Final Evaluation Report

Stage 1 Evaluation of the IPARVAN Framework

1 September 2022

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

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This report should be read in conjunction with two supplementary reports (Reports for South West Sydney and Hunter New England Aboriginal communities). These reports contain the findings and recommendations from consultations with Aboriginal clients and workers across the violence, abuse and neglect sector.

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High-level Summary of Findings

There are high rates of violence, abuse and neglect in NSW and, in many instances, people experiencing violence, abuse and neglect do not receive an optimal response. Too often, the NSW health system provides a response that is fragmented and crisis-driven, rather than one that is holistic, seamless and person and family-centred. This is particularly true for Aboriginal people, who have been disproportionately impacted by violence, abuse and neglect due to colonisation, harmful government policies and systemic inequalities.

In response to this, the NSW Ministry of Health (the Ministry) has invested significant resources into the Violence, Abuse and Neglect (VAN) Redesign Program, including the development and implementation of the Integrated Prevention and Response to Violence, Abuse and Neglect Framework (the IPARVAN Framework).

This report presents the findings from the Stage 1 evaluation of the implementation of the IPARVAN Framework. The Stage 1 evaluation commenced in April 2020 and concluded in June 2022. The Stage 1 evaluation focused on understanding what activities had been delivered to date, how well these activities had been delivered and are leading to enhanced integration, and whether these activities were leading to immediate outcomes. The Stage 2 evaluation (scheduled for 2024/25) and Stage 3 evaluation (scheduled for 2025/26) will focus on medium-term outcomes and economic impact.

Overall, the evaluation found that progress had been made by all levels of the NSW health system. This progress was slower than expected, driven in large part by delays due to the COVID-19 pandemic. These delays were exacerbated by ongoing workforce challenges, and leadership transitions within some organisations.

Progress at all levels of the NSW health system proceeded rapidly across 2018/19 and 2019/20, and then slowed considerably. In some instances, key activities stopped entirely in 2020 and 2021 as the NSW health system prepared for and responded to the COVID-19 pandemic.

The Ministry (led by the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit) made progress establishing the foundations for enhanced integration. This included providing system-level implementation guidance, supporting state-wide governance structures, and developing and disseminating key frameworks, strategies and policies such as a suite of VAN Service Standards. Recent resourcing changes within the PARVAN Unit – with some key personnel moving to other roles – presents a risk to continued successful implementation.

The Education Centre Against Violence (ECAV) made good progress in the early stages of implementation – including successfully pivoting to virtual education and training during the COVID-19 pandemic. However, this progress ceased entirely in 2020 and 2021 as the result of sustained periods of leadership change. As a result, key activities such as work to develop and implement qualifications and strategies that assist priority groups (including Aboriginal workers) to achieve the entry-level qualification, skills and experience for employment in VAN services did not progress. Recommencing these activities should be an immediate priority.

The Agency for Clinical Innovation (ACI) successfully delivered the activities assigned to it under the IPARVAN Framework, including work to support 12 Districts/SCHN develop locally appropriate integrated service models. Despite this support from ACI, and additional resourcing that was made available to Districts/SCHN, all Districts/SCHN reported very little progress with the development of integrated service models, noting this as an area of future focus.

Districts/SCHN reported progress against each objective in the IPARVAN Framework each year. There was no consistent area of focus across Districts/SCHN – each focused their efforts on areas aligned with their local context.

The evaluation data indicates that Districts/SCHN spread their implementation efforts thinly across the entire IPARVAN Framework, rather than focusing efforts in a staged or prioritised manner. There are opportunities for the Ministry to provide greater guidance to Districts/SCHN in future regarding prioritisation of efforts including, for example., by co-developing with each District/SCHN bi-annual implementation plans.

Insights from consultations, focus groups, and site visits highlighted some key activities that are supporting implementation progress and that are leading to enhanced integration. These include:

Building strong Executive-level leadership and championing change. Strong leadership means Executives that understand the significant impact of violence, abuse and neglect and are committed to implementation of the IPARVAN Framework. Strong leadership creates the authorising environment for change at a whole of health system level.

Nurturing 'bottom-up' leadership from VAN services managers and staff. In some Districts/SCHN, VAN services managers and staff drive implementation of the IPARVAN Framework. This includes leading work to revise governance structures and proactively providing mentorship and informal training/upskilling to broader health service staff. This work is vitally important – Districts/SCHN should ensure staff are appropriately supported to do this (for example by providing sufficient non-client time to support delivery of capacity-building activities).

Developing appropriate state-wide governance structures. The PARVAN Unit has successfully developed and supported structures that support ongoing implementation and shared learning. These structures create a consistent state-wide VAN response, and provide the opportunity for Districts/SCHN to share best practice and learn from each other.

Revising VAN service governance structures within Districts/SCHN. Where this has worked well, revised structures have built connections across previously separate VAN services, between VAN services and related health services (such as mental health and AOD), and created a sense of 'one VAN team' providing a holistic and person-and-family centred care model. Districts/SCHN that have not yet revised governance structures should prioritise this, learning from those Districts/SCHN where it is working well or has been thwarted by senior Executives.

Supporting sharing of health information about clients of VAN services with relevant clinicians across the health system. Some Districts/SCHN have developed approaches to sharing health information within electronic medical records systems, ensuring that clinicians (both those working in VAN services and those in the broader health system) can access relevant records, whilst maintaining client privacy and confidentiality. Stakeholders report this has resulted in improved experiences and outcomes for consumers and staff.

In Districts/SCHN where these activities are happening, stakeholders reported integration was progressing within and across VAN services and with broader NSW health services and interagency services.

There are some activities where all Districts/SCHN reported limited progress. This includes efforts to develop locally appropriate integrated service models (including co-design with local communities), and efforts to ensure services are culturally safe and culturally appropriate.

Consultations with Aboriginal clients and Aboriginal health/community workers highlighted positive experiences and outcomes when engaging with some counsellors and caseworkers. Overall, however, stakeholders reported negative experiences with VAN services and the broader health system, including fragmented services, having to 'retell' their stories, lack of understanding of culture and trauma, and condescending and racist treatment by staff in the broader health system. Stakeholders reported that the skills, knowledge and experience of Aboriginal staff is not valued by the health system and suggested that a more flexible approach to recruitment, support and retention is required.

There is limited data at this stage of the evaluation to understand the impact of the IPARVAN Framework and whether integration is improving client experience, client outcomes, staff experience, or system sustainability. While this was not an explicit focus of the Stage 1 evaluation, limited outcomes data does present a challenge for the Stage 2 and Stage 3 evaluations, as there is to-date no quasi-baseline from which future evaluations can measure progress. While the Ministry has made great strides in improving the data landscape in recent years, progressing work to enhance the quality and comprehensiveness of outcomes data should be prioritised.

Successful ongoing implementation will be supported by enhanced system-level coordination (noting that the IPARVAN Framework is just one of many interrelated policies, strategies, and frameworks); greater local-level guidance from the Ministry to Districts/SCHN; and efforts to enhance the data landscape.

Glossary of key terms and acronyms

Acronyms

Term	Description
ACCHO	Aboriginal Community Controlled Health Organisations
ACCO	Aboriginal Community Controlled Organisation
ACI	Agency for Clinical Innovation
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
BOCSAR	Bureau of Crime Statistics and Research, NSW Department of Communities and Justice
CCHC	Central Coast Multi-Agency Response Centre
CEC	Clinical Excellence Commission
CPCS	Child Protection Counselling Service
CPU	Child Protection Unit
CWU	Child Well-being Units
DCJ	NSW Department of Communities and Justice
DFV	Domestic and Family Violence
DV	Domestic Violence
ECAV	Education Centre Against Violence
ED	Emergency Departments
Education	NSW Department of Education
FTE	Full time equivalent
HERO	Health Establishment Registration Online
HETI	Health Education and Training Institute
JCPRP	Joint Child Protection and Response Program
KLEs	Key lines of enquiry (evaluation questions)
KPIs	Key performance indicators
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex (community)

Term	Description
LHD	Local Health Districts (Districts)
LPR	Local Planning Response Meetings
MH-OAT	Mental Health Outcomes Assessment Tool
MOU	Memorandums of understanding
NAP	Non-Admitted Patient (dataset)
OOHC	Out of Home Care
PREMs	Patient Recorded Experience Measures
PROMs	Patient Recorded Outcome Measures
PS	Provider Survey
ROSH	Risk of Significant Harm
SAMs	Safety Action Meetings
SAS	Sexual Assault Service
SAT	Self-Assessment Tool
SHN	Speciality Health Networks
SCHN	Sydney Children's Hospitals Network
The Ministry	NSW Ministry of Health
VAN	Violence, abuse and neglect
WHO	World Health Organization
WFT	Whole Family Team
YAMs	Youth Action Meeting

Definitions

Term	Description
Aboriginal Community Controlled Health Organisations/ Aboriginal Community Controlled Health Organisations	An ACCO refers to an independent, not-for-profit organisation that is incorporated as an Aboriginal and/or Torres Strait Islander organisation and/or is a registered community service. An ACCHO refers to a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally

Term	Description
	appropriate health care to the community which controls it, through a locally elected Board of Management.[1]
Burden of disease	Refers to the impact of living with illness and injury and dying prematurely.[2]
Closing the Gap	Closing the Gap is the National Agreement with the objective of enabling Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.[3]
Culturally safe	Refers to an environment or practice where everyone examines their own cultural identities and attitudes and is open-minded and flexible in their attitudes towards people from cultures other than their own. It also requires everyone to understand that their own values or practices are not always or only the best way to solve problems.[4]
Culturally appropriate / culturally appropriate care	Culturally appropriate care is an extension of person-centred care that includes paying attention to social and cultural factors in managing therapeutic encounters with consumers from diverse cultural and social backgrounds. It is an ongoing process requiring health professionals to continuously self-reflect and proactively respond to the consumer, their carer or the family with whom they interact.[5]
Cultural competency training	Cultural competence refers to a set of behaviours, attitudes and policies that come together in a system or agency or among health professionals that enables them to work effectively in cross-cultural situations. Cultural competency training facilitates cultural competence.[5]
Family-focused	Refers to an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings. In patient- and family-centred care, patients and families define their "family" and determine how they will participate in care and decision-making.[6]
First 2000 Days Framework	The First 2000 Days Framework is a strategic policy document which outlines the importance of the first 2000 days of a child's life (from conception to age 5) and what action people within the NSW health system need to take to ensure that all children have the best possible start in life.[7]
Institutional racism	Refers to the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and

[1] NACCHO. (2022). Aboriginal Community Controlled Health Organisations. Retrieved from: https://www.naccho.org.au/acchos/
[2] Australian Institute of Health and Welfare (AIHW). (2019). Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW.
[3] Closing the Gap. (2022). National Agreement. Retrieved from: https://www.closingthegap.gov.au/
[4] NSW Government Safework. (n.d.). What is cultural safety?. Retrieved from: https://www.safework.nsw.gov.au/safety-starts-here/our-aboriginal-program/culturally-safe-workplaces/what-is-cultural-safety
[5] NSW Health. (2019). NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023
[6] Institute for Patient and Family-Centered Care. (n.d.) Patient- and Family-Centered Care. Retrieved from: https://www.ipfcc.org/about/pfcc.html
[7] NSW Health. (2019). The First 2000 Days Framework.

Term	Description
	racist stereotyping which disadvantage minority ethnic people (Macpherson 1991).[8]
Integrated / Integrated service responses	Integrated service responses to violence, abuse and neglect are defined as the provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma informed approach, and is designed around the holistic needs of the individual throughout the life course. An integrated, public health approach recognises that people affected by violence, abuse and neglect and their families often have complex needs requiring multiple interventions provided by a range of services.
IPARVAN Framework	The Integrated Prevention and Response to Violence, Abuse and Neglect Framework (IPARVAN Framework) outlines the vision, guiding principles, objectives and strategic priorities to strengthen NSW Health services in responding to violence, abuse and neglect in NSW.
Journey mapping	In a health context as it is used in this framework, journey mapping refers to a visual depiction of a client's interaction with health services.
NSW Health	Refers to the whole public health system in NSW. It includes the Ministry, pillar organisations, Statewide Health Services, Shared Services and Districts and SHNs.
Patient Recorded Measures	Refers to distinct types of metrics to capture patients' perspective of their care and are integral to building a patient-centred system of structuring, monitoring, delivering and financing health care.[9]
People who have experienced violence, abuse and neglect	Refers to all children, young people and adults who have experienced interpersonal violence, abuse and/or neglect. This includes people who have or have not accessed a service in response to violence, abuse and neglect.
Pillar organisations	Pillar organisations are part of NSW Health and provide expert advice, guidance and workforce education to Districts and SHNs in consultation with clinicians. They include the Agency for Clinical Innovation, the Clinical Excellence Commission, Cancer Institute NSW, Bureau of Health Information and the Health Education and Training Institute.
Person-centred	Refers to the whole person, going beyond the narrow focus on their symptoms and treatment, and applies a holistic approach to care that acknowledges the wider social, psychological, societal and cultural factors that may affect the individual and their healthcare journey. This includes incorporating the patient's family and/or carer in decision making to the extent the patient chooses.[10]
Psychosocial	In a health context as it is used in this framework, it refers to services and interventions focusing on people's mental, emotional, social and spiritual health and wellbeing that are provided by health staff trained in disciplines such as, but not limited to, social work, psychology, and counselling.
Quadruple aim	Refers to the purpose of the IPARVAN framework: client health and wellbeing, client experience, staff experience and system sustainability

[8] Macpherson W. (1991). The Stephen Lawrence Inquiry: Report of an inquiry by Sir William Macpherson of Cluny.
[9] NSW Health. (2019). Patient Reported Measures Framework. Retrieved from: https://www.health.nsw.gov.au/Value/Pages/prm-framework.aspx
[10] Clinical Excellence Commission. (n.d.). Person centred care. Retrieved from: https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/person-centred-care

Term	Description
Regression analysis	Refers to a set of statistical methods used to understand the relationship between a dependent variable and one or more independent variables.
Secondary trauma or re-traumatisation	Refers to experiences that occur after an initial trauma as a result of that event or the subsequent actions or inactions of others (Herman, 1997)[11]. This could be brought on by painful medical treatment, adversarial legal action, or a child being removed from their family. Other secondary traumas are induced by people's lack of understanding, disbelief, denial, blame, or even poor professional practice (Jackson et al., 2013)[12]. Secondary trauma can have the same impact on a person as the direct initial exposure to trauma and can lead to a number of consequences such as increasing the risk of harm, or complicating a client's efforts in recovery (Pynoos, Steinberg, & Goenjian, 1996)[13].
System integration	Refers to integration within the health system as well as integration with other service systems that support people impacted by violence, abuse and neglect.
'Tight-loose-tight' approach	Refers to a leadership model where 'Tight' refers to providing purpose and goals to a team, 'Loose' refers to providing the team the autonomy to deliver the goals, and 'Tight' refers to providing definitive goals too measure against.
Towards Zero Suicides	Towards Zero Suicides is the NSW Ministry of Health's initiative that address priorities in the Strategic Framework for Suicide Prevention and contribute to the Premier's Priority to reduce the suicide rate by 20 per cent by 2023.[14]
Trauma-informed care	Refers to a strengths-based model of care that seeks to provide a safe, supportive environment to clients and staff that reflects available research about the prevalence and effects of trauma-exposure and the best methods for supporting clients exposed to trauma, helping to minimise the impact of the trauma and prevent re-traumatisation (Wall, Higgins, & Hunter 2016)[15]. An outline of the key elements of trauma-informed care is provided in the companion document The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health. A trauma-informed system uses trauma-informed care as a 'universal precaution' (Gentile, J.P. F., n.d)[16], presuming that every person seeking support in a treatment setting has been exposed to trauma. It employs actions, relational approaches and language that makes people feel safe, offers choice and is collaborative. This approach also takes into account that some staff may also have experienced trauma.
Trauma-specific	Refers to a service that is aware of the possibility of ongoing or re-traumatisation of clients and of its direct and indirect impacts on its staff and takes steps to reduce this wherever possible. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients.

[11] Herman, J. L. (1997). Trauma and recovery: the aftermath of violence — from domestic abuse to political terror (Rev. ed.). New York: Basic Books

[12] Jackson, A., Waters, S., Meehan, T., Hunter, S.-A., & Corlett, L. (2013). Making tracks: A trauma informed framework for supporting Aboriginal young people leaving care. Melbourne: Berry Street.

[13] Pynoos, R. S., Steinberg, A. M., & Goenjian, A. (1996). Traumatic stress in childhood and adolescence: Recent developments and current controversies. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), Traumatic stress: The effects of overwhelming experience on mind, body, and society (pp. 331-358). New York, NY, US: Guilford Press.

[14] NSW Health. (2022). Towards Zero Suicides. Retrieved from: https://www.health.nsw.gov.au/towardszerosuicides

[15] Wall, L., Higgins, D., & Hunter, C. (2016). Trauma informed care in child/family welfare services (CFCA Paper No. 37). Melbourne: Australian Institute of Family Studies. https://aifs.gov.au/ cfca/publications/trauma-informed-care-childfamily-welfare-services/what-trauma-informedcare

[16] Gentile, J. P. F. (n.d). The Universal Precaution of Trauma-Informed Care: Making Sure Each Individual Feels Safe and In Control [PowerPoint slides]. Retrieved from: https://www.nasddds. org/uploads/files/Presentations/2014MYC/ New_Orleans_06-14.pdf

Term	Description
VAN client / VAN services client	Refers to a person who has received a service from a NSW Health VAN service (see definition below).
VAN Redesign Program	The VAN Redesign Program refers to a program of work within NSW Health to enhance the capacity of the public health system to provide 24-hour, trauma-informed and trauma-specific, integrated psychosocial, medical and forensic responses to sexual assault, child physical abuse and neglect, and domestic and family violence presentations. Funding for the VAN Redesign Program began in 2017. The IPARVAN Framework is a key component of the VAN Redesign Program.
VAN services	NSW Health services with principal responsibility for prevention and response to specific types of interpersonal violence, abuse and neglect (e.g., sexual assault services)
VAN services client	Refers to a person who has received a service from a NSW Health VAN service (see above).
Violence, abuse and neglect	An umbrella term used by NSW Health to describe three primary types of interpersonal violence that are widespread in the Australian community. It refers to domestic and family violence, sexual assault and all forms of child abuse and neglect. It also refers to children and young people displaying problematic sexual behaviour or engaging in harmful sexual behaviour, who often have their own experiences as victims of abuse and neglect

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Executive summary

The IPARVAN Framework promotes an integrated, public health approach to preventing and responding to violence, abuse and neglect.

There are high rates of violence, abuse and neglect in NSW and across Australia. In many instances, people who experience violence, abuse and neglect, their families and communities, do not receive an optimal response from the NSW health system. Too often, the NSW health system provides a response that is fragmented and crisis-driven, rather than one that is holistic, seamless and person and family-centred. This is particularly true for Aboriginal people, who have been disproportionately impacted by violence, abuse and neglect due to colonisation, harmful government policies and systemic inequalities. Aboriginal people often face structural discrimination and institutional racism when accessing health services.

In response to this, the NSW Ministry of Health (the Ministry) has invested significant resources into the Violence, Abuse and Neglect (VAN) Redesign Program, which aims to enhance the capacity of the public health system to provide 24-hour, trauma-informed and trauma-specific, integrated psychosocial, medical and forensic responses to sexual assault, child physical abuse and neglect, and domestic and family violence presentations.

The Integrated Prevention and Response to Violence, Abuse and Neglect Framework (the IPARVAN Framework) is a core component of the VAN Redesign Program.[17] It includes four objectives, each with associated strategic priorities.

The IPARVAN Framework is being implemented over two phases. Phase 1 commenced in January 2019 and had a focus on integration of VAN services. Phase 2 was scheduled to commence in July 2020 but was delayed due to the COVID-19 pandemic. Phase 2 will broaden the focus to include integration of VAN services with the whole NSW health system and other government and non-government services.

The Stage 1 evaluation aimed to understand the impact of the IPARVAN Framework to support ongoing implementation.

The Ministry engaged Nous Group (Nous) to develop the Monitoring and Evaluation Framework for the IPARVAN Framework, and to conduct the Stage 1 evaluation. The Monitoring and Evaluation Framework details evaluations at three stages:

- The Stage 1 evaluation, scheduled for 1.5 to 2 years post implementation, with a focus on process and short-term outcomes.
- The Stage 2 evaluation, scheduled for 4 to 5 years post implementation, with a focus on medium and longer-term outcomes.
- The Stage 3 evaluation, scheduled for 5 to 6 years post implementation, with a focus on assessing economic benefit.

This report details findings from the Stage 1 evaluation, which was completed between April 2020 and June 2022. The evaluation was guided by four key lines of enquiry:

1. What activities have been undertaken to implement the IPARVAN Framework?
2. How well have the activities contributed towards system integration (within and external to NSW Health)?

[17] Further information on the VAN Redesign Program and the IPARVAN Framework can be found at https://www.health.nsw.gov.au/parvan/Pages/van-redesign-program.aspx

3. To what extent has the purpose of the IPARVAN Framework been achieved (focusing on the quadruple aim: client health and wellbeing, client experience, staff experience and system sustainability)?
4. What are the opportunities to improve?

The Stage 1 evaluation incorporated quantitative and qualitative data from a variety of sources including interviews with clients of NSW Health violence, abuse and neglect services (VAN services). Importantly, the evaluation separately explored the experience of Aboriginal people who have experienced violence, abuse and/or neglect through place-based consultations in two Local Health Districts (LHDs). This included consultations with Aboriginal clients and Aboriginal staff from NSW Health and local Aboriginal community controlled organisations (ACCOs).[18]

There was good progress on integration within VAN services, however integration across all parts of the NSW health system was significantly impacted by the COVID-19 pandemic and leadership challenges.

Phase 1 implementation of the IPARVAN Framework had a focus on building integration between and across VAN services. Data indicated that there had been some progress with Phase 1 implementation, although this was much slower than expected. Progress was hindered by the COVID-19 pandemic – requiring the NSW health system to reprioritise efforts away from implementation – as well as resource constraints (at the Ministry, NSW Health Pillar Organisation and District/SCHN levels) and leadership challenges within some organisations.

Key findings include:

- The Ministry progressed activities that provided the foundation for continued implementation. This included developing and disseminating key strategies and documents to support ongoing implementation – such as the full suite of VAN Service Standards – and providing management of the VAN Redesign Program. However, there have been significant delays in the last twelve to eighteen months – implementation of Phase 2 was scheduled to commence in July 2020 but is not yet underway.
- The Education Centre Against Violence (ECAV) made good progress in the early stages of Phase 1 implementation, including rapidly pivoting to online education and training opportunities in response to the COVID-19 pandemic. Activities came to a complete stop across 2021 and 2022, due to leadership challenges and changes within the organisation.
- The Agency for Clinical Innovation (ACI) delivered activities under Phase 1 of IPARVAN. This included support to 12 Districts/SCHN to help with the development of local integrated service models. Whilst these activities were delivered by ACI, Districts/SCHN reported little progress in implementing local integrated models.
- At the District/SCHN-level, greater progress was made against objectives 1 and 2, compared to objectives 3 and 4. This indicates that Districts/SCHN focused their efforts on enhancing leadership, governance and accountability (objective 1) and building the skills, capabilities and confidence of the NSW health workforce (objective 2). Slower progress against strategic objective 4 is to be expected, given that this strategic objective is a focus for Phase 2 implementation.

Implementation proceeded rapidly between 2018/19 and 2019/20, but slowed between 2019/20 and 2020/21.

Reasons for this include:

[18] Note that Aboriginal staff and clients shared their experiences across the health system (not just VAN services). The experiences of Aboriginal people vary considerably within Districts and across the state and therefore these consultations in two Districts cannot be attributed to state-wide findings. However, many of the issues raised reflect findings of inquiries and reviews that have been made for decades.

- **The COVID-19 pandemic.** This impacted all levels of the NSW health system, including the Ministry, NSW Health Pillar Organisations, and Districts and SCHN as many parts of the health system were in a crisis response.
- **Natural disasters including the 2019/20 summer bushfires, and floods in 2020, 2021 and 2022.** The impact of these natural disasters was more acute for regional, rural and remote Districts.
- **Focus on other District/SCHN priorities.** Some Districts/SCHN prioritised other Ministry priorities, in line with their local context. District/SCHN Executives and other stakeholders reported that the IPARVAN Framework is just one of multiple, often overlapping, priorities developed and disseminated by all areas of the Ministry (including and beyond the Government Relations Branch/Prevention and Response to Violence, Abuse and Neglect Unit).

There was no consistent area of focus within or across Districts/SCHN as each targeted their efforts at different strategic priorities depending on their context.

Quantitative analysis of data from the Self-Assessment Tool (SAT) and provider survey[19] indicated that:

- **Each District/SCHN spread implementation effort across all four objectives.** Over the course of Phase 1 implementation, each District/SCHN reported progress against each strategic objective each year. Some District/SCHN Executives and VAN services staff reported that the nature of the SAT and provider survey – which require an update on implementation progress across all four objectives each year – created an expectation that all four objectives were equally important for Phase 1 implementation.
- **There was no consistent state-wide focus for implementation.** Whilst Districts/SCHN reported progress in the SAT against all objectives, the data showed no consistency regarding where this effort was focused across the state. Whilst some District/SCHN Executives appreciated this flexibility – in line with the 'tight-loose-tight' framework that guides the relationship between the Ministry and Districts/SCHN – others reported that they would have appreciated greater Ministry guidance to help them prioritise and focus their efforts and limited resources.

There were some areas where all Districts/SCHN made limited progress, including ensuring that the NSW health system is culturally safe for Aboriginal clients and staff.

There were some cross-cutting areas where few Districts/SCHN had made progress. These are detailed below – addressing these should be an immediate focus for Phase 2 implementation:

- **Ensuring VAN services and other NSW health services are culturally safe and culturally appropriate.** Aboriginal clients and health workers reported experiences of cultural insensitivity and subconscious racism from non-Aboriginal staff. This is consistent with what has been reported in previous reviews and inquiries for decades. Barriers to cultural safety include a deep mistrust of the health system, lack of cultural competency and trauma-awareness among health staff, inflexible and individualised models of care that do not respond to complex family circumstances or trauma, and long waitlists.
- **Recruiting, retaining and valuing quality Aboriginal and other culturally diverse staff within NSW Health**. All Districts and SCHN reported challenges with recruitment and retention of Aboriginal staff, whilst some reported successfully recruiting staff that reflect the multicultural nature of the communities that they serve. Consultations highlighted that a more flexible approach is needed to recruitment, qualification and other workforce policies to attract and retain Aboriginal health staff – including in management positions – that values cultural knowledge and skills.

[19] The Self-Assessment Tool is a tool completed annually where District/SCHN Executives and Senior Managers self-assess District/SCHN progress against the objectives and strategic priorities of the IPARVAN Framework. The provider survey is a similar tool – distributed by the evaluation team – to understand VAN service managers and staff perspectives on progress with implementation.

- **Successfully designing and implementing locally-appropriate integrated models, including engaging consumers in co-design.** Whilst some Districts/SCHN reported success with designing local integrated service models – such as 'no wrong door' or integrated intake models – overall there was limited progress in this space. This is despite additional resources being provided to Districts/SCHN for local design efforts, and the support provided through ACI. All Districts and SCHN identified enhanced engagement with consumers, including consumer journey mapping and co-design as a future area of focus.

Districts/SCHN reported that Executive support, reviewing governance structures and support from state-wide governance led to enhanced integration – the Ministry and Districts/SCHN should continue to prioritise and embed these activities.

The evaluation highlighted some activities that, to date, have led to greater integration between VAN services. Executives and staff in some Districts/SCHN further reported activities that have contributed to enhanced integration between VAN services and the broader health system.[20] Activities that have led to integration include:

- **Championing of the IPARVAN Framework at the Chief Executive and Executive Team level.** Executive level leadership and championship created the authorising environment for implementation and provided momentum for change. Strong Executive-level leadership was not evident across all Districts/SCHN. Where this does not yet exist, the Ministry in partnership with VAN services managers and staff should consider opportunities to generate this buy in.
- **Development of state-wide VAN governance structures.** These structures brought together Senior Executives and Senior Managers from across Districts and SCHN, building relationships and supporting the sharing of good practice. As implementation progresses, the Ministry should continue to support these structures (and refine them when necessary).
- **Revision of District/SCHN governance structures.** All Districts and SCHN reported in the SAT efforts to review their internal governance structures to elevate Executive support for the IPARVAN Framework and of violence, abuse and neglect. Many Districts/SCHN – although not all – had revised governance structures in response to this review. Changes to governance structures included ensuring that data about violence, abuse and neglect were routinely reported at Board meetings or to sub-committees. Some Districts included Aboriginal representatives from NSW Health and Aboriginal Community Controlled Organisations (ACCOs) in governance bodies which had led to some improvements in the integration and cultural responsiveness of services for Aboriginal people, though all agreed there was a long way to go.
- **Revision of VAN services governance structures.** Some Districts reported in the SAT that they had reviewed and revised the structures that underpin how VAN services work together. In some Districts/SCHN this meant a shift towards a matrix reporting structure, with VAN staff reporting to both clinical leads and facility leads. Where VAN services structures had been revised, VAN services managers and staff reported that these revisions built connections between formerly independent VAN services, encouraging cross-referral and collaborative working practices, and generating a sense of 'one VAN'.

There is some evidence of enhanced integration between VAN services and broader NSW Health services, as well as with interagency partners through training, information sharing and joint case management.

Activities that contributed to broader integration include:

[20] Note that limited integration between VAN services and the broader health system is to be expected at this stage of implementation. This integration will be a focus for Phase 2 implementation.

- **Providing education and training opportunities for staff who identify and provide a response to people experiencing violence, abuse and neglect but who do not work in VAN services.** These opportunities built broader awareness of violence, abuse and neglect across the NSW health system, as well as awareness of referral pathways and the services available to people experiencing violence, abuse and neglect. Stakeholders reported both formal and informal opportunities for education and training:
    - Formal opportunities include training provided by ECAV and the Health Education and Training Institute (HETI). These serve to build the skills and confidence of staff to identify and respond to instances of violence, abuse and neglect. Staff reported that these opportunities became less available over the course of the implementation period, likely due to challenges within ECAV. These formal opportunities need to be made available again.
    - Informal opportunities include mentorships and 'in-service' training provided by VAN services staff. In addition to building skills and confidence, these opportunities serve to build relationships between VAN services staff and broader NSW health staff – which may support strengthened referral pathways. These informal opportunities should be supported by the Ministry and Districts/SCHN – including formally recognising the value these bring and ensuring that VAN services staff have time allocated in their working day to complete these tasks.
- **'Bottom up' leadership from VAN services staff.** VAN services staff worked to raise the awareness and profile of the IPARVAN Framework. Some staff also began acting in a consultative or advisory role, providing guidance and advice to colleagues on appropriate responses to presentations of violence, abuse and neglect.
- **Development of adaptations to electronic medical records systems to share VAN services client information with other health staff.** In early stages of implementation, staff in some Districts/SCHN reported challenges with sharing information related to VAN services clients within electronic medical records systems. These restrictions are due to concerns related to maintaining patient privacy and confidentiality – although they can impact the delivery of safe and high-quality care, negatively impact client experience, and risk retraumatising clients if they are required to continually retell their stories. As implementation progressed, some Districts/SCHN developed systems for sharing information about VAN services clients with other NSW Health staff within the electronic medical record, whilst maintaining privacy and confidentiality.
- **Participation in cross-agency structures and coordination mechanisms.** These include Safety Action Meetings (SAMs), Youth Action Meetings (YAMs), and the Joint Child Protection and Response Program (JCPRP). Stakeholders reported that these structures and coordination mechanisms were successful in building relationships between VAN services, other NSW Health services, and interagency partners. Consultations with Aboriginal workers indicated that in some locations, the SAMs and other interagency groups had a lack of Aboriginal representation at the decision-making level – despite Aboriginal people making up the majority of the client list.

Whilst there has been success in building broader integration, some key stakeholders reported that this integration was dependent on relationships, and that there was a risk that integration could be lost when members of staff moved into different roles, left the District/SCHN, or left the health system. As implementation progresses, there needs to be a focus on embedding the structures that support integrated ways of working (such as governance structures and formal coordination mechanisms) so that these endure beyond individual relationships.

Despite some progress, there is a lack of integration between NSW Health, ACCOs and other services that interact with Aboriginal people and families who have experienced violence, abuse and neglect.

Consultations with Aboriginal clients and health workers highlighted a lack of integration between NSW Health, ACCOs and other services that interact with people who have experienced violence, abuse and neglect. This meant clients had to retell their story, which was often re-traumatising. Greater integration with ACCOs should be a focus for Phase 2 implementation.

Stakeholders reported that there was very little coordinated case planning between NSW Health services and ACCOs – with stakeholders reporting instances where NSW Health staff were not aware that a client was also accessing a service or program managed by an ACCO. This disconnection was exacerbated by the fact that families do not feel safe to disclose the support services they are accessing for fear that it may lead to their children being taken away.

Non-Aboriginal clients of VAN services were largely positive about health services and clinicians, but reported disconnected experiences across the system – by contrast, Aboriginal clients reported feeling unsafe and experiencing institutional racism.

Whilst most non-Aboriginal clients of VAN services spoke highly of the care and support they had received from VAN services, many reported that they found it difficult to identify and to access the services they needed. Clients identified a number of challenges with access to care, including:

- **Poor understanding or awareness of VAN services by other stakeholders.** Many clients reported that their General Practitioner, counsellor, or other primary care provider was unaware of NSW Health-provided VAN services. Some clients spent many years seeking help without finding it, before finally being referred to a VAN service. In some instances, clients heard about VAN services by word of mouth, and then had to find the appropriate way to be referred into the service. Building greater awareness of VAN services and VAN clinicians is a crucial next step to support further integration.
- **Poor communication and coordination between VAN services, NSW Health services, and other stakeholders.** Many clients reported poor communication between VAN services and other services. As a result, they were required to continually retell their story and risk re-traumatisation. Efforts to support greater communication and coordination – such as shared medical records – should be an immediate focus for ongoing implementation.
- **Overall lack of VAN service capacity and long waitlists**. Many clients reported that they were required to wait long periods of time before they could access required VAN services. For some clients, this wait may have hindered progress towards their goals.

Aboriginal clients experienced similar challenges but also reported experiences of culturally insensitivity and blatant or subjective racism across the broader health system, contributing to a distrust of VAN services. Aboriginal clients and staff reported that this distrust is exacerbated by a fear that NSW Health staff will make a mandatory child protection report leading to their children being removed. Despite these challenges, most Aboriginal clients reported that they felt supported by ACCOs and some individual staff (e.g. counsellors) in VAN services where there was a close relationship.

There is limited data at this stage of the evaluation to understand the impact of the implementation of the IPARVAN Framework on outcomes aligned with the quadruple aim and Future Health.

This Stage 1 evaluation was primarily focused on understanding implementation progress, and short-term impact on progress towards integration. Nonetheless, the evaluation did seek to understand the extent to

which implementation of the IPARVAN Framework was contributing to changes in client health and wellbeing, client experience, staff experience, and system sustainability.[21]

Whilst the evaluation did not expect to see changes against these outcomes at this stage, it is important to define and measure this at Stage 1 to provide a quasi-baseline against which Stage 2 and Stage 3 evaluations can track progress.

The Ministry has made good progress across the course of the evaluation to improve the quality and completeness of data to support the evaluation. This qualitative data indicates that the implementation of the IPARVAN Framework is leading to improvements across the four outcomes however there are some important learnings for ongoing implementation, particularly to support improved workforce experience. These are summarised in Table 1.

Table 1 | Key outcome-related insights from the Stage 1 evaluation

Outcome	Key insights from the Stage 1 evaluation
Client health and wellbeing	• VAN services staff report that VAN system integration has led to improvements in health and wellbeing outcomes for clients. • New programs and the expansion of services resulted in an increase in the reported number of clients receiving services, although this increase is not sufficient to meet the needs of people experiencing violence, abuse and neglect in NSW. • There are still significant gaps in the availability of some services, for example some Districts/SCHN do not have a domestic violence counselling service and most Districts/SCHN have challenges providing culturally safe care to Aboriginal clients.
Client experience	• Non-Aboriginal clients reported overall positive experiences with VAN services staff and programs, but experience with other NSW Health services was mixed. Some clients reported experience with NSW Health staff that did not understand violence, abuse and neglect or who were not sensitive to their experience of trauma or cultural background. • Non-Aboriginal clients and VAN services staff reported that when VAN services are integrated through joint case management and appropriate referral pathways, clients have better experience. • Aboriginal clients highlighted positive relationships with some individual counsellors or case workers, but overall reported negative experiences in VAN services and the broader health system, including fragmented services, having to 'retell' their stories, lack of understanding of culture and trauma, and condescending and racist treatment by staff. • Aboriginal staff reported a lack of evidence on what works for Aboriginal people who have experienced violence, abuse and neglect, with most service responses based on evidence from programs delivered to non-Aboriginal people.
Staff experience	• VAN services staff reported mixed experience regarding implementation of the IPARVAN Framework, both within and across Districts/SCHN. Some reported a greater sense of appreciation and empowerment stemming from greater health system recognition of violence, abuse and neglect. Insights from site visits indicate

[21] These outcomes are aligned with the Quadruple Aim and the NSW Health Future Health Strategy.

	that positive staff experience is enabled by strong leadership, Executive support, and appropriate governance structures. • Other staff reported feeling disempowered by the change management process and challenges with new integrated ways of working. Insights from site visits indicate that staff feel disempowered when decisions related to integration and ongoing implementation of the IPARVAN Framework are made without their input, or where they feel they have provided input that did not translate into action. • Aboriginal staff working in VAN services for both Aboriginal Community Controlled Organisations (ACCOs) and NSW Health reported many instances where their specific skills, knowledge and experience were not valued by the NSW Health system.
System sustainability	• The majority of VAN services staff agree or strongly agree that VAN system integration has led to improvements in system sustainability. In focus groups and as part of site visits, staff reported that greater integration supported clients to access appropriate care and support earlier, reducing the risk of clients presenting following crisis, and that integration supported client access to a range of complementary services and supports – including from other VAN services that may support individual or family needs. • Additional funding supported the expansion of VAN services. Full time equivalent (FTE) staffing and service costs varied across the system, which reflects different service contexts and inconsistencies in how FTE is reported. • Client reflections on the current system indicated that a more integrated system could lead to positive outcomes including reduced Emergency Department presentations, reduced need for clients to be admitted to hospital (due to earlier intervention), and more clients across the system meeting their therapeutic goals.

The evaluation identified 12 considerations to support enhanced implementation of the IPARVAN Framework.

A summary of considerations is presented in Table 2.

Table 2 | Summary of considerations to support future implementation

#	Considerations
Considerations to support ongoing and enhanced implementation of the IPARVAN Framework	
1	The Ministry, ECAV and other NSW Health Pillar Organisations to consider recommencing implementation of key system-level initiatives. Many of these activities slowed considerably or stopped entirely in 2020/21, particularly those related to capacity and capability development.
2	The Ministry to consider ensuring greater alignment and coordination between the IPARVAN Framework and other related policies, frameworks and strategies (e.g., suicide prevention, First 2000 days, Brighter Beginnings, Aboriginal Mental Health Strategy).
3	The Ministry and Districts/SCHN to consider working collaboratively to build and embed connections between VAN services and the broader health system such as through existing state-wide governance structures and workforce planning initiatives.

4	District and SCHN Executives, with the support of the Ministry, to consider continuing efforts to develop Executive-level leadership and buy-in, leveraging Executives who champion change across the system.
5	Districts and SCHN to consider prioritising efforts to engage with clients of VAN services and community organisations, including through co-design and community representation on governance bodies and interagency groups, to ensure that services better meet clients' needs and deliver positive experiences and outcomes that matter.
6	The Ministry to consider providing greater local guidance to Districts/SCHN, including guidance on sequencing and prioritisation of activities. This could serve to concentrate efforts within Districts/SCHN and accelerate progress. Greater guidance could include collaboratively agreeing on bi-annual implementation priorities, such as through a co-designed implementation plan.
7	The Ministry to consider continuing to strengthen mechanisms that enable Districts and SCHN to share good practice and lessons learnt.
8	The Ministry, ECAV and Districts/SCHN to consider prioritising efforts to improve the capacity of the NSW Health workforce to deliver culturally appropriate care, including: • Reviewing and enhancing cultural competency training for non-Aboriginal staff. • Reviewing and revising workforce policies to improve recognition of cultural skills and experiences, increasing flexibility regarding qualification requirements and improving training pathways. • Reviewing and revising strategies to increase the number of Aboriginal staff in NSW Health, including in management positions. • Advocating for changes to awards to better recognise cultural skills and experience, including introduction of an award for non-clinical Aboriginal health workers.
9	The Ministry and Districts/SCHN to consider prioritising efforts to engage with ACCOs through co-design of services, increasing Aboriginal representation on governance bodies and interagency groups, and increasing and/or redirecting funding to ACCOs.
Considerations to support enhanced monitoring and evaluation activities	
10	The Ministry to consider prioritising addressing key data reporting and collection issues to improve the tracking of progress towards key outcome domains. Data will be key to demonstrate outcomes and economic impact in future evaluations.
11	The Ministry, in collaboration with the independent evaluator for the Stage 2 and Stage 3 evaluations, to consider reviewing and revising (where necessary) monitoring and evaluation data collection tools.
12	The Ministry to consider prioritising efforts to collect evidence on Aboriginal people's experiences through data reporting and collection, Aboriginal community-controlled governance for the Stage 2 and Stage 3 evaluations, and commissioned research.

2 Background and introduction

This section provides an overview of the IPARVAN Framework and the context for the evaluation.

2.1 Introduction to the IPARVAN Framework

The NSW Government and the NSW Ministry of Health (the Ministry) have committed significant funding to address the impacts of violence, abuse and neglect and improve the delivery of VAN services. As part of these funding enhancements, the Ministry, in partnership with Districts, SCHN and Pillar Organisations undertook a statewide VAN Redesign Program.[22]

The Integrated Prevention and Response to Violence, Abuse and Neglect Framework (IPARVAN Framework) is a key component of the VAN Redesign Program. The IPARVAN Framework promotes a public health approach to preventing and responding to interpersonal violence, abuse and neglect. Integral to this public health approach is the promotion of integrated service delivery at system, service, practice and workforce levels.

A one-page summary of the IPARVAN Framework is presented in Appendix A.

