Impact of COVID-19 on the Health Response to Family Violence in Aotearoa New Zealand: A Qualitative Study

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Abstract

COVID-19 pandemic planning and response has resulted in unprecedented upheaval within health systems internationally. With a concern for increasing frequency and escalation of family violence, the so called "shadow pandemic," we wondered how health system violence intervention programs were operating during this time. In Aotearoa New Zealand, the Ministry of Health Violence Intervention Program (VIP), using a systems approach, seeks to reduce and prevent the health impacts of family violence and abuse through early identification, assessment, and referral of victims presenting to designated health services. In this qualitative descriptive study, we explored how the VIP program was impacted during the first year of the COVID-19 pandemic. Forty-one VIP coordinators and managers representing 15 of the 20 New Zealand District Health Boards and the National VIP Team participated. Across 12 focus groups (8 face to face and 4 via Zoom) and 7 individual interviews (all via Zoom) participants shared their experience navigating systems to support frontline health providers' responsiveness to people impacted by family violence during the pandemic. In our reflexive thematic analysis, we generated 3 themes: Responding to the moment, valuing relationships, and reflecting on the status quo. Our findings demonstrate the dynamic environment in which participants found creative ways to adapt to the uncertainty and engage with communities to re-shape interventions and ensure continued implementation of the program. At the same time, challenges within the system prior to the pandemic were brought into view and highlighted the need for action. These included, for example, the need for improved engagement with Māori (Indigenous people of Aotearoa New Zealand) to address long-standing health inequities. Having quality essential services for those impacted by family violence that engages with local knowledge and networks and routinely copes with uncertainty will strengthen our systems to minimize risk of harm during emergencies.

Keywords

family violence, COVID-19, SARS-CoV-2, program development, Aotearoa New Zealand, equity, qualitative research

What do we already know about this topic?
A consequence of the COVID-19 pandemic has been an increase in frequency and severity of violence against women and children alongside unprecedented upheaval in the delivery of health and social services.

How does your research contribute to the field?
Aotearoa New Zealand health system family violence program leaders 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.

What are your research's implications towards theory, practice, or policy?
Lessons from the experience of the first year of the COVID-19 pandemic suggests strengthening engagement with local communities, embracing uncertainty, and normalizing adapting to shocks will support a resilient health system response to family violence across future challenges.

Introduction

We are continuing to learn about the consequences of the COVID-19 pandemic, and the unintended consequences of policies put in place to halt the spread of disease. While the virus' direct health effects are a primary outcome, there are wide-ranging impacts on economies, societies, and families. One such impact of the COVID-19 pandemic has been the escalating risk and severity of family violence. The

COVID-19 "shadow pandemic" of violence against women and children is being documented internationally.[1] In a survey of Australian women, both new onset intimate partner violence and escalation (increases in frequency and severity) were documented in the first 12 months of the pandemic.[2]

While the shadow pandemic of violence against women and children is generally attributed to the various public health policies in which people are asked to confine themselves in their homes to reduce the spread of COVID-19, evidence suggests it is more complex. For example, the pre-pandemic structural inequities for marginalized groups, including Indigenous people,[3,4] have meant the intersectionality of the pandemic with precarious housing, employment, and access to appropriate health services.[5] The following examples evidence how inequities and mainstream policies are, in turn, contributing to differential rates of COVID-19, hospitalization, mortality, and vaccination rates. Given the well-known life-expectancy gap for Māori (Indigenous people of Aotearoa New Zealand) versus non-Māori (7.5 years for males and 7.3 years for females),[6] and over-representation of Māori living with chronic conditions,[3] the Waitangi Tribunal found that the government's rejection of a COVID-19 vaccination rollout age adjustment for Māori breached Te Tiriti o Waitangi principles of protection and equity.[7] In addition, vaccination targets (90%)[8] are based on total population rather than ensuring marginalized groups are afforded sufficient resources and time for vaccination equity ahead of lifting restrictions. In New Zealand, while accounting for approximately 17 per cent of the population, Māori "represented 43 per cent of COVID-19 cases, 32 per cent of all hospitalized cases, and 43 per cent of all deaths" during the Delta transmission period August to November 2021.[7] Similar statistics are mirrored in family violence: Māori are over-represented as deceased and offenders in all family violence deaths; Māori children are 3 times more likely to die from child abuse or neglect than non-Māori.[9] Given the intersecting disadvantages, it is important to consider how family violence health services can be delivered in the context of the pandemic for both Māori and non-Māori.

From the perspective of health and social services, COVID-19 pandemic planning and adapting to health and government initiatives is causing unprecedented upheaval internationally. While Aotearoa New Zealand's rapid implementation of an elimination strategy shielded the country from the ravages of Delta that other countries experienced in the first year of the pandemic,[10,11] significant resources were diverted to the pandemic. Across health settings, some family violence program workers were directed to work from home, some were seconded into pandemic response roles (particularly nurses) and some resigned. Front line health staff prioritized their care, wore protective gear, and minimized their face-to-face interaction time with patients. During this period of turmoil, could Aotearoa New Zealand's health system be resilient to meet the needs of those impacted by family violence? Haldane et al[12] describe a resilient health system as "absorbing unforeseen shocks precipitated by emerging health needs, but also on ensuring continuity in health improvement, sustaining gains in systems functioning and fostering people centeredness, while delivering high-quality health care." In this context of the COVID-19 pandemic, we set out to explore whether family violence health system leaders and frontline health staff could create pathways to safety, and whether any responsiveness to family violence could be prioritized and maintained.

