IPV routine enquiry, disclosures and referrals are documented on the standardised templates (e.g. Intimate Partner Violence (IPV) Assessment and Intervention Documentation)	18 (90%)	18 (90%)	N/A	19 (95%)	18 (90%)
2	The national form (Report of Concern) is used for referral to Oranga Tamariki	20 (100%)	20 (100%)	N/A	20 (100%)	20 (100%)
3	Patients with injuries caused by family violence are routinely offered a medical photography option, either in the district or by the police.	16 (80%)	18 (90%)	N/A	18 (90%)	12 (60%)

APPENDIX G. POPULATION ESTIMATES OF CHILD ABUSE AND NEGLECT SERVICE (APRIL – JUNE; 2014 – 2024)

	2014	2015	2016	2017	2018	2019	2020	2021	2024
		N = 20	N = 20	N = 20	N = 20	N = 20	N = 17	N = 9	N = 20
Children ASSESSED CAN indicators									
Weighted mean	27%	26%	26%	39%	48%	55%	53%	51%	50.4%
(95% CI)	20, 34	21, 32	21, 32	33, 45	41, 54	46, 65	47, 59	43, 59	46, 55
Population estimate	4,163	4,242	3,404	6,197	7,953	9,308	2,932	2,082	10,757
(95% CI)		3,387, 5,096			6,845, 9,061	7,713, 10,902	25,95, 3,269	1,755, 2,409	
Protection CONCERN (≥1 indicator)									
Weighted mean	13%	9%	12%	10%	9%	5%	10%	6%	2%
(95% CI)	8, 18	6, 12	8, 15	7, 13	7, 11	4, 7	7, 12	3, 10	0.2, 3.3
Population estimate	549	374	394	601	742	495	285	130	190
(95% CI)		251, 497			582, 901	352, 637	206, 364	60, 201	
Specialist CONSULTATION*									
Weighted mean	89%	100%	93%	100%	96%	90%	82%	83%	80%
Population estimate	489	374	380	601	690	429	247	107	152

Notes: proportion of child protection concern is among those who received a CAN assessment; proportion of specialist consultation is among those with an identified concern; CI = Confidence Intervals; *Weighted means and CI not computed for consultations due to small numbers within individual districts. Districts had choice in completing Snapshot clinic audits in 2021.

APPENDIX H. POPULATION ESTIMATES OF INTIMATE PARTNER VIOLENCE SERVICE (APRIL – JUNE 2015 – 2024)

ASSESSMENT								
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2024**
Emergency Department								
		N = 20	N = 20	N = 20	N = 20	N = 18	N = 9	N = 20
Weighted mean (95% CI)	23% (20, 26)	27% (24, 29	30% (26, 34)	32% (27, 37)	26% (23, 28)	27% (24, 29)	20% (14, 26)	25.5% (22, 29)
Population estimate (95% CI)	21,924 (18,819; 25,029)	25,758 (22,887; 28,628)	30,330 (26,418; 34,243)	34,314 (28,665; 39,963)	28,084 (24,946, 31,222)	17,844 (16,021; 19,667)	10,068 (7,055; 13,080)	31,241
Community Mental Health								
		N = 19	N = 18	N = 19	N = 19	N = 15	N = 5	N = 19
Weighted mean (95% CI)	N/A	52% (43, 62)	40% (32, 48)	44% (36, 51)	49% (42, 56)	46% (37, 54)	NR	37.3% (33, 42)
Population estimate (95% CI)	N/A	1,769 (1,444, 2,095)	2,369 (1,977, 2,987)	2,878 (2,366, 3,391)	3,172 (2,720, 3,624)	2,364 (1,914, 2,814)		2,042
Postnatal Maternity In-Patient								
		N = 20	N = 20	N = 20	N = 20		N = 7	N = 20
Weighted mean (95% CI)	48% (42, 55)	52% (46, 58)	53% (49, 57)	62% (57, 68)	53% (48, 59)	N/A	32% (22, 42)	24.1% (21, 28)
Population estimate (95% CI)	4637 (4,033, 5241	4954 (4,374, 5,533)	5965 (5,484, 6,446)	7531 (6,870, 8,193)	7154 (6,450, 7,858)		1721 (1,181, 2,260)	2,743