2.2 Implementation of the IPARVAN Framework

Implementation of the IPARVAN Framework is occurring over two phases:

- **Phase 1 has a statewide focus on VAN services within NSW Health**, which have principal responsibility for responding to violence, abuse and neglect, including children and young people displaying problematic sexual behaviours or engaging in harmful sexual behaviours. Social workers who provide significant violence, abuse and neglect responses as well as paediatricians providing medical and forensic responses to child physical abuse and neglect are also included. This is because these responses have such an integral and critical role to play in the delivery of integrated VAN services that they need to be considered as part of Phase 1.
- **Phase 2 has a state-wide focus on broadening the integrated response for violence, abuse and neglect across the whole NSW health system and other systems and organisations.** This includes priority health areas such as mental health, alcohol and other drugs, Aboriginal health, maternity, child and family health, youth health and services for people with disabilities. These longer-term reforms, supported by VAN services, will provide a cultural shift across NSW Health services towards person-centred and trauma-informed care and practice, recognising that all stakeholders have a responsibility to contribute to the prevention and response to violence, abuse and neglect. Phase 2 also includes the continuation of Phase 1.

Phase 1 commenced in January 2019 when the IPARVAN Framework was released, although initial activities contributing to the Framework began when VAN Redesign Program funding was provided to Districts and SCHN[23] in July 2017/18. Development of Phase 2 commenced in July 2020. There have been some delays in implementation timeframes due to the COVID-19 pandemic and competing priorities across the health system.

[22] Further information on the VAN Redesign Program is available at: https://www.health.nsw.gov.au/parvan/Pages/van-redesign-program.aspx.
[23] Note that the Sydney Children's Hospitals Network (SCHN) is the only specialty health network that was involved in Phase 1 implementation.

Implementation is occurring in a staggered and overlapping manner. All Districts/SCHN commenced some integration-related activities prior to the start of Phase 1, with some more progressed than others. This means that prior to the IPARVAN Framework's release there was variability in levels of integration across the state. Some Districts and SCHN are also commencing activities related to Phase 2 prior to implementation of Phase 1 being completed.

The IPARVAN Framework has been designed to allow flexibility for Districts and SCHN to implement activities based on their local context. The IPARVAN Framework provides the overarching objectives and activities and aims to ensure that people in NSW receive a consistent, quality and integrated response to violence, abuse and neglect across the state, while supporting flexibility for different implementation approaches at the local level. This approach aligns with NSW Health's devolved health system and acknowledges that what works best to respond to violence, abuse and neglect will vary significantly across the state, particularly between rural/remote and metropolitan areas.

2.3 Monitoring and evaluation of the IPARVAN Framework

The IPARVAN Monitoring and Evaluation Framework details the overarching the monitoring and evaluation approach. Activities occur over three stages:

- **Stage 1 (2020/21/22) (this evaluation)** is focusing on process and a limited number of immediate outcomes.
- **Stage 2 (2024/25)** will focus on medium- and longer-term outcomes.
- **Stage 3 (2025/26)** will focus on assessing the economic benefit of the IPARVAN Framework.

The purpose of the Stage 1 Evaluation is to enable the Ministry, Pillar Organisations, Districts and SCHN and other key stakeholders to understand the activities that have been undertaken to implement the IPARVAN Framework to date; how well those activities have contributed to system integration; and whether increased integration is contributing to changes in outcomes aligned with the quadruple aim.[24]

2.4 Overview of methodology for the Stage 1 Evaluation

The Stage 1 Evaluation commenced in April 2020 and was intended to conclude in December 2021. The evaluation was paused in mid-2021 as Districts/SCHN and the broader health system responded to the COVID-19 pandemic. The evaluation recommenced in January 2022 and concluded in June 2022.

To supplement the findings of this evaluation, in June 2021 the PARVAN Unit engaged Nous to conduct a parallel project to understand the perspectives of Aboriginal clients and service providers in two Local Health Districts (LHDs). This report contains findings from these consultations. More detail on the findings and recommendations can be found in the two supplementary community reports.

The Monitoring and Evaluation Framework details five key lines of enquiry (KLEs) as presented in Table 3. This Stage 1 Evaluation focused on KLEs 1 and 2 (process evaluation), KLE 3 (limited immediate outcomes evaluation) and KLE 5 (ongoing monitoring for continuous improvement). Stage 2 and Stage 3 evaluations will include KLE 4 (economic evaluation).

[24] Note that it is not possible to directly attribute changes in outcomes to the implementation of the IPARVAN Framework at this stage. This will be a focus of the Stage 2 evaluation, scheduled for 2024/2025.

Table 3 | Key lines of enquiry for all stages of the IPARVAN Evaluation

#	KLE	Component	Evaluation stage
1	What activities have been undertaken to implement the IPARVAN Framework?	Process evaluation	Focus for Stage 1 Evaluation
2	How well have the activities contributed towards system integration (within and external to NSW Health)?	Process evaluation	Focus for Stage 1 Evaluation
3	To what extent has the purpose of the IPARVAN Framework been achieved (focusing on health and wellbeing, client experience, staff experience and system sustainability outcomes?)[25] *This will be assessed across three timeframes:* *Immediate (1-2 years)* *Intermediate (4-5 years)* *Long-term (5-6 years)*	Outcomes evaluation	Focus for Stages 2 and 3 Evaluations (limited focus on immediate outcomes for Stage 1 Evaluation)
4	*What is the economic impact of the IPARVAN Framework?*	*Economic evaluation*	*Focus for Stage 3 Evaluation*
5	What are the opportunities to improve?	Monitoring for continuous improvement	Focus for all Stages

Mixed methods data collection and analysis enabled triangulation of evaluation findings to answer the KLEs. The data collection methods for the Stage 1 evaluation along with the purpose and timing of these methods is described in Table 4 below.

A key part of the evaluation included defining and measuring integration, drawing from the definition of integrated service responses presented in the IPARVAN Framework.[26] Defining and measuring integration included identifying a set of 13 'integration indicators' – that is, indicators that indicate what is happening when integration is achieved – and measuring change over time against these indicators. Further detail on the approach to defining and measuring integration is presented in Appendix D.

The Stage 1 Evaluation Plan (a separate document) presents the detailed methodology for this stage of the evaluation, including an ethics strategy. The evaluation of the IPARVAN Framework received ethics review and approval from the Hunter New England Human Research Ethics Committee (reference 2020/ETH03323). The Aboriginal engagement project received ethics review and approval from the Aboriginal Health and Medical Research Council of NSW (AH&MRC) (reference 1763/21).

[25] The Stage 2 and 3 Evaluations will also explore changes in staff experience outcomes based on available data.
[26] The IPARVAN Framework defines integrated responses as 'the provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course'.

Table 4 | Data collection methods for the Stage 1 Evaluation

METHOD	DESCRIPTION AND PURPOSE	TIMING
Desktop review	Desktop review of relevant **NSW Health documents** (including LHD/SCHN Service Profiles and ACI, ECAV and Ministry documents) to understand the context for VAN Services and implementation activities, as well as **published literature** to explore the links between service integration and changes in client outcomes and system sustainability.	2020-2022
Data analysis	Analysis of routinely collected **administrative data, and other data as relevant** to understand current demand and use of VAN Services and, where data is available, health and wellbeing, client experience and system sustainability outcomes.	2020-2022
Online Provider Survey	Online survey of **VAN service providers** to understand, at the provider level, implementation activities, perceived changes in integration and outcomes, and change over time.	July 2020 July 2021 *(paused)* February 2022
Self-Assessment Tool	Self-Assessment Tool (online survey) completed by **VAN Senior Managers and/or LHD/SCHN Executives** to understand at the LHD/SCHN manager level implementation activities, perceived changes in integration and outcomes, and change over time.	July 2019 July 2020 July 2021
Teleconference focus groups and targeted interviews	Twelve teleconference focus groups with **48 VAN Service staff across NSW Health, 20 staff who provide a psychosocial response to violence, abuse and neglect and 17 staff who provide medical and forensic responses to violence, abuse and neglect** to understand, at the service level implementation activities, perceived changes in integration, impact on outcomes, and opportunities for continuous improvement. Targeted interviews with representatives from **NSW Health Pillar organisations** to explore additional context to understand perceived changes in integration and outcomes, and opportunities for continuous improvement	August 2020 March 2022
'Deep dive' site visits	Deep dive site visit to **seven LHDs/SCHN** representing a cross section of rural, metropolitan and state-wide health services to enable a deeper understanding of the impact of the Framework in different contexts and lessons learned from implementation. Visits included interviews and focus groups with **Executives, VAN service managers, staff and 29 clients**.	May 2021 March – June 2022
Consultation with VAN governance groups	Ongoing consultation with relevant PARVAN governance groups including the **PARVAN Senior Executives Steering Committee, PARVAN Senior Managers Advisory Group, and VAN Evaluation Advisory Committee** to test and refine evaluation findings, opportunities for continuous improvement and considerations for future directions.	2020-2022
Consultation with Aboriginal clients and service providers	Interviews with **six Aboriginal clients** and six focus groups with **Aboriginal staff** at community controlled organisations and NSW Health to understand Aboriginal perspectives and experience of VAN services. These consultations were conducted across two regions – Hunter New England and South West Sydney – and were overseen by an Aboriginal Reference Group in each region.	May – July 2022

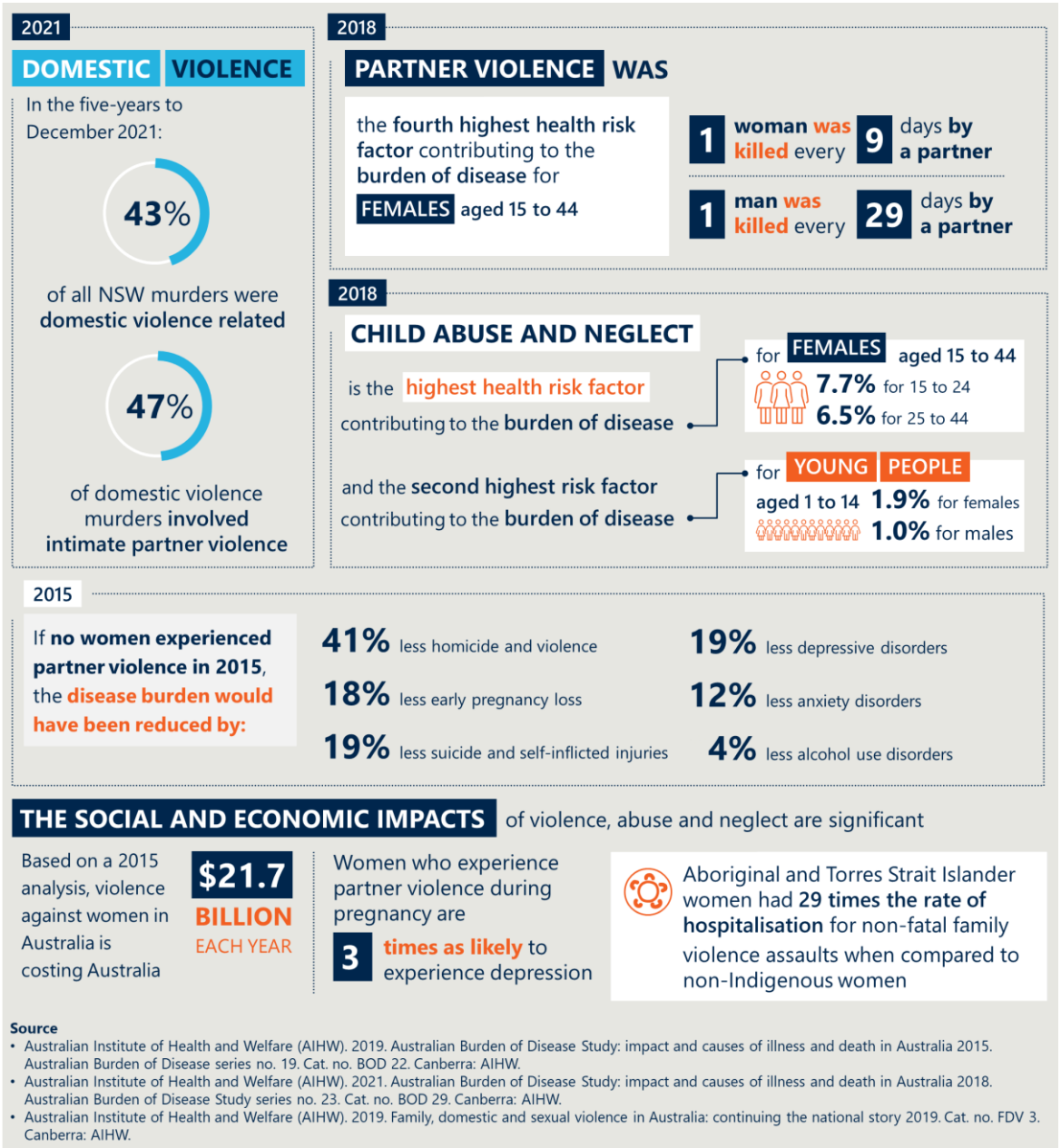
3 Context for the IPARVAN Framework

This section provides an overview of the context for violence, abuse and neglect services (VAN services) in NSW.

3.1 Violence, abuse and neglect in NSW

As demonstrated in Figure 1, violence abuse and neglect are significant public health issues, contributing to overall burden of disease in NSW. Providing appropriate responses to preventing and responding to violence, abuse and neglect is, therefore, core business for NSW Health.

Figure 1 | The impact of violence, abuse and neglect



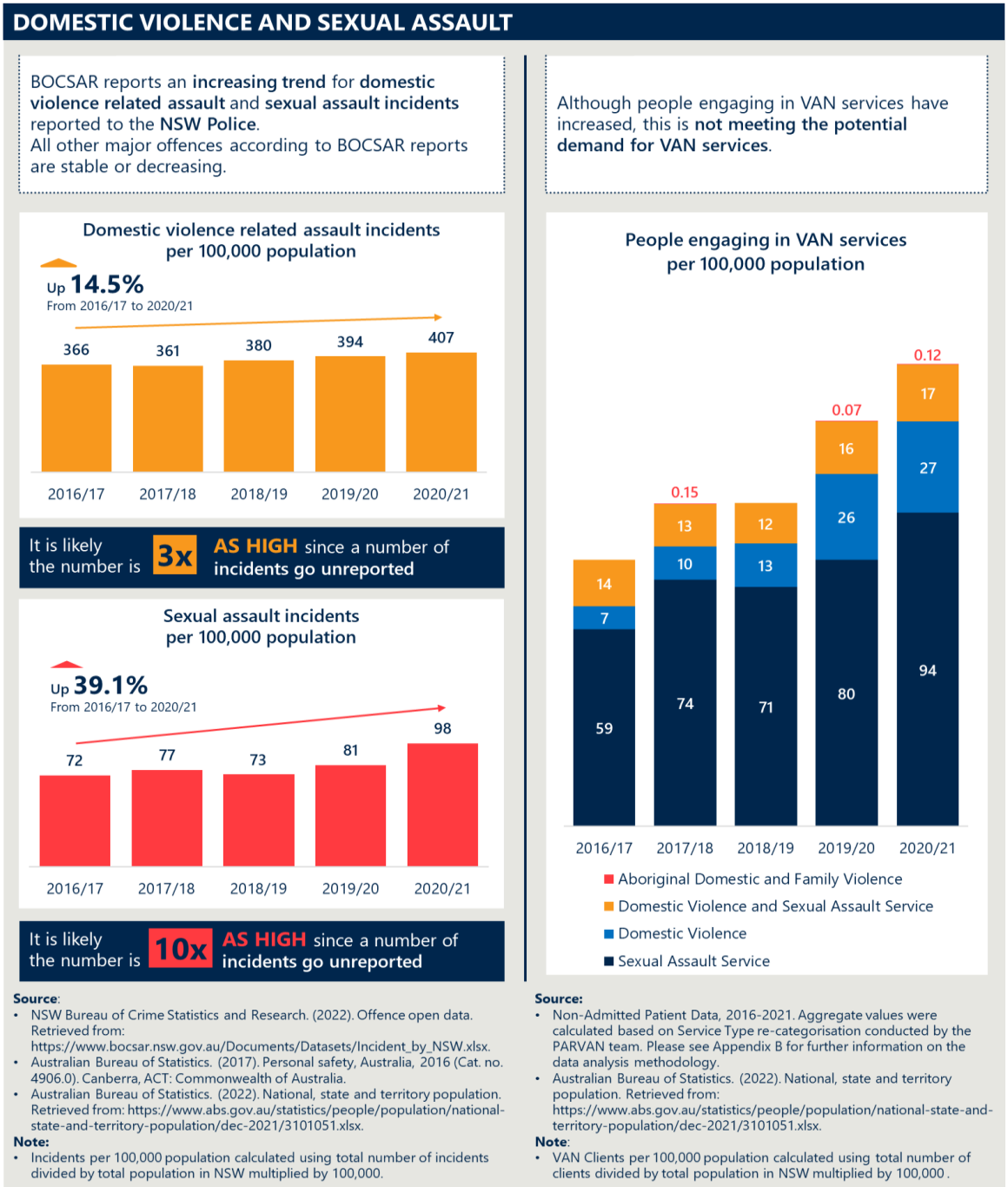
Source

- Australian Institute of Health and Welfare (AIHW). 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW.
- Australian Institute of Health and Welfare (AIHW). 2021. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018. Australian Burden of Disease Study series no. 23. Cat. no. BOD 29. Canberra: AIHW.
- Australian Institute of Health and Welfare (AIHW). 2019. Family, domestic and sexual violence in Australia: continuing the national story 2019. Cat. no. FDV 3. Canberra: AIHW.

There are high rates of violence, abuse and neglect in NSW, with rates increasing year on year. It is likely that these rates are an under-estimation – for example, the Australian Bureau of Statistics (ABS) suggests two-thirds of physical assault incidents go unreported and nine out of ten women do not contact police after a sexual assault incident.[27] As a result, whilst the number of VAN clients have increased, it is likely that services are still not meeting overall need.

Figure 2 and Figure 3 present an overview of trends related to domestic violence and sexual assault, and risk of significant harm (ROSH) reports.

Figure 2 | Domestic violence and sexual assault incidents compared with VAN service events between 2016/17 and 2020/21

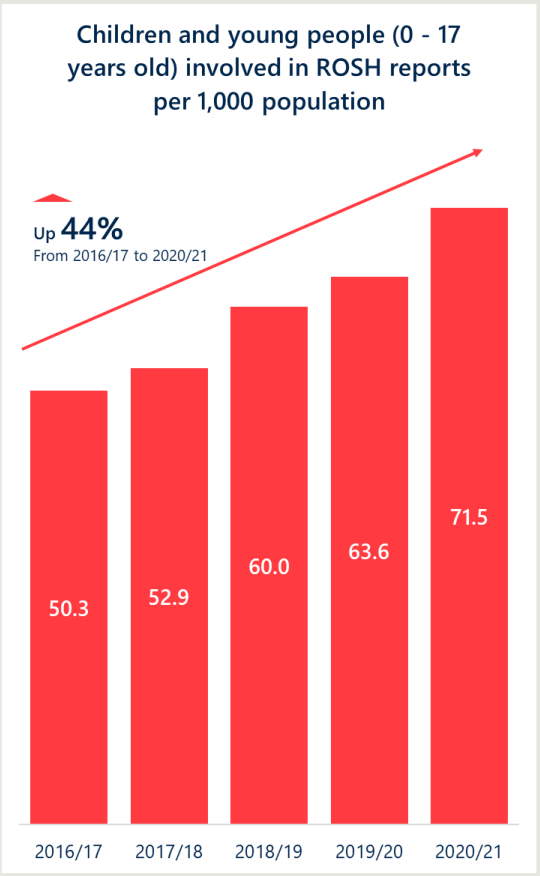


[27] Australian Bureau of Statistics. (2017). Personal safety, Australia, 2016 (Cat. no. 4906.0). Canberra, ACT: Commonwealth of Australia.

Figure 3 | Risk of serious harm (ROSH) reported compared with VAN service events between 2016/17 and 2020/21

CHILDREN AND YOUNG PEOPLE

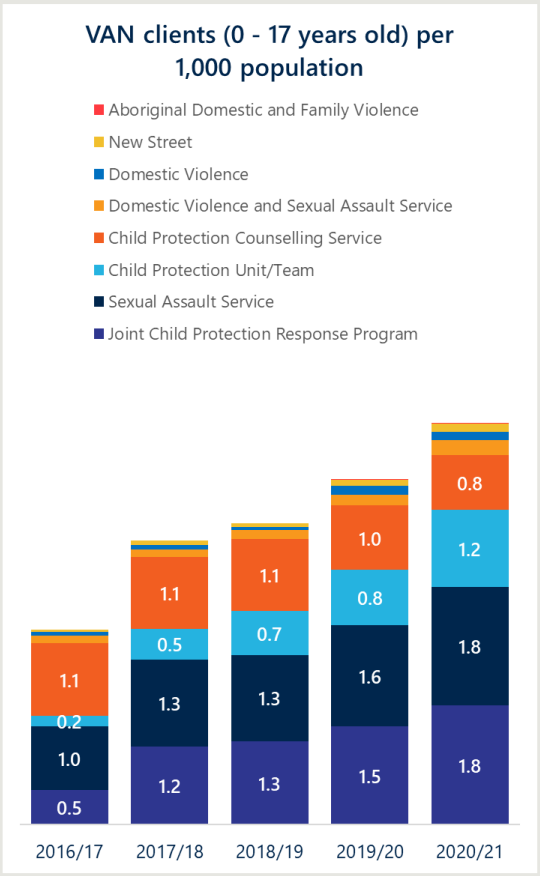
The DCJ reports an **44% increase in total child and young person concern reports per 1,000 population** from 2016/17 to 2020/21.



Source:
- NSW Department of Communities and Justice (2019). Annual Statistical Report 2017-18. Improving the lives of children and young people. Retrieved from: https://public.tableau.com/app/profile/facs.statistics/viz/Objective2-Improvingthelivesofchildrenandyoungpeople/Objective2Highlights
- NSW Department of Communities and Justice (2022). Annual Statistical Report 2020-21 Measure List. Retrieved from: https://public.tableau.com/app/profile/dcj.statistics/viz/TableA1B2C2D1N16-N20N27_/Performance_measure

Note:
- For 2016/17, 2017/18, children and young people involved in ROSH reports per 1,000 population as reported by NSW Department of Communities and Justice. Data unavailable for 2018/19, 2019/20, and 2020/21.
- For 2018/19, 2019/20, and 2020/21, children and young people involved in ROSH reports per 1,000 population calculated using total number of children and young people involved in ROSH reports divided by population of 0 – 17 years old in NSW multiplied by 1,000.

Although children and young people (0 – 17 years old) engaging in VAN services have increased, this is **not meeting the potential demand for VAN services.**



Source:
- Non-Admitted Patient Data, 2016-2021. Aggregate values were calculated based on Service Type re-categorisation conducted by the PARVAN team. Please see Appendix B for further information on the data analysis methodology.
- Australian Bureau of Statistics. (2022). National, state and territory population. Retrieved from: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/dec-2021/3101051.xlsx

Note:
- VAN clients per 1,000 population calculated using total number of VAN clients Under 18 divided by population of 0 – 17 years old in NSW multiplied by 1,000.

Many services across health and other government systems respond to violence, abuse and neglect. These include:

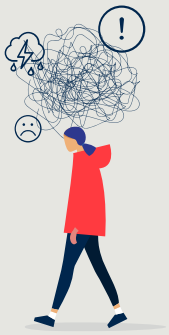
- VAN service responses (tertiary responses), which provide crisis responses, follow up psychosocial and medical care, and court support as well as prevention and community education, systems advocacy, and support on violence, abuse, and neglect issues.

- Secondary/targeted responses that respond to people at heightened risk of experiencing or perpetuating violence, abuse and neglect such as mental health services, and alcohol and other drug services.
- Primary/universal responses that help reduce vulnerability and risk of violence, abuse and neglect such as maternity services, child health services, and general practice.
- ACCOs and ACCHOs, which includes Aboriginal Medical Services, child and family services and services that respond specifically to violence, abuse and/or neglect.

Figure 4 overleaf provides an overview of the complex system of services that support people experiencing violence, abuse and neglect. This highlights the benefits provided to people experiencing violence, abuse and neglect, their families and communities, and the broader health and social services systems, from more integrated service responses such as those championed by the IPARVAN Framework. Further information on the benefits of integrated responses to violence, abuse and neglect is provided in the IPARVAN Framework Case for Change.[28]

Table 5 summarises key messages that are highlighted in the system diagram.

Table 5 | System diagram key messages

CURRENT FRAGMENTED SYSTEM (LEFT SIDE) 	• People experiencing violence, abuse and neglect are generally not to be able to access early intervention supports. This is due to low levels of awareness about early intervention services, and mainstream services not being able to identify early signs of violence, abuse and neglect, before the risk and need escalates. • As a result, the level of risk and need becomes increasingly complex, and people do not always receive the care and support that they need until they are in crisis. • Once in crisis, people experiencing violence, abuse and neglect are often forced to present at Emergency Departments (ED). Once in the ED, they may be admitted to the hospital as an inpatient, contributing to avoidable bed days. • There are poor links, referrals and communication between services that support people experiencing violence, abuse and neglect – across primary, secondary and tertiary care settings. Clients are not referred appropriately and therefore do not get the support that they need, when they need it. • When people experiencing violence, abuse and neglect attend mainstream health services, there is often no coordination or effective communication between these services and VAN services. This means that clients often experience a disjointed, fragmented system that is not culturally safe or person-centred, not always comprehensive, and tends to be an incident-based response. • Aboriginal people experience culturally inappropriate care and are afraid to seek help from mainstream health services. They access the system in crisis (e.g. ED), experience long wait times to access other services and have to retell their story many times. They rarely get access to an Aboriginal health worker and the care they receive does not address broader needs in their family or their prior experiences of trauma.

[28] NSW Ministry of Health. (2019). The Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health

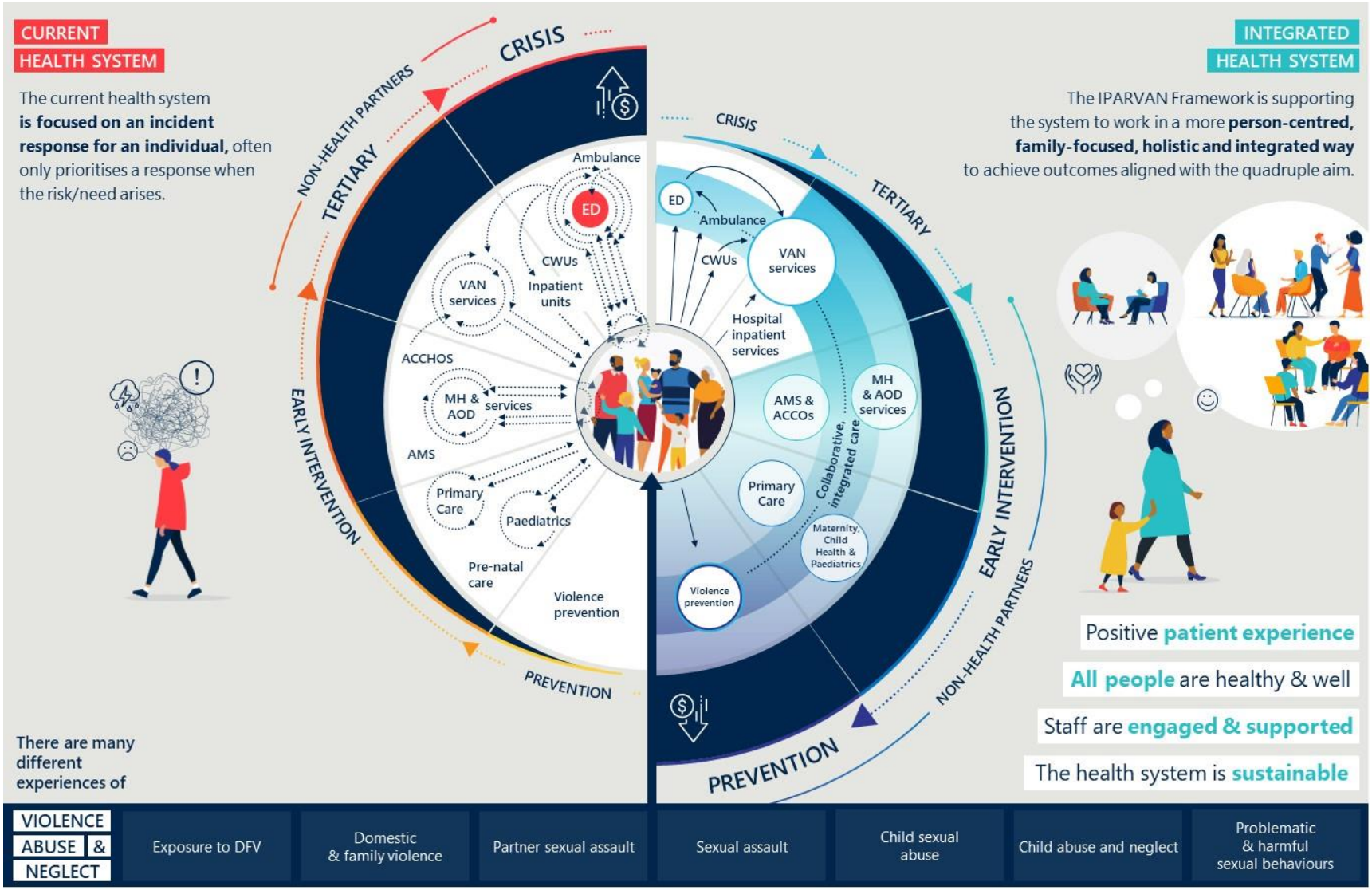
- Some of the clinicians who should provide support to people experiencing violence, abuse and neglect lack the awareness, capabilities and confidence to provide an appropriate response and instead refer to VAN services, placing unnecessary pressure on these already overstretched services.

IDEAL INTEGRATED SYSTEM (RIGHT SIDE)

- People experiencing violence, abuse and neglect have their needs identified early. They are offered support early and are more likely to receive supports that address their needs and de-escalate their level of risk.
- They do not need to present to the ED as often. If they do present to the ED, clinicians are able to identify and appropriately respond or refer – reducing re-presentations or hospital admissions.
- The services that support a person experiencing violence, abuse and neglect – and their families where relevant – have strong communication links and referral pathways. Services share information and work together to provide holistic and wrap-around services that consider the needs and protective factors for the individual and their family.
- Clinicians, including the primary care workforce, are confident in their ability to identify and support people experiencing violence, abuse and neglect. VAN services staff have the capability and capacity to work in partnership with the broader health workforce, support the health system to improve capability and awareness of violence, abuse and neglect, and provide holistic psycho-social case management and therapeutic counselling which are trauma-informed, family-centred and strengths-based. All staff have the skills to provide culturally safe care to Aboriginal people and connect them to culturally appropriate services and supports.
- People and their families' needs are met through the health system and their risk of experiencing a crisis is reduced. They can be effectively supported through primary-care health professionals, Aboriginal community controlled organisations and in their community.
- Services are often co-located and the service setting is warm and welcoming to people and their families. Outreach services are available to those who need it.
- This approach leads to better outcomes including improved health and wellbeing outcomes, reduction in secondary trauma, better quality care, better client experience, increased perpetrator and offender accountability, and improved cost effectiveness and service efficiency. [29] Importantly, these outcomes align with the strategic outcomes detailed in Future Health: Guiding the next decade of care for NSW 2022-2032.[30]

[29] NSW Ministry of Health. (2019). The Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health
[30] NSW Ministry of Health. (2022). Future Health: Guiding the next decade of care in NSW 2022-2032.

Figure 4 | Summary of the service landscape for violence, abuse and neglect in NSW



4 Detailed findings

4.1 KLE 1 | What activities have been undertaken to implement the Framework?

This section presents progress on activities that have been undertaken across the NSW Health system to implement the IPARVAN Framework.

This section first provides a summary of all findings for this KLE, then an overview of the cross-cutting findings against all objectives in the IPARVAN Framework, recognising that the elements of the Framework are interrelated and collectively contribute to the vision. It then highlights key activities that were progressed under each of the four strategic objectives. Additional information is provided in Appendix G.

SUMMARY OF FINDINGS

Progress was made at all levels of the system, and across all four objectives, but this progress was slower than expected

- All levels of the system – including the Ministry, ECAV, ACI, and Districts/SCHN – made progress against the activities assigned to them under the IPARVAN Framework. Progress proceeded rapidly across 2018/19 and 2019/20, but then slowed dramatically. Progress was slower than anticipated due to a number of factors, including the COVID-19 pandemic, resource limitations, and leadership transitions in some organisations.
- The Ministry made progress establishing the foundations for future implementation and for integration. This included developing and managing state-wide governance structures and developing key policies, strategies and frameworks (such as the suite of VAN Service Standards). Some key activities – such as the development of the Integrated Trauma Informed Care Framework – occurred later than anticipated. Ongoing resourcing challenges at the Ministry – including key staff moving into new roles – may contribute to continued slow progress in the immediate future.
- ECAV made good progress across 2018/19 and 2019/20, including successfully adapting capacity and capability building activities to be delivered virtually in response to the COVID-19 pandemic. Progress ceased across 2020/21 and into 2022 due to resource constraints and prolonged leadership transition. As a result, key foundational work – such as efforts to develop qualifications and strategies to increase recruitment and retention of Aboriginal staff – did not progress.
- ACI made progress on the activities assigned to it – including supporting 12 Districts/SCHN to develop integrated service models. However despite this support, and additional resourcing as part of the VAN Redesign Program, few Districts/SCHN reported the development or implementation of integrated approaches.
- Districts/SCHN reported progress across all four objectives of the IPARVAN Framework – data did not indicate any consistent state-wide areas of focus. It may be that this led to overall slower progress, as efforts were spread across a breadth of activities as opposed to focused on a select number. The Ministry could provide greater guidance regarding sequencing and prioritisation of activities to support Districts/SCHN focus their efforts.

- Qualitative data indicated that Districts/SCHN focused efforts on implementing objectives 1 and 2, as these were important foundations to make further progression against the IPARVAN Framework. This was not reflected in the quantitative data.
- There were a number of cross-cutting areas where limited progress was made by most Districts/SCHN, including:
    - Development of culturally safe services. Most Districts/SCHN indicated that whilst culturally competency training was available to NSW Health staff, including VAN staff, little progress was made to ensure services were accessible, appropriate and culturally safe, particularly for Aboriginal people. Aboriginal clients and health workers consulted for the evaluation reported experiences of cultural insensitivity and blatant or subconscious racism across many parts of the health system.
    - Recruiting, retaining and valuing quality Aboriginal and culturally-diverse staff within NSW Health. All Districts/SCHN reported challenges recruiting staff that reflect the cultural diversity of their local communities, including in management positions. Aboriginal staff are highly skilled, but their cultural skills and experience are not valued, they are often over-burdened, and they are almost entirely managed by non-Aboriginal staff.
    - Consumer engagement and journey mapping. There was limited evidence of Districts/SCHN engaging consumers directly and improving processes to engage consumers.

Some progress has been made to implement Phase 1 of the IPARVAN Framework across all four objectives, however, it significantly slowed in the last eighteen months.

There was some progress across all parts of the system – including the Ministry, ECAV, ACI, and Districts/SCHN against the activities assigned to them under the IPARVAN Framework. As expected, given the staged implementation of the IPARVAN Framework:

- **Not all activities commenced during the evaluation period.** For example, as part of Phase 2 implementation, the Ministry will explore whether to develop a consistent statewide approach to identifying (screening and assessing risk) and responding to violence, abuse and neglect across the NSW health system. This was not intended to be progressed during the evaluation period.
- **Progress on key activities was constrained by the COVID-19 pandemic and other stressors including leadership transitions.** Stakeholders across all levels of the system were diverted away from business as usual and redeployed to COVID-19 preparedness and response. For example, the development of the Trauma Informed Care (TIC) Framework was significantly delayed – the TIC Framework was a key enabler to support Districts/SCHN to further embed trauma informed care across the system.

  Similarly, key activities to be led by ECAV were delayed significantly. This includes work to develop and implement qualifications and strategies that assist priority groups (including Aboriginal workers) to achieve the entry-level qualification, skills and experience for employment in VAN services did not progress.
- **In some Districts/SCHN, progress was limited by decisions at the Executive level to prioritise implementation of other strategies, policies and frameworks.** District/SCHN Executives highlighted the multiple strategies, policies, frameworks and other guiding documents that are developed and distributed by the Ministry each year. Each of these are given equal importance by the Ministry. Some Districts/SCHN chose to prioritise the implementation of other strategies (for example First 2000 Days or Towards Zero Suicides) over the IPARVAN Framework, as these better aligned with District/SCHN strategic priorities and community need.

- **Activities under objectives 1 and 2 progressed faster than activities under objectives 3 and 4.** Qualitative data suggests that activities under strategic objectives 1 and 2 progressed at a faster rate over the evaluation period, and this was because some of these activities had already commenced by Districts/SCHN and the Ministry (e.g., revising governance structures and leaders championing change).

The COVID-19 pandemic exacerbated other implementation delays – for example Phase 2 implementation of the IPARVAN Framework was originally scheduled to commence in July 2020, but this was already delayed prior to the COVID-19 pandemic due to resourcing challenges and other competing health system priorities.

As the NSW health system shifts away from the immediate pandemic response – and increasingly towards a response that treats COVID-19 as a seasonal infectious disease with identifiable peaks and troughs – there is a need for stakeholders across the system to review and reset their plans and associated timelines for implementation of the IPARVAN Framework.

The Ministry made progress providing system-level support for implementation, although this was slower than expected largely due to the COVID-19 pandemic.

The IPARVAN Framework details key activities to be completed by system-level stakeholders including the NSW Ministry of Health. These activities are intended to provide the system-wide strategic direction and support needed for Districts/SCHN to successfully implement the IPARVAN Framework.

> "The policies and procedures that come from the Ministry are great. But there are a lot of them, and they don't come in a coordinated way"
>
> *District/SCHN Executive*

Overall, the Ministry made good progress with implementation up to November 2020 – a summary of this progress is presented in Table 6. Further detail is provided in Appendix G and in the Interim Progress Report.

The Ministry continued to make progress with implementation across 2021 and 2022 although this progress slowed and, in some instances, ceased as a result of efforts to prepare and respond to the COVID-19 pandemic. Key Ministry staff were seconded into COVID-19-related roles for significant periods of time, limiting the ability of the Ministry to make progress with key activities and initiatives. Key initiatives progressed since 2020 include:

- **Ongoing system management of the implementation of the IPARVAN Framework and VAN Redesign Program.** The Ministry provided system-level guidance and project management, including supporting data collection for evaluation purposes and continuous improvement. The Ministry's ability to provide active project management was impacted by COVID-19-related staff secondments – Ministry stakeholders reported that this likely led to overall delays with implementation.
- **Development and review of governance structures to support implementation of the IPARVAN Framework and VAN Redesign Program.** The Ministry established and supported a number of governance structures and frameworks to support ongoing implementation.
- **Development and distribution of system-level standards, strategies, policies and procedures.** The Ministry led the development of key documents such as the VAN Service Standards and the Integrated Trauma Informed Care Framework. District/SCHN stakeholders reported that they appreciated and valued this guidance. Some stakeholders reported feeling overwhelmed by the quantity of new policies, procedures and other guidance that emerged from the Ministry, and others reported delays with transforming these documents into local-level guidance.
- **Support to the delivery of VAN services, including culturally safe services.** The Ministry supported the development and roll out of a number of new services including Safe Wayz, and the expansion of

others such as New Street. In addition, the Ministry provided support to ensure services in Districts/SCHN were delivered in a culturally safe manner.

- **Support to the development of VAN-specific data and data sets.** Ministry stakeholders reported significant investment – both time and human resources – to develop systemwide VAN-specific data and data sets. The Ministry also reviewed and identified areas for improvement and enhancement of existing data sets.

Ongoing resourcing constraints within the Ministry – including within the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit – may contribute to future challenges with implementation. In mid-2022, key staff responsible for implementation of the IPARVAN Framework shifted to other roles within the Unit, with previous roles remaining vacant. This may impact the ability of the Unit to successfully support timely implementation into the future.

There are a number of areas of potential future focus for the Ministry as implementation proceeds. These include:

- **Reviewing and refining, where necessary, state-wide governance structures.** Some District/SCHN stakeholders reported in the SAT responses and in consultations that there are opportunities to review and refine governance mechanisms – for example through ensuring more active and frequent participation by representatives from broader health services (such as services that provide a psychosocial response).
- **Continuing efforts to improve VAN-specific data and data sets.** Whilst much effort was invested in improving VAN data and data sets as part of implementation, Ministry stakeholders reported that more work was needed in this area. This work has been impeded to date by staffing limitations.

Table 6 | Progress reported by the NSW Ministry of Health between April 2020 and June 2022

Responsibility	Summary of progress reported in the Interim Progress Report	Additional progress between November 2020 and June 2022
As the system steward, the IPARVAN Framework requires the NSW Ministry of Health to develop the policies, protocols, guidance and frameworks necessary to support system-wide implementation of the IPARVAN Framework.	• Provided system-wide leadership and direction to support ongoing implementation, including publishing key strategies and policies and refining and finalising state-wide governance structures. • Supported District/SCHN rollout of the VAN Service Contact form in clinical source systems to standardise the capture of VAN-related service activity data by frontline staff. • Registration of the Violence, Abuse and Neglect Data Set (containing VAN Service Contact form data) as a statewide data asset on the NSW Health Data Asset Registry. • Began the process of embedding elements of good practice in integrated VAN service models into system-wide strategies, policies and procedures. • In collaboration with ECAV, commenced work on a NSW Health domestic and family violence integrated psychosocial, medical and forensic crisis model. *System-wide implementation proceeded slower than expected, due to the impact of the 2019/20 summer bushfire crisis, the COVID-19 pandemic, and limited staffing.*	• Continued to provide overall direction and management of the VAN Redesign Program, including convening and managing state-wide governance meetings. • Developed a quarterly VAN Performance Dashboard to help Districts/SCHN monitor how they are tracking against VAN-related KPIs and improvement measures in their service agreements. • Continued work to develop system-level policies, processes and guidance including the NSW Problematic and Harmful Sexual Behaviours Framework and Evaluation Strategy and the Integrated Trauma Informed Care Framework. • Supported Districts/SCHN to deliver culturally safe services including assessing Sexual Assault Services Aboriginal Action Plans, finalising workforce enhancements for SAS Aboriginal Counsellor and Safe Wayz roles, and developing a Cultural Safety Toolkit and Roadmap as a resource for Districts/SCHN. • In the process of implementing a range of funding initiatives to expand VAN service delivery in the context of implementing the NSW Government's response to the Royal Commission into Institutional Responses to Child Sexual Abuse. • Supported implementation of a range of additional VAN services across the state. These include Safe Wayz and new service approaches for adult survivors of child sexual abuse in South East Sydney and Mid North Coast LHDs. • Limited progress on improving the recognition of violence, abuse and neglect as a serious public health issue and ensuring it is profiled in key reports. This may be considered for Phase 2 implementation.