The New Zealand Ministry of Health supports a comprehensive health systems approach to responding to family violence across 20 District Health Boards (DHBs; since July 2022, health reforms have meant the restructuring of health services and dissolution of DHBs). The Aotearoa New Zealand population of 5 million are distributed across DHBs with catchment populations ranging from 32,380 to 646,140.[13] The Violence Intervention Program (VIP), launched in 2007, is directed by national assessment and intervention guidelines for intimate partner violence (IPV) and child abuse and neglect.[14] The guidelines outline a 6-step process that includes, for example, routinely asking women in selected services 4 brief IPV assessment questions (sometimes referred to as "routine screening"). The Ministry of Health funds national program management, standardized training, evaluation, and resources such as coordinator salary, policy templates, and brochures and posters. The aim is to reduce and prevent the health impacts of family violence and abuse through early identification, assessment, and referral of victims presenting to 6 designated acute (hospital based) and community health services.[15] Individual DHB structure typically includes a program sponsor, 1 or more family VIP coordinators, a steering group, and service champions. VIP coordinators are leaders in program implementation, including strategic planning, interagency relationships, training, and evaluation. Coordinators include nurses, social workers, advocates, or other community members that have expert family violence knowledge and leadership skills. In March 2020, across the 20 DHBs, there were 44 VIP coordinators and 3 vacancies.

The purpose of this study was to understand how the pandemic impacted on delivering and maintaining the program

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to support the health response to family violence in Aotearoa New Zealand in the first year of the COVID-19 pandemic. Aotearoa New Zealand's first case of COVID-19 was 28 February 2020. In the first year of the pandemic various levels of alert were instituted, dictated by changing community transmission in regions over time. Nationwide, the most restrictive Level 4 "lockdown" was in place from 25 March to 27 April 2020.[10,16] This included, for example, "staying home in your bubble [household unit]," no travel except for basic needs, and closing of all public and education facilities.[16] In 2021, Aucklanders also experienced "severe restrictions" for 107 days.[17] Recognizing the ripple short-, medium-, and long-term effects of the pandemic, we aimed to investigate VIP team experiences to influence and inform system changes to better respond to the needs of women and families, particularly for Indigenous Māori, across the life cycle of the pandemic and beyond.

Method

This study sought to answer the question: How was the Violence Intervention Program implemented and maintained in Aotearoa New Zealand during the first year of the COVID-19 pandemic? Given the nature of the research, a qualitative descriptive design was utilized in order to generate knowledge grounded in the human experience.[18] Specifically, reflexive thematic analysis (RTA), as informed by Braun and Clark[19] was chosen as it offers a flexible approach capable of providing a rich and detailed, yet complex account of data. The study protocol was approved by the New Zealand Health and Disability Ethics Committee (AKY/03/09/218/AM11). Participants provided written consent. Given the likely stress associated with responding to family violence during the COVID-19 pandemic, a referral pathway to support services was available for researchers and participants.

Recruitment

We emailed the 20 designated DHB VIP managers and associated program coordinators outlining the study purpose and attached the study information sheet and consent form. As the experts of their programs, we asked that they identify potential focus group participants who were in the best position to describe how their program was impacted by the pandemic. We suggested a diversity of disciplines, roles, health services and ethnicity to gather a range of perspectives, including representatives from their local Māori Health Unit. Participation in the focus group was optional, with no impact on their employment. The national VIP leadership team were also invited to participate in a focus group or individual interview independent of DHB focus groups and interviews.

Procedure

Researchers liaised with VIP coordinators to identify a suitable time and place to convene a focus group. While our preference was to convene focus groups kanohi-ki-te-kanohi (face to face), we included the option of a focus group on Zoom, or an individual interview. In some cases, Zoom was necessary due to various alert lockdown levels across the country.[20] We complied with Ministry of Health public health guidelines applicable for the COVID-19 Alert Level across our data collection settings. We also offered for a Māori researcher to facilitate a focus group or interview from a Kaupapa Māori (by Māori for Māori) perspective.[21]

Focus groups had 2 to 5 participants and ran between 60 and 90 min. Individual interviews were between 45 and 60 min. Focus groups and interviews began with an opening that included the opportunity to ask any questions about the study. Confidential handling of data was discussed, clarifying that the DHBs that participated would be noted but the source of data would not be identified. While focus group participants were encouraged to continue the discussion about the impact of the pandemic on themselves and their services beyond the focus group, they were asked to keep specific speaker comments confidential. The focus group was convened by 1 or 2 researchers. Shortly following each focus group and interview a debriefing session took place with the first author. These sessions were valuable in discussing observations and impressions that contributed to our analysis. A gift of food was provided for kanohi-ki-te-kanohi participants.

An interview schedule guided focus group participants to share: (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 Indigenous 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. Focus groups procedures were aligned with best practice guides[22,23] and were consistent with the health systems team approach embedded in the VIP.

Focus groups and interviews were digitally audio-recorded with participant consent. Audio-recordings were then transcribed verbatim by one of the researchers and checked for accuracy by the focus group facilitator before being anonymized and used for analysis. Repeated words and words such as "um," "like," and "you know" were removed.

Data Analysis

All researchers participated in data analysis with the common understanding that our approach would be consistent with a qualitative paradigm. Research team members represented a diverse group of women with discipline knowledge in nursing, social work, occupational therapy, and psychology. One of the researchers (the primary interviewer) had been a DHB VIP Coordinator, 1 had been a VIP Team Leader, and 2 were involved with VIP evaluation.

Table 1. Example of Coding Process.