ASSESSMENT – Continued								
Child Health In-Patient								
		N = 20	N = 20	N = 20	N = 20		N = 8	N = 19
Weighted mean (95% CI)	35% (33, 38)	42% (36, 48)	39% (36, 43)	43% (39, 48)	44% (38, 49)	N/A	35% (27, 43)	35.3% (31, 40)
Population estimate (95% CI)	4,213 (4,180, 4,847)	5,180 (4,423, 5,937)	5,118 (4,640, 5,595)	4,655 (4,163, 5,146)	4,864 (7,208, 5,520)		1,647 (1,272, 2,022)	3,205
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2024**
Sexual Health								
		N = 14	N = 14	N = 15	N = 15		N = 1	N = 14
Weighted mean (95% CI)	48% (42, 55)	54% (44, 63)	67% (56, 79)	69% (53, 85)	75% (68, 82)	N/A	N/R	75.9% (71, 80)
Population estimate (95% CI)	2,703 (2,330, 3,076)	3,917 (3,243, 4,591)	4,643 (3,835, 5,450)	5,298 (4,076, 6,520)	4,543 (3,377, 4,105)			4,740
Alcohol & Drug								
		N = 15	N = 12	N = 14	N = 15		N = 3	N = 15
Weighted mean (95% CI)	N/A	52% (38, 67)						
Population estimate (95% CI)	N/A	829 (602, 1,055)						

DISCLOSURE								
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2024**
Emergency Department								
Weighted mean (95% CI)	6% (4, 8)	14% (11, 18)	12% (9, 15)	22% (14, 31)	6% (4, 8)	7% (5, 10)	6% (2, 11)	9.4% (5, 14)
Population estimate (95% CI)	1310 (917, 1,702)	3568 (2,806, 4,510)	3544 (2,639, 4,448)	7677 (4,736, 10617)	1612 (1,040, 2183)	1266 (847, 1,684)	641 (167, 1,115)	2,943

Community Mental Health								
Weighted mean (95% CI)	N/A	24% (19, 29)	28% (22, 34)	20% (17, 23)	29% (23, 36)	28% (17, 40)	N/R	29.0% (23, 35)
Population estimate (95% CI)	N/A	422 (336, 511)	661 (538, 839)	576 (483, 669)	933 (726, 1,141)	673 (398, 948)		592
Postnatal Maternity In-Patient								
Weighted mean (95% CI)	4% (2, 6)	3% (2, 4)	4% (3, 6)	3% (1, 4)	8% (6, 10)	N/A	2% (0, 7)	7.6% (3, 12)
Population estimate (95% CI)	197 (114, 280)	138 (79, 197)	264 (156, 373)	191 (109, 272)	580 (422, 737)		33 (0, 124)	210
Child Health In-Patient								
Weighted mean (95% CI)	4% (2, 5)	4% (2, 5)	7% (5, 9)	11% (7,15)	11% (7, 14)	N/A	7% (2, 13)	2.2% (0.1, 4)
Population estimate (95% CI)	160 (83, 237)	193 (116, 271)	339 (237, 441)	505 (327, 683)	513 (363, 662)		119 (26, 213)	72
Sexual Health								
Weighted mean (95% CI)	20% (13, 27)	15% (11, 19)	19% (11, 26)	10% (7, 13)	16% (12, 19)	N/A	N/R	13.8% (10, 18)
Population estimate (95% CI)	537 (349, 725)	589F (437, 742)	860 (500, 1220)	530 (366, 693)	713 (554, 873)			654
Alcohol & Drug								
Weighted mean (95% CI)	N/A	34% (25, 44)	27% (19, 35)	30 (23, 37)	25% (20, 30)	N/A	N/R	24.7% (18, 31)
Population estimate (95% CI)	N/A	285 (205, 365)	239 (168, 311)	410 (316, 504)	248 (194, 302)			110

REFERRAL*								
	2015	2016	2017	2018	2019	2020	2021	2024
Emergency Department								
Mean	75%	94%	78%	88%	80%	91%	100%	92.3%
Population estimate	982	3,581	2,418	7,031	1,066	1,080	641	2,717
Community Mental Health								
Mean	N/A	64%	90%	82%	77%	76%	23%	69.6%
Population estimate	N/A	257	597	394	693	625	47	413
Postnatal Maternity In-Patient								
Mean	100%	83%	60%	82%	78%	N/A	100%	81.8%
Population estimate	197	125	232	169	516		33	171
Child Health In-Patient								
Mean	100%	75%	69%	72%	90%	N/A	N/R	75.0%
Population estimate	160	125	255	366	492		86	54
Sexual Health								
Mean	83%	69%	55%	58%	63%	N/A	N/R	55.6%
Population estimate	466	388	627	425	437			363
Alcohol & Drug								
Mean	N/A	59%	88%	87%	78%	N/A	N/R	68.9%
Population estimate	N/A	152	175	350	210			76

Notes: a New female clients presenting to service; b districts could elect most valuable evaluation activity in 2021; * weighted means and CI not computed for referrals due to small numbers; N/A not applicable as audit not conducted that year; NR not reported due to small number of participating districts (in 2021).

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