ECAV made limited progress implementing the activities assigned to it under the IPARVAN Framework, which contributed to slower capability development of staff across the health system.

ECAV has a key role to play under the IPARVAN Framework to build the skills, capabilities and confidence of the NSW health workforce to identify and respond to violence, abuse and neglect. ECAV is tasked with:

- Developing and delivering training and capability development programs to build the skills, capabilities and confidence of VAN service staff and of all staff across the NSW health system.
- Developing and implementing strategies that assist priority groups including Aboriginal workers and medical and forensic examiners to achieve entry-level skills and qualifications.
- Working with the Ministry and other stakeholders, including the Health Education and Training Institute (HETI) to review and update relevant guidance, training and resources.

The Interim Progress Report found that ECAV had made good progress against the activities assigned to it under the IPARVAN Framework. This included developing and delivering a range of training programs for VAN services staff and other NSW Health staff, developing a Graduate Diploma of Medical and Forensic Management of Violence, Abuse and Neglect, and commencing work on a NSW Health domestic and family violence integrated psychosocial, medical and forensic crisis model.

> "It was fantastic having virtual training options – especially for those of us in regional areas. I could do the training, but I didn't have to leave my family"
>
> *VAN services staff*

The Interim Progress Report also found that ECAV had adapted well to the initial stages of the COVID-19 pandemic, redesigning training modules so that they could be delivered virtually. District and SCHN staff reported positive experiences with virtual training delivered by ECAV.

Stakeholders from the Ministry reported that ECAV made little to no progress across 2021 and 2022.[31] This was due to two key factors:

- **The COVID-19 pandemic.** As with all other areas of the NSW health system, ECAV staff and resources were redeployed to support COVID-19 preparedness and response. This limited resources available to progress implementation of the IPARVAN Framework.
- **Changes in leadership, including significant transitional periods.** Stakeholders from the Ministry reported that ECAV faced significant resourcing challenges across 2020, 2021 and 2022, including periods of time without confirmed formal leadership. This created a period of extreme organisational uncertainty, including staff turnover, which diverted resources away from delivery of activities under the IPARVAN Framework.

The Ministry reported that, as of mid-2022, ECAV is emerging from this extended period of uncertainty. This may provide a foundation to restart implementation of key activities.

ECAV has a vitally important role to play in successful implementation – as implementation progresses, it is important that the Ministry and other key stakeholders support the organisation as it restarts its engagement in the IPARVAN Framework. This likely includes the Ministry working closely with ECAV, including the new leadership team, to prioritise and agree key activities to be delivered in the next 12 and 24-months, including reviewing and enhancing training opportunities for Aboriginal staff.

[31] Note that limited information on ECAV's progress was available for the final evaluation report, as ECAV did not submit a response to the evaluation request for information. Given ongoing resourcing limitations and changes in leadership, the Ministry advised the evaluation team not to conduct a consultation with ECAV.

ACI successfully delivered the activities under the IPARVAN Framework, although there is limited evidence to understand the impact of these activities on enhanced implementation.

ACI has a key role to play in supporting Districts/SCHN to implement the IPARVAN Framework, including developing a VAN Clinical Network for health workers, and supporting Districts/SCHN with service redesign.

The Interim Progress Report found that ACI had made good progress with implementation of these activities. ACI successfully launched the VAN Clinical Network, including ensuring consumer representation on the Network, and supported 12 Districts/SCHN with local service redesign projects through the VAN Redesign Local Implementation Project. Implementation of the VAN Redesign Local Implementation Project was slower than expected, due to delays in the design of the program, lack of internal ACI resources, and ACI's decision to support 12 Districts/SCHN (rather than 9 as originally agreed).

ACI continued to progress implementation across 2021 and 2022. ACI stakeholders reported that the organisation successfully completed support to local implementation projects, continued to support the VAN Clinical Network, and continued to support consumer engagement in VAN redesign projects.

Whilst ACI delivered the activities under the IPARVAN Framework, there is little evidence to indicate that these activities had a measurable or lasting impact on enhanced implementation. For example:

- ACI supported 12 Districts/SCHN to build their skills and capacity to undertake local service redesign projects, with the aim of supporting the development of local VAN service models. However, despite successfully completing this project, SAT and provider survey scores indicate there has been limited progress with developing local integrated service models. VAN services staff and District/SCHN Executives reported this as an area of future implementation focus.
- ACI reported ongoing support to enable consumers to be engaged in VAN redesign projects. However, despite this support, all Districts/SCHN reported limited consumer engagement to date and most highlighted consumer engagement and patient journey mapping as an area of future implementation focus.

It may be that the impact of ACI activities will become more apparent as implementation progresses – for example, emerging evidence indicates the VAN Redesign Local Implementation Project may have built District/SCHN skills and capabilities in co-design and service redesign. Stakeholders reported that these skills may support the effective development of local VAN service models once Districts/SCHN are ready to prioritise these activities.

At this stage of implementation, it is an opportune time for the Ministry, ACI and other key stakeholders to collaboratively reflect on ACI's involvement in the implementation of the IPARVAN Framework to date, including how ACI can support Districts/SCHN to increase Aboriginal engagement in governance, consumer engagement and other mechanisms. This reflection would offer the opportunity to identify successes, challenges faced, and lessons learnt, and to agree ACI's role in future implementation.

Districts and SCHN reported progress against all four strategic objectives – with greater progress against objectives 1 and 2.

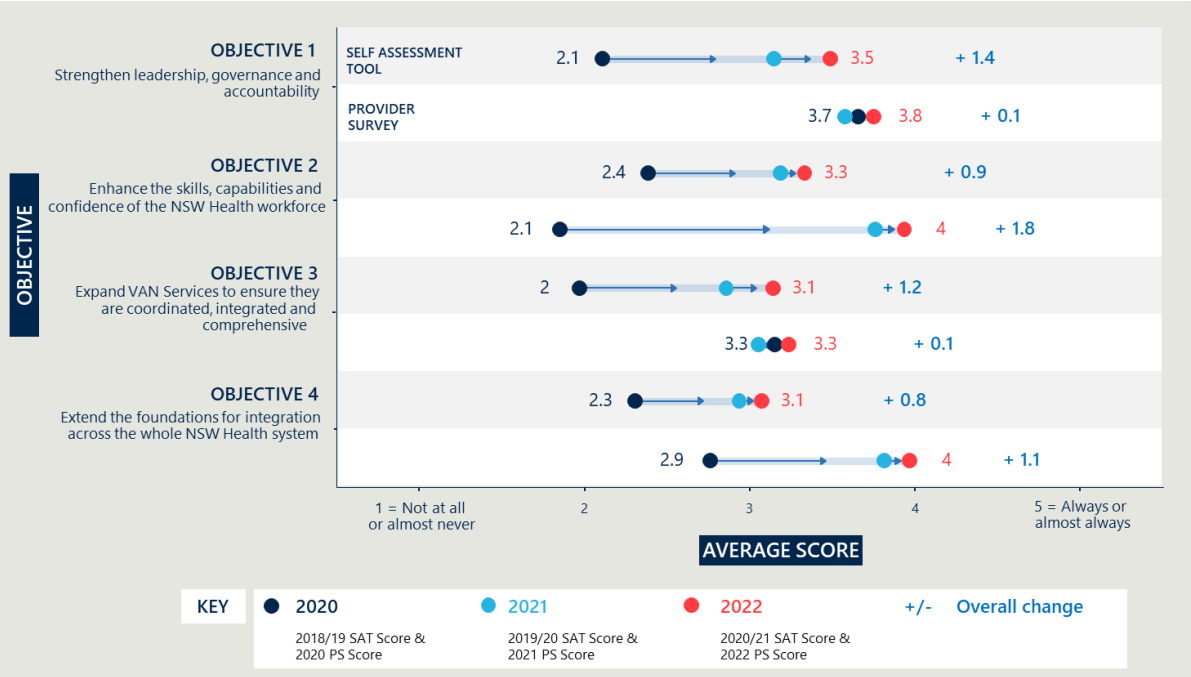
This continues a trend identified in the Interim Progress Report. Figure 5 presents an overview of the change in Self-Assessment Tool (SAT) scores and provider survey scores over time for each of the four objectives.[32] It indicates that:

- Objectives 1 and 2 are more progressed, compared to objectives 3 and 4. The average SAT score in 2020/21 was 3.5 for objective 1 and 3.3 for objective 2, compared to 3.1 for both objectives 3 and 4. Provider survey scores echo this trend, with the exception of objective 4.
- There was similar progress over time for all objectives, with SAT scores rising between a minimum of 0.8 points (objective 4) and a maximum of 1.4 points (objective 1).

Provider survey scores tend to show greater progression as compared to SAT scores. For all 4 objectives, the average final provider survey score is higher than the final SAT score.

Table 7 provides a high-level overview of progress against each of the strategic objectives, drawing from both qualitative and quantitative data sources. Further detail on progress made against each of the objectives can be found at Appendix G.

Figure 5 | Change in average SAT scores between 2018/19 and 2020/21, and provider survey scores between 2020 and 2022



[32] Further information on the Self-Assessment Tool and provider survey is provided in Section 2.4 .

Table 7 | Assessment of average progress against IPARVAN Framework strategic priorities for SAT scores between 2018/19 and 2020/21, and provider survey scores between 2020 and 22.[33,34]

Strategic priority for each objective	Assessment of progress across all Districts/Networks	Average change in scores from baseline to current	Overall change
		SAT 1 / PS 1	SAT 2 / PS 2	SAT 3 / PS 3	SAT 4 / PS 4	SAT 5 / PS 5	
OBJECTIVE 1 | Strengthen leadership, governance and accountability							
Leadership drives health system reform and service improvement	• Good progress was made against this priority. VAN service managers tended to be strongly advocating for change in their LHDs/SCHN. Senior executives were also advocating for implementation of the IPARVAN Framework. • Some LHDs/SCHN reported that greater buy-in was needed from Executives to provide the authorising environment to support ongoing implementation.		2.2 →	3.6 →			+1.4 -0.06
Robust system for monitoring service improvement	• Activities to implement this strategic priority included the rollout of the VAN Service Contact form in clinical source systems to standardise the capture of VAN-related service activity data by frontline staff. • Few LHDs/SCHN reported good progress in using data to inform service planning. • Work is still needed to progress against this priority given the limited availability of client outcomes data.	1.9 →		3.9 →	4.0		+2 +0.10
Strong governance	• Ten LHDs/SCHN reported activities to enhance governance arrangements to support collaboration between VAN services, and between VAN services and non-VAN health services. • Nine LHDs/SCHN also reported the development of new policies and procedures or service agreements to formalise referral pathways and to provide guidance to NSW Health workers on appropriate responses to violence, abuse and neglect.		2.2 →	3.4 →			+1.2 +0.14
OBJECTIVE 2 | Enhance the skills, capabilities and confidence of the NSW Health workforce							
Education, training and professional development to equip Health workers with the right knowledge, skills, aptitudes and values	• Ten LHDs/SCHN reported that VAN staff receive formal and mandatory training opportunities. Quantitative data suggests that limited progression was made against this strategic priority between 2019/20 and 2020/21 with an increase of +0.1. • VAN service managers and staff reflected in focus groups and during site visits that the COVID-19 pandemic impeded health workers' ability to access training, as face-to-face training was no longer available, and workloads were higher. Nine LHDs/SCHN reported that staff were able to access virtual training opportunities to improve accessibility and completion rates. • Six LHDs/SCHN reported that they had made certain training courses mandatory for some non-VAN health workers, such as Emergency Department and mental health workers. • Eleven LHDs/SCHN reported that VAN staff provide ad-hoc and informal training and support to non-VAN health workers, including acting in an advisory or consultative role.		2.4 →	3.0 →	4.0 | 4.2 →		+0.6 +0.21
Health workers receive appropriate supervision and support	• VAN service staff had access to formal and informal clinical supervision arrangements. • Many LHDs/SCHN shared concerns with the ongoing availability of appropriate clinical supervision to non-VAN staff – particularly those who are often in contact with clients of VAN services and/or people who have experienced violence, abuse and neglect. • SAT responses suggested that limited funding and time constraints prohibited non-VAN staff from accessing these supports.		2.4 →	3.6 →	4.2 | 4.3 →		+1.2 +0.16

Increase the workforce to meet demand	• While there was some success with increasing the workforce for some LHDs/SCHN through the recruitment of VAN service staff, increasing workforce to meet demand continues to be a challenge for almost all LHDs/SCHN.
	  • Recruitment and retention of Aboriginal staff in VAN services is particularly difficult. LHD/SCHN Executives and VAN service managers and staff indicated that it remained a challenge to recruit Aboriginal people with the right capabilities to fill Aboriginal-identified roles.
	  • Aboriginal staff members highlighted experiences of institutional racism, perceived lack of support, and perceived lack of acknowledgement of their skills and expertise as key barriers to recruitment and retention into Aboriginal-identified roles.
	• Regional, rural and remote LHDs reported specific challenges with recruiting VAN staff. These include the perception that staff may be isolated in smaller facilities, may have less access to clinical supervision, and may need to travel long distances as part of their role.
	• Two metropolitan LHDs anecdotally reported that it was difficult for the workforce to meet demand due to significant population growth across their district.
			2.5 →	3.0 →	3.0 | 3.0 ←		+0.5
							-0.02

[33] This assessment is based on collective insights from both quantitative (i.e., provider survey from 2020 and 2022 data and SAT scores from 2018/19 and 2020/21 data) and qualitative data (i.e., interviews, focus groups and site visits and qualitative responses from provider survey and SAT scores). Note that the comprehensiveness of SAT responses is not consistent across Districts/SCHN – some provided more detail than others. As a result, some Districts/SCHN may be progressing activities but have not reported this in the SAT.

[34] Note: Baseline set as: 2019/19 SAT responses from District/SCHN Senior Managers and 2020 PS responses from VAN service managers. Current set as: 2020/21 SAT responses from District/Network Senior Managers and 2022 PS responses from VAN service managers.

Strategic priority under each objective	Assessment of progress across all Districts/Networks	Average change in scores from baseline to current						
		SAT	1	2	3	4	5	Overall change
		PS	1	2	3	4	5	
OBJECTIVE 3 | Expand VAN services to ensure they are coordinated, integrated and comprehensive								
Enhancement and expansion of VAN services	• Expansion and enhancement of VAN services was a challenge for all LHDs/SCHN. • Ten LHDs/SCHN established 24-hour VAN services responses, though these responses did not respond to all forms of violence abuse neglect and were not available in all locations of the District or the Network. • LHDs/SCHN appeared to focus on implementing 24-hour responses for clients who experienced sexual assault or domestic and family violence.			2.2	3.0 3.1 – 3.1			+0.8 +0.02
Integrated VAN service models	• Almost all LHDs/SCHN reported that VAN staff are guided by a common vision and have a culture of respectful, trauma informed care. Some LHDs have also worked to co-locate VAN services. • Six LHDs/SCHN reported the implementation of LHDs intake client intake models (e.g. no-wrong door and central intake models) to better integrate VAN services. One LHD/SCHN had implemented a centralised intake model that incorporated VAN services and other community health services. • LHDs/SCHN compliance with the VAN Service Standards varied. Some LHDs reported in the SAT they made active efforts to comply with the Standards. Two LHDs reported that they were yet start implementing activity to comply with the Standards.			2.5	3.5 3.4 | 3.4			+1.0 +0.02
VAN services improve the patient journey and empower people and families to be partners in their care	• There was limited evidence to suggest that much progress was made to implement this strategic priority. • Further work is needed across all LHDs/SCHN to develop strategies to involve consumers and to develop patient journey maps. There was limited evidence of involving the consumer through administering surveys to clients to seek data on their experience.			2.0 – 2.7 2.9	3.0			+0.7 +0.18
VAN services quality improvement, consistency and reducing clinical variation across NSW	• All LHDs/SCHN were undertaking initiatives to improve VAN services that were appropriate for their context. • Eleven LHDs/SCHN reported activities to quality assure VAN services. These included audits of clinical documentation, conducting quality and safety meetings and undertaking evaluations of service initiatives.		1.7		3.2 3.5 – 3.5			+1.5 +0.18
OBJECTIVE 4 | Extend the foundations for integration across the whole NSW Health system								
Identification, response, referral and coordination	• Linkages between VAN services have progressed well with the establishment of standardised and documented referral pathways. • Collaboration and coordination between VAN services and other health and interagency services progressed through the development of informal relationships and attendance at interagency meetings. There was limited evidence of formal mechanisms to better link these services			2.5	3.3 3.9	4.0		+0.8 +0.1
Integrated electronic clinical information systems	• Progress against this priority was bound by LHDs/SCHN interpretation of relevant legislation and Ministry policies. • VAN service staff reported interest in identifying ways to better share information with other health services but were cognisant of legislative requirements and the need to maintain privacy and confidentiality. This was particularly important in regional, rural and remote LHDs. • Good progress was made by some LHDs/SCHN to implement better information sharing processes through the rollout of the VAN Service Contact form in clinical source systems to standardise the capture of VAN-related service activity data by frontline staff.			2.8	3.4	4.1 | 4.2		+0.6 +0.08
System improvement – trauma-informed care and child safe organisations	• All LHDs/SCHN acknowledged the importance of trauma-informed care, but there was very limited evidence available to show what activities were undertaken to implement trauma-informed care, outside of formal training opportunities. Progress against this strategic objective was hindered by delays from the Ministry in finalising and distributing the Trauma Informed Care Framework. • Efforts to ensure LHDs/SCHN are child safe was progressing. Over half of all LHDs/SCHN reported they have begun embedding Child Safe Standards in their districts.		1.6 | 1.9		3.5 | 3.6			+0.3 +0.11

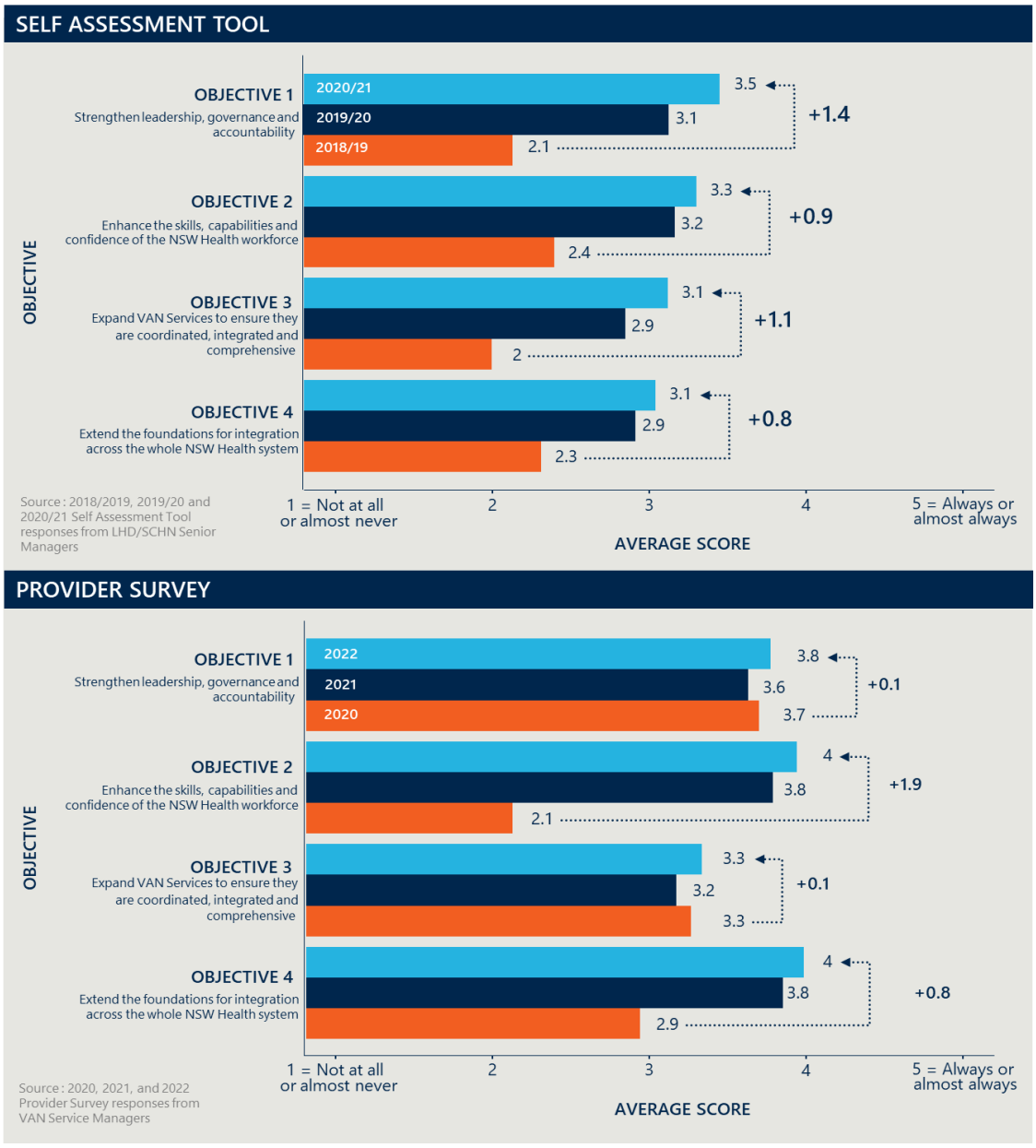
Progress on implementation at the District/SCHN level slowed significantly in 2020/21, when compared 2018/19 and 2019/20.

Figure 6 presents SAT scores from 2018/19 to 2020/2021 and provider survey scores from 2020 to 2022. The graph indicates:

- SAT scores across all four objectives increased substantially between 2018/19 and 2019/20, but to a much lesser extent between 2019/20 and 2020/21.
- SAT scores increased, on average, 0.6 points (30 per cent) between 2018/19 and 2019/20. By contrast, the average increase between 2019/20 and 2020/21 was 0.3 points (10 per cent).

A similar trend can be observed in provider survey scores across objectives 2 and objective 4 which rose, on average 1.68 points (79 per cent), and 0.92 points (32 per cent) respectively between 2020 and 2021 and 0.16 points (4 per cent) and 0.13 points (3 per cent) between 2021 and 2022.

Figure 6 | Change in SAT scores between 2018/19 and 2020/21 and provider survey scores between 2020 and 2022 across all objectives



District/SCHN Executives, VAN services managers and VAN services staff identified multiple reasons for implementation slowing, including:

- **The initial implementation of the IPARVAN Framework, including initial VAN Redesign Program funding, created momentum for change which has diminished over time**. The release of the IPARVAN Framework, compounded with additional funding provided as part of the VAN Redesign Program, created interest in and awareness of the IPARVAN Framework across Districts and SCHN. Over time attention has shifted to other priorities.

> "When the Framework came up there was a lot of anticipation and lots of excitement. But things move quickly in health, and other things came around."
>
> *VAN services manager*

- **Districts and SCHN focused initial efforts on those activities that were easier to implement, or which required less whole-of-system buy-in**. VAN services managers reported that they prioritised activities where had the authority to lead and create change – for example, revising VAN services leadership and governance structures, or recruiting to new VAN services positions.

  The next tranche of activities – such as building a trauma-informed workforce or embedding referral pathways and links between VAN services and the broader health system – are more difficult to progress. These activities require focused engagement with and buy in from other parts of the health system. Implementation of these activities is slower, as authority for change sits outside of VAN services.

> "Our initial focus to implement the Framework was on 'low hanging fruit'. You could get stuff done under the umbrella of VAN services."
>
> *District/SCHN Executive*

- **Districts/SCHN reprioritised efforts between 2020 and 2022 to respond to the COVID-19 pandemic and other challenges such as natural disasters.** District/SCHN Executives, VAN services managers and VAN services staff reported that the COVID-19 pandemic impacted their ability to progress implementation. At the Executive level, focus within Districts and SCHN shifted to pandemic preparedness and response. At the VAN service level, many staff were redeployed to COVID-19 related roles. Staff that remained were overwhelmed with service delivery.

  In some Districts/SCHN, this impact was compounded by other natural disasters such as bushfires and floods. These also caused some staff to be seconded to other temporary roles, further stretching resources.

- **Districts and SCHN reprioritised efforts on other strategies, frameworks and/or policies distributed by the Ministry.** During site visits, District/SCHN Executives noted the large number of other strategies, frameworks, policies and other documents developed by the Ministry. These are distributed by disparate parts of the Ministry, with each part placing high emphasis on the document for which they were responsible. Limited resources resulted in some Districts/SCHN prioritising other strategies, frameworks and policies over the IPARVAN Framework.

District/SCHN Executives, VAN services managers and staff, and non-VAN services staff all noted a significant societal shift regarding violence, abuse and neglect – the feeling that society is becoming increasingly aware of the prevalence of violence, abuse and neglect. This should provide a base for momentum for future implementation of the IPARVAN Framework.

Whilst all Districts/SCHN made progress, there was significant variation in the degree of progress across the system.

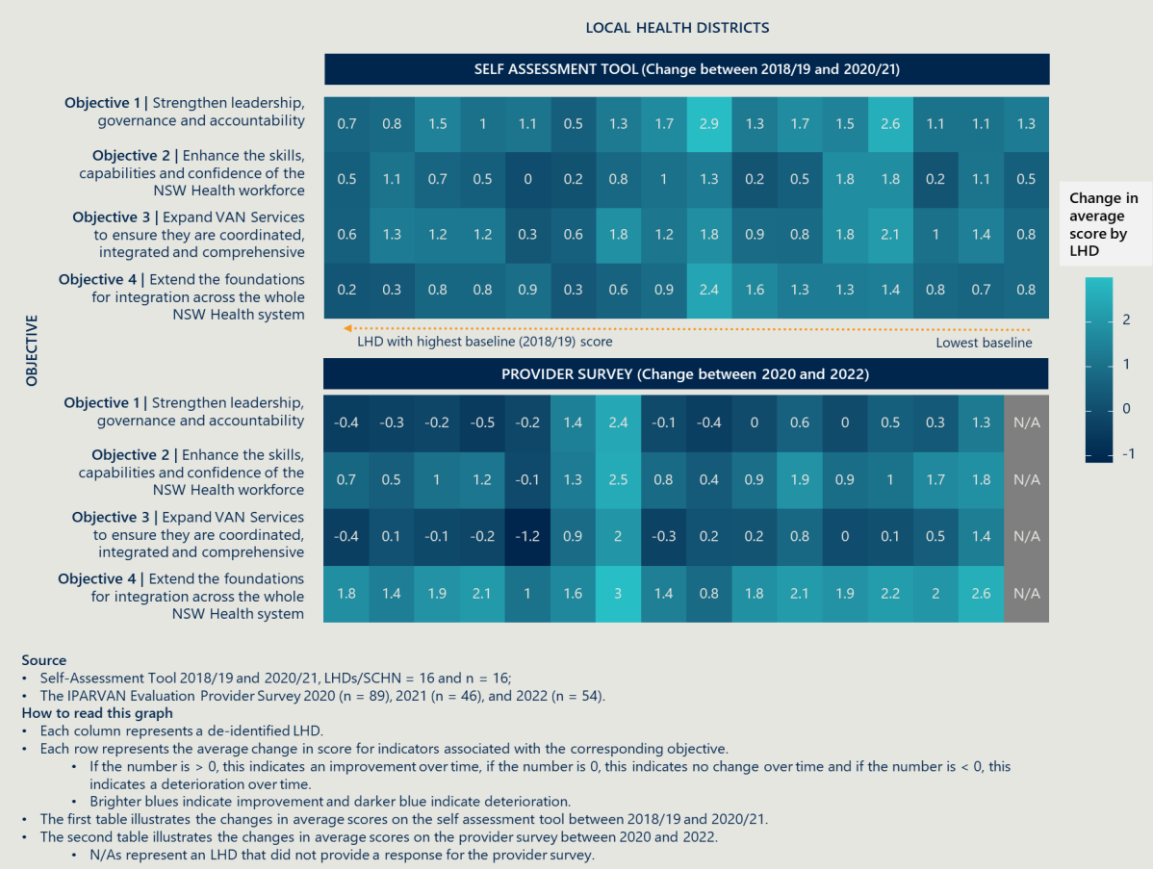
There is substantial variation in Districts/SCHN progress towards implementation of the IPARVAN Framework. Some of this variation is to be expected and was also reported in the Interim Progress Report.

Figure 7 presents an overview of the change in SAT and provider survey scores over time, stratified by each District/SCHN.[35] [36] The data indicates that:

> "We were already quite integrated when IPARVAN came in…it was a good basis for rapid progression"
>
> *District/SCHN Executive*

- Some Districts/SCHN made substantially more progress over time than others.
- There does not appear to be consistent correlation between SAT scores and provider survey scores. Some Districts/SCHN have higher changes in SAT scores than provider scores, other Districts/SCHN present the opposite picture.

Figure 7 | Change in SAT scores between 2018/19 and 2020/21 and provider survey scores between 2020 and 2021 by District/SCHN[37]



Source
- Self-Assessment Tool 2018/19 and 2020/21, LHDs/SCHN = 16 and n = 16;
- The IPARVAN Evaluation Provider Survey 2020 (n = 89), 2021 (n = 46), and 2022 (n = 54).

How to read this graph
- Each column represents a de-identified LHD.
- Each row represents the average change in score for indicators associated with the corresponding objective.
  - If the number is > 0, this indicates an improvement over time, if the number is 0, this indicates no change over time and if the number is < 0, this indicates a deterioration over time.
  - Brighter blues indicate improvement and darker blue indicate deterioration.
- The first table illustrates the changes in average scores on the self assessment tool between 2018/19 and 2020/21.
- The second table illustrates the changes in average scores on the provider survey between 2020 and 2022.
  - N/As represent an LHD that did not provide a response for the provider survey.

[35] As described in Appendix B above, the provider survey was completed in 2019/20 while the Self-Assessment Tool was completed in 2018/19 so the average scores for the provider survey were expected to be higher given that it was completed at a later stage of implementation of the IPARVAN Framework.

[36] Note that one District/SCHN did not provide a response to the 2022 provider survey, so change over time is unable to be calculated.

[37] Note: 2020 Self-Assessment Tool responses were collected in 2018-2019 based on the original template. The responses were rescored in 2020 by the PARVAN team and Nous according to the new Self-Assessment Tool template and were finalised following a review by LHD/SCHN managers, n = 16
The provider survey was conducted each year; 2020 (n = 89), 2021 (n = 46), and 2022 (n = 54).

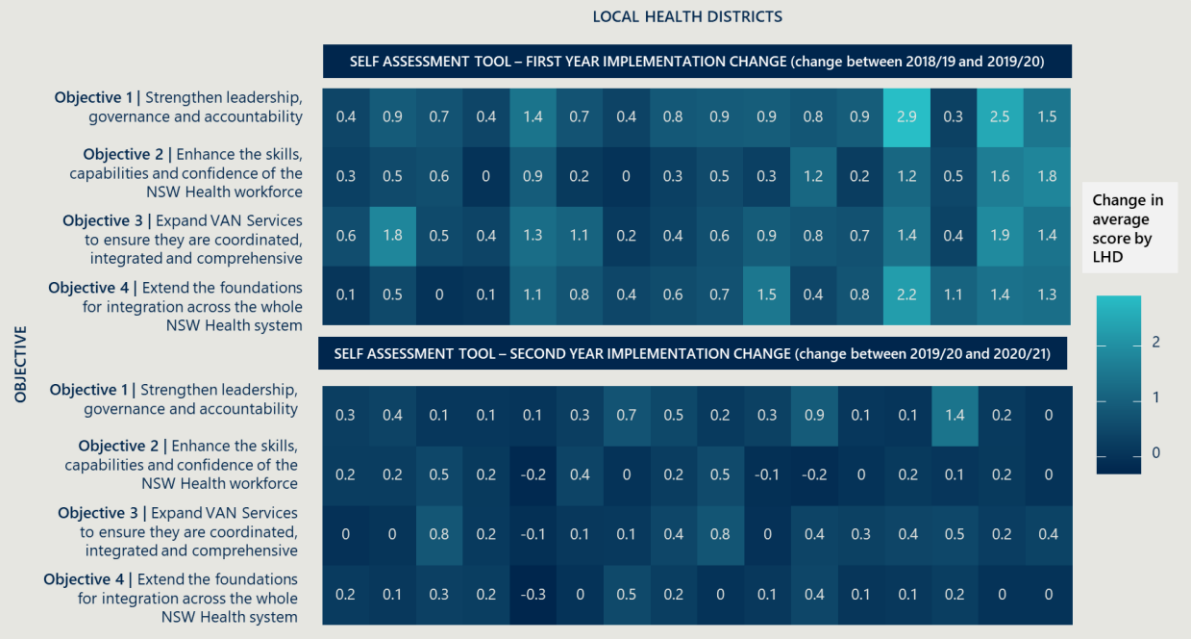
Variation is explained by a number of factors, including:

- **Districts/SCHN began implementation of the IPARVAN Framework at different levels of integration.** Some Districts/SCHN had more integrated services than others when implementation of the IPARVAN Framework commenced. These Districts/SCHN were beginning from a higher 'baseline' level of integration, which may have provided them with the foundations for more rapid progress.
- **Some Districts/SCHN were more impacted by the COVID-19 pandemic and other natural disasters than others.** All Districts/SCHN were impacted by the COVID-19 pandemic, and some had additional challenges related to bushfires, floods, and other natural disasters. These external challenges impacted the ability of these Districts/SCHN to progress implementation by drawing resources and effort to other priorities.
- **The self-reported nature of the SAT and provider survey.** Both the SAT and the provider survey are self-reported measures. It is likely that some Districts/SCHN had a positive bias. In addition, respondents did not have access to other District/SCHN data or benchmarking data for to comparison.

There was no consistent state-wide focus for implementation; Districts and SCHN focused efforts on different objectives and made different levels of progress – this may reflect the limited implementation guidance provided by the Ministry.

There was no consistent trend regarding where Districts/SCHN focused their efforts, nor any trend that indicated that progression against one objective supported future implementation of other objectives. Figure 8 shows there was no single objective where all Districts/SCHN progressed at a similar rate.

Figure 8 | Change in SAT average score between first and second year of implementation between 2018/19 and 2020/21, by District/SCHN



The inconsistent areas of focus may be attributed to a number of factors, including:

> "It would be good if there was some scaffolding around the Framework, so we knew what we had to hit first"
>
> *VAN services staff*

- **The 'tight-loose-tight' approach that guides the relationship between the Ministry and Districts/SCHN.** Each District/SCHN is empowered to focus efforts on areas that meet their local strategic context and community need. As a result, each District/SCHN prioritised implementation of different IPARVAN activities, aligned with their contexts and Executive priorities.
- **Limited guidance from the Ministry regarding implementation priorities**. Some District/SCHN stakeholders reported a desire for greater guidance from the Ministry regarding implementation – particularly those activities that should be prioritised for initial implementation. The Ministry offered limited direct guidance or directives, to allow Districts/SCHN the opportunity to choose implementation priorities aligned with their local contexts.
- **Data collection and reporting tools unintentionally encouraging Districts/SCHN to spread their efforts across all four objectives.** The SAT process requires District/SCHN Executives to assess and report their progress against all strategic objectives each year. Some stakeholders expressed their view that one unintended consequence of this was a pressure to make progress across all objectives equally, where in fact the intent was to provide a self-assessment platform for Districts/SCHN regardless of where they were up to in the implementation process

Qualitative data suggests that Districts/SCHN initially focused on objectives 1 and 2, and that Districts/SCHN should be encouraged to focus on these objectives as core to successful future implementation.

> "Not having [an appropriate governance] structure makes it extremely difficult to implement the processes for VAN integration"
>
> *District/SCHN SAT response*

The Interim Progress Report found that efforts to focus on strong leadership and governance arrangements (objective 1), and enhancing the skills, confidence and capability of the health workforce (objective 2) were likely laying the foundations for further progress against the IPARVAN Framework. Districts and SCHN continued to make progress against these objectives across 2021 and 2022 – further detail on the specific activities that were progressed under each objective is provided in Appendix G.

However, as shown in Figure 8 (above), SAT data indicates no correlation between progress against objectives 1 and 2 between 2018/19 and 2019/20, and greater progress on any of the objectives between 2019/20 and 2020/21. This may be the result of:

- **The COVID-19 pandemic impacting Districts/SCHN ability to build on earlier good progression.**
- **Districts/SCHN reaching a certain threshold that makes it more difficult to see quantitative progression.** As Districts/SCHN score themselves closer to 5 on the SAT, they may become more conservative with future assessments. By contrast, Districts/SCHN with lower initial scores may over-estimate the importance of incremental improvements.

To note, while Districts/SCHN reported good progress against objective 2 overall, as described in Table 7 above they all struggled to recruit and retain Aboriginal-identified positions.

Limited progress was made across all Districts/SCHN in ensuring services are culturally safe and engaging consumers in service design and delivery.

Development of culturally safe services and involvement of consumers in service design and delivery are relevant to all objectives of the IPARVAN Framework. While all stakeholders agreed that these areas were both highly important, the evaluation found that, overall, limited progress had been made:

- **Development of culturally safe and culturally appropriate services.** Most Districts/SCHN reported that whilst they had some form of cultural competency training, they had made little progress on other activities to ensure their services were accessible, appropriate and culturally safe for Aboriginal people, including a focus on Aboriginal recruitment and retention and engagement and collaboration with ACCOs. The impact of this lack of progress is discussed in sections 4.2.2 and 4.3.2, as well as the Aboriginal community reports.

  There were some notable exceptions where good progress had been made through partnerships with local Aboriginal service providers and community organisations, comprehensive training for non-Aboriginal staff and hiring Aboriginal workers. Some Districts also reported an Aboriginal traineeship program. Another District had started to offer cultural supervision to both Aboriginal and non-Indigenous staff. One District involved Aboriginal staff and ACCO representatives in District governance mechanisms, including at senior levels, which they said contributed to stronger relationships and better decision making that better considered the needs of Aboriginal people. Staff recognised these were important steps towards supporting more culturally safe and responsive services.

- **Consumer engagement and journey mapping.** Few Districts/SCHN reported engaging consumers directly, and there was limited evidence of activities to improve processes to engage consumers. Aboriginal staff noted that it was important to understand and collect evidence on the journeys and experiences of Aboriginal people who have experienced violence, abuse and/or neglect as these may differ considerably from non-Indigenous experiences.

4.2 KLE 2 | How well have the activities contributed towards system integration?

The previous section (Section 4.1) described the activities that have been undertaken to date to implement the IPARVAN Framework. This section begins to explore how these activities are contributing towards system integration. The approach to measuring integration for this evaluation is described further below. The following section (Section 4.3) explores how enhanced integration is contributing to changes in outcomes aligned with the quadruple aim.

SUMMARY OF FINDINGS

Joint case management is associated with progress towards successful integration.

- There is limited data available to understand whether the NSW health system is progressing towards integration. Whilst the primary focus of the Stage 1 evaluation was to understand progress towards implementation, understanding whether and how integration is occurring is important to provide a quasi-baseline for Stage 2 and Stage 3 evaluations.
- 13 indicators were identified through review of key literature to define integration. Regression analysis indicates that joint case management within NSW Health as well as between NSW Health and other agencies was associated with successful integration across multiple years, indicating that this is activity in particular is likely to contribute to enhanced integration.
- The importance of case management is supported by insights from VAN managers and VAN staff. They reported that joint case management approaches such as Safety Action Meetings (SAMs) built better connections between services, which subsequently led to an increase in referrals and requests for assistance.

Staff reported that integration is progressing across three distinct levels and are supported by key activities outlined against each level.

WITHIN VAN SERVICES

- Buy-in and engagement from Executive leadership is critical for driving forward implementation. This improves awareness of the IPARVAN Framework across the District/SCHN and provides VAN service managers with authority to drive forward change. The Ministry and Districts/SCHN should focus efforts on continuing to build and nurture Executive leadership, as this could serve to accelerate implementation.
- All Districts/SCHN reported efforts to review governance and reporting structures, and many had implemented revised structures. Where structures had been revised, each District/SCHN had developed a unique structure that reflected their local District/SCHN context.
- In some cases, revised governance and reporting structures had supported integration through building links between VAN services located within the same facility/site and between clinicians working in the same VAN service (e.g. Sexual Assault Services) across facilities/sites. Where these revised structures were successful, they served to build links between clinicians and between sites, creating a sense of 'one VAN service' that could provide holistic, wrap-around services to meet client and family needs.

BETWEEN VAN SERVICES AND THE BROADER NSW HEALTH SYSTEM

- Efforts to build non-VAN staff awareness of violence, abuse and neglect and appropriate referral pathways was supported by enhanced access to education and training opportunities and though building strong stronger relationships between VAN services and other broader health services.
- Bottom-up leadership from VAN services managers and staff drove integration through continuing momentum for change and building awareness of violence, abuse and neglect, and of the IPARVAN Framework. VAN services staff reported they have limited time to dedicate this due to resourcing constraints.
- Some Districts/SCHN reported bespoke approaches to sharing VAN services client information through electronic record systems. This sharing of information further supported integrated ways of working across the health system, by ensuring all members of a care team had access to relevant client information, whilst maintaining client privacy and confidentiality.
- Cross-agency structures such as SAMs and JCPRP are important for building cross-agency connections. These support improved ways of working to provide holistic, coordinated care to the client. However, Aboriginal staff reported that there was a lack of Aboriginal representation in these structures and that they often did not result in a good outcome for Aboriginal clients.

Clients reported that there is still much work to do deliver a holistic, integrated response

- Non-Indigenous clients spoke highly of the support they received through VAN services; Aboriginal clients said that they received good support from ACCOs and some non-Indigenous staff in VAN services but most reported significant challenges when seeking support, with fragmented and culturally insensitive care.
- Non-Indigenous and Aboriginal clients reported a number of challenges with accessing care, including:
    - Poor understanding or awareness of the availability of VAN services.
    - Poor communication and coordination between different service systems such as between VAN services, NSW health services and other stakeholders, including having to 'retell' their stories multiple times
    - Lack of VAN service capacity and long waitlists.
- Non-Indigenous and Aboriginal clients reported that a good relationship with their counsellor or case worker was vitally important and that it was challenging to rebuild trust if they had to change services or see someone new.

4.2.1 Measuring integration quantitatively

As detailed in Section 2.4 and Appendix D, the evaluation conducted a regression analysis to understand quantitatively the extent to which integration was occurring, and to identify activities (if any) that were contributing towards enhanced integration.