Open codes	Sub-themes	Theme
Understanding different roles	Community connection	Valuing Relationships
Keep connected		
Really nice to connect		
Communicating		
Building relationships	Supporting health staff	
Working with HR		
Being consistent		
Realized importance of team		
Don't reinvent the wheel	Sharing resources	
Doing things differently		
Sharing documents		
Sharing regionally		
Creating national guidelines		

Researchers had a breadth of qualitative research experience; for example, grounded theory, Kaupapa Māori, and community based participatory research which provided what Braun and Clarke[19] referred to as "flexible starting points."

RTA provided the appropriate tools to guide our data interpretation to "identify and make sense of patterns of meaning across the dataset."[19,24] RTA is consistent with the researchers' understanding of knowledge as contextual, subjective, and partial. RTA offered the research team the opportunity to bring their understandings and experiences of the VIP (as outlined above) into analysis of the data; and, in some instances, offer greater context for participants' words. RTA also allowed flexibility for 1 researcher to code in word, another in NVivo and yet another to use mind mapping. Prior to analysis, the team agreed we did not have an *a priori* codebook. Alongside the process of RTA, the Māori researcher had oversight of all Māori data guided by principles of Māori data sovereignty.[25] As a team we engaged in a series of meetings in which we brought together our individual analysis and discussed the commonalities and differences that were being identified until we came to agreement in generating the final themes. Table 1 provides an example of how analysis progressed from open coding to the development of sub-themes and themes. The theme of Valuing Relationships was initially named Community Networking. It was felt that Valuing Relationships better captured the tone of the open codes which highlighted the importance of relationship (building, connecting, and communicating) and aligned with our collective understandings of the need to acknowledge and value relationships throughout the process of implementing the VIP during a global pandemic. Participant quotes are used to illustrate our final themes. During analysis, focus groups and individual interviews were assigned a random number. We have elected not to include the anonymized codes to protect participant confidentiality within the small VIP community.

Findings

Between 16 June and 3 December 2021, 41 people participated across 12 focus groups (8 face to face and 4 via Zoom) and 7 individual interviews (all via Zoom) representing 15 of the 20 DHBs and the National VIP team. One individual interview was conducted according to Kaupapa Māori principles. Participants included national VIP leaders (n = 5) and District Health Board VIP managers (n = 5), child protection coordinators (n = 6), and family violence coordinators (in most cases family violence coordinators have dual IPV and child abuse and neglect roles; n = 25). At the time of data collection, participants had been in their role between 1 week and 12 years. All participants were female. Among the 30 DHB participants who provided their ethnicity, the majority self-identified as New Zealand European (n = 23); non-New Zealand European ethnicities were identified by either 1 or 2 people (details withheld for confidentiality).

From our analysis we generated 3 themes that captured how the VIP was implemented and maintained in Aotearoa New Zealand during the COVID-19 pandemic. The 3 themes included: Responding to the moment, valuing relationships, and reflecting on the status quo (Table 2).

Responding to the Moment

As health systems were trying to understand the international impact of the pandemic and translate that into a national response, VIP coordinators were quickly doing the same for the VIP. This theme reflects how the VIP coordinators were on ever changing ground:

> in terms of the programme response, in terms of how we sort of dealt with it, in terms of VIP, it was kind of constantly, evolving a little bit of the expectation or the, the unknown I guess. 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 but we actually didn't really know in what context that was going to be. (FG1)

Coordinators constantly had to assess and determine how to support frontline health staff to continue to respond to family violence based on information they were receiving from the government, hospital management, and the national VIP leadership team. This communication was sometimes unclear; indeed, sometimes absent or contradictory, leaving coordinators to determine what they felt to be the "need of the hour." It was "just a constant, evolving work in progress I guess so as updates would come from VIP leadership team and then we'd try and adapt" (FG1). The coordinators often had to reshape how to support and respond to frontline staff providing health services. They were challenged to support hospital and community staff differently to assist those experiencing family violence. Three subthemes included

Table 2. How the Health System Violence Intervention Program (VIP) Was Implemented and Maintained During the 2020 to 2021 COVID-19 Pandemic in Aotearoa New Zealand.

Theme	Sub-themes
Responding to the moment	Assessing, reflecting, and reassessing
	Being visible
	A practical approach
Valuing relationships	Community connection
	Supporting health staff
	Sharing resources
Reflecting on the status quo	Lack of Māori engagement
	Encountering service resistance
	Not a priority

assessing, reflecting, reassessing; being visible; and a practical approach.

Assessing, reflecting, and reassessing

> Within about 4-weeks COVID was busy flying around the world. And so a lot of our systems, process, policies had kind of, become outdated and, and with the impact of COVID just, did not have the robustness to be able to cope. (FG10)

> In the early days when it was still unknown what the impact would be and how the VIP was expected to operate, some staff valued the change in focus commenting it "gave me a bit more down time and more time to focus on training development knowing that one day we'd be back up and running and maybe we could do an improved version" (II7).

> 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. (FG1)

> Coordinators spoke of coming to realize how many of the paper forms were redundant

> For our risk assessment forms for positive disclosures yeah we realised that with social workers and other people not all working on site because people were working from home in various capacities, that we couldn't do our usual process of paper pushing. So we, yeah the team got quite quickly into action with clinical records and got a new writeable electronic form that's been, we've continued to use which has been awesome. . .one of the biggest things was the electronic writeable PDF which has changed the way we get our alerts and things in terms of our process going paperless. . . And that was a really good thing because it meant a) we can read people's writing but b) it actually made it more seamless taking away snail mail and faxing. (FG1)

For some coordinators, however, it was the system that forced them into going paperless:

> our DHB decided because of COVID that they would transition particularly our emergency department from paper records to electronic and we didn't know. . . . they literally did it overnight and so we suddenly in terms of our usual, the child protection checklist, the risk assessment form, the [attempted strangulation clinical assessment tool]. Recording routine enquiry – Gone. (FG2)

Some coordinators used the time to "do some of the policy development" (FG6) and clean up files within their workplace:

> We did a whole cull. . .Just like really odd statements on policies and old forms that had just sat there, we never knew about them. . .. So, there's actually been a lot of cleansing and a certain amount of trying to clean up the stuff that should never have been there. (FG1)

As a result, policies were re-written and new content developed with regards to the VIP actionables and increasing visibility.

Being visible. As a result of personal protective equipment and isolation policies during lockdown, many coordinators were unable to access wards and units as they had done previously. Most had no face-to-face contact with service-based program champions or their team leaders. In addition, all face-to-face core VIP training was cancelled. In some settings, VIP staff were seconded from their role within the program to work in other areas:

> if they were nurses, they were far more likely to be impacted in terms of request or requirement to divert to other activity. . . some nurses that had worked in public health, district nursing, were more likely to be diverted to COVID response so taken completely out of their VIP coordinator roles and asked to have a nursing response to COVID. . . .That dictated a huge amount around how the VIP programme actually maintained itself during the period of COVID. (FG11)

To enhance their visibility and that of the VIP during lockdown many coordinators created an online presence. Coordinators used different mediums to communicate family violence response messages and tools to the public and health professionals. These included bulletin boards, short videos, and a FAQ resource.

> Even in the staff corridors. . . I theme the bulletin board to like, say 'this is not love'. . . . to me it's all about capturing, making things real, bringing things to life and having it relatable. (FG9)

> Nobody was allowed in ED, we decided to record a video just to remind people to routinely screen and sent the video out to different [hospital wards] so they could just show it. It was like a 2-minute video just reminding them that we were there for consults and available for people if they needed. Yeah so I think for us, it just got our creative juices going. (FG9)

> 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. . .Can I still make a report of concern to Oranga Tamariki [statutory child protection agency]? Will they be doing visits? Should I ask routine enquiry via Zoom all those kind of questions. (FG2)

Being visible was also about having a physical presence. Some coordinators, once allowed, relished the opportunity to get out of the office and back "on the floor," setting up stations in the Emergency Department (ED) to be active assessors and going on to wards.

> I sat down in ED and, kind of, helped staff on the floor to just routinely screen and to keep that at the forefront. . . just said you know make yourself available, set yourself up in a corner and if people come to you that's cool and if you want to just grab different files and if you see people aren't screening just go and screen which I got to do, all of that. (FG9)

A practical approach. With the loss of face-to-face core training due to COVID-19, coordinators looked to provide "an alternative training to the 8-h in person core training. Prior to COVID there'd been a few conversations had about this, but obviously in 2020 the need for it was really exacerbated" (FG8); "One DHB has provided the core training via Zoom. . . Another DHB is putting the core training into online modules" (FG11). Training innovation often resulted in positive sustained change.

> As a result of the lockdown, X, she and I and the Learning and Development team did a huge push and we developed our online prerequisite training. . . we had an awesome team in the DHB Learning and Development team there was a fabulous lady there was highly skilled in creating online stuff. And she just rocked so she basically helped us put it all together and that became, turned into the standard for our online prerequisites. . . That's been a fantastic thing that came out of the first lockdown actually. (II4)

> Beyond the online training, coordinators developed other innovations. "What strikes me as innovation is just when you get out of the way - and you let people innovate - how it can work well" (FG8).

> But what COVID let us do was it stopped us from doing all of the stuff we usually do but it, it, granted the time for creative thinking and like X created that awesome resource where she put together basic like electronic VIP resource full of all sorts, with, you know that big thought around safety planning, around, whether you've done routine enquiry or not if you get a disclosure, if somebody just tells you, what are you going to do with it in this time? And she created this awesome resource file and emailed that out to all of the areas, so whilst we couldn't do on the floor support, you know like we'd been able to do that and that's been a fantastic resource for people who don't want to ring us, can't ring us, we're not available for when you know it's Friday night or something, they've got this resource there. (FG9)

> I would say ED was your frontline staff. . . we made like packs that they could just like grab and complete for documentation. (FG5)

> Coordinators also responded by adapting the screening (routine enquiry) questions to make them relevant to the lockdown conditions and to ensure increased safety during telehealth interactions. This required practical, fast thinking where coordinators "had to quickly format, how do you do routine enquiry that you can only do on the phone? And we were told not to do all those, the ethics on how we work" (FG1).

> X and I were really clear from the onset that routine enquiry and certain ways of finding out information around risk had to be different because there's always that overall risk of, of being in a home where you. . . don't know who's there. People listening. Despite them saying that they're on their own or safe to talk. Anecdotally that's not always the case. (II1)

> Yeah so we had to quickly put in a few processes because people were still asking routine enquiry questions via Zoom. And we were starting to hear stories of how that's really unsafe obviously because the partner could be there or we had one case where the partner had been recording the conversation so, we had to quickly kind of come up with a way to inform staff. So I did a flow chart that we sent out to how we get the information without asking and that you shouldn't ask via Zoom because it's not safe basically. (FG2)

> from a VIP point of view, we immediately received an email from the top [DHB leadership]. They had like a promotional COVID team established in the hospital and they would ask what could we as a team, I suppose every ward had to say, what would their procedures be and so we delivered. I took the family violence, questions, you know talking the conversation about family violence and we wrote it COVID related. And we took it specifically to ED. So they put it on the wall so that, the questions that was asked [about] family violence were specifically related to the lockdown. . . we've got it on our intranet . . .there's a specific area for 'Top of COVID' resources and under that we've got family violence and . . .the routine questions relating specifically to COVID. (FG5)

Underpinning the theme of Responding to the Moment was recognition of creativity among VIP teams who continued to support front line staff with the tools and messages to assist with family violence assessment, disclosures, support, and referral. They strategized ways to maintain engagement with their colleagues and the communities they served.