The regression analysis indicates five activities had a positive relationship with progress towards successful integration: joint case management, client journey mapping, 24-hour crisis responses, local evaluation activities, and service improvement

The regression analysis[38] explored the relationship between service provider's scores for all activities associated with the IPARVAN Framework, with those that have been identified as integration indicators (see Appendix D for further detail). Only the responses from the provider survey were used because there were too few respondents to the SAT (n=16) for the analysis. The relationship was tested across the three years of available data; 2020 (n = 89), 2021 (n = 46), and 2022 (n = 54).

For most activities there was no statistically significant evidence of a relationship with integration. However, as noted in Table 8 below, five distinctive activities (one activity noted in multiple years) were identified to have a positive relationship with progress towards integration (i.e., performing these activities indicates that integration is progressing well).

These activities can be associated with early progress towards integration. This means that increased focus on these activities in the future is likely to contribute to enhanced integration across the health system.

Table 8 | Provider survey questions most associated with indicators of successful integration identified through regression with integration indicators as response variable

	Indicators identified to have a positive relationship with progress towards integration
2020[39] *n = 89*	• There are formal governance arrangements for joint case management and referral between NSW Health services and VAN services • The patient experience journey is mapped with consideration to the VAN service model or models developed in your local context, which is used by your organisation to inform service practices • There is a 24-hour integrated crisis counselling response, which is available to all cohorts of people who have experienced violence, abuse and neglect
2021 *n = 46*	• Identified and undertaken local evaluation and/or service improvement activities for VAN services • Local evaluation, quality assurance, and service improvement activities undertaken by your District/SCHN have informed your service's practice
2022 *n = 54*	• There are formal governance arrangements for joint case management and referral between NSW Health services and VAN services

The regression analysis indicated over multiple years the positive relationship between joint case management with progress towards successful integration

The regression over multiple years highlighted a positive relationship between integration and 'there are formal governance arrangements for joint case management and referral between NSW Health services and VAN services.' In both 2020 and 2022, the analyses indicated improvement in joint case management would result in approximately +0.06 improvement across integration activities (as detailed in Appendix D).[40]

[38] Regression analysis estimates the relationship between a number of different explanatory variables (in this case, survey questions about activities that are part of the process or inputs to integration) and a single response variable (in this case, the average score of the 13 questions in **Error! Reference source not found.** that collectively form an indicator of the extent of integration). The regression model used for this analysis tested for the impact of around 60 activity-based survey questions on the integration indicator, using appropriate modern statistical methods ('bootstrap', 'elastic net regularisation' and 'multiple imputation') to identify the activities with the strongest relationship to integration.

[39] See 0 for further detail on the regression analyses methodology and the detailed confidence interval breakdowns

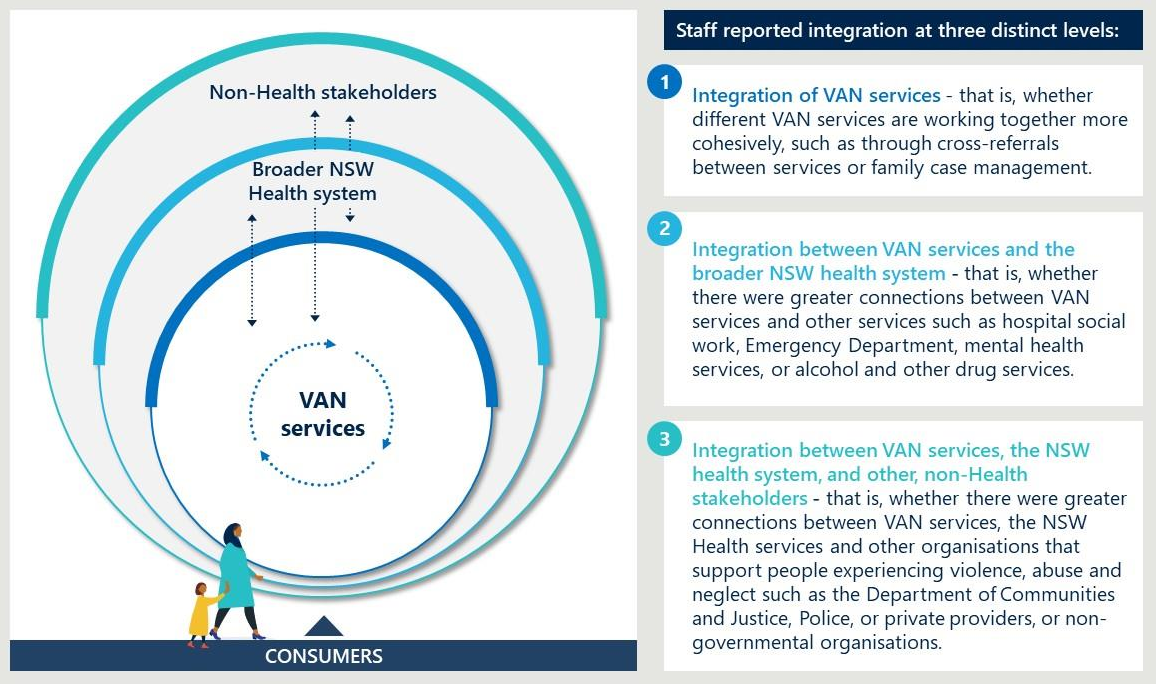
[40] See 0 for further detail on the regression analyses methodology, including graphs illustrating the confidence intervals and overall positive relationship indicated.

A link between joint case management and referral and enhanced integration is supported by qualitative data, including insights from VAN services managers and VAN services staff. Across the evaluation, managers and staff spoke positively of joint case management including interagency approaches – such as Safety Action Meetings (SAMs) – as a mechanism for building greater connections between VAN services, non-VAN services, and interagency partners. VAN managers and staff reflected those approaches helped to build relationships at the staff level and, they believed, lead to an increase in subsequent referrals and requests for assistance.

4.2.2 Understanding the extent to which the system is becoming more integrated

The Stage 1 evaluation was not able to quantitatively assess the extent to which the IPARVAN Framework is contributing to enhanced integration. However, qualitative insights from interviews, focus groups and site visits provide evidence that District/SCHN Executives, VAN services managers and staff, and other NSW Health staff perceive integration progressing. Staff have reported that integration is occurring at three distinct levels of the system, as shown in Figure 9.

Figure 9 | Staff reported integration at three distinct levels



Integration is occurring across all three levels of the system, but there has been greater progress within VAN services.

Focus group participants reported that although integration is occurring at all three levels of the system, initial focus has been on integration between VAN services. Staff reported examples of integration between VAN services and other NSW Health services, and between the health system and other partners that provide a response to people experiencing violence, abuse and neglect, but these were not consistent and had not been embedded.

Greater progress on integration between VAN services is expected, given this was a focus of Phase 1 implementation. Integration at the other two levels will be a focus for Phase 2 and ongoing implementation.

Strong and committed Executive leadership is critical for progressing integration – ensuring this leadership exists should be a focus for all Districts/SCHN as implementation progresses.

Qualitative insights indicate there are varying levels of Executive commitment to implementation of the IPARVAN Framework across NSW Health. In Districts/SCHN where there were high levels of awareness and commitment:

- **Executive level staff who were interviewed – including Chief Executives – were aware of the IPARVAN Framework and described the system-wide impacts of violence, abuse and neglect.** Executives were able to articulate the benefits of a more integrated and coordinated response including on indicators such as Emergency Department presentations or demand for mental health or drug and alcohol services. This awareness created momentum for change and buy-in across the Executive Team and Board.

> "Executive support is critical…there's a clear message now that VAN is everyone's business, and we all have a role to play in prevention and response"
>
> *VAN services staff*

- **VAN managers described the importance of Executive support to create the authorising environment for continued implementation of the IPARVAN Framework.** Managers reported the need for leadership support to refine governance structures, push for the inclusion of violence, abuse and neglect on the standing agenda for Board and sub-committees, and revise service structures to encourage more integrated working arrangements. In some instances, VAN managers reported that this Executive support gave them the authority to more closely work with hospital staff such as social work, to drive change across the system.
- **VAN staff echoed the importance of top-down leadership to drive change**. Staff reported that Executive support and championing of the IPARVAN Framework had raised the profile of VAN services within Districts/SCHN and increased staff awareness of the incidence and prevalence of violence, abuse and neglect.
- **In one District, there was Aboriginal representation in senior governance bodies, which was reported to increase executive support for efforts to improve experiences for Aboriginal people.** Aboriginal staff and representatives from local ACCOs were included in governance bodies from the leadership level through to frontline service delivery. Aboriginal staff reported that this had contributed to increased awareness and support from Executives to address issues affecting Aboriginal people, improved decision making, and stronger partnerships between the District and local ACCOs.

  Conversely, in some Districts/SCHN Executive level commitment or leadership was less evident. In these Districts/SCHN, VAN managers and staff reported that the District/SCHN focused efforts on priorities other than the IPARVAN Framework. As a result, they did not have the authorising environment to drive change.

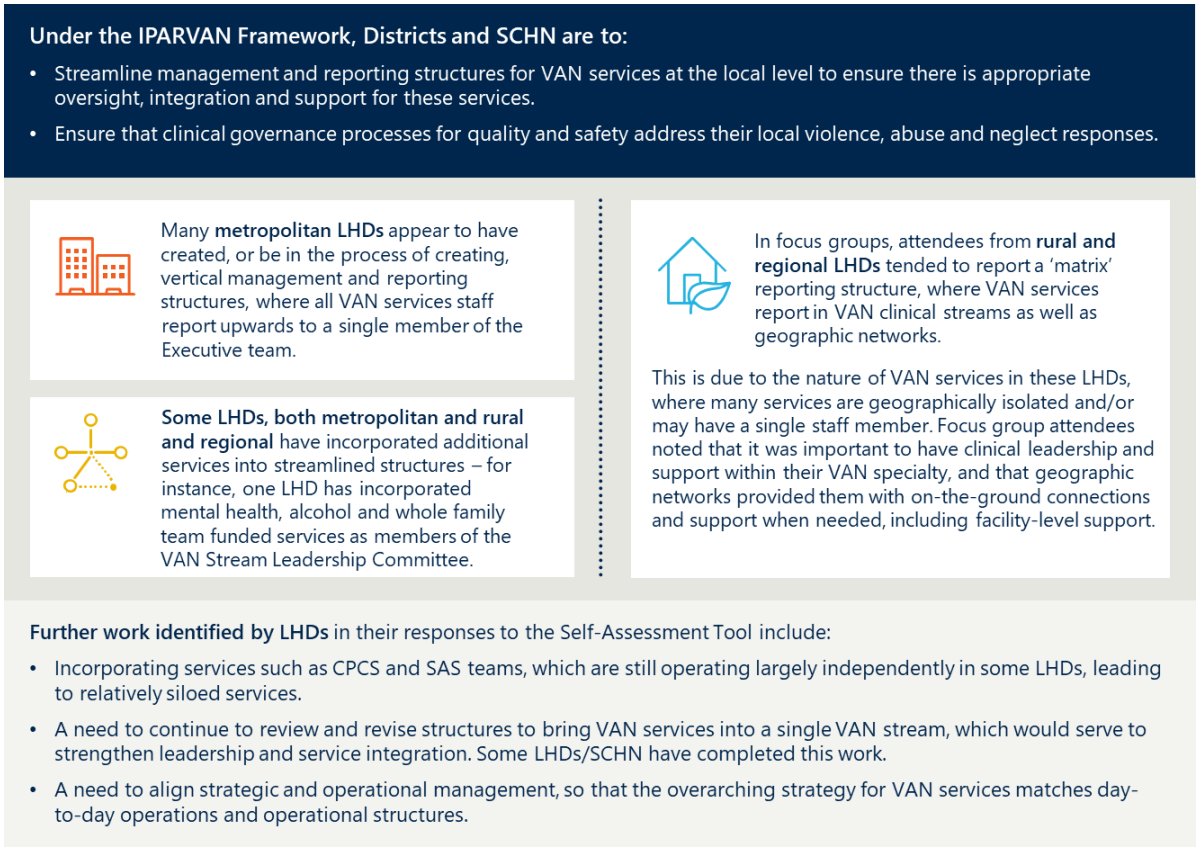
Case Study – Committed leadership as a key driver for implementation of the IPARVAN Framework

During the 2022 focus groups, staff from one District reported on the critical role of leadership in their organisation. They noted that their District had made limited progress with implementation between 2018 and 2021, but that this had shifted towards the end of 2021. Staff directly attributed this shift to a change in Executive leadership, and a renewed commitment to the IPARVAN Framework. They saw that leadership and public commitment to IPARVAN was creating the momentum for implementation.

Appropriate governance and reporting structures – especially for VAN services – support VAN staff to work in more integrated ways.

All Districts and SCHN reported progressing activities to review their governance structures, and many progressed work to revise and refine these structures as part of implementation of the IPARAN Framework – many with a specific focus on governance of VAN services. Figure 10 provides an overview of some key features of effective governance models.

Figure 10 | Key features of governance models



VAN service managers and staff reported the importance of revised governance structures for supporting new and integrated ways of working within VAN services. In some Districts/SCHN these revisions brought all VAN services under a single reporting line. In these instances, staff reported that this created a sense of 'one VAN service', rather than staff considering themselves as working in individual, specialised services (such as sexual assault or child protection). As a result, staff noted that they built or deepened relationships with other VAN clinicians and were more likely to work cross-service or cross-refer.

VAN managers echoed this, with some noting the value of a hybrid or matrix reporting structure with staff reporting through geographic/facility lines as well as clinical lines – noting that this approach will not make sense in all Districts/SCHN. Particularly in regional, rural and remote Districts, geographic reporting lines facilitate relationship building across services whilst clinical reporting provides appropriate clinical governance and support.

Aboriginal staff reported that there were opportunities to increase the number of Aboriginal people in governance bodies and in management and supervisory positions to support both Aboriginal and non-Aboriginal staff deliver culturally safe care to Aboriginal clients.

Case Study – Matrix reporting structures build relationships whilst providing appropriate clinical support

One geographically diverse District revised their VAN services governance structures to incorporate geographic SCHN and clinical streams. VAN service managers and staff reported on the benefits of supporting integrated working – geographic networks brought together clinicians from different VAN services, building relationships and encouraging them to work together, whilst clinical streams provided appropriate peer support and clinical governance.

"**Before [the governance reforms] I didn't know the SAS worker, but now we work together, we talk to each other, we think about how we can provide the best wrap-around support to meet the needs of our clients**"

VAN service managers and staff drive integration within VAN services and between VAN services and other NSW health services – these staff need greater support, including dedicated non-clinical time, for this to be effective.

In addition to strong Executive-level leadership, all stakeholders reported on the importance of leadership from VAN services managers and staff themselves for driving forward implementation – leading to enhanced integration.

"They [VAN services managers and staff] have done so much of the leg work, building awareness and supporting staff uplift"

LHD/SCHN Executive

District/SCHN Executives noted the important role of VAN managers and their staff in progressing implementation of the IPARVAN Framework. This includes:

1. Continuing the momentum for change within VAN services teams.
2. Building awareness of the IPARVAN Framework with staff outside of VAN services.
3. Proactively providing training and upskilling to broader health service staff, such as through in-services and other informal training mechanisms.
4. Acting in a consultancy or advisory role, providing support to broader health service staff when they are providing a response to someone presenting with experience of violence, abuse and neglect.

VAN services staff noted that, whilst they see this leadership as a key part of their role, the amount of time they can dedicate to this work is limited by resourcing constraints. Staff prioritise delivering therapeutic care over and above work such as upskilling. Some staff also noted that it is difficult to account for time upskilling and/or providing advice to others under the activity-based funding model.

Aboriginal staff in two Districts reported that while there had been some progress in recent years, overall there was very little integration between VAN services and local ACCOs. Staff in ACCOs were often unaware of the IPARVAN Framework and some were unaware of VAN services in their area. Aboriginal staff reported that where there were partnerships between ACCOs and VAN services, this was often driven by ACCOs or based on strong relationships with individual staff from VAN services.

Efforts to build the skills, capabilities and confidence of broader health service staff are building relationships and resulting in greater integration between VAN services and other NSW Health services.

Objective 2 of the IPARVAN Framework focuses on building the skills, capabilities and confidence of the NSW Health workforce. Districts and SCHN have focused efforts to date on progressing activities under this objective. This includes both formal and informal training opportunities.

Insights from interviews, focus groups and site visits indicate that these efforts are leading to greater integration between VAN services and other NSW Health services. The impact of these education and training opportunities include:

- **Enhanced awareness of the incidence and prevalence of violence, abuse and neglect.** Enhanced awareness enables broader health services staff to identify experiences of violence, abuse and neglect, and embed an appropriate response that adequately responds to client needs.
- **Strengthened relationships between VAN services staff and broader health services staff.** Some VAN services staff reported that strengthened relationships mean that broader health services staff are more likely to be aware of violence, abuse and neglect and have informal contact points when they have questions or need advice about violence, abuse and neglect.

As a result, broader health services staff now know how to refer clients to VAN services when needed. As detailed above, efforts to build the skills, capabilities and confidence of the broader health workforce may have been constrained by challenges faced by ECAV during the initial stages of implementation.

More can be done to strengthen the cultural competency of non-Aboriginal staff across the health system, particularly those working in mainstream health services.

Aboriginal staff and clients interviewed for the evaluation reported that many staff across the health system lacked the cultural competency and skills to provide culturally appropriate and trauma-informed care to Aboriginal clients. Mostly they referred to the services that refer in and out of VAN services, such as maternity, child and family health, allied health, drug and alcohol, and general practice. They also mentioned some services that provide a direct VAN response such as mental health and emergency departments. Examples of poor cultural competency reported by clients and staff included:

- Staff treating a sexual assault victim for 'intoxication' rather than focusing on the sexual assault.
- Staff assuming a heart attack patient was under the influence of alcohol.
- Staff dismissing a client's repeated complaints of pain (subsequently diagnosed as a tumour) as anxiety from previous trauma.
- A mental health clinician writing to a court to say a client with a trauma-history 'could do with time in custody'.
- Several instances of judgemental approaches such as criticising mothers for untidy homes or unhealthy diets when the family is experiencing violence or has a trauma history.

Aboriginal staff reported that this lack of cultural competency has a flow on impact to all VAN services as it means non-Aboriginal staff are not understanding and engaging appropriately with Aboriginal clients, and for a client, it can perpetuate feelings of mistrust and being "let down" by the health system. Aboriginal stakeholders called for improved cultural competency training for all NSW Health staff with a key focus on understanding Aboriginal cultural and past trauma.

Bespoke approaches to sharing client information in some Districts/SCHN – including through adaptations to electronic medical records systems – are further supporting integrated ways of

working across the health system. Other Districts/SCHN should explore opportunities to build on these successful approaches.

In the Interim Progress Report, some broader health services staff reported challenges providing appropriate and safe care to clients of VAN services, given limitations on accessing client medical records. Staff acknowledged the importance of maintaining client privacy and confidentiality – particularly in regional, rural and remote Districts – but highlighted the need to balance this with ensuring clinicians have the information they need to provide care.

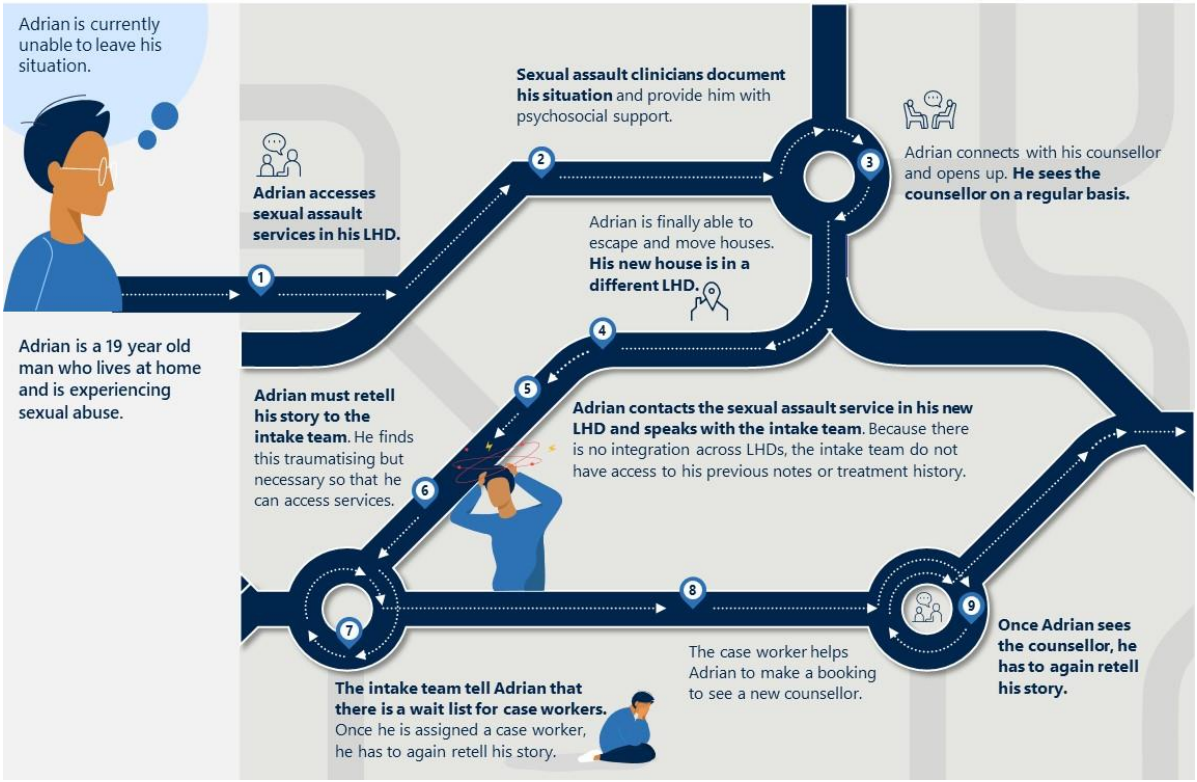
In focus groups in 2022, clinicians in some Districts/SCHN reported changes that enabled them to access the VAN service history of clients. Districts/SCHN approached this in different ways – some added a 'VAN services flag' to client notes, others provided a summary of the interaction a client had with VAN services.

> "Before we couldn't see their notes – we had no way of knowing if someone was a client of a VAN service. It's good now, I can make sure I'm providing the best care possible.
>
> *Broader health services staff*

Clinicians noted this had supported them to work more closely with their VAN services colleagues. They were able to identify when a client was currently, or had previously, engaged with a VAN service and could tailor the care and support they provided accordingly. Some clinicians reported proactively contacting with VAN services to ensure the care provide would contribute to supporting clients to meet their therapeutic goals.

Adrian's story (Client Story 1) highlights the potential negative impacts on health and wellbeing and client experience that can result from poor communication between VAN services and across NSW Health.

Client Story 1 | Adrian's story



Much of the integration that has occurred to date has been due to relationships. As implementation progresses, work is needed to embed integration across the system including through cross-specialty governance groups and dedicated resources focused on building partnerships and promoting collaboration.

Whilst VAN services managers and staff spoke positively of the relationships that had been built with broader health services colleagues, they did report that relationship-based processes bring significant risks.

When key people shift teams or move on from the District/SCHN, these relationships are broken, and it requires considerable time and effort to rebuild. Some VAN services staff reported times this had happened in the past, noting that it felt like they had to start 'from the ground up'.

Some Districts/SCHN have put in place structures that serve to embed integration between VAN services and broader health services. These include:

- Formal cross-speciality governance groups, routinely bringing together the leaders of VAN services and broader health services. These governance groups endure even if key leaders depart.
- Using VAN Redesign Program funding to create positions that are designed to build connections between VAN services and broader health services. Some Districts/SCHN used funding to create additional VAN services positions that sit within broader health services (for example, within generalist or hospital-based social work).

"It's working because it's me, I can straddle VAN and non-VAN services so I can build those links. But what happens when I'm gone?

VAN services staff

"[Health] can change the trajectory of a child's life through lack of consultation. They are very "us and them" and they don't work in a collaborative way. Sometimes they take action without thinking to engage [the Aboriginal case worker]"

VAN services staff

Consultations with Aboriginal staff working within NSW Health and Aboriginal Community Controlled Organisations highlighted the importance of building respect between Aboriginal and non-Aboriginal health workers (both within and external to NSW Health). This is a critical first step to supporting greater integration between VAN services staff and Aboriginal staff in NSW Health, and also between NSW Health and Aboriginal Community Controlled Organisations.

Case Study – VAN positions sitting within broader health service teams

One District has used the VAN Redesign Program finding to create VAN specialist social work positions that sit within ED social work to work alongside the ED social work team. Through these positions, the District is building the skills and capabilities of generalist ED social workers to recognise and respond to violence, abuse and neglect, and to refer onwards to VAN services when needed. These positions should also address concerns around relationship-based integration – if and when the VAN specialist social worker leaves the role, a new clinician can be recruited to maintain coordination and referral pathways.

VAN staff reported that efforts to improve awareness of violence, abuse and neglect have resulted in an increased demand for already stretched VAN services.

VAN services managers and staff in all Districts/SCHN spoke highly of the value that greater integration brings, and the potential of integration to lead to better client experience, client outcomes, staff experience and system sustainability.

Some Districts/SCHN noted that as a result of activities delivered under the IPARVAN Framework, broader health services staff were more likely to identify and refer to VAN services. This was increasing the demand for an already stretched VAN service system.

> "It's great that more staff identify violence, abuse and neglect, but they don't yet have the confidence to respond so we end up with so many more referrals we can't deal with"
>
> *VAN services staff*

Many VAN services staff reported that more work was needed to build broader health service staff confidence to respond to violence, abuse and neglect (within their scope of practice), rather than simply identifying and referring to VAN services. This reflects one of the intended purposes of the IPARVAN Framework.

Cross-agency structures and coordination mechanisms such as SAMs are contributing to broader integration between VAN services, broader NSW health services and interagency partners.

Many VAN service staff reported the importance of coordination mechanisms such as Safety Action Meetings (SAMs), Youth Action Meetings (YAMs) and the Joint Child Protection Response Program (JCPRP) for building connections between VAN services, broader NSW health services, and other interagency partners. Many staff – both from VAN services and from broader health services – noted that the IPARVAN Framework had provided an impetus to formalise case coordination, as well as referral and clinical governance processes. Some stakeholders reported inconsistencies in the quality and performance of SAMs across the state.

However, Aboriginal stakeholders reported that there was a lack of Aboriginal representation in SAMs, which meant that decisions did not always result in the best outcome for Aboriginal clients. One example shared included an Aboriginal woman who had presented to the police after experiencing domestic and family violence. Her level of risk led to her case being discussed at the SAM and as such, the family were allocated to the NSW Department of Communities and Justice (DCJ). In this instance, the client felt they were held accountable (and could have her children taken away) because she was experiencing violence.

Clients of VAN services reported that there is still much work to do to deliver a holistic, integrated response across NSW.

Non-Aboriginal clients of VAN services spoke highly of the care and support they had received from VAN services – but all noted that they found it exceptionally difficult to identify the services that were available to them and understand how to access these services. Many reported feeling 'lucky' that they were eventually connected with their VAN service clinician – but once they were connected with a VAN service, they were able to receive the care they needed to progress towards their therapeutic goals.

Non-Aboriginal clients identified several challenges with accessing care, including:

- **Poor understanding or awareness of VAN services by other stakeholders.** Many clients reported that their GP, psychologist, primary care provider, case worker or police officer was simply unaware of the VAN services that were available in their geographic area. Some clients had instead been referred to private providers rather than NSW Health services, which they were unable to afford.
- **Poor communication and coordination between VAN services, NSW Health services, and other stakeholders.** Many clients reported a lack of communication and coordination between NSW Health, the Department of Communities and Justice, and local police services. In many instances, clients had to repeat their story multiple times because relevant information about their case had not been passed on. Some clients also reported feeling overwhelmed by the number of specialist appointments.

> The policeman raised his voice at me and then I just shut down. I've been around aggressive men all my life – there's no way I'll feel safe with that"
>
> *VAN services client*

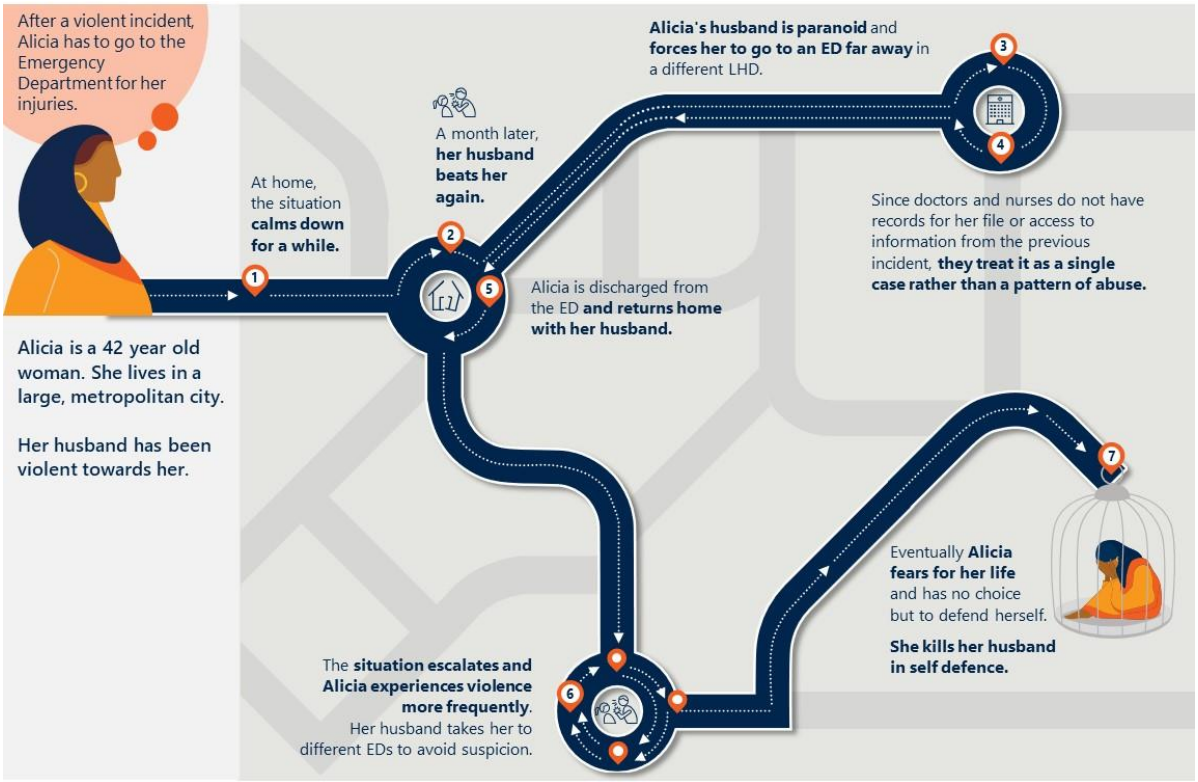
> "I didn't know where I was supposed to go, who I was supposed to talk to, what I was supposed to do"
>
> *VAN services client*

- **Poor communication between clients and VAN services, NSW Health services, and other stakeholders.** Some clients spoke of receiving calls from unknown service providers months after their initial engagement with system stakeholders. They had not been informed that their details were passed on, nor were they aware that these services were available, which poses a safety issue.
- **Overall lack of VAN service capacity.** Many clients mentioned that they knew the capacity constraints facing their VAN service clinicians and noted that there were likely many more people in the community who could benefit from these services, were they made available.
- **Lack of services that meet client needs and expectations, including lack of culturally safe services.** Some VAN services do not allow parents/carers to attend appointments with their children, which can place additional barriers and obstacles for clients in vulnerable circumstances. Other clients reported receiving care in 'clinical rooms' within hospitals and health centres, which was not conducive to the therapeutic relationship with their VAN services clinician.

Aboriginal clients reported similar challenges to non-Aboriginal clients, particularly lack of communication between services and having to retell their story. In addition, Aboriginal clients reported experiencing condescending treatment and racism from NSW Health staff across the health system as well as fear of being reported for children protection concerns, feeding into a distrust of health services. This is discussed in further detail in the supplementary Aboriginal community reports. Despite these challenges, most Aboriginal clients reported that they felt well supported by ACCOs as well as by individual NSW Health staff that they had a strong relationship with (e.g., counsellor in a VAN service).

Alicia's story (Client Story 2) highlights some of the challenges faced by clients of VAN services including poor connection between VAN services, and between different Districts.

Client Story 2 | Alicia's story



4.3 KLE 3 | To what extent has the purpose of the IPARVAN Framework been achieved?

This section presents findings on the extent to which the purpose of the IPARVAN Framework is being achieved by examining progress towards four outcomes – health and wellbeing outcomes[41], client experience, staff experience and system sustainability (detailed in Figure 11).[42] These findings are largely descriptive and based predominantly on qualitative data, as limited quantitative data was available throughout the evaluation to explore progress against these domains.

It is not possible in the Stage 1 evaluation to directly attribute changes in outcomes to the IPARVAN Framework (and the level of integration). It is important to note that the Stage 1 evaluation was intended to primarily focus on process and short-term outcomes.

Nonetheless, improvements in the data landscape and additional indicators aligned to each of the four outcomes need to be agreed and collected to enable robust and successful Stage 2 and Stage 3 evaluations. This is important to understand the relationship between IPARVAN Framework activities, integration, and the extent to which progress towards outcomes is being achieved over time (see Appendix B for further discussion on data limitations).

Section 5 (below) of this report includes recommendations and guidance on what data is important to collect to measure outcomes in the Stage 2 outcomes evaluation and Stage 3 economics evaluation.

Figure 11 | Outcome domains for the evaluation of the IPARVAN Framework

[41] The Monitoring and Evaluation Framework originally labelled this outcomes domain as clinical outcomes, however, the outcomes statement and objectives of the Framework encompass the broader range of health and wellbeing outcomes for people impacted by violence, abuse and neglect. Therefore, the term 'health and wellbeing outcomes' rather than 'clinical outcomes' is being used in this report and the evaluation moving forward.

[42] Staff experience was added as a domain during the evaluation period, as it is a key component of the quadruple aim.

SUMMARY OF FINDINGS

There is limited quantitative data available to demonstrate whether integration is leading to better outcomes.

- Whilst the Stage 1 evaluation primarily focused on process and immediate outcomes, it was important to seek to understand progress towards medium and longer-term outcomes, in order to establish a quasi-baseline for future evaluations. The Stage 2 and 3 evaluations could use this quasi-baseline to understand progress over time.
- The limited availability of quantitative data was due to:
  - Data quality issues throughout the evaluation, although many of these have now been identified and progress is being made to rectify these issues.
  - Data variables not consistently reported across the system.
  - Datasets and variables still in development.
  - Limited unit record data available to the evaluation to understand clients' experience in the health system, although such data is available to Ministry staff.

Qualitative insights from clients and VAN services staff and managers indicated that integration was leading to better outcomes across the quadruple aim.

HEALTH AND WELLBEING OUTCOMES

- VAN service managers and staff reported that due to integrated ways of working, some clients are now receiving more holistic, wrap-around care and experiencing improved client health, wellbeing and safety.
- New program and expansions of services have resulted in an increase in the reported number of clients receiving services. However, it is unlikely that this increase in service is sufficient to meet current estimated demand and rising demand.

CLIENT EXPERIENCE

- There was some evidence of progress within VAN services to provide timely responses to people who experienced violence, abuse and neglect.
- Clients reported difficulties with accessing VAN services – many spent significant periods of time searching for the right service to meet their needs. Many non-Aboriginal clients who were able to access VAN services were positive about the care and support they received from VAN services staff.
- Integrated approaches and better relationships – both within VAN services and with broader health services – meant that clients did not need to repeat their stories each time they were in contact with the system.
- More focus is needed to ensure care is culturally safe and culturally appropriate – many Aboriginal clients reported experiences of racism within the health system, alongside fragmented and culturally insensitive services.

STAFF EXPERIENCE

- Staff experiences differed across and within Districts/SCHN:

- Some VAN managers and staff felt more empowered by the IPARVAN Framework to actively drive change to better integrate supports for people experiencing violence, abuse and neglect.
- Other staff reported issues with having to take on additional duties outside their original roles, such as being involved in 24/7 crisis responses or providing responses in a centralised intake team, rather than provide care specialised to their specific area of expertise.

- VAN services staff reported concerns with increasing risk of burnout due to increased referrals into VAN services, but no corresponding increase in resourcing to meet this demand.
- Some Aboriginal staff working in VAN services reported not feeling valued for their skills, knowledge and experience, as well as being over-burdened with being expected to respond to all issues regarding Aboriginal clients.
- District/SCHN Executives noted efforts to build a trauma-informed workforce is likely having a positive impact on NSW Health staff overall.

SYSTEM SUSTAINABILITY

- It is not possible to quantitatively demonstrate the impact of violence, abuse and neglect, and the potential positive impact of integration on system sustainability. However, VAN service managers reported that integration is leading to system sustainability.
- Societal changes in attitudes towards violence, abuse and neglect and activities as part of the IPARVAN Framework may be leading to greater awareness of violence, abuse and neglect. However, this greater awareness may be placing increased pressure on the system through:
  - Greater presentations of violence, abuse and neglect across the system.
  - Other health services increasingly recognising and referring incidences to VAN services.
- Clients reported that further integration could improve system sustainability, such as through:
  - Increasing access to early intervention services, reducing the change that people who have experienced violence, abuse and neglect may find themselves in crisis.
  - Reducing Emergency Department presentations through earlier identification of clients experiencing violence, abuse and neglect and better early support.
  - Better connecting VAN services with other health services such as mental health services and/or alcohol and other drug services to better meet clients interconnected therapeutic goals.

4.3.1 Health and wellbeing outcomes

VAN services staff reported that VAN system integration has led to improvements in health and wellbeing outcomes.

VAN services staff who responded to the provider survey (between 46 and 84 responses each year)[43] were asked the extent to which they agreed that VAN system integration had led to improvements in the health and wellbeing outcomes domain and outcomes statement: '*VAN client health, wellbeing, safety and access to support being optimised and sustained.*' Over the three years the provider survey was collected (2020 to 2022), on average respondents agreed with the statement. In 2022, a total of 69 per cent of respondents agreed or strongly agreed with this statement.

In interviews, focus groups and site visits VAN services staff identified that integration has resulted in new ways of working, particularly within VAN services. As 'one VAN service', staff reported that they were more likely to work with their VAN services colleagues to provide a whole of client or whole of family response.

> "We're really working together now – I know CPCS and will bring them in if needed. We're really working on providing a 'whole of client' or 'whole of family' response.
>
> *VAN services staff*

New programs and expansion of services has resulted in an increase in the reported number of clients receiving services, although this is likely not sufficient to meet need and potential demand.

Most Districts/SCHN have introduced new VAN programs and expanded existing programs as a result of the VAN Redesign Program and the IPARVAN Framework, resulting in more clients receiving a clinical service. This included introduction of new services for domestic and family violence and children and young people with harmful and problematic sexual behaviours, additional psychosocial services, and improved availability of 24-hour responses.

This increase in service availability contributed to an increase in the reported number of clients being supported and service events. Across all VAN services, the reported number of service events increased by 52 per cent from 2016/17 to 2020/21 and the number of distinct clients increased by 83 per cent over the same period.[44]

Whilst more people are accessing VAN services, this is likely not sufficient to meet potential demand. VAN services staff from most Districts/SCHN highlighted notable gaps in service availability. For example, most Districts/SCHN have not filled Aboriginal identified positions in VAN services, and some Districts/SCHN do not have domestic violence counselling services, or these may not be available consistently across the District/SCHN.

Additional data on VAN services including service events is provided in Appendix E and Appendix F.

4.3.2 Client experience outcomes

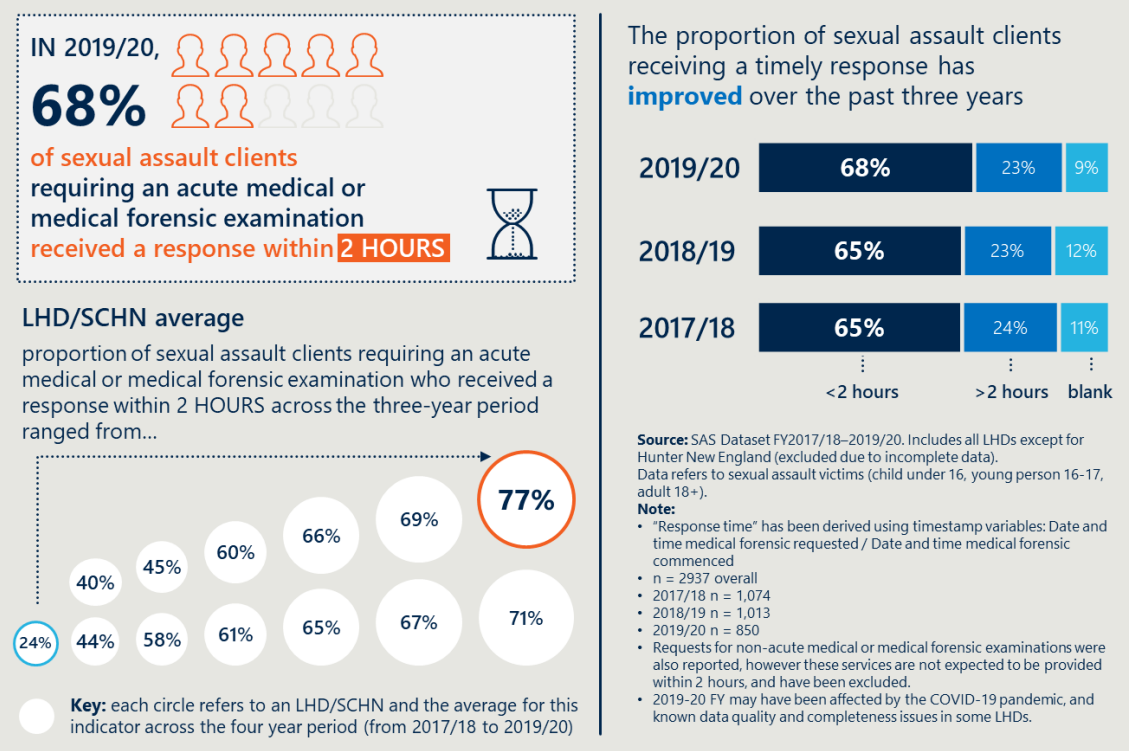
As illustrated in Figure 12 below, VAN services made progress towards providing a timely response to people who have experienced violence, abuse and neglect. In 2019/20, 68 per cent of sexual assault clients

[43] Provider survey response rate: July 2020 (n=84 representing 15 of 16 LHDs/SCHN), July 2021 (n=46) and March 2022 (n=54)
[44] While there has been an increase in the reported number of service events and distinct clients in the NAP data, this increase may also reflect improvements in the reporting by service providers. There was also an increase in number of services reporting which impacted the numbers reported (an additional 59 services between 2016 and 2021 reporting clients). See Appendix B for further detail. Source: Non-Admitted Patient Data, 2016-2021.

requiring an acute medical or medical forensic examination received a response within 2 hours of request. This varied greatly between Districts/SCHN, which might suggest that a timely response for sexual assault clients requiring an acute medical examination has not been progressed at the same rate across the state.

Some variation might also be due to the need for clients in some regional, rural and remote locations to travel more than two hours in order to receive a medical forensic response. While meeting policy requirements, there are limitations in improving response times due to extensive geographical areas needing coverage.

Figure 12 | Proportion of sexual assault clients requiring an acute medical or medical forensic examination receiving a response within 2 hours between 2017/18 and 2019/20[45]



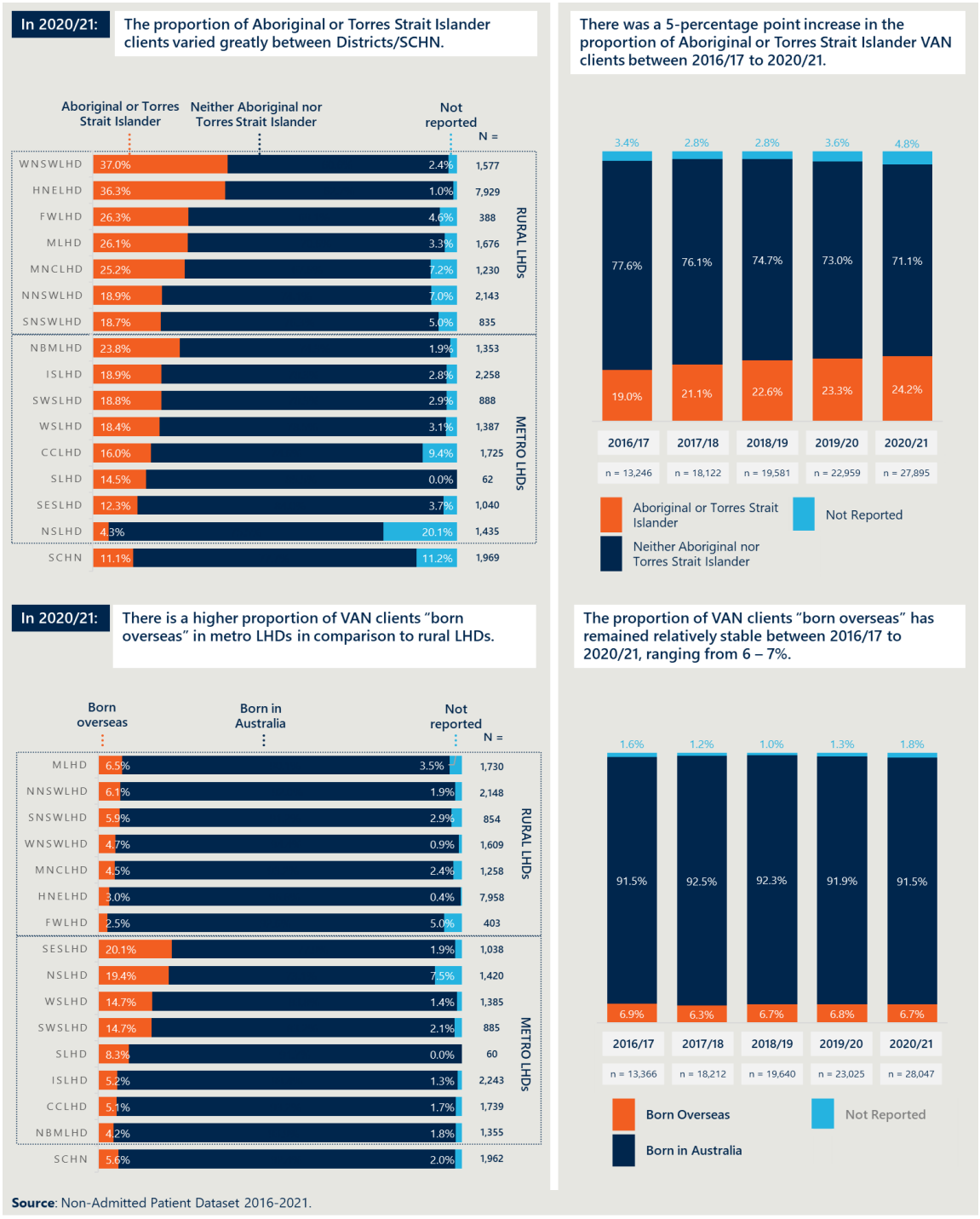
There was little change in the proportion of Aboriginal people, people born overseas, and people aged under 18 accessing VAN services - indicating an increased focus is required to understand and meet the needs of these populations.

Among VAN services clients, there was no significant change in the proportion of clients born overseas using VAN services (see Figure 13). Overall, there was a slight increase of 5 per cent in the number of Aboriginal clients (see Figure 13) and a slight increase of 6 per cent in the number of clients under 18[46] who accessed VAN services from 2016-2017 to 2020/21 (Figure 14).[47] More work is needed to ensure VAN

[45] The source of this data was the Kids and Families Data Warehouse, which was decommissioned in June 2021 following the rollout of the VAN Service Contact form to most districts/networks. Data quality in 2020/21 was impacted by this transition period and is not suitable for inclusion in this report. Similar data is now being collected through the VAN Service Contact form; however, it will take time for the quality and consistency of this data to improve and stabilise before it can be used for analysis.
[46] "Born overseas" is used as a proxy indicator for culturally and linguistically diverse (CALD) populations.
[47] Source for these graphs is the Non-Admitted Patient Dataset (NAP) 2016-2021. Total n is calculated based on the total number of clients recorded in each distinct dataset, which is what is used as the denominator for calculating the proportions for each sub-group. Analysis may be incomplete or incorrect for NSLHD and SLHD due to issues with reporting of client level data in the NAP.
Client values of <5 or <10 were suppressed in the extracted dataset to mitigate potential identifiability. These values were recoded based on a predictive imputation model, as outline here: freerangestats.info/blog/2018/11/06/suppressed-data

services are culturally safe, culturally appropriate, and meet the needs of younger cohorts experiencing violence, abuse and neglect.

Figure 13 | Proportion of Aboriginal or Torres Strait Islander VAN services clients[48] and proportion of VAN clients identified as "born overseas" between 2016/17 and 2020/21[49]

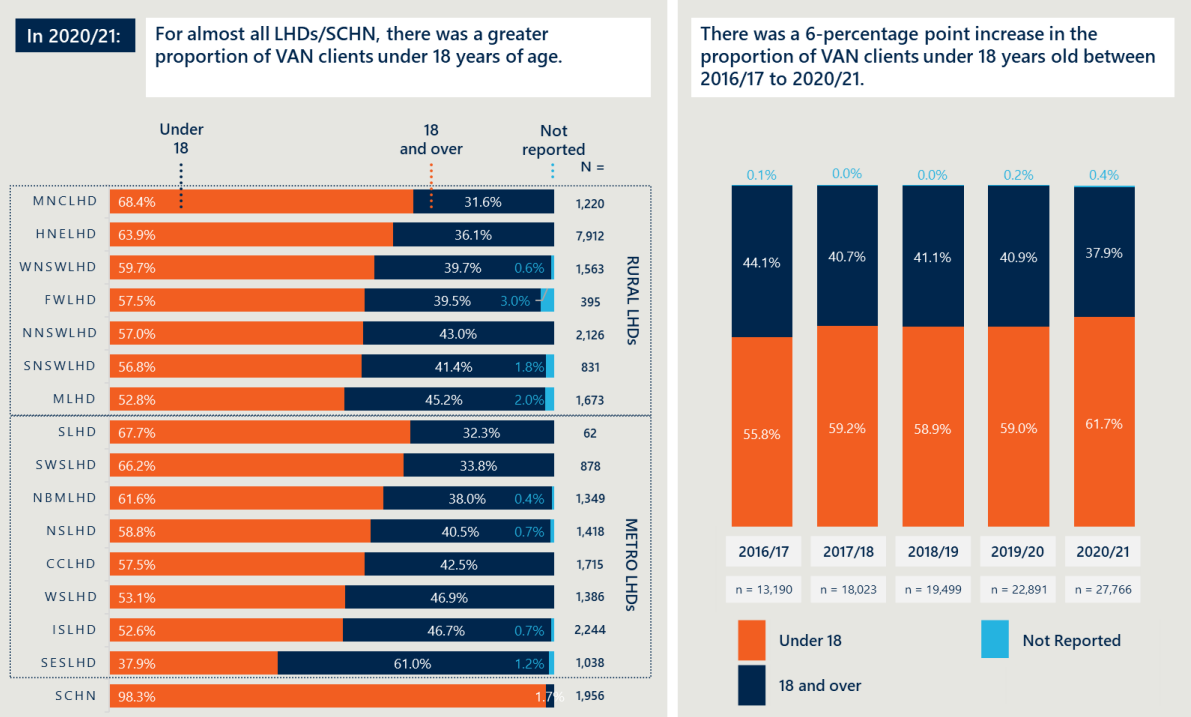


Source: Non-Admitted Patient Dataset 2016-2021.

[48] For comparative reference, according to 2016 Census data 2.9% of the broader NSW population are Aboriginal and/or Torres Strait Islander people. Australian Bureau of Statistics. (2016).

[49] For comparative reference, according to 2021 National, state and territory population data 24.2% of the broader NSW population were between the ages of 0-19, and 75.8% were 20 years and over. Australian Bureau of Statistics. (2021). Analysis presented here may be incomplete or incorrect for NSLHD and SLHD due to issues with reporting of client level data in the Non-Admitted Patient Dataset.

Figure 14 | Proportion of VAN clients above and under 18 years of age between 2016/17 and 2020/21



Source: Non-Admitted Patient Dataset 2016-2021.

Non-Aboriginal clients reported overall positive experiences with VAN services staff and programs, but experience with non-VAN services was mixed.

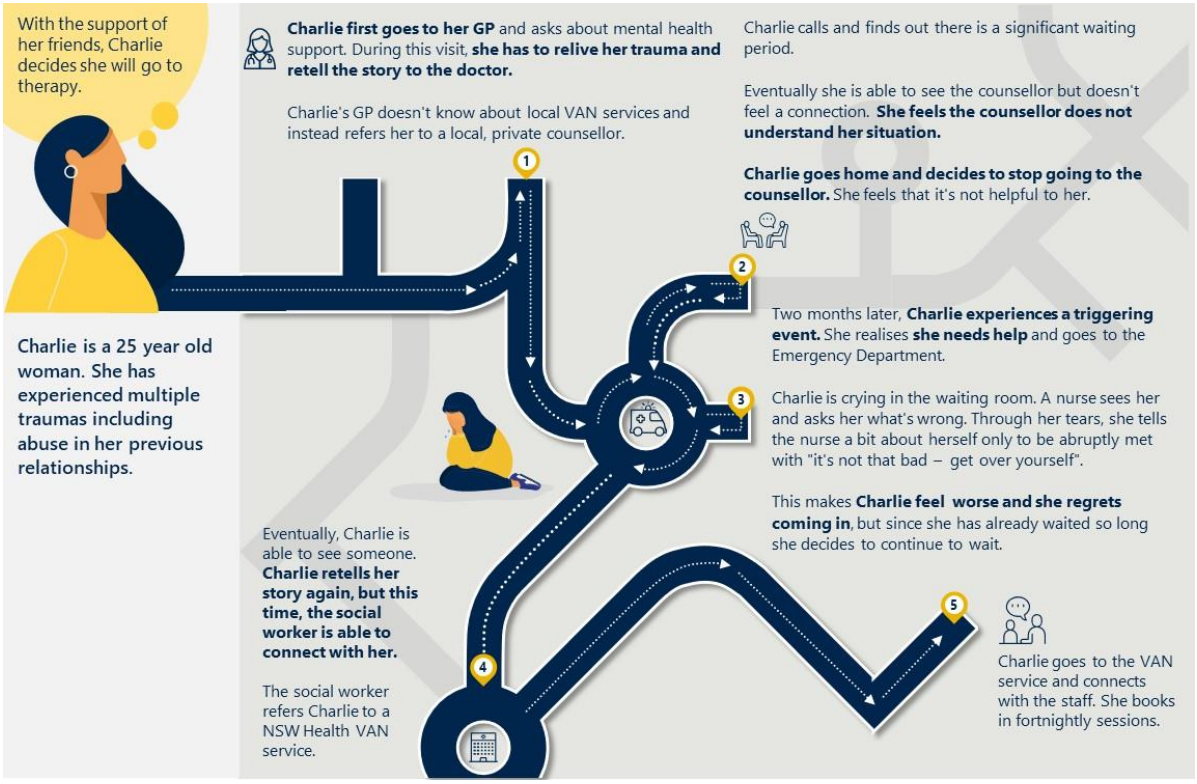
Interviews with non-Aboriginal clients of VAN services highlighted the need to continue efforts towards integration – clients do not yet experience an integrated system. Most clients reported difficulty with finding and accessing VAN services – many had spent extensive periods of time trying to find a service to support them, including private and non-governmental services (where available). However, once non-Aboriginal clients were able to access VAN services, they generally reported extremely positive experiences. Clients highlighted the role of VAN services staff in connecting them with other services – both within and beyond the NSW health system.

> "My social worker is just amazing. I don't know what I'd do without her"
>
> *VAN services client*

By contrast, clients reported mixed experiences with broader health services. Some clients reported extremely positive experiences – kind and caring staff who went out of their way to connect clients with appropriate services. Other clients reported encountering staff who did not understand violence, abuse and neglect or who were not sensitive to their experience of trauma or cultural background. In some cases, this hindered clients' progression towards their therapeutic goals.

Charlie's story (Client Story 3) highlights the mixed experience of one client, including the need to build the skills and capabilities of the broader health workforce, poor awareness of VAN services, and lack of service availability.

Client Story 3 | Charlie's story



Aboriginal clients reported experiences of cultural insensitivity, racism, fragmentated services when seeking support for violence, abuse and/or neglect

Interviews with Aboriginal clients and staff highlighted the lack of culturally safe and culturally appropriate services. Many clients reported experiencing racism and did not feel safe attending NSW Health services, including VAN services. They identified a number of factors hindering Aboriginal clients' engagement with VAN services, including:

- **Condescending and racist treatment.** This was reported by most Aboriginal clients and staff consulted for the evaluation and reflects the findings of other reviews and inquiries in NSW. Further detail and examples are provided in Section 4.2.2 above (which includes a list of examples portraying the result of a lack of cultural competency) and the supplementary Aboriginal community reports. While most examples that were reported were from the broader health system, there were several examples from mental health services and emergency departments that respond directly to violence, abuse and neglect. Clients and staff reported that these examples only further fuel a distrust of VAN services for Aboriginal people.
- **Fear of being reported and child removal.** Aboriginal staff and clients emphasised that this was a very real fear for Aboriginal people who have experienced violence, abuse and neglect, particularly for Aboriginal mothers. They said NSW Health staff often make reports because they misinterpret disclosure of past trauma as a current risk and/or do not realise that a client is already seeking help through other services. Aboriginal staff identified the reputation of maternal health services as one of the biggest barriers to Aboriginal people accessing health services. Some Aboriginal staff said that were reluctant to write about Aboriginal clients' family connections in their records through fear that this will be

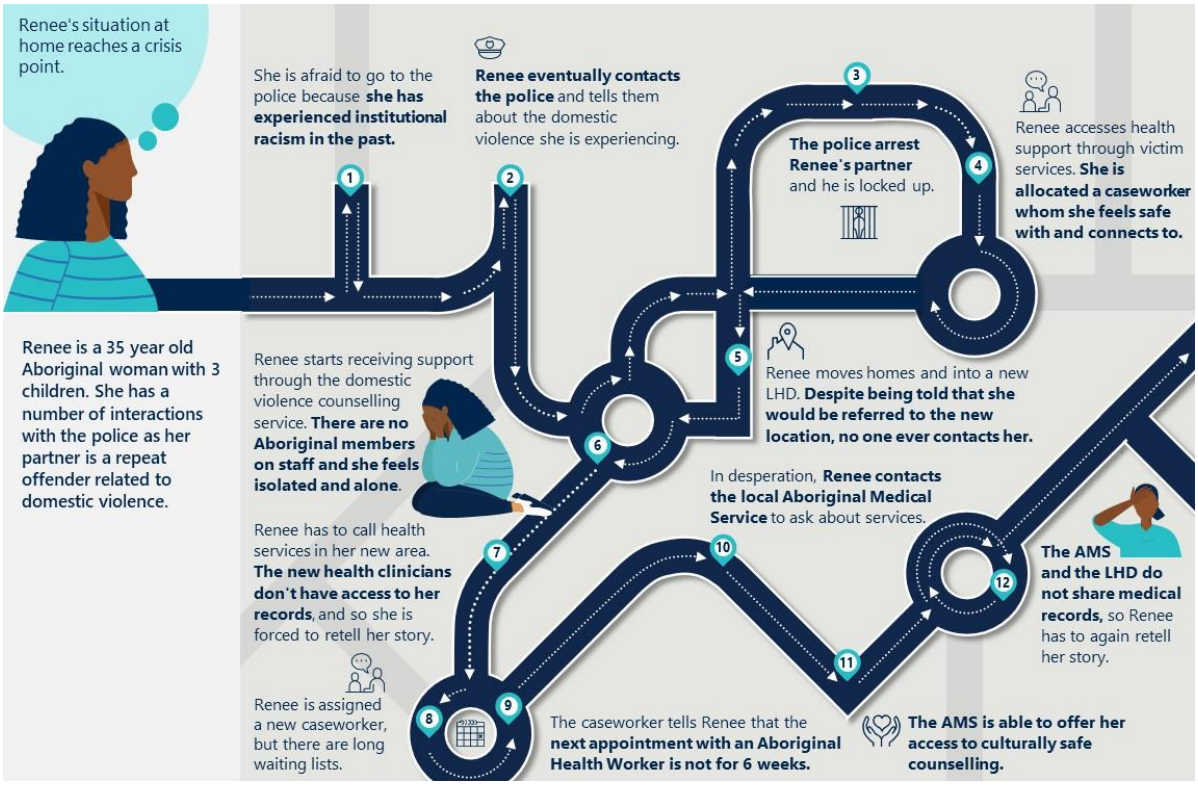
> "We've got a saying with maternal health "you're going to be reported, not supported"
>
> *Aboriginal health worker*

used to justify removal of their children into family-based kinship care. In one District, Aboriginal staff reported that the saying "they don't support us, they report us" was well known.

- **Fragmented services and having to 'retell' their story.** Most Aboriginal clients interviewed for the evaluation indicated that they had a fragmented, confusing and distressing journey through health and broader government service systems when seeking support. They reported that it took a long time to access the VAN services, there was poor communication between services and they had to retell their story several times which was distressing.
- **Long waitlists, lack of service availability, and culturally inappropriate assessment protocols.** Long waitlists for services and/or lengthy assessment periods are a deterrent for families. CPCS take eight weeks to conduct an assessment, which was considered too long and often means that families disengage with the service as they cannot commit to the eight weeks due to sorry business and/or travel to visit family members across the region/state.
- **Stigma and poor promotion of VAN services.** Aboriginal clients reported that they would be more likely to access services if they had different names and were more appropriately promoted. For example, clients are less likely to use a service with 'domestic violence' in the name. Staff reported clients who would not access a drug and alcohol service if engaged with DCJ due to fear of stigma and having children removed.

Renee's story (Client Story 4) highlights some challenges faced by Aboriginal clients of VAN services.

Client Story 4 | Renee's story



Aboriginal clients and staff reported that more needs to be done to ensure the delivery of culturally safe and culturally appropriate care.

Interviews indicated that more needs to be done to better understand why Aboriginal clients disengage from the system, and what could be done to better support these clients, such as:

- **Revising service engagement criteria.** Services can have a strict engagement criterion, where failure to 'engage' in a service results in immediate discharge. However, a service's definition of engagement may not be culturally sensitive. Multiple staff reported that clients may experience certain events that prevent them from attending an appointment which would usually be seen as disengagement (such as a funeral/sorry business, not enough credit on the phone to text or call, not enough money to travel to the appointment). A more holistic and culturally sensitive approach to engagement would mean that clients are better supported.
- **Addressing individual and community fear and distrust with the system.** Aboriginal staff reported being hesitant to record cultural strengths and family connections on health records due to a fear that it could be used to support the removal of children. Some staff expressed concerns over access to data, and how this data may be used.

> "When we see a client struggling, we come together to talk about what needs to be done. In the [NSW] Health space it's 'quick let's report."
>
> *Aboriginal staff*

> "When I had my baby, a child and family health nurse came to my home. I thought it was odd when they said with surprise, 'Oh, it's so clean'"
>
> *Aboriginal VAN services staff*

- **Building cultural awareness and competencies of non-Aboriginal staff.** VAN services staff and broader health system workers do not always have a culturally appropriate interpretation of what is an immediate or imminent risk of harm, and what is culturally normal. As an example, for a family with a newborn, mattresses on the floor of the lounge room does not represent over-crowding; rather it is a reflection of the family supporting the mother who is up during the night feeding her baby.
- **Addressing institutional racism.** Some VAN services staff and broader health system workers fail to recognise and appropriately respond to institutional racism, both individual and within the system.
- **Increasing the number of Aboriginal staff across the health system.** A lack of Aboriginal staff across services reinforces a culturally unsafe system. Consultations with clients and staff reiterated the importance of having a safe and familiar face within services. Consultations also highlighted the importance of providing a client with the choice to have an Aboriginal worker involved, as ultimately it should be up to the client to decide.

Where Aboriginal clients felt supported, the following elements were often in place:

- Where clients interacted with multiple services, these services connected regularly to agree on priorities and streamline communication and appointments, always with the consent of the client.
- The location of service delivery was convenient, warm and comforting. Aboriginal clients were grateful when services could offer warm drinks and/or meals for them and their children.
- Services consider clients' ability to travel to and from the services and outreach is provided where necessary.
- Clients feel they can reach out to their case worker at any time – usually text message was the preferred mechanism. Aboriginal health workers noted that a 'private number' call was less likely to be answered by an Aboriginal client.

- Services offer a safe environment where clients feel they can say anything without being judged and without fear that other agencies such as the Department of Communities and Justice would get involved without their permission.
- Clients receive all the information they need, when needed. For example, VAN services staff they interacted with were knowledgeable about what claims they could make in relation to domestic violence.
- There is a choice of having an Aboriginal staff member involved.

Case Study – Establishment of an Anti-racism Committee

One metropolitan District has established an Anti-racism committee. This is a formalised governance structure with Executives that meet regularly to look at recruitment gaps, conduct cultural services audits and ensure quality improvement. They have also arranged webinars to encourage learning and understanding. The first topic was on white privilege and fragility.

4.3.3 Staff experience outcomes

The experience of VAN services staff has been mixed – both within and across Districts and SCHN.

Interviews, focus groups and site visits with VAN services managers and staff highlighted mixed experiences within and across Districts and SCHN.

Some staff reported positive experiences as a result of the implementation of the IPARVAN Framework. They reported feeling empowered by District/SCHN Executives and VAN service managers to drive forward integration, contributing to 'bottom up' leadership. Other staff spoke highly of revised leadership and governance structures, reporting that these new structures enabled them to work more efficiently and effectively, provided greater levels of support than under previous models, and supported the delivery of better and higher-quality care to clients.

"It's great to have the support of Executives and our managers to go ahead and just get things done"

VAN services staff

"Suddenly I've been asked to be part of the on-call roster. I understand that it's an important service, but it's not something I signed up for"

VAN services staff

By contrast, a minority VAN services staff expressed dissatisfaction with the implementation of the IPARVAN Framework and resulting changes to their work and roles. Identified concerns included:

- Inability to effectively engage with broader health services staff and to get them 'on board' with the IPARVAN Framework due to competing priorities.
- Risk of burn out, due to the IPARVAN Framework raising the profile of violence, abuse and neglect, leading to more referrals to VAN services but without resources to increase service availability.
- A feeling that staff were expected to be 'VAN generalists', providing support to anyone who presented with an experience of violence, abuse and neglect, rather than the area of their speciality (such as sexual assault or child protection).
- A feeling that staff were being asked to take on new and different aspects to existing roles, such as supporting a centralised intake line or participating in the on-call roster to provide 24/7 crisis support.

Interviews with Aboriginal VAN services staff highlighted that some staff felt that their specific skills, knowledge and experience were not valued by the system. Many Aboriginal staff felt overburdened due to a lack of other Aboriginal staff to support Aboriginal clients. Some also highlighted experiences of institutional racism within the health system.

Some psychosocial staff have felt excluded from the design and implementation of the IPARVAN Framework.

The Interim Progress Report reported that psychosocial staff in some Districts/SCHN reported that they felt they had been excluded from the design and delivery of the IPARVAN Framework. Some staff felt that their expertise in responding to violence, abuse and neglect had not been recognised, and that the IPARVAN Framework was changing the way they worked without their input or consultation.

During interviews conducted in 2022, some stakeholders reported greater engagement by the Ministry, with staff providing a psychosocial response, such as through active engagement in relevant governance meetings.

4.3.4 System sustainability outcomes

Over half of provider survey respondents agreed or strongly agreed that VAN system integration had led to improvements in system sustainability.

VAN services managers who responded to the provider survey (between 46 and 84 responses each year)[50] were asked the extent to which they agreed that VAN system integration had led to improvements in the system sustainability outcome domain and outcomes statement: *'Reduced duplication of service provision improves cost effectiveness and health system efficiency.'* Over the three years the provider survey was collected (2020 to 2022), on average respondents agreed with the statement. In 2022, a total of 52 per cent of respondents agreed or strongly agreed with this statement.

Additional funding initially supported the expansion of VAN services; FTE and service costs varied across the system; this may reflect different service contexts and/or inconsistencies in how FTE is reported.

This includes $10 million per annum from 2017/18 to provide 24-hour integrated psychosocial, medical and forensic crisis responses and $67.1 million for NSW Health from 2018/19 to 2022-2023 (and $19 million per annum thereafter) to implement recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse.[51] This contributed to the establishment of new VAN services and expansion of existing VAN services, with a 52 per cent increase in the number of service events from 2016/17 to 2020/21.[52]

Although this initial funding was significant, it is important to note that there has been no additional funding provided. Most Districts/SCHN reported that more resources are needed to support continued implementation.

[50] Provider survey response rate: July 2020 (n=84 representing 15 of 16 LHDs/SCHN), July 2021 (n=46) and March 2022 (n=54)
[51] NSW Health (2019). Integrated Prevention and Response to Violence, Abuse and Neglect Framework. NSW Health Violence, Abuse and Neglect Redesign Program. August 2019. Retrieved from: https://www.health.nsw.gov.au/parvan/Publications/iparvan-framework.pdf.
[52] While there has been an increase in the reported number of service events and distinct clients in the NAP data, this increase may also reflect improvements in the reporting by service providers. There was also an increase in number of services reporting which impacted the numbers reported (an additional 59 services between 2016 and 2021 reporting clients). See Appendix B for further detail. Source: Non-Admitted Patient Data, 2016-2021. Source: Non-Admitted Patient Data, 2016-2021.

In the SAT, many VAN service managers reported additional positions to support the expansion of VAN services. The ratio of annual service events to Full Time Equivalent (FTE) positions varied considerably between different types of VAN services in 2020/21, which likely reflects different client needs and service delivery contexts (Table 9).

Table 9 | Service Events and Clinical FTE in VAN services by service type in 2020/21[53]

Service Type††	Total no. service events 2020/21	Matched service events 2020/21	Number of services in NAP data	Number of services in FTE data	Matched services†	Clinical FTE : Annual service events ratio
Sexual Assault Service	56,023	48,359	56	66	50	1 : 340
Child Protection Counselling Service	21,036	21,021	39	42	39	1 : 270
Domestic Violence	11,932	10,482	26	25	23	1 : 331
Domestic Violence and Sexual Assault Service	9,670	9,670	3	3	3	1 : 420
Joint Child Protection Response Program	8,259	8,259	23	24	23	1 : 199
Child Protection Unit/Team	8,633	8,633	3	3	3	1 : 294
New Street	5,193	3,806	11	15	9	1 : 134

Source: Service Events | EDWARD, Non-Admitted Patient Data Collection 2016/17-2020/21[54]
FTE | Data manually collected by the IPARVAN team based on template distributed to District managers[55]
† Matched number of services refers to the number of individual service records included in analysis after exclusions have been applied. *The number of Services has been extracted from two data sources: (1) the evaluation team asked VAN services to provide the number of FTE per Service (FTE data) and (2) the evaluation team extracted the number of VAN services identified in the NAP data set (NAP data). The discrepancy in the number of services reported is due to factors including: NAP data includes all services which serve VAN clients, although these services may not include FTE aligned with VAN services funding; recently established VAN services may have FTE aligned but have yet to record VAN Service Events.* The difference is shown here to indicate that there may be further FTE for these service types which are not represented in the table above.
†† *Aboriginal Domestic and Family Violence has been excluded from this table due to the small number of matched services (n = 1).*

[53] Breakdown of clinical FTEs to psychosocial FTEs, medical / forensic FTE and aboriginal staff FTE available in Appendix E.
[54] Suppressed values have been recoded -- previously <10 or <5, updated to be 5 or 3 respectively. Further information on the imputation model included in in Appendix B.
[55] Clinical FTE is reported and management FTE is not reported based on advice from the PARVAN as management FTE is not reported consistently across LHDs/SHNs. In some cases, managers may perform clinical duties, which is not reflected here. In some instances, clinical FTE were split across multiple services based on advice from the Districts/SCHNs that provided the FTE data. These FTE were divided appropriately across the noted services.
Excluded service HERO IDs where there were no FTE, excepted those which noted FTE was recorded elsewhere.
Excluded services which did not have NAP data reported in 2020/21. This has resulted in 29 less services than full FTE data list (FTE Service count = 180, Ratio Service count = 151). Services excluded: SAS (16 services); CPCS (3 services); DV (2 services); JCPRP (1 service); New Street (6 services); ADFV (1 service). This has resulted in 30 less Clinical FTE than full FTE data list (FTE Clinical FTE total = 405.6, Ratio Clinical FTE total = 376.0)

Despite funding for new positions, many Districts/SCHN reported difficulties with recruitment, particularly for on-call positions and Aboriginal identified positions. This has hindered the delivery of culturally safe services.

Many Districts/SCHN expressed difficulties with recruitment and retention of key staff. This was particularly true for Aboriginal identified staff positions, and for positions that were expected to support 24/7 crisis responses.

Staff across VAN services and Aboriginal Community Controlled Organisations highlighted ongoing challenges with recruitment into Aboriginal-identified positions. One District/SCHN reported that these positions had remained vacant for more than 2 years, despite multiple recruitment rounds. A different District/SCHN had actively worked in partnership with the District/SCHN Aboriginal Workforce unit to make positions enticing to Aboriginal applicants, however they were still unable to recruit to the position.

> "If you're not a doctor or nurse, [you feel like] you're a nobody. The [qualification] piece of paper defines you and that makes Aboriginal health workers feel 'less' and yet we upskill non-Indigenous staff so much"
>
> *Aboriginal health worker*

Aboriginal health workers reported that they did not always feel their knowledge, skills and experience were valued; yet many reported that they were regularly involved in teaching and upskilling non-Aboriginal staff on how to work with and support Aboriginal clients. They also noted instances where a non-Aboriginal staff member had been promoted or awarded a role that Aboriginal staff were just as capable of doing, but were unable to be promoted to because they were not university qualified. In one example, an Aboriginal staff member had left one District for another because the other District recognised their cultural skill set and provided a higher award rate and salary.

District/SCHN Executives and VAN managers and staff expressed a need for a more systematic approach or support through interventions such as mentorship pathways or traineeships to improve culturally appropriate service delivery. Aboriginal health workers suggested there are opportunities to review the current approach to recruitment and consider alternative pathways and/or opportunities for Aboriginal people to demonstrate their expertise through experience, rather than just qualifications. All stakeholders noted that recruitment of Aboriginal workforce was a challenge across the NSW Health system as a whole and would likely require a whole-of-system response.

Aboriginal health workers reflected positively on services that had cultural supervision for Aboriginal and non-Aboriginal staff as it gave individuals the opportunity to reflect and learn. Aboriginal staff reported that to improve the culture of the health system, more non-Aboriginal staff should understand Aboriginal culture and the impact of colonisation on trauma and psychosocial risks. All Aboriginal health workers identified a need to build the cultural competency of all NSW Health staff.

Case Study – Successful approaches to recruiting and retaining Aboriginal VAN service staff

One regional, rural and remote District has developed a traineeship model to recruit and support Aboriginal VAN service staff. The District actively recruits from local high schools and provides extensive opportunities for training, including mentorship alongside university studies and access to relevant ECAV training courses. The District is also exploring the potential of co-funding some training positions, to further enhance the attractiveness of these positions.

Ongoing workforce constraints have created difficulties with meeting demand.

District/SCHN Executives highlighted the growing community awareness of violence, abuse and neglect – driven in part by prominent campaigners such as Rosie Batty, Grace Tame and Brittany Higgins. Executives praised this work and noted that this growing awareness was likely leading to increased identification and presentations.

During interviews and focus groups, VAN services managers and staff were careful to highlight that there was no issue with increased presentations, but they did express concern regarding the health system's capacity to respond to these increased presentations. Many noted that they felt they did not have the resources to provide appropriate care to those already engaged with services, let alone take on additional clients.

> "The ED is sending us more referrals than ever before. It's fantastic that we've got those pathways now, but not everyone needs to be referred to a VAN service. We need to build the confidence of non-VAN staff so they can provide a response"
>
> *VAN service staff*

Some VAN service managers and staff spoke of their hope that this was a short-term issue that would be resolved as implementation of the IPARVAN Framework continued. They noted that, to date, some Districts and SCHN had focused efforts on building the skills of broader health service staff to identify presentations of violence, abuse and neglect and then appropriately refer to VAN services. The next step should be to build the confidence of these staff to provide an appropriate and safe response, in partnership with VAN services staff where necessary. This is a key element of the IPARVAN Framework. Many staff felt that, if successful, this would lead to enhanced system sustainability.

Aboriginal services that respond to violence, abuse and/or neglect are highly valued by Aboriginal clients but struggle to compete for funding.

Aboriginal clients and staff emphasised that ACCOs are often best placed to provide culturally safe, holistic and high-quality services to Aboriginal people who have experienced violence, abuse and neglect. However, Aboriginal staff of NSW Health and ACCOs emphasised that the funding they receive does not reflect the significant supports they provide to Aboriginal people. Aboriginal staff reported that in addition to providing direct VAN responses to clients, ACCOs are often required to 'fill in the gap' to support Aboriginal clients of NSW Health VAN services who are in crisis or on long waitlists. Funding arrangements for ACCOs do not reflect the case complexity for Aboriginal clients who often require long-term intensive support. Further, ACCOs struggle to compete for funding against non-Aboriginal services with more sophisticated grant management capabilities. This is compounded by a lack of evaluation capacity and evidence on what works for Aboriginal people, which would enable ACCOs to demonstrate the outcomes they are achieving.

Interviews with clients of VAN services highlighted the potential positive impact of enhanced integration on system sustainability.

All interviews with clients of VAN services highlighted the ongoing, non-integrated nature of the current system. This is to be expected, as implementation of the IPARVAN Framework commenced in 2018 and it is likely to take considerable time for clients to see the visible impacts of integration.

Whilst clients could not talk to their experience in an integrated system, their reflections on the current system provide some insights into the potential system-wide benefits of a more integrated system. These include:

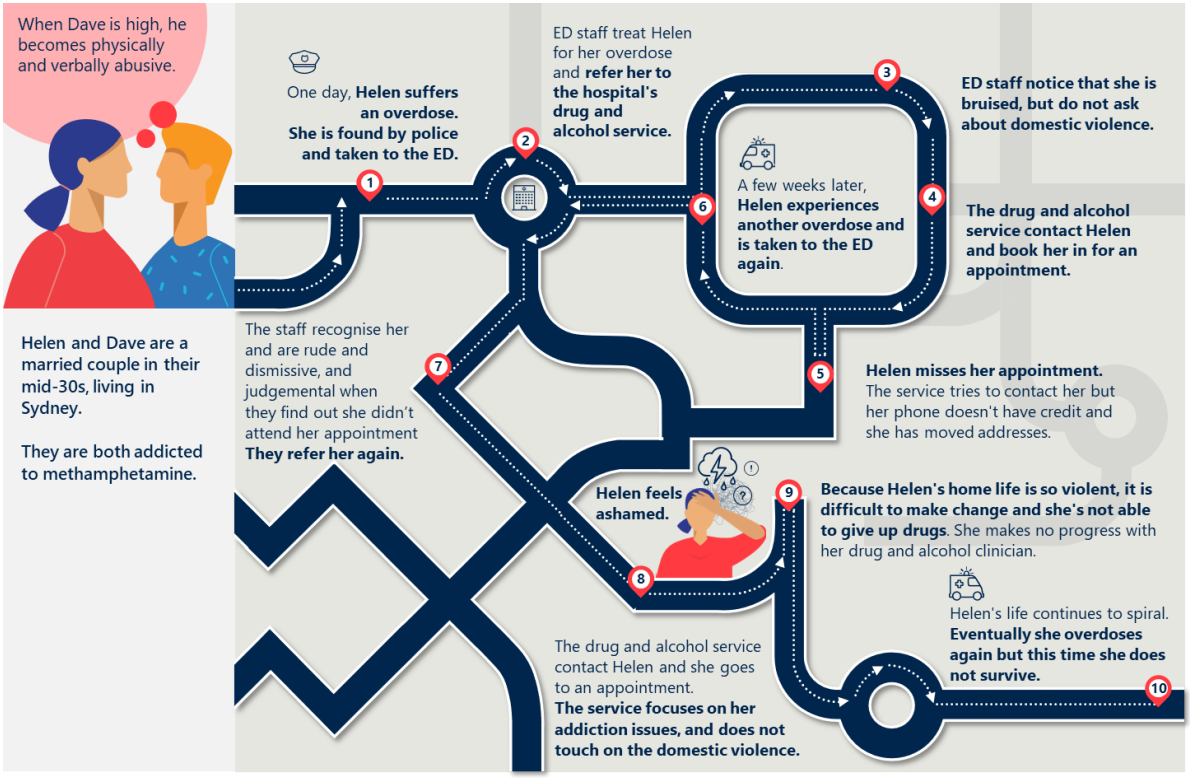
- **Reduced Emergency Department presentations.** Many clients spoke of attending the Emergency Department during a period of crisis and as a 'last resort', after many failed attempts to access other

services. Often clients did not know about or had been unable to access prevention or early intervention services.

- **Reduced inpatient bed days, including within mental health services.** Following presentation to the Emergency Department, some clients were admitted to the hospital to access the care they needed during their period of crisis. Earlier intervention could prevent the need for clients to be admitted.
- **More clients across the system meeting their therapeutic goals – including in mental health services and alcohol and other drug services.** Many clients spoke of the interconnectedness between their experience of violence, abuse and neglect and other challenges such as mental health concerns or use of alcohol and other drugs. They noted that support for one concern had flow on effects to meeting their therapeutic goals more broadly. For example, support to escape experience of domestic violence leading to reduced unhealthy reliance on alcohol.

Helen and Dave's story (Client Story 5) highlights some of the long-term system-level impacts that arise in the current fragmented system. These include lack of identification of violence, lack of early intervention, abuse and neglect, lack of connection between VAN services and broader health services as well as increased Emergency Department presentations. Ultimately, these responses lead to poor outcomes for clients of VAN services.

Client Story 5 | Helen and Dave's story



5 KLE 4 | Considerations for future implementation

This section presents insights on considerations to inform and improve implementation of the Framework across the NSW Health system, drawing from triangulation of data collected as part of the Stage 1 evaluation. These considerations are detailed in Table 10.

The evaluation identified 12 considerations within two themes that could support ongoing and enhanced implementation of the IPARVAN Framework.

Table 10 | Considerations for future implementation

#	Considerations
Considerations to support ongoing and enhanced implementation of the IPARVAN Framework	
1	The Ministry, ECAV and other NSW Health Pillar Organisations to consider recommencing implementation of key system-level initiatives. Many of these activities slowed considerably or stopped entirely in 2020/21, particularly those related to capacity and capability development.
2	The Ministry to consider ensuring greater alignment and coordination between the IPARVAN Framework and other related policies, frameworks and strategies (e.g. suicide prevention, First 2000 Days, Brighter Beginnings, Aboriginal Mental Health Strategy).
3	The Ministry and Districts/SCHN to consider working collaboratively to build and embed connections between VAN services and the broader health system such as through existing statewide governance structures and workforce planning initiatives.
4	District and SCHN Executives, with the support of the Ministry, to consider continuing efforts to develop Executive-level leadership and buy-in, leveraging Executives who champion change across the system.
5	Districts and SCHN to consider prioritising efforts to engage with clients of VAN services and community organisations, including through co-design and community representation on governance bodies and interagency groups, to ensure that services better meet clients' needs and deliver positive experiences and outcomes that matter.
6	The Ministry to consider providing greater local guidance to Districts/SCHN, including guidance on sequencing and prioritisation of activities. This could serve to concentrate efforts within Districts/SCHN and accelerate progress. Greater guidance could include collaboratively agreeing on bi-annual implementation priorities, such as through a co-designed implementation plan.
7	The Ministry to consider continuing to strengthen mechanisms that enable Districts and SCHN to share good practice and lessons learnt.
8	The Ministry, ECAV and Districts/SCHN to consider prioritising efforts to improve the capacity of the NSW Health workforce deliver culturally appropriate care, including: • Reviewing and enhancing cultural competency training for non-Aboriginal staff.

	• Reviewing and revising workforce policies to improve recognition of cultural skills and experience, increasing flexibility regarding qualification requirements and improving training pathways. • Reviewing and revising strategies to increase the number of Aboriginal staff in NSW Health, including in management positions. • Advocating for changes to awards to better recognise cultural skills and experience, including introduction of an award for non-clinical Aboriginal health workers.
9	The Ministry and Districts/SCHN to consider prioritising efforts to engage with ACCOs through co-design of services, increasing Aboriginal representation on governance bodies and interagency groups, and increasing and/or redirecting funding to ACCOs.
Considerations to support enhanced monitoring and evaluation activities	
10	The Ministry to consider prioritising addressing key data collection and reporting issues to improve the tracking of progress towards key outcome domains. Data will be key to demonstrate outcomes and economic impact in future evaluation.
11	The Ministry, in collaboration with the independent evaluator for the Stage 2 and Stage 3 evaluations, to consider reviewing and revising (where necessary) monitoring and evaluation data collection tools.
12	The Ministry to consider prioritising efforts to collect evidence on Aboriginal people's experiences through data reporting and collection, Aboriginal community-controlled governance for the Stage 2 and Stage 3 evaluations, and commissioned research.