> there's some great creativity that's really come out during this time. . . across the country there's been some amazing creative new ways of working and new ways of engaging. Like how do we use video or create short videos. . . how can we keep people engaged, how can we get this information across in ways that are not just a click and flick online or death by powerpoint. (FG8)

Valuing Relationships

The second theme was valuing relationships. Participants discussed the impact of COVID-19 on their communications and interactions with various stakeholders including staff within the DHB; fellow VIP coordinators across the country; government agencies, including Oranga Tamariki (statutory child protection agency) and Police; non government agencies, including Women's Refugee; as well as local iwi (indigenous Māori extended kinship group). At times, constrained ways of working strained relationships:

> Oranga Tamariki . . . are super, super cautious. . . . our Oranga Tamariki liaison person . . . was not allowed to come to the hospital, she worked from home for a really long time. And that was quite challenging for us but also it was challenging for Oranga Tamariki. (II7)

Despite these frustrations, overall, participants spoke positively about how their networks had been strengthened as a result of the lockdowns, the benefits of Zoom, and their desire to keep the safety of women and children at the forefront of people's minds. Three valuing relationship subthemes included community connections, supporting DHB staff, and sharing resources.

Community connections. When the government was calling for everyone to socially isolate, work from home where possible, and stay in your "bubbles," VIP coordinators "did try to let the services know we're still here; . . .you're still doing your mahi [work], we're still here doing our mahi so you know we're still at the end of the phone, we're still available" (FG2). The primary connections participants noted were "communicating quite a lot with the police and Oranga Tamariki" (II3). One way in which they facilitated connection was through use of technology.

> A significant shift for everyone in the COVID-19 context was the move to Zoom and online interagency meetings. For some, "when we first went into lockdown we really didn't know about Zoom and Teams and all these other things that have now kind of become everyday parts of our work" (II5).

> I hadn't done Zoom before, I'd done Skype and all that, but hadn't really done Zoom and not Zoom meetings, so for the child protection alert meetings we did that over Zoom. And shared documents and things like that which we hadn't done before. So I thought that was really good. (FG12)

Once procurement of technology and initial glitches were sorted, participants spoke positively about shifting meetings online. They found that meetings were more efficient, cases were prioritized, and more than 1 member of the VIP team could attend as the barriers to travel and time were no longer in play. Technology made it "really good to be able to Zoom into meetings, normally I can't physically attend" (FG1). In some instances, because the meetings became more efficient, they started to happen on a more regular basis.

> Previous to COVID I would attend a weekly meeting which is with the police, Oranga Tamariki, Women's Refuge, and [an Indigenous Māori organisation] . . .where we would go through all of the previous [weeks' police call outs]. And of course, once COVID hit, that completely changed. . . 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 and . . .we kept working in that respect rather than going back to the weekly meeting. (FG5)

Many participants spoke positively about their relationships with the Police, who were often their eyes and ears in the community when they were to remain in their bubbles.

> We were catching up with the police on a daily basis in the emergency operation centre, having a look at police calls that are come in, looking at any issues that there were around the police. . . and the police moved quite into a proactive rather than a reactive mode across the district which was fairly nice. (II2)

> it was really nice to be able to keep connected with those other agencies just to hear what their reality was for them and what was going on outside of health. (FG1)

As indicated above, community connections were not always smooth as other services were at full or limited capacity. Indeed,

> People are really good at giving leaflets, so go away and get your protection order, go away and ring victim support. Yeah, but even if they did go away and ring them, they were shut because it was COVID so there wasn't somebody who could meet them and walk them down the journey that they would have done potentially previously. (FG9)

To assist where they could and stay connected, some coordinators worked to take lead roles in organizing meetings and keep community organizations updated: "our role was. . . collecting information for Oranga Tamariki and the other statutory agency which is police" (FG6).

Supporting health staff. It was not just the external (community) relationships that were strengthened during pandemic movement restrictions. Coordinators worked to build relationships with colleagues in the health setting and support the service-based VIP champions.

> What it allowed last year, that building of relationships. . . we started. . . doing a monthly child protection case review so every month we review one of our unexplained injuries and we invite ED, paediatricians, anybody who was involved you know to look at what we did, is there anything we can do? So that's kind of raised our profile with the ED SMOs [senior medical officers]. . .as a service. (FG9)

> we're now meeting them [service champions] on Zoom every two months . . .we were doing two a year and then some people

> can't come obviously and they miss it for a year so just having a little check in like 45-minute, hour check in every two months we just started that so if we do go into another lockdown then that can just continue and it's something that's consistent. (FG2)

In their VIP role, participants also found themselves in the position of supporting staff who were experiencing family violence and "understanding our staff as members of a community that are also impacted" (FG3). In some instance, it was only because of their community connections that VIP coordinators came to realize the situation:

> in safety meetings, we were assessing, we were putting the plans in place, we were doing monitoring, we forgot to look after our staff. And like I say if the police hadn't . . . said to me this person actually is a nurse at your hospital and I'm like what? Holy moly and then we had a doctor, and then we had two doctors. . . it just continued. And so, I went back and said how do we get [staff who had been sent home to work and as a result were in an unsafe environment at risk of harm] to come back into the hospital, how do we bring them back in? (FG3)

> For staff who might have been affected by the lockdown and in a violent relationship, where violence was happening. . . how managers should support the staff, we did some info sheets. (FG4)

Under the banner of VIP some coordinators found themselves working closely with human resources to implement systems to support staff.