5.2 Considerations to support ongoing and enhanced implementation of the IPARVAN Framework

Consideration 1 | The Ministry, ECAV and other NSW Health Pillar Organisations to consider recommencing implementation of key system-level initiatives. Many of these activities slowed considerably or stopped entirely in 2020/21, particularly those related to capability and capacity development.

Responsibility: PARVAN Unit, NSW Ministry of Health; ECAV; other NSW Health Pillar Organisations; District/SCHN Executive Teams; VAN service managers.

The IPARVAN Framework outlines several specific activities and initiatives to be progressed by system-level stakeholders including the Ministry, ECAV, ACI and other NSW Health Pillar Organisations. These are core activities that are designed to establish foundations for successful implementation within and across Districts and SCHN.

"There are some things we've been wanting to do, but we're just waiting on final guidance from the Ministry"

LHD/SCHN Executive

The Interim Progress Report found that there had been good progress with delivering these activities.

System-level progress slowed markedly in 2021 and 2022, due to several factors including the impact of the COVID-19 pandemic and leadership changes within some organisations. As a result, Districts/SCHN were not in the position to progress key initiatives.

The Ministry, ECAV and other key stakeholders should recommence implementation of these system-level activities once possible, as these are critical for successful ongoing implementation. These are detailed in Table 11.

Table 11 | Key system-level activities that should be progressed

Category of activity	Specific activities
Providing foundational strategies, policies and procedures	• The Ministry to update (where needed) and release (where unavailable), the full suite of VAN Service Standards Policy and Procedures: New Street, Child Protection Counselling Services, Sexual Assault Services, Domestic Violence Identifying and Responding, and Responding to children under ten with problematic or harmful sexual behaviour. • The Ministry to finalise and release other strategies, frameworks and guidance that are still under development, including a policy on vicarious trauma and vicarious resilience.
Building systems for accurate and consistent data collection	• The Ministry to collaborate with Districts/SCHN and other data stakeholders to improve the quality and consistency of data being entered into the VAN Service Contact form by clinicians and made available in the VAN Data Set for analysis and reporting. • The Ministry to continue working with eHealth and SIA Branch on data system enhancements to improve access to unit-record data for analysis and reporting. This includes the establishment of a Domestic Violence Routine Screening Data Set. • The Ministry, the Bureau for Health Information and Districts/SCHN to work together to identify and implement appropriate mechanisms to capture data from people who have experienced violence, abuse and neglect and their families on their experience with the health system.
Building the capacity of the workforce to respond to violence, abuse and neglect	• The Ministry, in partnership with ECAV and Districts and SCHN to accelerate work to increase recruitment and retention of Aboriginal staff to VAN services.
Offering education, training and professional development opportunities	• ECAV to restart efforts to develop and implement qualifications and strategies that assist priority groups (including Aboriginal workers) to achieve the entry-level qualification, skills and experience for employment in VAN services. • ECAV and HETI to restart efforts to work in partnership to explore opportunities to continue to deliver and further develop a suite of education, training and professional development opportunities for VAN service workers and the broader health service workforce.
Supporting Districts and SCHN to develop locally appropriate, integrated VAN service models	• The Ministry and ACI to explore further opportunities to support Districts and SCHN develop integrated VAN service models, building on lessons learned from earlier phases of implementation of the IPARVAN Framework. • The Ministry in partnership with relevant Pillar Organisations to provide clear guidance to Districts/SCHN on effective engagement

Category of activity	Specific activities
	with consumers, including the expectation that consumer engagement and co-design be a focus for Phase 2 implementation.
Enhancing the sharing of clinical information	• The Ministry to work with eHealth, Districts/SCHN, ACI and the Clinical Excellence Commission to develop consistent guidance on clinical systems to meet business requirements on information sharing and to support client safety. This should build on successful approaches that have been developed by individual Districts/SCHN.

District/SCHN Executives and VAN services managers need to complement these system-level activities with specific support at the District/Network-level. For example, Executives and managers need to ensure that staff are provided with the time and support required to participate in education and training programs.

Consideration 2 | The Ministry to consider ensuring greater alignment and coordination between the IPARVAN Framework and other related policies, frameworks and strategies (e.g. suicide prevention, First 2000 Days, Brighter Beginnings, Aboriginal Mental Health Strategy).

Responsibility: Deputy Secretaries across key Ministry Divisions, NSW Ministry of Health

Executive staff and VAN services managers across Districts and SCHN, including Chief Executives, noted the large number of policies, frameworks, strategies and other guidance that has been released by the Ministry. Many of these have critical dependencies and are interrelated – for example, there is significant overlap between the IPARVAN Framework, the First 2000 Days Framework, Towards Zero Suicides initiatives, and Closing the Gap.

However, as noted in Section 4.1 Chief Executives and Executive teams expressed challenges with implementing all these strategies and initiatives in a coordinated and integrated way. Each have different key performance indicators (KPIs), funding models, governance structures and reporting requirements.

> "We've got IPARVAN, but we've also got all these other things that Ministry wants us to implement.
>
> It sometimes seems like the right hand doesn't know what the left hand is doing"
>
> *District/SCHN Chief Executive*

Districts/SCHN have limited resources and many competing priorities and would appreciate guidance on prioritisation of these from the Ministry. Some Executives, including Chief Executives, questioned the degree of overarching collaboration and coordination between different areas of the Ministry, even within the same Division.

Greater alignment and coordination are needed to better support Districts/SCHN to implement the IPARVAN Framework. The Ministry committed to ensuring alignment and coordination – both with VAN services and across the broader health system – as part of the IPARVAN Framework. Alignment and coordination would also likely support enhanced implementation of other key system-wide initiatives.

This could be achieved through:

- **Ownership of the suite of strategies, policies, priorities and other guidance at the Secretary or Deputy Secretary level.** In partnership with other Divisions, the PARVAN Unit should explore work to ensure ownership of a suite of interrelated guidance at the Secretary or Deputy Secretary level. This would enable the building of links between interrelated initiatives and provide Districts/SCHN and other stakeholders with clear guidance on implementation, including prioritisation.

- **Development of standing committees, chaired by the Secretary or a Deputy Secretary, to bring together different parts of the Ministry**. In partnership with other Divisions, the PARVAN Unit should explore work to develop standing committees (or other appropriate mechanisms) to discuss alignment of strategies, policies and priorities. This must include alignment of KPIs, funding models, governance structures and reporting requirements. This would support greater implementation, cross-initiative evaluations (where appropriate), and reduce reporting burden for Districts/SCHN.

> "One Deputy Secretary should own IPARVAN and the intersecting pieces of work. There needs to be one person with ultimate oversight to bring together all the different threads"
>
> *District/SCHN Chief Executive*

- **Development of IPARVAN Framework-specific guidance on alignment with other strategies, policies and priorities.** The PARVAN Unit should develop specific guidance for VAN services on opportunities to align the IPARVAN Framework with other closely related initiatives. This could include, for example, a navigation guide detailing the intersections between the IPARVAN Framework and the First 2000 Days Framework and highlighting opportunities for collaboration.

Consideration 3 | The Ministry and Districts/SCHN to consider working collaboratively to build and embed connections between VAN services and the broader health system such as through existing statewide governance structures and workforce planning initiatives.

Responsibility: Relevant Deputy Secretaries and Executive Directors, NSW Ministry of Health; District/SCHN Executive Teams

In many instances, successful implementation of the IPARVAN Framework is reliant on other initiatives across the NSW health system, both at the Ministry level and within individual Districts and SCHN.

The evaluation highlighted several instances where implementation of the IPARVAN Framework slowed or stopped as a result of factors beyond the control of the PARVAN Unit within the Ministry or VAN services within Districts/SCHN. These include:

> "We're starting to make some progress [with social work] now, but it's been near impossible to date – they didn't have a Head of Department so who did we talk to?"
>
> *VAN services manager*

- **Competing District/SCHN-specific priorities.** As noted in Consideration 2, there are multiple priorities across the system, and some Districts/SCHN may choose to focus efforts on other priorities, in line with their local community need and context.
- **Fragmented leadership and governance structures of other parts of** the **health system.** Enhanced integration between VAN services and other parts of the health system relies on those parts having leaders that are engaged in, and supportive of, integration, as well as appropriate governance structures that enable integration.
- **System-wide challenges with recruitment, including of Aboriginal identified staff.** All parts of the NSW health system experience challenges with recruitment and retention of staff, particularly into Aboriginal-identified positions. Addressing these challenges requires system-level – rather than VAN specific – strategies and approaches. These include system-wide education and training pathways and workforce strategies that support recruitment and retention, such as flexible approaches to recruitment that recognise experience and knowledge in addition to qualifications. Further discussion on the recruitment and retention of Aboriginal staff is provided in Consideration 8 below.

  As part of the IPARVAN Framework, the Ministry has committed to undertake state-wide systematic workforce planning consistent with the *Health Professionals Workforce Plan 2021-2022*.

The PARVAN unit within the Ministry and VAN services within Districts/SCHN should work in partnership with colleagues across the Ministry and within Districts/SCHN to develop strategies and approaches to enhance engagement and collaboration with other parts of the system. This may include:

- **The Ministry implementing the mechanisms identified in Consideration 2,** which would serve to build system alignment and coordination across policies, frameworks and strategies.
- **The PARVAN Unit within the Ministry reviewing, refining and expanding (where necessary) existing VAN state-wide governance structures.** Expansion could include inviting key representatives from outside VAN services - such as Workforce Planning and Talent Development or the Centre for Aboriginal Health – to governance committee meetings.
- **The PARVAN unit within the Ministry continuing to build links with other relevant sections of the Ministry such as Workforce Planning and Talent Development or the Centre for Aboriginal Health.** These links would help the PARVAN unit to influence key system-wide decisions that will impact ongoing implementation.

> "We've got good connections with local Aboriginal organisations and an Aboriginal Support Committee that reports to the Board. Having these in place has really helped address some of our recruitment and retention challenges"
>
> *LHD/SCHN Chief Executive*

- **VAN services within each District and Network proactively building links with other relevant sections of the District/Network.** These links would raise the profile of violence, abuse and neglect within Districts/SCHN, and help VAN services influence District/Network-specific decisions such as revisions to broader health service governance structures, or reviews of Board reporting requirements.
- **VAN services within each District and SCHN proactively building links with other services outside of NSW Health, including with Aboriginal Community Controlled Health Organisations and multicultural community organisations.** These links would improve referral pathways, strengthen opportunities for joint learning/training and provide opportunities to build cultural safety and responsiveness within VAN services and the broader health system.
- **The PARVAN Unit within the Ministry, in partnership with VAN services in Districts and SCHN, continuing to build broad awareness of violence, abuse and neglect and the IPARVAN Framework across the health system.** This would ensure that violence, abuse and neglect and VAN services are known by other parts of the health system and considered in broader health system planning. This could include an 'IPARVAN Roadshow' to each District/SCHN, following on from the successful roadshows that were held at the start of implementation of the IPARVAN Framework.

Consideration 4 | District and SCHN Executives, with the support of the Ministry, to consider continuing efforts to develop Executive-level leadership and buy-in, leveraging Executives who champion change across the system.

Responsibility: District/SCHN Executive Teams; PARVAN Unit, NSW Ministry of Health.

The evaluation identified strong top-down leadership from District/SCHN Executives, including Chief Executives, as a critical foundation for implementation of the IPARVAN Framework.

Top-down leadership builds District/SCHN awareness of the incidence and prevalence of violence, abuse and neglect and the impact that violence, abuse and neglect have on individuals and the health system. Executive leadership is also crucial for providing the authorising environment for implementation of the IPARVAN Framework to progress.

> "The Ministry needs to realise that IPARVAN is not the only thing on my agenda, and it's not always going to be my top priority. We'll progress it, but it's not always helpful when they have such forceful advocacy"
>
> *LHD/SCHN Chief Executive*

Some Districts/SCHN have made good progress with building this Executive-level awareness and support for the IPARVAN Framework. Strategies have included:

- Ensuring that violence, abuse, and neglect is a standing agenda item for Board and Executive Team meetings.
- Ensuring reporting of violence, abuse and neglect is included in periodic Board reports.

Efforts should be made to maintain this support. In Districts/SCHN where there is not yet strong Executive-level support, building this should be prioritised.

As part of building Executive-level support, the PARVAN unit within the Ministry and VAN services within Districts/SCHN should ensure they are responsive to competing District/SCHN demands and priorities. This will support prioritisation of efforts and alignment across priorities.

Consideration 5 | Districts and SCHN to consider prioritising efforts to engage with clients of VAN services and community organisations, including through co-design and community representation on governance bodies and interagency groups, to ensure that services better meet clients' needs and deliver positive experiences and outcomes that matter.

Responsibility: District/SCHN Executives and VAN services managers.

To date, few Districts/SCHN reported progress in effectively engaging with consumers, including through consumer journey mapping, co-design, or collecting VAN-specific Patient Reported Measures.

Meaningful and ongoing engagement is critical for successful implementation of the IPARVAN Framework. Consumer engagement would help to address some of the key challenges identified by the evaluation, including lack of culturally safe services that meet consumer needs and expectations, and the delivery of services in spaces that are not conducive to clients meeting their therapeutic goals.

Districts and SCHN should prioritise efforts to engage with clients of VAN services in the next Phase of implementation. Successful engagement would include:

- Ensuring that consumer representatives, including Aboriginal community representatives, multicultural community representatives, and representatives of other diverse communities, have positions on (and input to) governance committees including the Board and Board sub-committees.
- Engaging with consumers to map client journeys, in order to better understand how client's access and interact with VAN services and other NSW Health services and identify challenges and pain points.

- Co-designing new integrated models of care, to ensure that these new models of care meet client needs and expectations.
- Co-developing Patient Reported Experience Measures and Patient Reported Outcome Measures for VAN services, including mechanisms for gathering data.

Consideration 6 | The Ministry to consider providing greater local guidance to Districts/SCHN, including guidance on sequencing and prioritisation of activities. This could serve to concentrate efforts within Districts/SCHN and accelerate progress. Greater guidance could include collaboratively agreeing on bi-annual implementation priorities, such as through a co-designed implementation plan.

Responsibility: PARVAN Unit, NSW Ministry of Health; District/SCHN Executives and VAN services managers.

The IPARVAN Framework is comprehensive and includes multiple implementation activities for Districts/SCHN to progress. In Phase 1 of implementation, the Ministry did not provide explicit guidance to Districts/SCHN on the activities to prioritise, or on sequencing of activities. Districts and SCHN were empowered to progress implementation aligned with their local needs and contexts.

Whilst Districts and SCHN appreciated implementation flexibility, some stakeholders reported that this made the task of delivering the IPARVAN Framework overwhelming – there was so much to do, and for some stakeholders the impression that all activities needed to be progressed at the same time.

To address this, the Ministry should consider providing stronger implementation guidance to Districts/SCHN, outlining the specific activities that should be progressed, and those that can be delayed for future phases of implementation.

This could be achieved through co-designing an implementation plan with each District/SCHN. The implementation plan would serve as an agreement between the Ministry and the District/SCHN and would detail:

- District/SCHN implementation priorities for the coming two-years.
- Key activities to be progressed including timeframes and dependencies.
- Key identified risks and suggested mitigation strategies.
- Details on additional support that Districts/SCHN would need to progress implementation.

The Ministry should ensure alignment across District/SCHN implementation plans (where possible) and ensure that implementation priorities align with other system-wide priorities.

Consideration 7 | The Ministry to consider continuing to strengthen mechanisms that enable Districts and SCHN to share good practice and lessons learnt.

Responsibility: PARVAN Unit, NSW Ministry of Health.

Throughout Phase 1 implementation, each District and SCHN focused implementation efforts on activities that aligned with their local priorities and community context. Where Districts and SCHN did focus on similar activities, their approach to progressing these activities varied across the system. Interviews during site visits highlighted that Districts and SCHN are keen to learn from each other.

> "It's great to learn what other Districts/SCHN are doing. We might not be able to do exactly the same thing, but it gives us ideas about future focus"
>
> *VAN services manager*

The Ministry is already facilitating the sharing of lessons learned through state-wide governance mechanisms such as the PARVAN Senior Manager Advisory Group. These

should continue to be supported (and expanded where appropriate, in line with other Considerations). In addition to this, the Ministry should consider:

- Reviewing the effectiveness of existing communities of practice and adapting communities of practice as needed.
- Developing an online repository of good practice, where Districts and SCHN could upload and share case studies and other resources.
- Cross-District/SCHN meetings attended by VAN services staff, to complement Senior Executive and Senior Manager governance groups. These could be organised by clinical specialty (for example sexual assault or child protection) or specific factors of interest (such as regional, rural and remote services).

These additional mechanisms would need to be appropriately resourced to ensure they remained useful. This includes both resources at the Ministry (for example to review case studies, and update and maintain the repository of good practice), and resources at District/SCHN level.

Consideration 8 | The Ministry, ECAV and Districts/SCHN to consider prioritising efforts to improve the capacity of the NSW Health workforce to deliver culturally appropriate care.

Responsibility: PARVAN Unit, NSW Ministry of Health; ECAV; District/SCHN Executives and VAN services managers

Consultations with Aboriginal stakeholders indicated that Aboriginal people who have experienced violence, abuse and neglect continue to experience cultural insensitivity, fragmented services and racism in the NSW health system, contributing to distrust and lack of engagement with VAN services. Aboriginal stakeholders emphasised that this is not a new challenge but has been reported for decades with little visible change. While these challenges relate to the broader health system, the evaluation identified a number of considerations for the continued implementation of the IPARVAN Framework to improve experiences and outcomes for Aboriginal people. Specifically, the Ministry, ECAV and Districts should consider the following:

- **Reviewing and enhancing cultural competency training for non-Aboriginal staff.** This includes integration of cultural competency into ECAV training programs, improved cultural competency training at the District/SCHN level that addresses local Aboriginal experiences, and advocacy to enhance state-wide cultural competency training for all NSW Health staff. Aboriginal stakeholders recognise that training should cover the impacts of intergenerational trauma and disadvantage stemming from colonisation, harmful government policies and structural inequalities, while promoting strengths-based, trauma-informed and holistic care that considers the whole family.
- **Reviewing and revising workforce policies to improve recognition of cultural skills and experience, increasing flexibility regarding qualification requirements and improving training pathways.** This includes redesigning position descriptions, recruitment processes and other workforce policies to place greater emphasis on cultural skills and experience (versus formal qualifications) and writing position descriptions in plain English (noting that current position descriptions are hard to understand, reducing the number of candidates who express interest). This also includes advocacy to District/SCHN Executives and the Ministry to reconsider qualification requirements for Aboriginal-identified positions and offer flexible on-the-job training pathways.
- **Reviewing and revising strategies to increase the number of Aboriginal staff in NSW Health, including in management positions.** This includes adapting implementation of *the NSW Health Good Health – Great Jobs Aboriginal Workforce Strategic Framework 2016 – 2020* to the VAN services context. Importantly, alongside increasing the number of Aboriginal clinicians and health workers at the frontline, these efforts should focus on increasing the number of Aboriginal managers and

supervisors as these positions are vital to support Aboriginal and non-Indigenous staff to deliver culturally safe and trauma-informed services to Aboriginal people.

- **Advocating for changes to awards to better recognise cultural skills and experience, including introduction of an award for non-clinical Aboriginal health workers**. While outside the implementation of the IPARVAN Framework, awards are a major barrier to attracting and retaining Aboriginal staff in VAN services. The PARVAN Unit and Districts/SCHN should consider coordinated advocacy to improve the recognition of cultural skills and experience in existing awards as well as introducing a non-clinical Aboriginal health worker award.

Consideration 9 | The Ministry and Districts/SCHN to consider prioritising efforts to engage with ACCOs through co-design of services, increasing Aboriginal representation on governance bodies and interagency groups, and increasing and/or redirecting funding to ACCOs.

Responsibility: PARVAN Unit, NSW Ministry of Health; District/SCHN Executives and VAN services managers

Aboriginal stakeholders highlighted that while ACCOs are highly valued by Aboriginal clients who have experienced violence, abuse and neglect, overall there is little engagement between ACCOs and NSW Health VAN services. Stakeholders highlighted a few examples of good engagement to learn from (often driven by ACCOs themselves or by individual staff at VAN services) as well as other examples where there was no relationship and ACCOs were unaware of local VAN services.

Stakeholders emphasised the importance of ACCO representation on governance bodies to strengthen partnerships and responses for Aboriginal people. They also highlighted the lack of engagement of Aboriginal people in the design of services and models of care in the VAN sector. While outside the scope of the IPARVAN Framework Implementation, stakeholders emphasised that funding arrangements did not adequately compensate ACCOs for the complex services they provide and that while ACCOs are often best placed to deliver VAN services to Aboriginal clients, they struggle to compete for funding with larger non-Indigenous services.

To address these challenges, the Ministry and Districts/SCHN should consider:

- Increasing engagement with Aboriginal consumers, including through journey mapping, service co-design and representation on governance bodies (see further detail under Consideration 5 above).
- Including Aboriginal representatives in governance bodies, from the Executive level through to frontline service delivery. This should include representatives from local ACCOs.
- Ensuring that Aboriginal representatives in governance bodies (including consumers and staff) receive proper induction, training and support to ensure Aboriginal representatives can meaningfully contribute to these bodies.
- Strengthening partnerships between Districts/SCHN/VAN services and ACCOs, including through relationship building, regular meetings to understand and address local needs, and coordinated case management.
- Strengthening partnerships between the Ministry and state-wide peaks such as the Aboriginal Health and Medical Research Council (AH&MRC) and the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec).
- Advocating to NSW Health, the Commonwealth and other funders to increase funding for ACCOs that respond to violence, abuse and/or neglect.

5.3 Considerations to support enhanced monitoring and evaluation activities

Consideration 10 | The Ministry to consider prioritising addressing key data collection and reporting issues to improve the tracking of progress towards key outcome domains. Data will be key to demonstrate outcomes and economic impact in future evaluations.

Responsibility: PARVAN Unit, NSW Ministry of Health; Activity Based Management Team, NSW Ministry of Health; System Information and Analytics Branch, Ministry of Health.

Measuring outcomes is critical to understanding whether the IPARVAN Framework is achieving its purpose. Tracking progress towards key outcome domains aligned to the Future Health strategy provides the evidence for continued investment and effort on implementation of the IPARVAN Framework. It is important to note that the Ministry has commenced work to address a number of the challenges identified in this report.

NSW Health data has historically been very fragmented, manual, siloed, and inaccessible. Though progress has been made to improve VAN datasets, the complexity and dependencies within these datasets have continued to create barriers.

Despite significant efforts, these barriers mean that it has not been possible through the Stage 1 evaluation to establish a quasi-baseline that could be used as part of the Stage 2 and Stage 3 evaluations to understand ongoing change over time.

Table 12 presents an overview of key identified data issues related to outcome measurements. Further detail on data limitations is provided in Appendix B.

Table 12 | Overview of key identified issues related to outcome measurements

Outcome	Data limitations and challenges
All outcomes	• **Data quality issues across multiple datasets.** These include, but are not limited to, inconsistent use of timestamp variables, assigning the incorrect service provider to a service event; assigning the incorrect service provided; and inability to identify missing data versus not applicable data in extracts due to the use of many non-mandatory data fields and lack of data coding in data extracts that is required by analysts. • **Data still in development.** Data items needed to understand multiple outcomes (for example patient experience and staff experience) are still in development and not yet available.
Health and wellbeing outcomes	• **Challenges measuring potential demand and identifying the prevalence of people experiencing violence, abuse and neglect.** Currently data focuses on those people accessing VAN services, but the broader population of focus for the IPARVAN Framework are those people experiencing (or at risk of) violence, abuse and neglect who may or may not have accessed VAN services. To identify the demand for services and the trajectory and outcomes for the broader population, a linked longitudinal data asset that brings together health service data with other Health datasets is required (for example the NSW admitted / non-admitted data collections, ED collections, PREMs, and the Mental Health Outcomes Assessment Tool (MH-OAT)).

	Work is underway, in partnership with the Evaluation DataLab, NSW Department of Customer Service, to understand the potential demand and need for VAN services.
Client experience outcomes	• **Unavailability of Patient Reported Measures.** PREMs (Patient Reported Experience Measures) and PROMs (Patient Reported Outcome Measures) are integral to tracking the client journey during and following engagement with the health system. These data assets are critical to tracking several outcome indicators relevant to the IPARVAN Framework. PREMs and PROMs are currently sporadically collected across Districts/SCHN and various service types. A focus on collecting this data will improve evidence of client experience outcomes. Whilst work is underway to collect PREMs and PROMs – driven by the Ministry and the Agency for Clinical Innovation – these do not yet cover the specific experience of people who experience violence, abuse, and neglect. Work is underway to consider the appropriateness of the surveys for people who access VAN services.
Staff experience outcomes	• **Unavailability of VAN-specific Staff Experience Measures.** Staff experience measures are integral to understand the extent to which the IPARVAN Framework is contributing to enhanced staff outcomes. Whilst some staff experience measures are available – for example through the annual NSW People Matter Employee Survey (PMES) – these measures are at a high level and do not provide the level of detail needed for the evaluation.
System sustainability outcomes	• **Issues with Activity Based Management (ABM) data.** Initially there were two major use cases for including ABM data in the report: 1. To illustrate change in costs per service event over time, to understand any improvements in system sustainability due to progress on integration due to IPARVAN. 2. To highlight the major data reporting issues as an impetus for improving data collection and reporting processes However, there were several issues with the current approach to recording and reporting of activity-based management data which impacts interpretation of cost data, particularly for VAN services. The issues, impact on interpretation and opportunities to improve are summarised in Appendix B.

The development of appropriate and robust outcome measures is critical to assessing whether the IPARVAN Framework is delivering the intended benefits for clients, the workforce, and the system.

There are several issues associated with measuring each outcome indicator. Appendix B provides a detailed breakdown of these priority issues and potential next steps for improvement, as well as a high-level summary of data issues corresponding to each outcome indicator.

Consideration 11 | The Ministry, in collaboration with the independent evaluator for the Stage 2 and Stage 3 evaluations, to consider reviewing and revising (where necessary) monitoring and evaluation data collection tools.

Responsibility: PARVAN unit, NSW Ministry of Health; independent evaluator for Stage 2 and Stage 3 evaluations.

As noted in Consideration 10, ongoing challenges with data availability, completeness and quality limited the ability of the Stage 1 evaluation to understand the extent to which integration was occurring, and the extent to which integration was leading to enhanced outcomes.

The SAT (developed by the Ministry in partnership with the evaluation team for continuous self-monitoring and improvement purposes) and the provider survey (developed by the evaluation team specifically for the evaluation) aimed to understand each District's progression towards integration. Unfortunately, several challenges arose during the evaluation and thus had limited utility.

> "I find the SAT quite difficult to complete. I think we're doing well, but maybe we're not? We don't know what we don't know, and there's nothing to say 'if you're a 3, you look like this'"
>
> *LHD/SCHN Executive*

These include:

- **Reliance on self-reported data with lack of benchmarks.** Both the SAT and the provider survey rely on District/SCHN Executives and VAN service managers to reflect and self-report on their progress against each of the objectives. As there was no benchmarking data provided, there is likely significant variation across Districts/SCHN – with some rating themselves higher than appropriate, and others lower.
- **Significant data collection burden using tools that were not fit-for-purpose**. Some District/SCHN Executives reflected that completing the SAT was burdensome. Though steps were taken to improve the SAT, Districts/SCHN continued to find it time-consuming and difficult to complete. This may mean that in some circumstances, some Districts/SCHN did not complete the SAT to the same level of depth and comprehensiveness as others – giving an incomplete picture of progress across the system and within each District/SCHN.
- **Variations in questions and timing for the SAT and the provider survey, meaning responses were not directly comparable.** The provider survey was developed after the SAT and, to the extent possible, reflected the language used in the SAT. However, in some instances wording had to be changed due to the different audiences of the tools (District/SCHN Executives as compared to VAN managers). As a result, the SAT and provider survey scores are not directly comparable.

  In addition, due to unavoidable delays in the evaluation timelines resulting from the COVID-19 pandemic, final SAT scores were submitted approximately 9 months before final provider survey scores (July 2021 as compared to March 2022).

As implementation progresses, and to support ongoing monitoring and future evaluations, the Ministry should review and revise (where needed) key data collection tools. This may include:

- Further simplifying the SAT to reduce data collection burden and exploring innovative and user-friendly tools such as leveraging online survey instruments to complete the SAT.
- Encouraging completion of the provider survey to provide a picture of progression across all Districts/SCHN.
- Continuing to build on the definition of integration and specific integrators to guide where Districts need to focus their efforts.

Consideration 12 | The Ministry to consider prioritising efforts to collect evidence on Aboriginal people's experiences through data reporting and collection, Aboriginal community-controlled governance for the Stage 2 and Stage 3 evaluations, and commissioned research.

Responsibility: PARVAN Unit, VAN Integration Team, NSW Ministry of Health; Activity Based Management Team, NSW Ministry of Health; System Information and Analytics Branch, Ministry of Health; independent evaluator for Stage 2 and Stage 3 evaluations.

While Aboriginal people are disproportionally impacted by violence, abuse and neglect due to colonisation and its impacts, there is a lack of data and evidence on Aboriginal experiences and outcomes.

Aboriginal stakeholders highlighted a number of challenges with monitoring, evaluation and research in addition to the challenges outlined under Considerations 10 and 11 above.

- Aboriginal people are less likely to engage with mainstream health services which means they may not be reflected in government datasets.
- Some Aboriginal people are reluctant to identify as Aboriginal when presenting at health services through fear of stigma or being asked to 'prove' their Aboriginality (which may be difficult for example due to stolen generations).

There are few evaluations that examine Aboriginal experiences in VAN services. Further, most evidence underlying current services and models of care for VAN services are based on studies involving non-Aboriginal participants, with very little published evidence on what works for Aboriginal people. This is compounded by a lack of community-controlled governance mechanisms to inform study designs, engagement activities, data analysis and the interpretation of study findings.

To improve monitoring, evaluation and research activities, the Ministry and the independent evaluator(s) for the Stage 2 and 3 evaluations should consider:

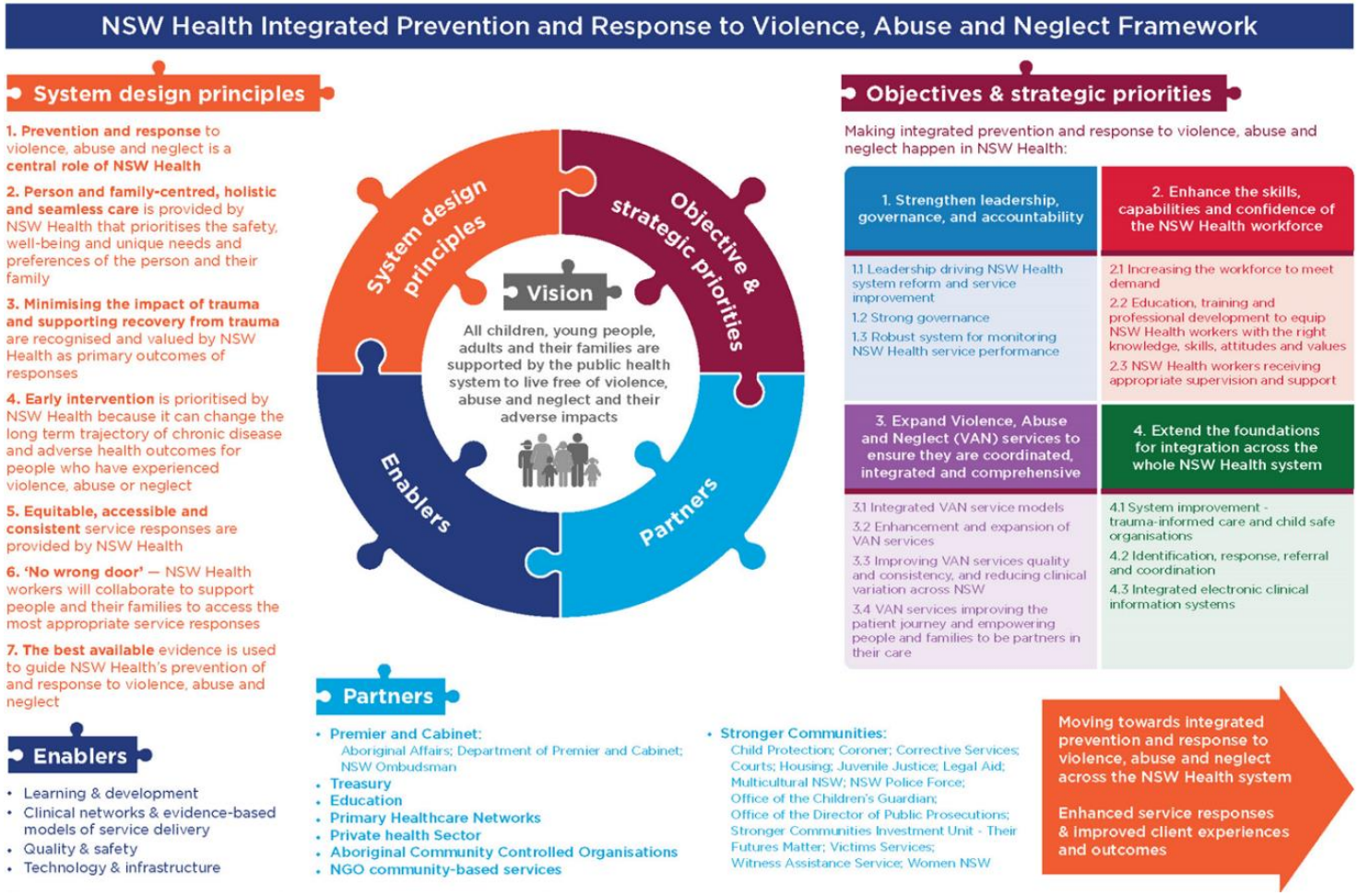
- Ensuring activities under Considerations 10 and 11 above incorporate a focus on Aboriginal data in line with relevant guidelines for the collection, analysis and governance of Aboriginal data, including appropriate representation on relevant data and evaluation governance bodies (including the PARVAN Evaluation Advisory Group).[56]
- Ensuring a community-controlled governance and a culturally sensitive approach to the components of the Stage 2 and Stage 3 evaluations that examine Aboriginal outcomes (this approach should align with the AH&MRC Ethical Guidelines).
- Advocating for increased support for ACCOs to undertake monitoring and evaluation activities (as anecdotal reports and limited evidence available indicates that their responses to violence, abuse and neglect are effective, with learnings for the broader VAN sector).

[56] This includes the AH&MR Ethical Guidelines: Key Principles (2020) V2.0.

Appendix A The IPARVAN Framework on a page

This appendix provides a one-page summary of the IPARVAN Framework (Figure 15). The full IPARVAN Framework is available online.

Figure 15 | The IPARVAN Framework on a page



Appendix B Data sources, limitations, and considerations

This appendix provides detailed information on data sources used throughout the evaluation (Table 13), as well as data limitations and considerations (Table 14)

Overview

The findings in this final Stage 1 Evaluation Report are based on triangulation of a range of qualitative and quantitative data sources.

Several data considerations and limitations are important to consider when interpreting the findings of this report. These are summarised and described in more detail below:

- The scores in the SAT and provider survey cannot be directly compared as the SAT responses are for 2020/21 while the provider survey responses are for 2022. Final SAT responses were provided in June 2021, and final provider survey responses in March 2022.
- The SAT and provider survey questions were slightly different as they were tailored for different respondents. However, the graphs in this report are based on questions which can be directly compared across both surveys.
- Respondents provided varying levels of detail in their responses to the SAT and provider survey. This means that where the evaluation reports a small number of Districts/SCHN reported an activity, it is possible that others are doing similar activities but did not include this in their responses. To address this, the evaluation team conducted further testing of findings from the SAT and provider survey with stakeholders at focus groups, VAN governance group meetings, and during site visits.
- Not all Districts/SCHN were represented in some consultations which means the responses are not entirely representative. Of the 16 Districts/SCHN involved in the Stage 1 Evaluation, six were not represented in the psychosocial focus group and six were not represented in the medical and forensic focus groups.
- Findings on changes in integration and outcomes are based predominantly on qualitative data sources and it was not possible to directly attribute to IPARVAN Framework activities to changes in integration and outcomes.

The evaluation focused on triangulating findings from stakeholder engagements and interviews where quantitative data was limited. Imputations and recoding were used to enable advanced analyses of data, such approaches are explained in Appendix D.

Data sources

Table 13 | Data sources for the Final Report

Data collection method	Time	Sample Size & Representation
Teleconference focus groups	Aug 2020	• 4 telephone focus groups with 24 VAN services staff members • 13 LHDs/SCHN represented and 1 JRU representative

Data collection method	Time	Sample Size & Representation
		• 1 telephone focus group with 10 social workers and psychologists • 5 LHDs/SCHN represented
		• 1 telephone focus group with 10 medical and forensic workers • 6 LHDs/SCHN represented
	March/April 2022	• 4 telephone focus groups with 24 VAN services staff members • 14 LHDs/SCHNs represented
		• 1 telephone focus group with 10 social workers and psychologists • 5 LHDs/SCHN represented
		• 1 telephone focus group with 7 medical and forensic workers • 6 LHDs/SCHN represented
Telephone Interviews	June 2020	• 1 telephone focus group • 10 social workers and psychologists • 5 LHDs/SCHN represented
	August 2021	• 1 telephone focus group • 7 medical and forensic workers who respond to violence, abuse and neglect • 6 LHDs/SCHN represented
'Deep dive' site visits	August 2021, March – June 2022	• Site visits to 6 LHDs and SCHN. • Each site visit involved interviews with LHD/SCHN Senior Executives, VAN services managers and VAN services staff. • Consultations with 5 Chief Executives of LHDs/SCHN • 29 interviews with clients of VAN services
Consultations with Aboriginal clients and service providers	May – July 2022	• 2 focus groups with Aboriginal service providers. • 2 teleconference focus groups with Aboriginal service providers. • 1 telephone focus group with Aboriginal VAN staff across NSW Health • 4 interviews with Aboriginal clients of VAN services. • 2 LHDs/SCHN represented.

Data collection method	Time	Sample Size & Representation
Consultations with VAN governance groups	2020 – 2022	• PARVAN Senior Executives Steering Committee • PARVAN Senior Managers Advisory Group • VAN Evaluation Advisory Committee
Self-Assessment Tool	2018/19	• n = 16 • 16 of 16 LHDs/SCHN represented
	2019/20	• n = 16 • 16 of 16 LHDs/SCHN represented
	2020/21	• n = 16 • 16 of 16 LHDs/SCHN represented
Provider Survey	July 2020	• n = 84 • 15 of 16 LHDs/SCHN represented
	Feb 2021	• n = 44 • 15 of 16 LHDs/SCHN represented
	Feb 2022	• n = 56 • 16 of 16 LHDs/SCHN represented
Kids and Families Data Warehouse on Sexual Assault Services[57]	FY2017/18–2019/20	• Data refers to sexual assault victims (child under 16, young person 16-17, adult 18+). • Includes all LHDs except for Hunter New England (excluded due to incomplete data).
Non-Admitted Patient data	2016/17	• 131 services
	2017/18	• 153 services
	2018/19	• 158 services
	2019/20	• 184 services
	2020/21	• 196 services

Data limitations and considerations

Table 14 | Data limitations and considerations

Data source	Consideration/limitation	Implication for the report
	Questions related to activities not yet expected to be implemented in the Phase 1 time period (e.g., due to	This may have resulted in lower average scores when

[57] Data source decommissioned in June 2021 following the rollout of the VAN Service Contact form to most districts/networks.

Data source	Consideration/limitation	Implication for the report
Self-Assessment Tool	policies not yet released), scores were recoded as 1 = Not at all or almost never. This will allow more realistic longitudinal analyses during Phase 2 of the evaluation.	reporting aggregate Making It Happen indicators (e.g., Figure 6 – 12)
	The Self-Assessment Tool responses noted throughout this report were collected across three-time periods; 2018/19, 2019/20, 2020/21. The questions asked in the original tool were asked at a higher level and did not necessarily target specific elements of Strategic Priority activities outlined in the Framework. The updated Self-Assessment Tool asks specific questions about each activity outlined in the Framework. The original scores submitted in 2018/19 were reviewed and rescored by PARVAN and Nous in 2020. The rescored values were reviewed by LHDs/SCHN managers and changes were made accordingly.	• The rescored values may not have captured the accurate implementation progress. However, they were reviewed by LHD/SCHN managers to ensure they were as accurate as possible • There were a number of indicators where there was "not enough information available" recorded in the original 2018/19 responses in order to rescore these in 2020. Where possible, information collected through LHD/SCHN manager reviews were used to inform the new scores.
Provider Survey	In order to develop the regression, an imputation model was required to address data gaps where no answer was provided. This is further outlined in Appendix B.	See Appendix E.

Kids and Families Data Warehouse on Sexual Assault Services (SAS)	• 'Response time' has been derived using timestamp variables: Date and time medical forensic requested / Date and time medical forensic commenced
	  • n = 2937 overall
	  • 2017/18 n = 1,074
	  • 2018/19 n = 1,013
	  • 2019/20 n = 850
	  • Requests for non-acute medical or medical forensic examinations were also reported, however these services are not expected to be provided within 2 hours and have been excluded.
	  • 2019/20 FY may have been affected by the COVID-19 pandemic and known data quality and completeness issues in some LHDs.
	• Decommissioned in June 2021 following the rollout of the VAN Service Contact form to most districts/networks. Data quality in 2020/21 was impacted by this transition period and is not
		Given these limitations, the insights drawn out in Section 3 should be considered with caution.

Data source	Consideration/limitation	Implication for the report
	suitable for inclusion in this report. Similar data is now being collected through the VAN Service Contact form, however it will take time for the quality and consistency of this data to improve and stabilise before it can be used for analysis	
Non-Admitted Patient data collection	Client values of <5 or <10 were suppressed in the extracted dataset to mitigate potential identifiability. These values were recoded based on a predictive imputation model, as outlined here: freerangestats.info/blog/2018/11/06/suppressed-data	The recoding of these datapoints may overstate or understate the extent to number of service events or clients. However, the risk of this is low given the predictive modelling applied.

ABM Cost data

Table 15 presents a summary of issues and opportunities to improve Activity Based Management Costs data.