> Being aware. Like, staff's different reactions, to that period of time. . . people's anxiety levels shot through the roof. . . But realising that actually staff were really anxious about coming to work. . . there was quite a lot of work we did with our HR department around staff wellbeing. (FG5)

While coordinators gave time and energy to others, some coordinators, especially those working on their own, reported feeling "extremely tired! You know, mentally brain tired" (II6). They felt that they were not offered the same support from their managers for their own wellbeing. Some had felt isolated and exhausted and did not feel that the support the VIP gave to wider DHB staff was reciprocated.

> I said I need supervision I'm telling you now. And the manager said, we need to get it approved and I said, I need supervision now because if you don't I'm, you know I recognise that I am burning out. . . it got to the point that I ended up crying and I'm really not a crier but they arranged that which was great but I still have to even fight for that stuff because it did, it had a huge impact. (II2)

Coordinators' mental health and well-being was not always taken into consideration when told by managers that they were to work from home:

> we were working from home for about 5 weeks and I found that towards the last couple of weeks I found it difficult. I live in a small house, my stuff's all set up on my kitchen table, so it's kind of here when I go to bed, here when I get up, I eat my dinner around it. I've got scraps of paper all over the place, it's just really hard to manage. But the other thing is that I also got to the point where I thought I've worked in family harm, family violence, child protection for many years and I've managed to keep myself sane. . . because I was working from an office, I could physically walk away from it at the end of the day. Whereas now I can't do that and I'm bringing all this stuff into my own home environment, which is my, supposedly peaceful place. And I don't like that, I just don't like it. You know we don't deal with good stuff, we deal with people who are struggling because they can't get the supports or whatever they need. So that was a really big thing for me. (II4)

Sharing resources. Coordinators spoke about liaising with other VIP coordinators around the country to learn what others were doing and to share resources. One DHB was recognized by many as being leaders in creating innovative resources.

> We did connect with [another programme] to ask how they're doing it because they're always a little bit ahead of the game. . . . and we learn a lot from them. . . .so we did do some sharing amongst each other, regionally. . . . I did find the regional, collaboration pretty good. And we continue doing some of it afterwards as well. (FG1)

> I've found [another DHB VIP] already had an [online] pre learning. And a second type of a e-learning [similar to] what we do in the core training - all that most important information. (FG5)

Many coordinators took on the job of filtering all the updates that they received from various organizations and condensing this into the "need to know" to then share with colleagues.

> Our team has a very strong ethos of what's the problem, how do we fix it and that's why we rapidly got on to the intranet, rapidly developed that resource. We tried as much as possible, we shared that with the other DHBs, we were like here, don't reinvent the wheel, we've put this work in if it's helpful to you. (FG2)

While coordinators were willing to share their innovations with colleagues, there was a general feeling that it would be helpful to have a standardized approach across the country:

> God bless [DHB] who are really proactive. They put together a COVID kind of tool. . . why haven't we got standardised stuff across the country with that kind of tool? . . .that pathway needs to be explored. Even to try and standardise response instead of the inequity that we get across New Zealand. (FG10)

In the process of Responding to the Moment and through their efforts of Valuing Relationships, participants also used

this time during the pandemic to reflect on the program as a whole—what was and was not working.

Reflecting on the Status Quo

The final theme was about the status quo; that is, what was the position of the VIP pre-COVID-19.

> COVID doesn't make a difference actually for the challenges. The challenges are the same whether COVID's there or not. And that's one of the things in my services that I see, because everyone sort of wonders if there have been more IPV reports identified or more reports of concern, during the period that there's been no training and that hasn't changed in my services. They still perform poorly. They still don't actually screen, routinely. (II5).

Three subthemes include lack of Māori engagement, encountering service resistance and being invisible.

Lack of Māori engagement. Across the data, there was a general absence or lack of specificity regarding responding to the needs of Māori as tangata whenua (Indigenous people born of the land): "Generally speaking, Māori presentations of IPV is a little higher than non-Māori. . . There was nothing specifically put in place for any particular group of people it was just everybody's the same" (II5). The need to recognize inequities and develop meaningful, collaborative, and reciprocal partnerships with Māori to inform culturally responsive services is well known.[15] VIP team members attributed the lack of cultural safety to the general whiteness[26,27] of staff and policy in this mainstream program, "none of us identify as Māori or Pacific and, for a long time I felt very uncomfortable presenting those kaupapa (principles that inform action)," and an insufficient capacity and resourcing of Māori health teams to support the program.

> 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 still do feel uncomfortable that we don't have that engagement with our Māori services, to support us to present this package. (FG1)

While some staff were committed to learning te reo Māori [Indigenous Māori language] and wanted to engage more with Māori, the question remained of how to do this in a meaningful way.

> We are trying to upskill. . . But, translating that into something that's not tokenistic that really honours biculturalism and the Treaty [te Tiriti o Waitangi between British Crown and Māori] in a really tangible and useful way I think is quite difficult without kind of support from the Māori health unit. (FG8)

When specific Māori culturally responsive COVID initiatives in the community were observed by VIP staff, it was from a position of outsider gaze rather than authentic engagement. They noticed that local Māori iwi (tribal group) and marae services (services by Māori for Māori) responded to the unique and diverse needs and realities of Māori.