Table 15 | Summary of issues and opportunities to improve Activity Based Management Costs data

Impact on interpretation	Opportunities to improve data
Issue 1 | Costs for client case management is allocated to ABM costs, but service events do not reflect the time allocated to these case management activities. Therefore, case management costs are spread equally across all service events from this cost centre.	
Generally, this creates an inaccurate ratio of costs to service events, as the denominator does not represent the actual services delivered which are broader than a clinical service event (in this case, case management). This is particularly an issue for services which spend a large proportion of their time on case management. For these services, we can expect the cost/service event ratio to be over-estimated, making it difficult to compare to the other services which may not require the same level of activities to support people with complex needs (i.e. case management).	National rules define how cost data related to non-service events are coded in Activity Based Management. Such rules impact how case management costs are allocated and reflected in reporting. The Ministry should lobby for change to these national rules so that the full spectrum of VAN service delivery is accounted for in Activity Based Management reporting.
Issue 2 | Each local cost centre can determine whether to allocate costing based on non-admitted patient and/or admitted patient service events.	
Similar to above, this will skew the denominator (number of service events) for some LHDs. Varied approaches to reporting by local cost centres (e.g. allocating costing based on non-admitted versus admitted patient service events), particularly in the	LHDs/SCHNs regularly collaborate on approaches to reporting ABM data. The Ministry can encourage the cost centres to determine a standardised approach to allocating costing so as to mitigate inconsistencies.

SCHN results in an over-estimated cost/service event ratio. If admitted patient service events are included in the costing, those service events will not be reflected in the denominator to develop a cost/service event ratio. For these services, we can expect the cost/service event ratio to be over-estimated, making it difficult to interpret and compare LHDs' cost per service event ratios.	
Issue 3 | Data reporting issues and gaps	
A number of records in the ABM data show anomalies such as increases over time in both service events and costs (e.g. 28% increase in costs, with a 120% increase in services delivered). This may be due to either a delayed reporting error, discrepancies as a result of the two issues noted above, or other data collection reporting issues. This restricts a longitudinal analysis of the cost per service event ratio, as trends may be skewed due to these errors.	A thorough review of unit-record level data will help to identify instances where data was reported late, mis-represented, or incorrectly reported.
Data gaps and issues, e.g. anomalies in trends over time and gaps in recording due to HERO (Health Establishment Registration Online) ID changes and very limited NAP reporting before 2018 may skew longitudinal analyses of the cost per service event ratio as well as count of service events and clients. A number of HERO IDs have no recorded data in some years. Similar to above, this restricts a longitudinal analysis of the cost per service event ratio, as trends may be skewed due to these errors.	Cross-referencing HERO ID changes over time will help to establish a longitudinal view of costs and service events for each service.

Outcomes data

The development of appropriate and robust outcome measures is critical to assessing whether the IPARVAN Framework is delivering the intended benefits for clients, the workforce and the system.

Table 16 presents the outcomes indicator framework that was developed and agreed at the start of the evaluation. It provides detail on intended outcomes of the implementation of the IPARVAN Framework – that is, what can and should be measured to understand whether the IPARVAN Framework is achieving its vision – as well as possible measurement indicators and status of the data available to track and monitor progress.

There are a number of issues associated with measuring each agreed outcome indicator. This detail is provided to support the Ministry's ongoing work to improve data quality and availability. It is presented as part of this evaluation report, as data availability will be critical for understanding medium and longer-term outcomes as part of the Stage 2 and Stage 3 evaluations.

Table 16 | Status of data for outcome indicators in the IPARVAN Data Collection Plan and Measurement Strategy

Outcome indicator	Potential measurement indicator	Status of proposed data for outcomes and evaluation
Health and wellbeing: Client health, wellbeing, safety and access to support is optimised and sustained		
VAN clients' therapeutic goals are achieved	Proportion of VAN clients within each LHD/SHN who meet their therapeutic goals	✕ SAS data available but data quality in 2020/21 was impacted by this transition period and is not suitable for inclusion in this report.
Reduction of secondary trauma for VAN clients accessing health services	Proportion of VAN clients where clinician reports the client has experienced secondary trauma when accessing health services	✓✕ Explored in client interviews during site visits but sample size not representative ✕ Clinician reported measure not available to evaluation team
VAN clients are safe from violence, abuse and neglect	Proportion of VAN clients where clinician reports the client are safe from violence, abuse and neglect.	✓✕ Explored in client interviews during site visits but sample size not representative ✕ Clinician reported measure not available to evaluation team *Due to the complexity of violence, abuse and neglect, and the fact clients may self-report feeling safe despite not feeling so, this outcome is difficult to measure.*
Client experience: VAN clients have trust and confidence in health services		

Outcome indicator	Potential measurement indicator	Status of proposed data for outcomes and evaluation
VAN clients have access to timely treatment	Proportion of VAN clients experiencing crisis who access service supports and receive a response within 2 hours (medical and forensic); 1 hour (psychosocial).	✓✕ Data available on timeliness of medical and forensic responses only; data quality issues mean the evaluation cannot report on timeliness of psychosocial responses; data not available on timeliness of other VAN services; data not representative of all VAN clients
	Proportion of VAN clients interviewed who report they feel they have access to timely treatment	✓✕ Explored in client interviews during site visits but sample size not representative; Patient Reported Experience Measures not available across all LHDs/SHNs and may not be able to fully measure this indicator
VAN clients feel safe and respected	Proportion of services that have culturally safe processes/protocols	✓Self-assessment tool
		✓Provider survey
		✓✕ Explored in VAN staff focus groups but sample size not representative
	Proportion of VAN clients who report they feel safe and respected	✓✕ Explored in client interviews during site visits but sample size not representative; Patient Reported Experience Measures not available across all LHDs/SHNs and may not be able to fully measure this indicator

Outcome indicator	Potential measurement indicator	Status of proposed data for outcomes and evaluation
System sustainability: Reduced duplication of service provision improves cost effectiveness and health system efficiency		
VAN services are cost efficient	Number of FTE per service	✓ FTE Data from LHDs/SHNs
	Number of service events per 184 VAN services across the state	✓ Non-Admitted Patient Data Collection
	Number of VAN clients per 184 VAN services across the state	✓ Non-Admitted Patient Data Collection
	Cost data per service event	✓ ABM data, though there are data quality issues still to be confirmed
The health system reduces duplication and is more effective at addressing client needs	Number of VAN clients with visits to hospital related to VAN within 12 months of interaction with VAN service	✕ NSW Emergency Department Data Collection data not available to the evaluation team
	Reduction in proportion of VAN clients re-presenting to ED/ambulance	✕ NSW Ambulance Data Collections data not available to the evaluation team
		✕ NSW APDC ED-only admissions data not available to the evaluation team
	Rates of retention and vacant positions in each LHD/SCHN	✕ LHD/SHN data on retention and vacancies not available

Outcome indicator	Potential measurement indicator	Status of proposed data for outcomes and evaluation
VAN services have an effective and sustainable workforce	Number of FTE and number of positions in each LHD	✓ FTE Data from LHDs/SHNs
	Proportion of VAN services workforce who feel supported and confident in their role	✓✕ Explored in VAN staff focus groups but sample size not representative

Appendix C List of NSW Health VAN services

This appendix (Table 17) provides a list and description of VAN services under the IPARVAN Framework.

Table 17 | NSW Health VAN services

VAN Service	Acronym	Service Description
Aboriginal Family Wellbeing and Violence Prevention Program	AFWVP	The NSW Aboriginal Family Health Strategy provides a framework for responding to family violence in Aboriginal communities within a culturally competent, family based context with a focus on healing. The strategy describes a model of care and presents positive action-based solutions which aim to: • Reduce the incidence and impact of family violence in Aboriginal communities. • Build the capacity and strength of individuals and communities to prevent, respond to and recover from family violence. • Nurture the spirit, resilience and cultural identity that builds Aboriginal families.
Child Protection Counselling Services	CPCS	The CPCS is a child and family-centred trauma-specific therapy service. Its overarching purpose is to work towards the recovery and ongoing safety and wellbeing of children and young people involved with the care and protection system.
Child Protection Units/Services	CPUs	The Sydney Children's Hospitals Network has a Child Protection Unit at Westmead and at Randwick. The John Hunter Children's Hospital at Newcastle has a child protection team. These units and team provide specialist paediatric and child protection services for NSW. These tertiary child protection services provide comprehensive paediatric medical, forensic and psychosocial assessments with access to intensive care, surgery and other subspecialties. Medical officers and paediatric sub-specialists are available for medical consultation and second opinions to staff across NSW.
Child Wellbeing Units	CWUs	NSW Health has three CWUs, which align with the existing NSW Child Health SCHN, and are located in Dubbo, Wollongong and Newcastle. Trained staff in CWUs assist mandatory reporters to use the Mandatory Reporter Guide and ensure that all concerns that reach the threshold of risk of significant harm are reported to the Child Protection Hotline.
Domestic violence services	DVs	NSW Health currently provides a response to domestic and family violence through the Domestic Violence Routine Screening (DVRS) program, Social Work services, Emergency

		Departments, specialist Mental Health, Drug and Alcohol services, Aboriginal Family Health services and one specialist Domestic Violence Service.
Joint Child Protection Response Program, including JRU (previously the Joint Investigative Response Teams or JIRTs)	JCPRP	The JCPRP aims to provide a seamless service response to children and young people at risk of significant harm as a result of sexual assault, serious physical abuse, and extreme neglect. JCPRP is a tri-agency program delivered by the NSW Police Force, Department of Communities and Justice, and NSW Health.
New Street Services (for children and young people aged 10-17 years and engaging in harmful sexual behaviours)	New Street	New Street Services provide therapeutic services for children and young people aged 10 to 17 years who have engaged in harmful sexual behaviours towards others, and their families and caregivers. New Street Services work with the young person to assist them to understand, acknowledge, take responsibility for and cease the harmful sexual behaviour.
Responses to children under 10 displaying problematic or harmful sexual behaviours (e.g. Kaleidoscope Sparks Clinics)	Children under 10	NSW Health provides a range of services to support children under 10 with problematic sexual behaviours, and their families. These services include: • Sexual Assault Services • Child Protection Units • Child Protection Counselling Services • Child and Adolescent Mental Health Services • Child and Family Health Services
Child Sexual Assault Services Adult Sexual Assault Services	SAS	NSW Health has a network of specialist Sexual Assault Services delivered by LHDs. Every LHD has an SAS that operates 24 hours a day, 7 days a week
Specialist Services for Children and Young People in Out-Of-Home Care[58]	OOHC	NSW Health provides health assessments, reviews and interventions for children and young people who enter statutory out of home care (OOHC). This is a critical health intervention for children in OOHC who have significant health care needs including poor mental and physical health compared with the general population. Health assessment services are provided through LHDs/SCHN upon referral from Community Services.
Whole Family Teams[59]	WFTs	Whole Family Teams (Drug and Alcohol and Mental Health) have been established to provide specialist tertiary health services for families where there are drug and alcohol and/or mental health problems and child protection concerns.

[58] Some services are not considered VAN services and are aligned to Child, Youth and Family services
[59] Most services are not considered VAN services and are aligned to Mental Health

Appendix D Detailed data analysis: regression and factor analysis

This appendix describes the method for the regression and factor analyses to inform the measurement of integration for this evaluation.

Defining and measuring integration

Why is integration important and how are we measuring it?

The IPARVAN Framework defines integrated service responses to violence, abuse and neglect as 'the provision of service responses, in accordance with a person-centred approach, that provides seamless care across multiple services, adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course.'

The IPARVAN Framework sets out evidence-based activities under each objective that collectively are designed to increase system integration and ultimately improve health, client experience and system sustainability outcomes. It is important to be able to objectively measure whether these activities are contributing to integration (and ultimately outcomes) and which activities should be prioritised to achieve the vision of the Framework. This list of activities could, in time, be used to develop a scorecard to measure progress on integration for each District/SCHN and guide decisions on which activities should be prioritised (based on benchmarking against outcomes to assess the level of importance).

This evaluation sought to understand the extent to which these activities are contributing to system integration through two steps:

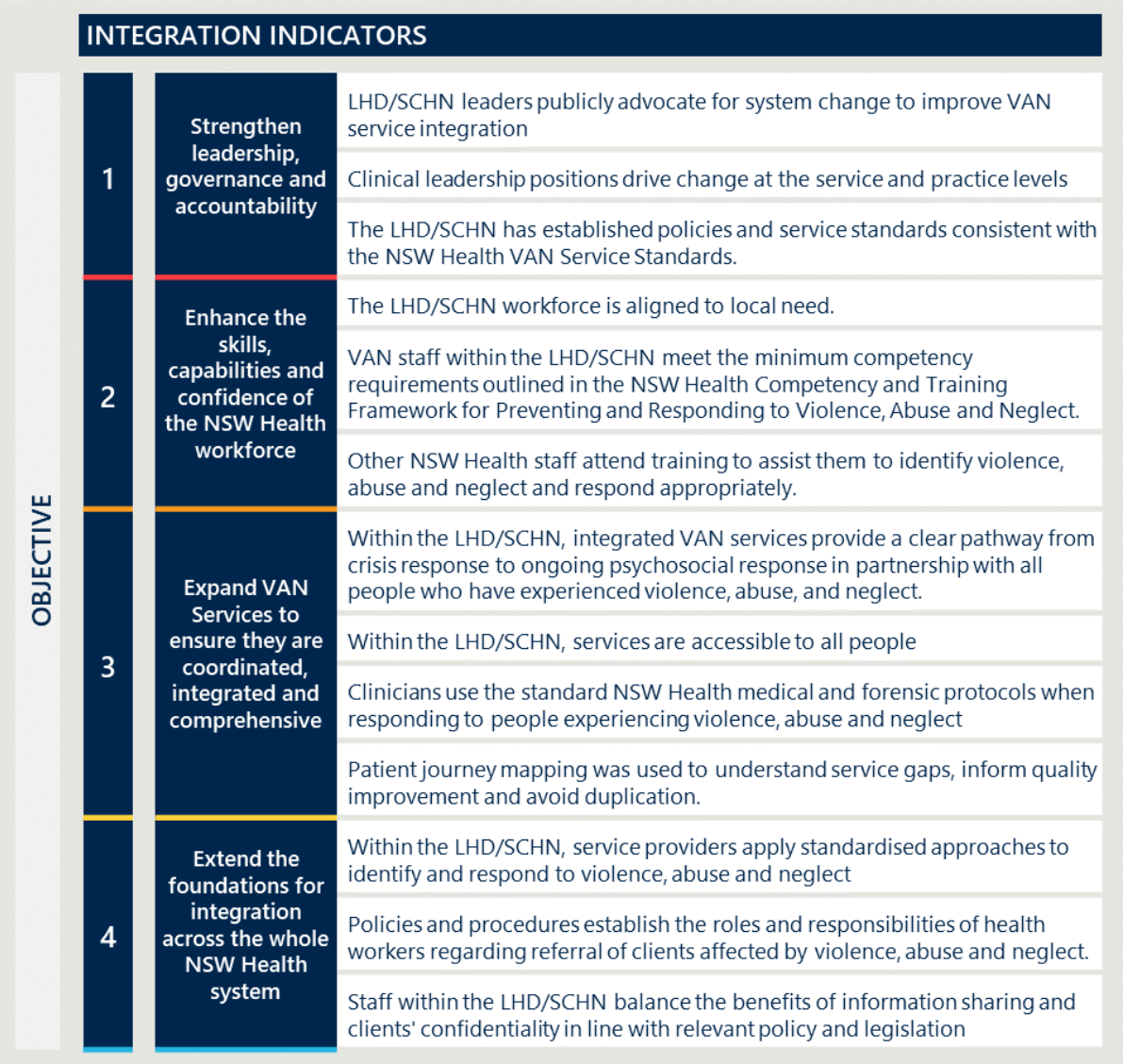
1. **Define integration and indicators of integration for the purpose of the evaluation:** In order to measure integration, it is important to define it and how it is operationalised (i.e., what activities contribute to integration). This includes identifying indicators that can be used to measure progress towards integration. This evaluation used published literature and analysis of SAT and provider survey responses to understand which activities are having the greatest impact on integration. The evaluation team then used these activities to identify indicators of integration which can be measured over time. This process means that the evaluation team can develop an objective definition of integration based on quantitative data from the evaluation.
2. **Measure integration:** The evaluation uses the definition and indicators of integration to objectively measure how activities in the IPARVAN Framework are contributing towards system integration by synthesising information from the following data sources:
    - views of NSW Health staff on changes in integration, based on qualitative responses to the SAT, provider survey, focus groups and interviews conducted as part of site visits.
    - views of clients of VAN services on the services that they experienced in response to violence, abuse and neglect, based on interviews with clients of VAN services that were conducted as part of site visits in April and May 2021, and March to June 2022.

This report synthesises information from the two data sources to measure integration and understand how integration has changed over time.

13 integration indicators were identified based on literature and preliminary insights.

Evidence from published literature and preliminary qualitative insights supported the identification and categorisation of thirteen indicators as outputs of integration – that is, these indicate what is happening when better integration is achieved. These indicators are detailed in Figure 16 below.

Figure 16 | Identified integration indicators based on literature and preliminary insights[60]



Each indicator aligns to activities that are progressed as part of the IPARVAN Framework. These indicators are included in the SAT and the provider survey.

Based on this categorisation, a regression analysis has been developed using provider survey responses. The average of each respondent's answers to the integration indicators in were used as the independent

[60] The published literature that informed these indicators includes the following, alongside literature used in the IPARVAN Framework Case for Change: Aarons, G. A., Ehrhart, M. G., & Farahnak, L. R. (2014). The implementation leadership scale (ILS): development of a brief measure of unit level implementation leadership. Implementation Science, 9(1), 45; Local Government Association, NHS Confederation and NHS Clinical Commissioners (2016). Stepping up to the place: the key to successful health and care integration; Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration (2014), SAMHSA-HRSA Center for Integrated Health Solutions.

variable (e.g., the anchor for assessing the relationship). All other activities in the Framework were used as explanatory variables.

Integration indicator regression

The regression analysis was developed using Provider Survey responses. Only the responses from the Provider Survey were used because there were too few respondents to the Self-Assessment Tool (n=16) for the analysis. The relationship was tested across the three years of available data; 2020 (n = 89), 2021 (n = 46), and 2022 (n = 54). The regression analysis explored the relationship between service provider's scores for all activities associated with the Framework, with those that have been identified as integration indicators (see Figure 17, Figure 18 and Figure 19 below).

For most activities there was no statistically significant evidence of a relationship with integration. However, as noted in Table 18, five distinctive activities (one activity noted in multiple years) were identified to have a positive relationship with progress towards integration (i.e. if you're doing these things, it appears integration is progressing well).

These activities can be associated with early progress towards integration. This means that increased focus on these activities in the future is likely to contribute to enhanced integration across the health system.

Table 18 | Provider Survey questions most associated with indicators of successful integration identified through regression with integration indicators as response variable

	Activities identified to have a positive relationship with progress towards integration
2020 *n = 89*	• There are **formal governance arrangements for joint case management and referral** between NSW Health services and VAN services • The **patient experience journey is mapped** with consideration to the VAN service model or models developed in your local context, which is used by your organisation to inform service practices • There is a **24-hour integrated crisis counselling response**, which is available to all cohorts of people who have experienced violence, abuse and neglect
2021 *n = 46*	• Identified and undertaken **local evaluation and/or service improvement activities** for VAN services • Local evaluation, quality assurance, and service improvement activities undertaken by your LHD/SCHN have **informed your service's practice**
2022 *n = 54*	• There are **formal governance arrangements for joint case management and referral** between NSW Health services and VAN services

Figure 17 | 2020 Provider Survey questions most associated with indicators of successful integration identified through regression with integration indicators as response variable

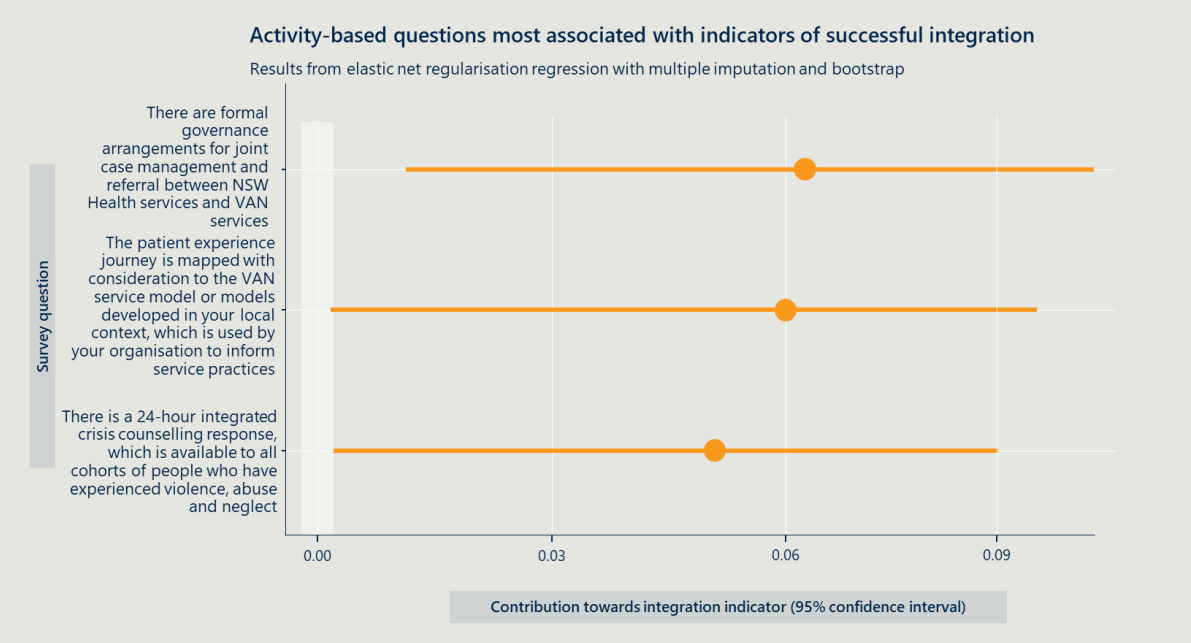


Figure 18 | 2021 Provider Survey questions most associated with indicators of successful integration identified through regression with integration indicators as response variable

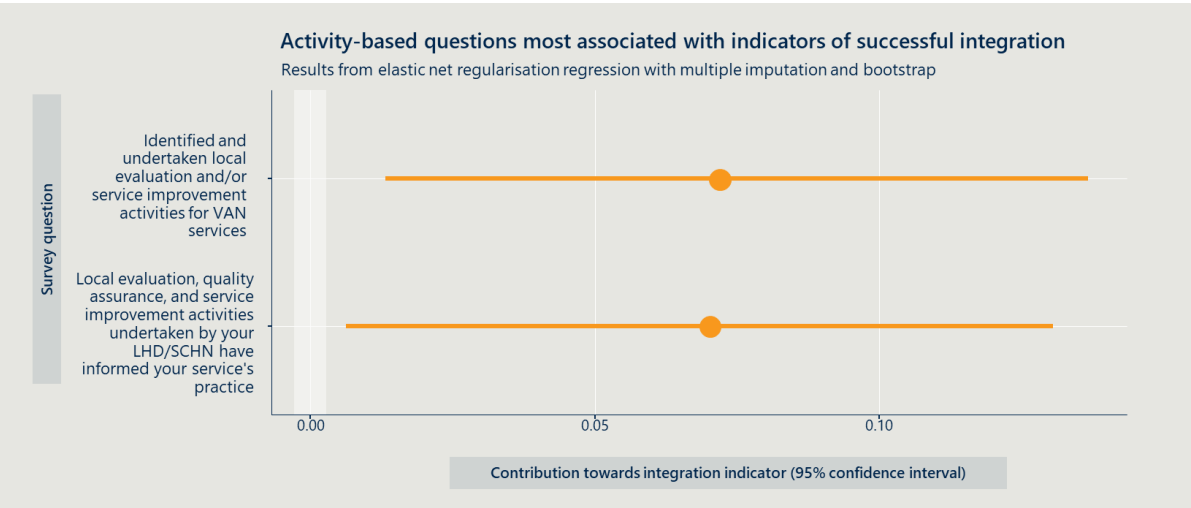
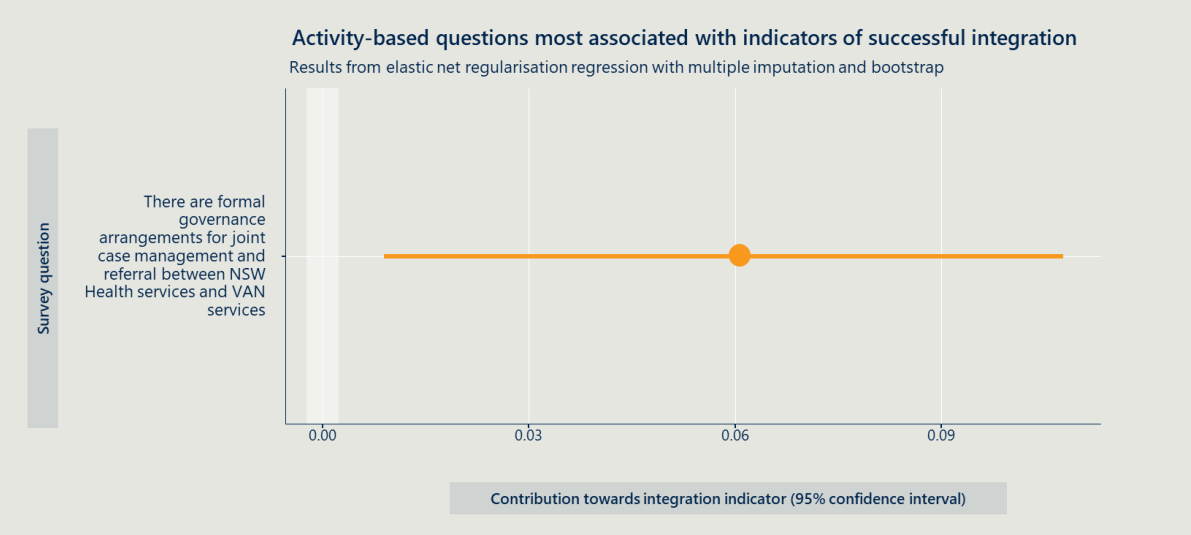


Figure 19 | 2022 Provider Survey questions most associated with indicators of successful integration identified through regression with integration indicators as response variable



The response variable of the regression was the mean numerical response (where 1 = 'Not at all or almost never' and 5 = 'Always or almost always') of the 13 questions. That is, for each respondent, a single number was calculated as an indicator of integration progress, from the average answer to those 13 questions.

The explanatory variables were the individual answers to the 63 other questions about integration activities.

There were 84 responses to the survey. Using classical methods, we would need at least 650 responses to meaningfully test for the effect of 63 candidate explanatory variables. To mitigate the problem of a relatively low number of observations given the number of explanatory variables creating noisy estimates of coefficients, we used "elastic net regularisation", a method that shrinks estimates of coefficients towards zero. Effectively, a budget of "total effects that can be gleaned from this small data" is set and assigned to the variables showing the strongest noise. Unlike stepwise selection methods that discard variables which aren't statistically significant, the estimates resulting from this process are not biased away from zero, i.e. our estimates are not biased to appear more significant than justified by the evidence.

The models were fit with the *glmnet* R package by Friedman et al.[61] We used cross validation to set the value of the 'budget' (the 'lambda' parameter in *glmnet*), and used 0.5 for alpha, so the resulting approach is midway between the 'lasso' and 'ridge regression' methods.

A small number of observations were missing answers to some questions. These results were imputed with the *mice* R package by van Buuren et al.[62] For valid and robust inference, the whole process (including imputation, and cross-validation to estimate of the best value of lambda) was wrapped in a bootstrap with 999 replicates, using the *boot* R package by Canty et al.[63]

95 per cent confidence intervals for the estimate of each coefficient were calculated using the bootstrap percentile method. These coefficients are the expected impact on combined integration indicator (average of 13 questions) of a one-point shift in the relevant explanatory variable i.e. one of the 63 survey questions

[61] Jerome Friedman, Trevor Hastie, Robert Tibshirani (2010). Regularization Paths for Generalized Linear Models via Coordinate Descent. *Journal of Statistical Software*, 33(1), 1-22. URL http://www.jstatsoft.org/v33/i01/.
[62] Stef van Buuren, Karin Groothuis-Oudshoorn (2011). mice: Multivariate Imputation by Chained Equations in R. *Journal of Statistical Software*, 45(3), 1-67. URL https://www.jstatsoft.org/v45/i03/.
[63] Angelo Canty and Brian Ripley (2020). *boot: Bootstrap R (S-Plus) Functions.* R package version 1.3-25. Davison, A. C. & Hinkley, D. V. (1997) *Bootstrap Methods and Their Applications*. Cambridge University Press, Cambridge. ISBN 0-521-57391-2

on integration activities. Note that nearly all the confidence intervals include zero as their lower bound, suggesting that the apparent impact may be due to noise. This is to be expected given the relatively small amount of data available.

Appendix E Additional data on services

This appendix presents data on the breakdown of clinical FTEs for VAN services, as well as additional data on service types that were not able to be included from data analysis in the body of the report. These service types were excluded because they could not be directly compared with other VAN services and/or data on these service types is reported against other health services datasets (e.g., Child and Adolescent Mental Health Services). Data on the following service types is reported on separately below:

- Under 10s
- Out of Home Care
- Child Wellbeing Unit
- Central Coast Multi-Agency Response Centre (CCMARC)

Clinical FTEs breakdown

Table 19 shows a breakdown of the clinical FTEs for each service type alongside the adjusted total no. service events and service events to clinical FTE ratio.

Table 19 | Detailed clinical FTE breakdown for 2020/21

Service Type	Detailed FTE breakdown					
	Psychosocial staff FTE	Medical / Forensic staff FTE	Aboriginal Staff FTE	Total clinical FTE	Matched service events 2020/21	Clinical FTE : Annual service events ratios
Sexual Assault Service	112	21	9	142	48,359	1 : 340
Child Protection Counselling Service	77	0	1	78	21,021	1 : 270
Domestic Violence	32	0	0	32	10,482	1 : 331
Domestic Violence and Sexual Assault Service	18	3	2	23	9,670	1 : 420
Joint Child Protection Response Program	40	0	2	41	8,259	1 : 199

Service Type	Detailed FTE breakdown					
Child Protection Unit/Team	15	14	1	29	8,633	1 : 294
New Street	24	0	4	28	3,806	1 : 134

Source: Service Events | EDWARD, Non-Admitted Patient Data Collection 2016/17-2020/21[64]
FTE | Data manually collected by the IPARVAN team, based on template distributed to LHD managers[65]
† Matched number of services refer to the adjusted number of services refers to the number of individual service records included in analysis after exclusions have been applied.
††Aboriginal Domestic and Family Violence has been excluded from this table due to the small number of matched services (n = 1) which is not representative.

Under 10s

NSW Health provides a range of services to support children under 10 with harmful and problematic sexual behaviours, and their families. While there are many services that provide these responses in NSW, only two services were classified as 'Under 10s' in the NAP data (the rest were likely classified under other service types such as sexual assault services). Therefore, the two services that were classified as 'Under 10s are reported on separately in this appendix (Table 20).

Table 20 | VAN services categorised as "Under 10s" in 2019/20

LHD/SCHN	Service	Service Unit Standardised Name		
HNELHD	Under 10s	John Hunter Children's Hospital - Community Paediatric Child Development Team SPARKS		
		Tamworth Community Health Centre Problematic Sexualised Behaviour - Under 10s		

Source: Service Events | EDWARD, Non-Admitted Patient Data Collection 2016/17-2019/21[66]
FTE data collected by the PARVAN team, based on template distributed to LHD managers[67]
† Number of clinical FTE and service events has been excluded from this table due to the small number of clinical FTEs (n = 2) which is not representative.

[64] Suppressed values have been recoded -- previously <10 or <5, updated to be 5 or 3 respectively. Further information on the imputation model included in in Appendix B.
[65] Clinical FTE is reported and management FTE is not reported based on advice from the PARVAN as management FTE is not reported consistently across LHDs/SHNs. In some cases, managers may perform clinical duties, which is not reflected here. In some instances, clinical FTE were split across multiple services based on advice from the LHDs/SHNs that provided the FTE data. These FTE were divided appropriately across the noted services.
Excluded service HERO IDs where there were no FTE, excepted those which noted FTE was recorded elsewhere.
Excluded services which did not have NAP data reported in 2020/21. This has resulted in 29 less services than full FTE data list (FTE Service count = 180, Ratio Service count = 151). Services excluded: SAS (16 services); CPCS (3 services); DV (2 services); JCPRP (1 service); New Street (6 services); ADFV (1 service). This has resulted in 30 less Clinical FTE than full FTE data list (FTE Clinical FTE total = 405.6, Ratio Clinical FTE total = 376.0)
[66] See above, footnote 64
[67] See above, footnote 65

Out of Home Care

NSW Health provides specialist services for children and young people in out of home care who have experienced violence, abuse and neglect. While some of these services are captured in VAN services data, many are reported on in other NSW Health datasets which were accessed for this evaluation. Therefore, OOHC services are reported on separately in this appendix (Table 21, Table 22).

Table 21 | Number of Service Events in VAN services categorised as "Out of Home Care" between 2016/17 and 2020/21

Service Type	Total no. service events 2016/17	Total no. service events 2017/18	Total no. service events 2018/19	Total no. service events 2019/20	Total no. service events 2020/21
OOHC	1,833	1,984	1,916	2,940	4,722
Number of services:	n = 16	n = 20	n = 21	n = 21	n = 22

Source: EDWARD, Non-Admitted Patient Data Collection 2016/17-2020/21

Table 22 | Number of Clients in VAN services categorised as "Out of Home Care" between 2016/17 and 2020/21

Service Type	Total no. clients 2016/17	Total no. clients 2017/18	Total no. clients 2018/19	Total no. clients 2019/20	Total no. clients 2020/21
OOHC	3,524	4,010	4,986	7,229	12,854
Number of services:	n = 16	n = 20	n = 21	n = 21	n = 22

Source: EDWARD, Non-Admitted Patient Data Collection 2016/17-2020/21[68]

CCMARC

Central Coast Multi-Agency Response Centre (CCMARC) is a multi-agency child protection response centre with staff from Health, Department of Communities and Justice, Education and Family Referral Service, working collaboratively sharing decision making about vulnerable children/young people and their families who reside on the Central Coast where risk of harm concerns have been identified.

CCMARC primarily has two functions:

- Localised Helpline – Gosford/Wyong area – Local Helpline call centre receiving reports from mandatory and non-mandatory reporters and is staffed by CS caseworkers.
- Interagency collaboration and decision making about how best to respond to children/young people and their parents/carers where risk of significant harm concerns have been identified. This includes sharing information under 16a legislation with agencies participating in Local Planning Response Meetings (LPR's) twice a week.

[68] Ibid.

Health's role also includes case navigation, advocacy and troubleshooting/escalating child protection matters and identification of practice gaps both within the interagency environment but also practice in our own agency.

CCMARC was reported on as its own separate service type and was therefore not able to be analysed under the other service types that are reported on in the report. Therefore, CCMARC is reported on separately in this appendix on separately in this appendix (see Table 23 below).

Table 23 | Number of Clients and Service Events attending CCMARC between 2016/17 and 2020/21

CCMARC	2016/17	2017/18	2018/19	2019/20	2020/21
Number of Clients	511	742	125	73	97
Number of Service Events	541	1,005	131	81	104

Source: EDWARD, Non-Admitted Patient Data Collection 2016/17-2019/20[69]

Child Wellbeing Units

NSW Health operates three Child Wellbeing Unit (CWU) teams. Along with being a service for all NSW Health employees, certain other public and primary health services can also access the Health CWUs. Since 6 May 2016 all medical practitioners in NSW, (including General Practitioners), as well as General Practice Nurses, have been able to access the Health CWU for assistance, information and to report child safety, welfare or wellbeing concerns. The Health CWUs are located at Dubbo, North Wollongong and Wallsend.

The Health CWUs provide advice and support to NSW Health staff and other staff that respond to violence, abuse and neglect, but they do not provide services directly to clients. Therefore, CWUs are reported on separately in this appendix.

The following tables (Table 24, Table 25) outline the total number of contacts to Child Wellbeing Units from 2016/17 to 2020/21, and FTE data based on the 2020 Child Wellbeing organisational structure.

The Primary Contact Reason has been classified slightly differently since 20 December 2017 when the ChildStory database was introduced. As a result, the tables below report on the number of contacts for each year, based on groups of similar classifications together to indicatively illustrate changes over time. Contacts may be received by telephone, email, fax, and since 20 December 2017 by eReport, contributing to the increase in contact from 2017/18.

Table 24 | Total contacts to NSW Health Child Wellbeing Units by grouped primary contact reason between 2016/17 and 2020/21

Primary Contact Reason	2016/17	2017/18	2018/19	2019/20	2020/21
Receive a C/YP Concern/Prenatal Concern	4,502	4,949	6,660	9,671	9,728
Legal Request	255	101	0	0	5,020

[69] Both Service Events and Client values include Non-Patient values
Number of Service Events derived from "Count of DERIVED_NATIONAL_SERVICE_EVENT_RECORD_NK" and "Distinct count of CLIENT_ENCRYPTED_ID_NK" in EDWARD
Number of Clients derived from "Distinct count of CLIENT_ENCRYPTED_ID_NK" in EDWARD

Obtain Information/Information Exchange	1,558	3,270	5,153	4,877	2,582
Provide Advice/Case Discussion/Coaching/Service and System Advice	7,114	6,087	2,892	2,081	620
Service Gap	1	2	6	3	9
Provide Information/Feedback to CWU	459	195	95	41	14
TOTAL:	**13,889**	**14,604**	**14,806**	**16,673**	**17,973**

Source: Child Wellbeing Unit Activity Data[70]

Table 25 | Children or young people appraised by NSW Health Child Wellbeing Units by primary harm concern between 2016/17 and 2020/21

Primary Harm Concern	2016/17	2017/18	2018/19	2019/20	2020/21
Domestic Violence	1,218	1,098	1,755	2,310	2,185
Parent/carer mental health	923	901	1,549	2,235	2,257
Parent/carer substance abuse	862	723	1,298	2,070	1,891
CYP is a Danger to Self and/or Others	440	488	891	1,274	1,661
Unborn Child	1,403	923	981	1,231	1,310
Physical Abuse	272	289	496	710	734
Psychological Harm	325	282	384	568	680
Neglect	890	831	1,310	1,873	1,901
Sexual abuse	307	301	395	565	319
Child/Young Person Problematic Sexual Behaviours	0	0	47	78	645
Relinquishing Care	29	27	52	58	75
Other	211	166	64	167	62
TOTAL:	**6,880**	**6,029**	**9,222**	**13,139**	**13,720**

Source: Child Wellbeing Unit Activity data[71]

[70] Ibid.

[71] Typically, only when the reason for contact is classified as a 'Receive a child/young person concern' (until 19/12/17) or 'CYP Concern/Prenatal Concern' (since 20/12/17) will the CWU appraise and document the harm type/s relevant to the concern/s.

Appendix F VAN service Events and Clients

VAN services

This appendix presents the number of service events and individual clients for VAN services from 2016/17 to 2020/21 in table form (Table 26, Table 27).

Table 26 | Number of service events by service type between 2016/17 and 2020/21

Service Type	Number of Service Events				
	2016/17	2017/18	2018/19	2019/20	2020/21
Sexual Assault Services	40,952	46,840	49,017	52,835	56,023
Number of services	*n = 51*	*n = 55*	*n = 52*	*n = 55*	*n = 56*
Child Protection Counselling Services	23,245	22,560	24,579	22,406	21,036
Number of services	*n = 44*	*n = 41*	*n = 41*	*n = 41*	*n = 40*
Joint Child Protection Response Program	1,862	5,739	6,497	6,451	8,259
Number of services	*n = 15*	*n = 16*	*n = 18*	*n = 21*	*n = 23*
Child Protection Unit/Service	1,096	3,621	5,520	6,208	8,633
Number of services	*n = 1*	*n = 3*	*n = 3*	*n = 3*	*n = 3*
Integrated Domestic Violence and Sexual Assault Services	5,878	5,643	5,104	8,313	9,670
Number of services	*n = 3*	*n = 3*	*n = 3*	*n = 3*	*n = 3*
Domestic Violence Services	5,657	4,258	5,797	9,362	11,932
Number of services	*n = 4*	*n = 11*	*n = 14*	*n = 23*	*n = 26*
New Street Services	944	2260	1302	2452	5193
Number of services	*n = 3*	*n = 3*	*n = 3*	*n = 9*	*n = 11*
Aboriginal Domestic and Family Violence	-	40	-	4	21
Number of services	*n = 0*	*n = 1*	*n = 0*	*n = 2*	*n = 1*
Total	**79,634**	**90,961**	**97,816**	**108,031**	**120,767**

Source: Non-Admitted Patient Data, 2016-2021[72]

[72] Client/Service event values of <5 or <10 were suppressed in the extracted dataset to mitigate potential identifiability. These values were recoded based on a predictive imputation model, see detail: freerangestats.info/blog/2018/11/06/suppressed-data

Table 27 | Number of clients by service type between 2016/17 and 2020/21

Service Type	Number of Clients				
	2016/17	2017/18	2018/19	2019/20	2020/21
Sexual Assault Services	4,616	5,850	5,741	6,441	7,576
Number of services	*n = 51*	*n = 55*	*n = 52*	*n = 55*	*n = 56*
Child Protection Counselling Services	2,947	2,922	2,924	2,706	2,307
Number of services	*n = 44*	*n = 41*	*n = 41*	*n = 41*	*n = 40*
Joint Child Protection Response Program	934	2,130	2,311	2,720	3,269
Number of services	*n = 15*	*n = 16*	*n = 18*	*n = 21*	*n = 23*
Child Protection Unit/Service	286	834	1,216	1,500	2,163
Number of services	*n = 1*	*n = 3*	*n = 3*	*n = 3*	*n = 3*
Integrated Domestic Violence and Sexual Assault Services	1,094	1,002	975	1,278	1,371
Number of services	*n = 3*	*n = 3*	*n = 3*	*n = 3*	*n = 3*
Domestic Violence Services	537	791	1,039	2,070	2,211
Number of services	*n = 4*	*n = 11*	*n = 14*	*n = 23*	*n = 26*
New Street Services	155	232	211	300	444
Number of services	*n = 3*	*n = 3*	*n = 3*	*n = 9*	*n = 11*
Aboriginal Domestic and Family Violence	-	12	-	6	10
Number of services	*n = 0*	*n = 1*	*n = 0*	*n = 2*	*n = 1*
Total	**10,569**	**13,773**	**14,417**	**17,021**	**19,351**

Source: Non-Admitted Patient Data, 2016-2021[73]

[73] Client/Service event values of <5 or <10 were suppressed in the extracted dataset to mitigate potential identifiability. These values were recoded based on a predictive imputation model, see detail: freerangestats.info/blog/2018/11/06/suppressed-data

Appendix G Additional detail on progress against each objective

This appendix provides additional detail on progress made against each of the IPARVAN Framework objectives. It draws on qualitative and quantitative data sources to provide:

- An overall assessment of progress against the strategic priorities.
- Key areas of progress across the four objectives
- Progress against the IPARVAN Framework Making it Happen indicators.