Encountering service resistance. Coordinators spoke of the struggle to get buy-in to the VIP from staff, managers, and professional leaders. A lack of endorsement for training suggested resistance to recognizing family violence as a health priority:

> There could be more ownership if there's better training for managers. . . even to say this is how you support your colleagues (FG8)

> 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. But in the ones where they're like it's not your job, you don't have time for this and they don't give them the support that's still a big issue in some of our services. . . Even with the COVID stuff where we've tried really hard to highlight this is really massive issue. . . it's really hard if you don't get that management support. (FG2)

> Certain services say they can't give their consultants 8-hours off. We're competing against so many other trainings that are mandatory and required so we've always had that tension. (FG1)

While not for all, a lack of management support was noted to create barriers to progress. This was sometimes related to restructuring and turnover, "We'd had a lot of internal structural changes like people leaving gaps. . . service level manager, we've had quite a few managers" (FG4). Another participant had experienced management actively discouraging staff engagement in the VIP system response:

> In areas where we've done our sessions, we've done our updates and we've had [health providers] who are like oh so excited and then they've been told by their manager, child protection is not our business, you can't be a champion, we don't have champions and you're like oh! (FG9)

Being invisible. Some coordinators talked about generally feeling invisible to managers and staff and that while COVID-19 gave face to the potential increase of family violence, since then things have "just gone back to the same old, same old" (FG12). Many coordinators had ideas for change but often felt "it's like talking to a brick wall in my role" (II5).

> It's a difficult role to be in because. . . we're just such a small percentage of the whole workforce and to get visibility at all

> levels. . . We've been waiting 5-years now I think to get a steering group up and running again and we've had three managers come through that have just given us the run around. (II4)

A key component of the VIP is completion of reports which are sent to management and the Ministry of Health. These reports cover information such as completed trainings and client assessments. Some participants reflected on the reporting requirements and perceived emphasis on numbers as measurements of success.

> What really worries me is that we are target focussed. . .We should be focussing on the quality not the quantity. So that's my worry when you get these KPIs and all these other sort of fancy terminology that you must do X amount otherwise you're not doing your job properly. (II4)

Others indicated that although they completed and sent off the reports, there was a lack of feedback. One participant suggested reports were altered to present a positive bias.

> We get no feedback from Ministry of Health. I think there's only been one year that I've been here that we got feedback from the Ministry of Health report, and we certainly don't get any feedback from within the organisation. (FG10)

> And then you get the dodgy manager who gets the Ministry of Health report or the [evaluation] report and changes things and makes you look good where it doesn't, you know it just. . .what do you do with it? (II4)

Coordinators discussed losing existing traction in the VIP. When they felt they were finally gaining momentum in service areas for training or routine enquiry, this fell to the wayside with the focus turning to the response to COVID-19: "when COVID first happened, we were dropped like hot cakes" (FG1). Coordinators spoke of the program being viewed as an "add on" and "not a priority."

> there's actually some real systemic issues within the organisation that are problematic and hinder progress and traction and probably stems from, right from the top, lack of priority given to VIP. So, yeah got a programme, got coordinators, we're meet, meeting standards, done. Job done. And with no actual real appreciation of the importance of the work, supporting the work, supporting the front-line staff to do the work and, and you know, resourcing. . . I still don't have family violence champion programme. (FG10)

> as a VIP programme, as a team that sits with the VIP programme, we don't sit on any governance structure, our reports weren't going in, into any governance structure. Other than the two advisory groups that we both sit on respectively. And just to give you an example, when the fire alarm goes off here, and the people come around with their hats to check if everyone exited the building, we're not on anyone's list, we don't exist! Organisationally, we're off the wall. (FG10)

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 program continued to be delivered in the hospital and community settings. While participants demonstrated innovation and resilience, they also experienced frustration and questioned their role.

Discussion

Violence Intervention Program team members experienced the uncertainty of how to support front line health staff in the hospital and community to respond to women and children impacted by family violence. The constraints during the first year of the COVID-19 pandemic and the associated measures to reduce transmission resulted in a mix of creative, innovative opportunities, and challenges for responding to family violence in the context of the COVID-19 pandemic. In this discussion we reflect on our 3 themes drawing on emergency and risk management literature addressing uncertainty, complexity, risk, and resilience.

In the first theme, "responding to the moment," participants 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 prioritized the health impact of the infectious COVID-19. VIP team members could no longer rely on delivering face-to-face 1 day family violence training to staff and had to work through how family violence assessment and support could be incorporated into telehealth, all while working with government and community agencies to clarify and communicate how to access family violence services. This theme is consistent with understanding uncertainty as both a lived experience and a characteristic of information.[28] VIP team members shared their lived experience of uncertainty in how the pandemic was impacting their work (eg, where and how they would be working) and their home lives (eg, concern for health and safety of themselves and family members). It was also evident that the ever changing and at times conflicting information compounded their sense of uncertainly. Guidelines Supporting the Wellbeing of Family Violence Workers During Times of Emergency and Crisis[29] support the need to attend to healthcare-based frontline and program staff doing this work. VIP team members equally worked to communicate information across their communities. This included developing resources specifying which community services were essential services and how services could be accessed.

In the second theme, "valuing relationships," VIP team members found energy and support from maintaining contact and sharing information and solutions with their regional colleagues. In addition, the VIP National Management Team

were available to offer support during the first year of the pandemic and disseminated several standardized documents such as guidance on telehealth service responses. In the face of the uncertainty that comes with health emergencies, a simple digital network solution allowing rapid communication across the health family violence response system would be valuable to enable sharing experiences and solutions in real time.

VIP team members also found value in strengthening their relationships across sectors. Relationships with police were essential during the highest level of lockdown (stay at home orders) as police were often the sole agency that continued to have eyes on women and children at risk. When there were concerns about escalating violence by a family member, the police were able to conduct home visits to assess safety.[30] Similarly, Haag et al[31] identified a "critical role of community engagement and outreach and the need to be creative and collaborative among new partnerships" when adapting to the COVID-19 pandemic in supporting those impacted by family violence.

In the third theme, "reflecting on the status quo," the COVID-19 pandemic provided time for VIP team members to take stock of the Violence Intervention Program. Thinking about the status of the program before the COVID-19 pandemic, coordinators considered their role, program relationships, what is measured, reporting systems, strengths, and conditions that prevent the vision of best practice from being realized. Assessing the strengths and vulnerabilities of the program that were evident in the pre-pandemic phase is consistent with disaster risk management and emergency humanitarian response literature documenting how vulnerabilities that exist before an emergency can make the difference between an "extensive" and a "catastrophic" event.[32,33] These vulnerabilities include societal conditions such as poverty,[28] gender norms,[33] as well as service inequities and how services work together.[34,35] For the VIP, the resistance by many frontline health workers to recognize family violence as a determinant of ill health and provide a supportive response, along with the invisibility of the program within the health structures, all evident before COVID-19, were manifest during the COVID-19 response. For example, over the past 6 years, despite a nationwide VIP training program, policy, and resources, clinical evaluation data indicates that fewer than 1 in 3 women presenting to a New Zealand emergency department are assessed for intimate partner violence.[15] Reflecting on the status quo was often the impetus for coordinators' innovation in "working around" embedded norms and prioritizing community relationships, as demonstrated in "in the moment" theme.

Reflecting on the status quo, the interviews also highlight a lack of engagement with Māori to overcome the systemic inequities in providing a culturally informed response to Māori whānau impacted by family violence. The ongoing systematic lack of resourcing for Māori capacity across the health system impacts on the overall uplift of Māori cultural capability, responsivity, and safety.[4] Within the violence intervention program, deferring to an explanation of insufficient Māori health service capacity, however, negates the responsibility of non-Māori to uphold Te Tiriti and act as anti-racism allies.[36] Some coordinators have taken individual responsibility to better understand a cultural response approach, however, for system transformation an overall committed strategy is needed "with Te Tiriti o Waitangi and Māori leadership at its heart."[37] An example of a Māori community-led response to COVID-19 was evident in the Tihei Mauri Ora Emergency Response Centre. The Centre took just 3 days to gear up to provide food, firewood, and blankets to anyone who needed that support, with a philosophy of "ngākau aotea—open heart, open mind, open arms."[38] Providing allyship to support such leadership is an opportunity that has yet to be undertaken.

This study provides only a window into the complexity of responding to the "wicked problem" of family violence within the context of a health system impacted by the COVID-19 pandemic. The ongoing impact of the pandemic, continuing inequities in the social determinants of health and overburdened health staff are just some of the continuing challenges violence intervention programs face to keep going in the response to preventing and reducing the impact of family violence. While the New Zealand government policies and the VIP teams have achieved much in response to the urgency created by the pandemic, more can be done to develop system resilience. Understanding the health response to family violence as a complex adaptive system provides a platform for feedback loops and ongoing learning to cope with the uncertainty that is inherent in being responsive to individuals and families impacted by family violence.[39] There is a need to move beyond the prescriptive approach and wide variability within and between services that existed in family violence responsiveness before the COVID-19 pandemic. We must learn from the COVID-19 pandemic to embrace uncertainty and be adaptive and robust to ongoing shocks and their subsequent ripple effects all while maintaining core functions.[12,40] As for the health system as a whole,[12] a resilient health system response to family violence will have community engagement at its core.[41] For New Zealand, this includes upholding Te Tiriti o Waitangi, enabling Māori leadership, and resourcing Māori led initiatives.

Strengths and Limitations

In this qualitative descriptive study, a sample of 41 key workers involved in leading the health response to intimate partner violence and child abuse and neglect from 15 New Zealand health boards shared their lived experience of the impact of COVID-19 on their services during the first year of the pandemic. The sample included those working in both large and small health boards with some continuing to work in their program offices (usually within hospital complex), while others worked from home. This provided a diverse

range of informants. The major limitation of this study is that it included only the voice of family violence program team members, it did not include those impacted by family violence (service users). How people experiencing family violence encountered health services during all phases of the pandemic is important work that can inform system improvements. By design of the current VIP, our findings are limited to hospital and several community services. A primary care response to family violence in New Zealand remains undeveloped.[42] Engaging with the primary care response will provide an important resource for a resilient health service providing support for those impacted by family violence across any systemic risks such as the COVID-19 pandemic.[12,43] We also acknowledge that the data gathered do not necessarily reflect 28 of participants operating at the most restrictive alert levels. Across participants in the less restrictive levels, however, there remained a sense of vulnerability and uncertainty, aware that community transmission could suddenly increase with a return to restrictions. Finally, we acknowledge that the perspective of some may be missing. Five DHBs were not represented in the sample and there was a lack of diversity in participant ethnicity and gender. This, however, is reflective of the VIP workforce, typically female and New Zealand European with underrepresentation of Indigenous Māori and Pacific people.

Conclusion

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.

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Ethical Approval

The study protocol was approved by the New Zealand Health and Disability Ethics Committee (AKY/03/09/218/AM11).

Written Informed Consent

All participants provided written consent.

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