Progress made by the NSW Ministry of Health

As the system steward, the IPARVAN Framework requires the NSW Ministry of Health to develop the policies, protocols, guidance and frameworks necessary to support system-wide implementation of the IPARVAN Framework.

Table 28 presents additional detail regarding the progress made by the NSW Ministry of Health between November 2020 and June 2022. Note that implementation progress was significantly hindered by the COVID-19 pandemic and ongoing resource constraints.

Table 28 | Progress made by the NSW Ministry of Health between November 2020 and June 2022

Progress made by the NSW Ministry of Health between November 2020 and June 2022

• Continued to provide overall direction and management of the VAN Redesign Program.
• Convened and managed state-wide governance meetings for VAN managers and clinicians. The effectiveness of governance meetings was reviewed, and approaches were updated as appropriate.
• Development of a quarterly VAN Performance Dashboard to help Districts/SCHN monitor how they are tracking against VAN-related KPIs and improvement measures in their service agreements.
• Continued work to develop system-level policies, processes and guidance. These include:
  • Completed NSW Problematic and Harmful Sexual Behaviours Framework and Evaluation Strategy.
  • Completed Integrated Trauma Informed Care Framework.
  • Commenced development of the NSW Health Child Safe Action Plan in accordance with recent amendments to the *Children's Guardian Act 2019*
• Supported District/SCHN to deliver culturally safe services including:
  • Assessed Sexual Assault Services Aboriginal Action Plans (AAPs) and Safe Wayz Implementation Plans (SWIPs) developed by Districts in 2021, with input from an Aboriginal Expert Group. Districts received readiness funding to assist in the development of the plans.
  • Finalised workforce enhancements for new SAS Aboriginal Counsellor and Safe Wayz roles, with funding linked to ongoing work on implementation of AAPs and SWIPs
  • Developed a range of tailored recruitment resources in consultation with the Aboriginal Expert Group to assist Districts with the recruitment of new roles.

    - Developed a Cultural Safety Toolkit and Roadmap as resources for Districts.
- In the process of implementing a range of funding initiatives to expand VAN service delivery in the context of implementing the NSW Government's response to the Royal Commission into Institutional Responses to Child Sexual Abuse. These include:
    - State-wide enhancement of the NSW Health Sexual Assault Service (SAS) Aboriginal workforce.
    - Expansion of New Street services for children 10 to 17 years with problematic and harmful sexual behaviours (PHSB).
- Supported implementation of a range of additional VAN services across the state. These include Safe Wayz and new service approaches for adult survivors of child sexual abuse in South East Sydney and Mid North Coast LHDs.
- Limited progress on improving the recognition of violence, abuse and neglect as a serious public health issue and ensuring it is profiled in key reports. This may be considered for Phase 2 implementation.

Objective 1 | Activities to establish governance arrangements, buy-in from senior leaders and clear reporting structures was an area of focus for LHDs/SCHNs.

LHD/SCHN Executives, VAN services managers and staff reported that objective 1 was a key focus area of the early phase of implementation. This is reflected in the quantitative data – the average SAT score across all LHDs/SCHNs was higher for objective 1 (3.5 in 2020/21), than the other objectives. Table 29 provides an overview of progress made against the strategic priorities of Objective 1.

Table 29 | Assessment of average progress against IPARVAN Framework objective 1 strategic priorities for SAT scores between 2018/19 and 2020/21, and provider survey scores between 2020 and 2022

Strategic priority for each objective	Assessment of progress across all Districts/Networks	Average change in scores from baseline to current (SAT / PS: 1 2 3 4 5)	Overall change
Leadership drives health system reform and service improvement	• Good progress was made against this priority. VAN service managers tended to be strongly advocating for change in their LHDs/SCHN. Senior executives were also advocating for implementation of the IPARVAN Framework. • Some LHDs/SCHN reported that greater buy-in was needed from Executives to provide the authorising environment to support ongoing implementation.	SAT: 2.2 → 3.6 PS: 3.8 | 3.8	+1.4 -0.06
Robust system for monitoring service improvement	• Activities to implement this strategic priority included the establishment of better data collection methods through VAN forms. • Few LHDs/SCHN reported good progress in using data to inform service planning. • Work is still needed to progress against this priority given the limited availability of client outcomes data.	SAT: 1.9 → 3.9 PS: 3.9 → 4.0	+2 +0.10
Strong governance	• Ten LHDs/SCHN reported activities to enhance governance arrangements to support collaboration between VAN services, and between VAN services and non-VAN health services. • Nine LHDs/SCHN also reported the development of new policies and procedures or service agreements to formalise referral pathways and to provide guidance to NSW Health workers on appropriate responses to violence, abuse and neglect.	SAT: 2.2 → 3.4 PS: 3.6 | 3.8	+1.2 +0.14

*Baseline set as: 2019/19 SAT responses from District/Network Senior Managers and 2020 PS responses from VAN service managers. Current set as: 2020/21 SAT responses from District/Network Senior Managers and 2022 PS responses from VAN service managers.

District/Network areas of focus within objective 1 include:

1. **Implementing structural changes.** All Districts/SCHN reporting reviewing and reorganising organisational structures to support better collaboration between VAN services, and between VAN services and broader health services. Districts and SCHN also reported reviewing where VAN services sat within overarching governance structures, in order to position them organisationally to support implementation.

   There were no trends regarding where Districts/SCHN placed VAN services within the organisational structure. Some placed VAN services within community health, some within allied health, and some within acute/hospital streams.

2. **Implementing new governance arrangements**. SAT responses highlighted activities across all Districts/SCHN to establish governance mechanisms such as VAN steering committees or working groups to oversee the implementation of the IPARVAN Framework.

> "Being part of acute care means we have the authority to go into ED and speak to those clinicians"
>
> *VAN services staff*

> "It's good being aligned with allied health, it builds good connections and relationships with social work"
>
> *VAN services staff*

3. **Developing formal reporting processes to Executives and broader health service staff.** The intention of these reporting processes was to build awareness of the IPARVAN Framework at the Executive level and generate momentum for change. Some Districts/SCHN reported incorporating VAN indicators in Board reports.

4. **Developing formal plans and strategies to implement the IPARVAN Framework.** Some Districts/SCHN indicated that VAN services developed IPARVAN service planning strategies to provide guidance on implementation.

Challenges related to implementation under objective 1 included:

- **Recruiting District/SCHN Executives and VAN service managers**. While efforts were made to recruit senior leaders, some LHDs/SCHN reported that there were ongoing recruitment difficulties and vacancies.
- **Delays to implementing structural changes.** Districts/SCHN experiencing such delays tended to attribute this to resistance from other parts within the District/Network.

Over half of Districts/SCHN have reported improved data collection methods through the use of new VAN forms. One District/SCHN reported that this has enabled them to better capture data in real time. Some Districts/SCHN have also implemented staff training to support capturing the required data. It is not clear the extent to which these recent changes have contributed to capturing better outcomes-based data, although enhanced activity-based data may support service planning.

Table 30, Figure 20 and Figure 21 provide additional detail on progress made against objective 1 Making It Happen indicators.

Table 30 | Assessment of progress against Making it Happen Indicators for IPARVAN objective 1

Making it Happen indicator	Assessment of progress between 2018/19 and 2020/21
Encouraging Executives to champion integration, and clinical leadership lead change	• VAN leaders strongly advocate for integration within their district, but there are ongoing difficulties in some Districts/SCHN with buy-in amongst more senior leaders in non-VAN services. Districts/SCHN noted that where there is a good Chief Executive and Executive buy-in, this supports greater incorporation of VAN services in service and business planning for the District/SCHN. • Since 2020, there has been some further progress in recruiting full-time clinical leaders across VAN services. Some Districts/SCHN continue to find recruitment challenging due to the availability of suitably skilled clinicians their local area.
Developing streamlined governance, accountability and reporting mechanisms	• Some Districts/SCHN have successfully implemented a centralised VAN unit which reports to a coordinator/manager. In these Districts/SCHN, this has helped to create clear reporting lines and escalation pathways. Other Districts/SCHN continue to have a de-centralised structure, or have intentions to implement a central VAN services structure, but have not implemented this yet due to time constrains or industrial relations issues. • Work has progressed across most Districts/SCHN to develop and implement policies and procedures to support more formalised arrangements for escalation and referral pathways. However Districts/SCHN noted that not all policies and procedures have been developed and implemented, leading to implementation delays.
Formalising governance arrangements where service provision crosses organisational boundaries	• There has been some good progression in further establishing formal arrangements between Districts/SCHN including across LHD boundaries or with services that provide support to clients in multiple Districts/SCHN. The number of formal arrangements between Districts/SCHN and New Street Services increased from 3 in 2018-19 to 5 in 2020-21. Additionally, more Districts/SCHN appear to have formal arrangements with JCPRP, and neighbouring Districts/SCHN. • Some Districts/SCHN have identified that further work is needed to establish formal arrangements with forensic and medical responses, pathways to respond to children with sexually harmful behaviours, and sexual assault services. • 4 Districts reported the development of service agreements or memorandums of understanding (MOU) (an additional 2 since 2018-19) with SCHN.
Ensuring clinical governance processes for quality and safety address VAN	• Districts/SCHN overall scores for the implementation of clinical governance processes increased significantly over last two years from 2.9 in 2019-20 to 3.6 in 2020-21. However, the reasons for this increase are not evident in qualitative SAT responses.

Evaluating local investment in services	• Overall, Districts/SCHN SAT scores against data collection and reporting requirements have increased substantially from 2.6 in 2018-19 to 3.7 in 2020-21. • Over half of Districts/SCHN have reported improved data collection methods through the use of new VAN forms. One District/SCHN reported that this has enabled them to better capture data in real time. Some Districts/SCHN have also implemented staff training to support capturing the required data. It is not clear the extent to which these recent changes have contributed to capturing better outcomes-based data, although enhanced activity-based data may support service planning.

Figure 20 | Average Self-Assessment Scores for progress towards Making it Happen indicators for IPARVAN Objective 1: Strengthen leadership, governance and accountability between 2018/19 and 2020/21

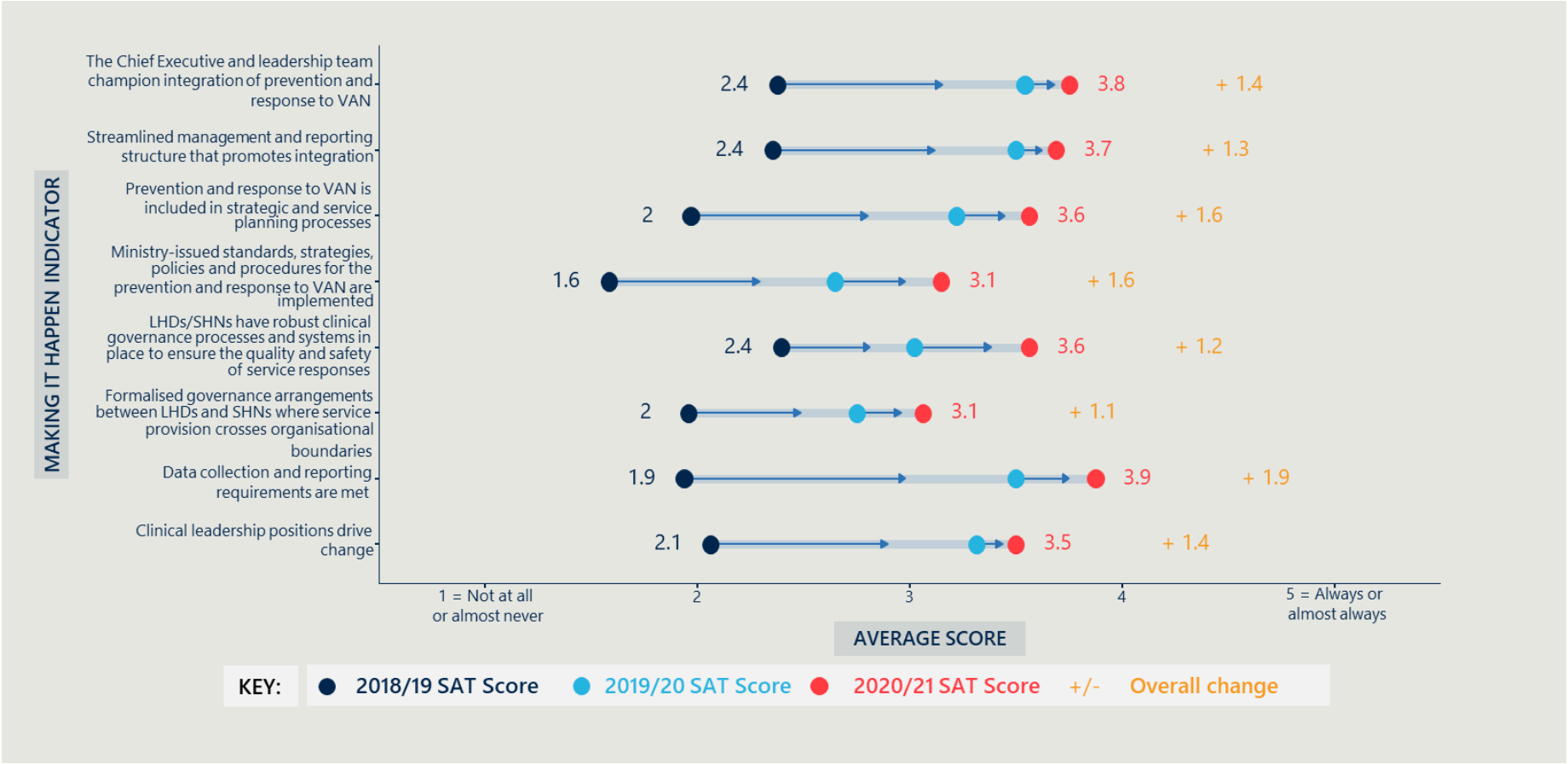
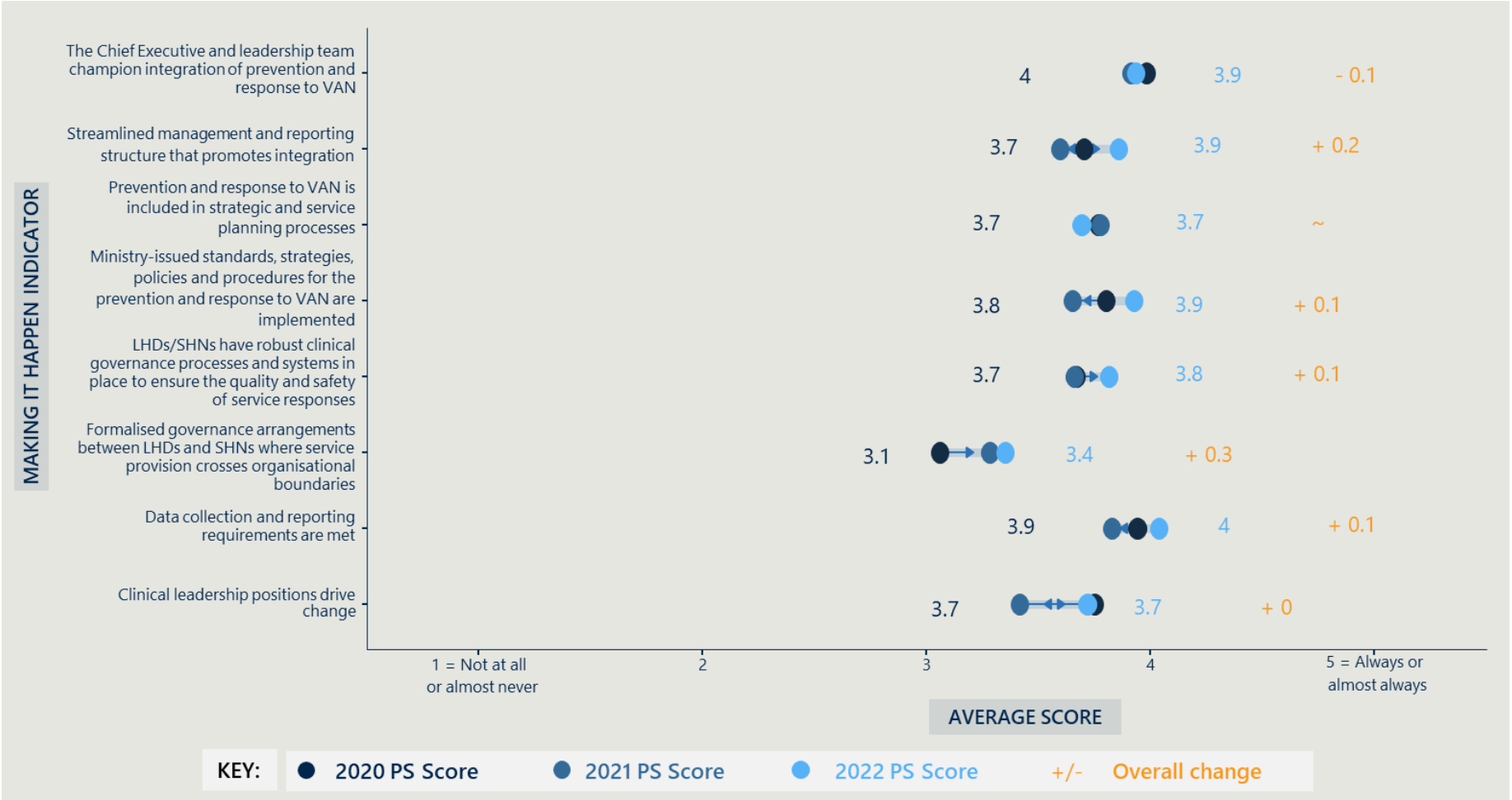


Figure 21 | Average Provider Survey Scores for progress towards Making it Happen indicators for IPARVAN Objective 1: Strengthen leadership, governance and accountability between 2020 and 2022



Objective 2 | Ongoing development of the broader health workforce's skills, confidence and capabilities was an area of focus over the evaluation period

The Interim Progress Report found that Districts/SCHN had made good progress to build the confidence and capability of VAN services staff, with less focus on the broader NSW Health workforce.

Interviews, focus groups and site visits completed in 2021 and 2022 indicated that some Districts/SCHN had begun to shift efforts towards providing education opportunities to broader health service staff as implementation progressed. Table 31 provides an overview of progress for objective 2

Table 31 | Assessment of average progress against IPARVAN Framework objective 2 strategic priorities for SAT scores between 2018/19 and 2020/21, and provider survey scores between 2020 and 2022

Strategic priority for each objective	Assessment of progress across all Districts/Networks	Average change in scores from baseline to current*	Overall change
Education, training and professional development to equip Health workers with the right knowledge, skills, aptitudes and values	• Ten LHDs/SCHN reported that VAN staff receive formal and mandatory training opportunities. Quantitative data suggests that limited progression was made against this strategic priority between 2019/20 and 2020/21 with an increase of +0.1. • VAN service managers and staff reflected in focus groups and during site visits that the COVID -19 pandemic impeded health workers' ability to access training, as face -to-face training was no longer available, and workloads were higher. Nine LHDs/SCHN reported that staff were able to access virtual training opportunities to improve accessibility and completion rates. • Six LHDs/SCHN reported that they had made certain training courses mandatory for some non -VAN health workers, such as Emergency Department and mental health workers. • Eleven LHDs/SCHN reported that VAN staff provide ad -hoc and informal training and support to non -VAN health workers, including acting in an advisory or consultative role.	SAT: 2.4 → 3.0 PS: 4.0 | 4.2	+0.6 +0.21
Health workers receive appropriate supervision and support	• VAN service staff had access to formal and informal clinical supervision arrangements. • Many LHDs/SCHNs shared concerns with the ongoing availability of appropriate clinical supervision to non -VAN staff – particularly those who are often in contact with clients of VAN services and/or people who have experienced violence, abuse and neglect. • SAT responses suggested that limited funding and time constraints prohibited non-VAN staff from accessing these supports.	SAT: 2.4 → 3.6 PS: 4.2 | 4.3	+1.2 +0.16

Increase the workforce to meet demand	• While there was some success with increasing the workforce for some LHDs/SCHN through the recruitment of VAN service staff, increasing workforce to meet demand continues to be a challenge for almost all LHDs/SCHN.
	  • Recruitment and retention of Aboriginal staff in VAN services is particularly difficult. LHD/SCHN Executives and VAN service managers and staff indicated that it remained a challenge to recruit Aboriginal people with the right capabilities to fill Aboriginal-identified roles.
	  • Aboriginal staff members highlighted experiences of institutional racism, perceived lack of support, and perceived lack of acknowledgement of their skills and expertise as key barriers to recruitment and retention into Aboriginal -identified roles.
	• Regional, rural and remote LHDs reported specific challenges with recruiting VAN staff. These include the perception that staff may be isolated in smaller facilities, may have less access to clinical supervision, and may need to travel long distances as part of their role.
	• Two metropolitan LHDs anecdotally reported that it was difficult for the workforce to meet demand due to significant population growth across their district.
		SAT: 2.5 → 3.0
		PS: 3.0 | 3.0
			+0.5
			-0.02

*Baseline set as: 2019/19 SAT responses from District/Network Senior Managers and 2020 PS responses from VAN service managers. Current set as: 2020/21 SAT responses from District/Network Senior Managers and 2022 PS responses from VAN service managers.

Key activities within objective 2 included:

- **Supporting workforce planning and the availability of formal education programs.** The Ministry and ECAV were important contributors to developing the broader health workforce's skills and capabilities in the early stages of implementation. For example, the Ministry developed a draft workforce development strategy to understand key workforce gaps and to identify education, training and professional development needs. ECAV and HETI developed a number of training programs related to the IPARVAN Framework. These efforts slowed considerably and, in some instances, ceased entirely in 2020/2021
- **Providing VAN Redesign Program funding to recruit skilled clinicians and expand services.** VAN Redesign Program funding aimed to support the recruitment of skilled clinicians who could appropriately respond to violence, abuse and neglect. SAT responses indicated that some Districts/SCHN were able to successfully recruit permanent staff to fully support service delivery, whilst this remained a challenge in others – particularly those in regional, rural and remote areas.

There were a number of initiatives that were commonly reported across most Districts/SCHN, including:

- **Increasing VAN staff awareness of learning and training opportunities.** Responses from the SAT and interviews with District/SCHN Executives indicated that some Districts/SCHN were posting VAN-related training opportunities on their intranet pages to increase awareness. Other Districts/SCHN undertook a targeted training approach, directly approached specific health workers they believed would benefit from training.

> "The requests are coming in thick and fast for the VAN teams to provide clinical supervision to our non-VAN partners in health."
>
> *LHD/SCHN Executive*

- Providing more opportunities for broader health service staff to build their skills. District/SCHN Executives reported that non-VAN staff were beginning to receive greater opportunities to build their skills; both through formal education and informal training, including training delivered by VAN services staff.
- Providing access to appropriate clinical supervision. SAT responses indicated that VAN services staff across Districts/SCHN had access to formal and informal clinical supervision arrangements. This included access to external clinical supervision support, and group supervision sessions. Districts/SCHN identified a need to provide better clinical support broader health service staff who provide a response to people experiencing violence, abuse and neglect.
- Implementing mandatory training requirements. SAT responses indicated that some Districts/SCHN have begun to mandate VAN-related training for broader health service staff.

Ongoing progression of objective 2 slowed throughout the evaluation period, aligned with trends across other strategic objectives. VAN services managers and staff attributed this to the impact of COVID-19, which limited opportunities for in-person training and placed significant pressure on clinical workers.

Importantly, whilst COVID-19 created difficulties for staff to access in-person training and education, some Districts/SCHN highlighted the opportunities provided by the rapid shift to virtual learning. Virtual learning made opportunities more accessible for many staff, particularly those in regional, rural and remote LHDs who no longer had to travel long distances to attend training.

> "COVID has been exciting for education – our staff can upskill from home rather than travelling to Sydney. We just have to make sure we give them the time and private space to learn effectively"
>
> *LHD/SCHN Executive*

Case Study – COVID-19 creating new opportunities to make training and education more accessible to staff

During the COVID-19 pandemic, staff were unable to access training that was traditionally delivered face to face. One regional, rural and remote LHD responded to this issue by developing virtual training modules. Given the sensitive subject matter and risk of vicarious trauma for participants, the LHD thought carefully about how best provide training. The LHD adapted the training sessions by decreasing their length and delivering sessions to a smaller group of people. The LHD reported that these adaptations worked well to ensure that staff continued to have access to training during the COVID-19 pandemic.

There was limited progress of some activities under objective 2, including:

- **Developing a trauma informed workforce action plan.** This is to be expected given that Districts/SCHN were waiting on formal guidance from the Ministry.
- **Establishing formal processes to manage vicarious trauma**. There was very limited evidence that reflected efforts to formally manage the risk of vicarious trauma. SAT responses reflected that eight Districts/SCHN did not have a formal policy or action plan in place to manage vicarious trauma.

Table 32, Figure 22 and Figure 23 provide additional detail on progress made against objective 2 Making It Happen indicators.

Table 32 | Assessment of progress against Making it Happen Indicators for IPARVAN objective 2

Making it Happen indicator	Assessment of progress between 2018/19 and 2020/21
Ensuring there is an effective and diverse workforce to meet community needs	• Districts and SCHN reported ongoing difficulties in relation to recruiting clinical staff to support local needs and demand for services. Metropolitan Districts reported that large population growth has created difficulties in ensuring that the workforce meets local demand. • Regional Districts indicated that challenges continue to exist with recruiting specialist staff across a large geographical area. It was common for these Districts to note that forensic positions were hard to fill in their areas. • Some Districts/SCHN have noted the successful recruitment of Aboriginal staff. However, as in previous cycles of the evaluation, most Districts/SCHN indicated that recruitment of Aboriginal staff continues to be a challenge, particularly for speciality roles like New Street. • A number of Districts/SCHN have reported using data to assess local needs to determine where to allocate resources going forward.
Ensuring VAN staff have appropriate clinical supervision	• District/SCHN overall scores for VAN staff access to appropriate clinical supervision showed a very minimal increase from 3.4 in 2019-20 to 3.5 in 2020-21. Some Districts/SCHN highlighted challenges with implementing a consistent clinical supervision approach for all staff, concerns around non-VAN staff (who are in contact with VAN services) access to clinical supervision, and challenges with the availability of funding, impeding staff access to external clinical supervision arrangements. • As per previous the previous SAT responses, VAN staff across Districts/SCHN continue to access formal and informal clinical supervision arrangements. Activities include individual external clinical supervision arrangements and group supervision sessions.
Providing VAN staff with access to education, training and professional development	• As compared to previous SAT responses, there was a limited increase in Districts/SCHN scoring of VAN staff access to training. Many Districts/SCHN reported that the COVID-19 pandemic made it difficult for staff to access training programs that were traditionally face to face. Some Districts/SCHN also reported that the increased workload during COVID-19 impacted staff ability to find time to access training. • 3 Districts/SCHN reported difficulties with recruiting an educator position to support staff training.
Providing non-VAN staff with access to education, training and professional development	• Scores in this domain increased substantially from 2018-19. However, there was no movement in scores from 2019-20 to 2020-21. Some Districts/SCHN implemented formalised approaches for broader health service staff to access training such as mandatory training requirements. In other instances, Districts/SCHN reported that broader health service staff access to training continued to be informal and was provided on an ad-hoc basis.

	• Districts/SCHN also reported concerns about whether broader health service staff are accessing VAN training and professional development opportunities. Most Districts/SCHN highlighted that this may be attributed to either lack of awareness of VAN training available to broader health service staff, or de-prioritisation of VAN training amongst broader health service staff.
Encouraging VAN staff to support non-VAN staff identify and respond to VAN presentations	• Districts/SCHN reported that VAN staff continue to provide consultation and support to broader health service staff in their District/SCHN. For some Districts/SCHN, the provision of consultation services to broader health service staff has become more formalised over time; often these are through regular meetings between staff to discuss complex cases. • VAN staff training to broader health service staff continues to be relatively informal and ad-hoc. Some Districts/SCHN reported VAN staff will provide individual consultations or support during team meetings as requested by broader health service staff.

Figure 22 | Average Self-Assessment Scores for progress towards Making it Happen indicators for IPARVAN Objective 2: Enhance the skills, capabilities and confidence of the NSW Health workforce between 2018/19 and 2020/21

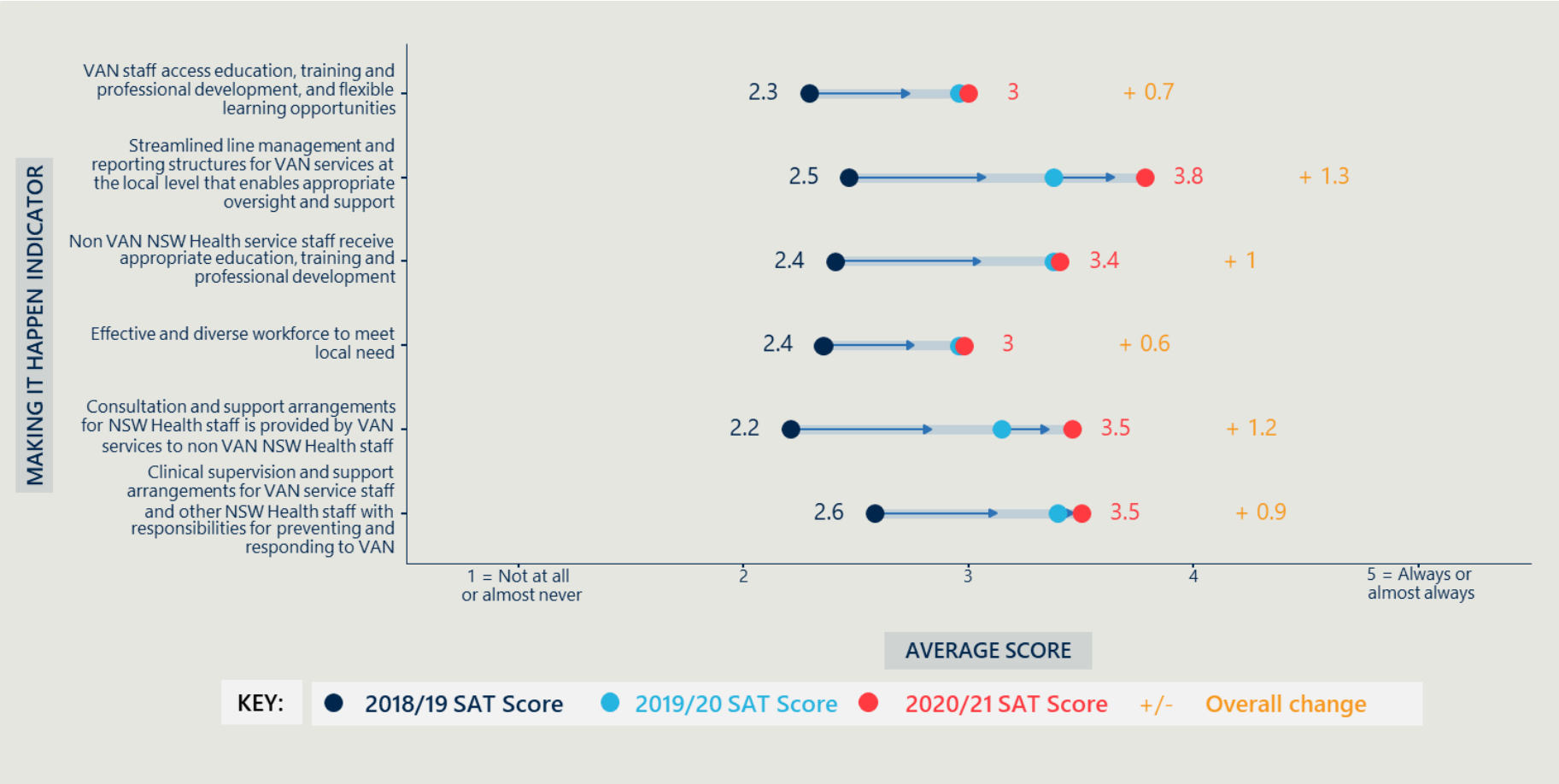
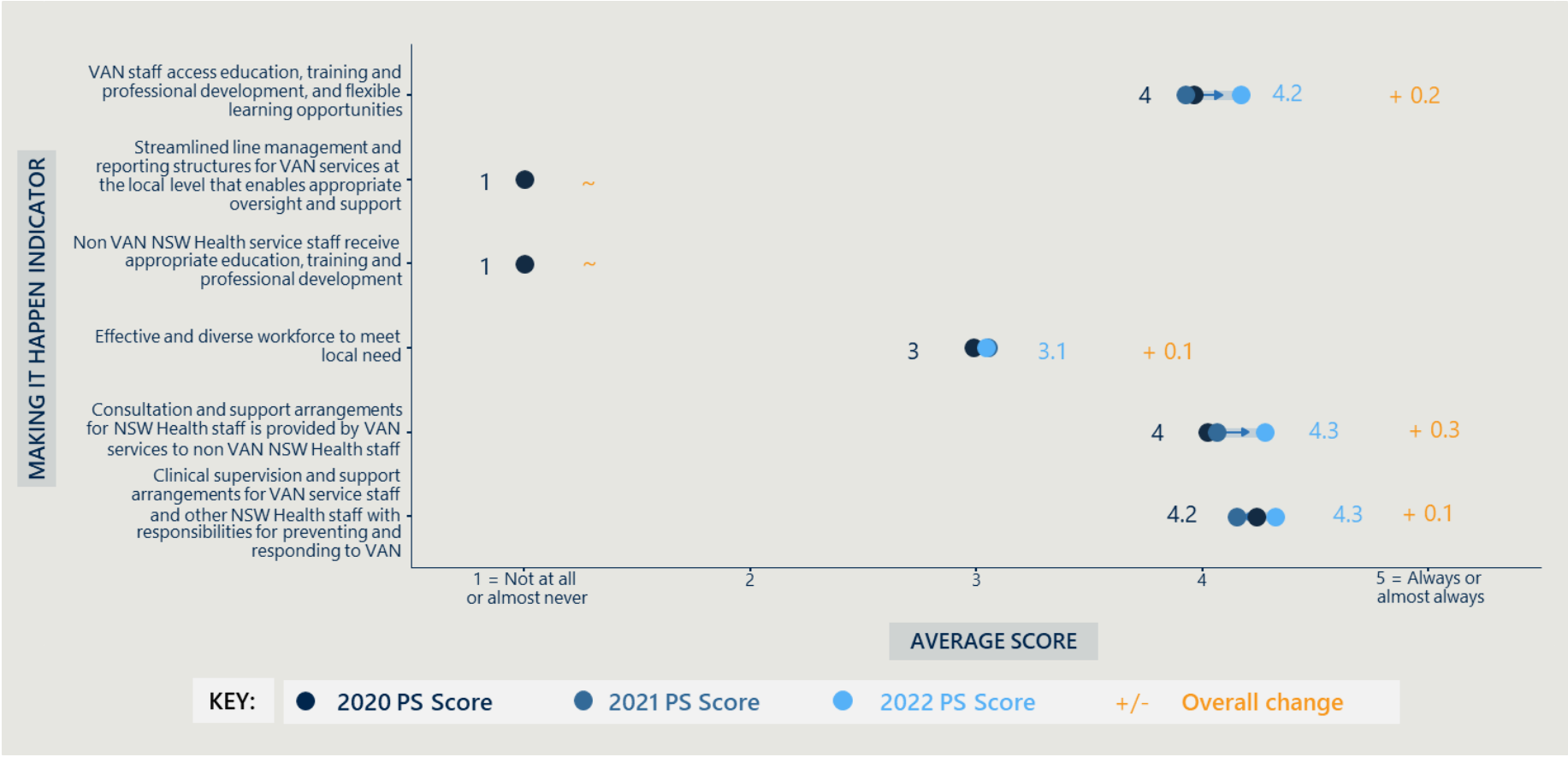


Figure 23 | Average Provider Survey Scores for progress towards Making it Happen indicators for IPARVAN Objective 2: Enhance the skills, capabilities and confidence of the NSW Health workforce between 2020 and 2022



Objective 3 | Less progress was made under objective 3. Some Districts/SCHN focused on building relationships and establishing new client management and intake models

Qualitative data suggests that less progress was made against objective 3, as compared to objectives 1 and 2. Table 33 provides an overview of progress made against the strategic priorities of objective 3.

Table 33 | Assessment of average progress against IPARVAN Framework objective 3 strategic priorities for SAT scores between 2018/19 and 2020/21, and provider survey scores between 2020 and 2022

Strategic priority under each objective	Assessment of progress across all Districts/Networks	Average change in scores from baseline to current (SAT 1 2 3 4 5 / PS 1 2 3 4 5)	Overall change
Enhancement and expansion of VAN services	• Expansion and enhancement of VAN services was a challenge for all LHDs/SCHN. • Ten LHDs/SCHN established 24-hour VAN services responses, though these responses did not respond to all forms of violence abuse neglect and were not available in all locations of the District or the Network. • LHDs/SCHN appeared to focus on implementing 24-hour responses for clients who experienced sexual assault or domestic and family violence.	SAT: 2.2 → 3.0 PS: 3.1 – 3.1	+0.8 +0.02
Integrated VAN service models	• Almost all LHDs/SCHN reported that VAN staff are guided by a common vision and have a culture of respectful, trauma informed care. Some LHDs have also worked to co-locate VAN services. • Six LHDs/SCHN reported the implementation of client intake models (e.g. no wrong door and central intake models) to better integrate VAN services. One LHD/SCHN had implemented a centralised intake model that incorporated VAN services and other community health services. • LHDs/SCHN compliance with the VAN Service Standards varied. Some LHDs reported in the SAT they made active efforts to comply with the Standards. Two LHDs reported that they were yet start implementing activity to comply with the Standards.	SAT: 2.5 → 3.5 PS: 3.4 | 3.4	+1.0 +0.02
VAN services improve the patient journey and empower people and families to be partners in their care	• There was limited evidence to suggest that much progress was made to implement this strategic priority. • Further work is needed across all LHDs/SCHN to develop strategies to involve consumers and to develop patient journey maps. There was limited evidence of involving the consumer through administering surveys to clients to seek data on their experience.	SAT: 2.0 | 2.7 → PS: 2.9 → 3.0	+0.7 +0.18
VAN services quality improvement, consistency and reducing clinical variation across NSW	• All LHDs/SCHN were undertaking initiatives to improve VAN services that were appropriate for their context. • Eleven LHDs/SCHN reported activities to quality assure VAN services. These included audits of clinical documentation, conducting quality and safety meetings and undertaking evaluations of service initiatives.	SAT: 1.7 → 3.2 PS: 3.5 – 3.5	+1.5 +0.18

*Baseline set as: 2019/19 SAT responses from District/Network Senior Managers and 2020 PS responses from VAN service managers. Current set as: 2020/21 SAT responses from District/Network Senior Managers and 2022 PS responses from VAN service managers.

SAT responses, consultations with District/SCHN Executives, and consultations with VAN services managers and staff highlighted some cross-cutting areas were Districts/SCHN tended to focus their efforts under strategic objective 3, including:

- **Developing a written vision and principles for VAN services.** Almost all Districts/SCHN reported a documented common vision and principles for VAN services to guide their work. They included the requirement to practice respect, confidentially, privacy and safety with clients.
- **Building relationships within and across VAN services.** Many Districts/SCHN reported running VAN service planning days, where staff had the opportunity to meet and build relationships with colleagues. These served to build and strengthen connections between VAN services, including developing a culture of 'one VAN'.
- **Formalising and documenting referral pathways.** SAT responses indicate that almost all Districts/SCHN began establishing written service-level agreements or referral pathway procedures to formalise working relationships between VAN services, and in some instances between VAN services and other NSW Health services. Some Districts/SCHN identified that further work is needed to establish formal arrangements with forensic and medical responses, pathways to respond to children with problematic and harmful sexual behaviours, and sexual assault services.
- **Implementing integrated client intake models**. Some Districts/SCHN reported the development of new client intake models to facilitate better integration between VAN services. These intake models varied between Districts/SCHN, with each developing a model that met their local context. For example:
    - One District/SCHN implemented a central intake team for all VAN services clients. The intake team assesses client needs and refers them to the VAN service that will best meet their needs.
    - Other Districts/SCHN developed a 'no wrong door' intake process for clients with complex needs – clients could enter the system through any service, with staff from different VAN services coming together to discuss client needs and determine appropriate services.
- **Facilitating case coordination meetings.** Almost all Districts/SCHN had established or reinforced the establishment of case coordination meetings that aim to ensure that VAN services and other services (where appropriate) provide holistic, wrap around care to clients.
- **Co-locating VAN services.** SAT responses indicated that some Districts/SCHN had made some efforts to co-locate VAN services.

The evaluation identified a number of activities where progress was variable across Districts/SCHN, including:

- **Expanding services to provide a 24-hour crisis response.** Ten Districts/SCHN reported on the availability of 24-hour response. No Districts/SCHN reported the availability of 24-hour response for all people who are experiencing violence, abuse and neglect. Rather, Districts/SCHN appear to have focused their initial efforts on specific presentations, for example, domestic violence or sexual assault.

> "No centralised repository of PARVAN quality improvement initiatives, or a coordinated, planned approach".
>
> *LHD/SCHN SAT response*

- **Progressing service improvement and quality assurance activities.** Eleven Districts/SCHN reported evaluation, service improvement and quality assurance activities, although these were often ad-hoc and informal. Districts/SCHN noted that their engagement in these activities was hampered by a lack of high-quality data.

Case Study – Integrating and coordinating VAN services through formal and informal activities

One metropolitan District made good progress integrating and coordinating VAN services through a combination of formal and informal activities. Formal arrangements exist through the establishment of service level agreements and regular meetings (e.g., sexual assault and forensic medical unit clinical governance meetings). VAN services staff also have the opportunities to collaborate with fellow colleagues informally, when needed.

Table 34, Figure 24, and Figure 25 provide additional detail on progress made against objective 3 Making It Happen indicator

Table 34 | Assessment of progress against Making it Happen Indicators for IPARVAN objective 3

Making it Happen indicator	Assessment of progress between 2018/19 and 2020/21
Developing and implementing a local, integrated VAN service delivery model	• Some Districts/SCHN have developed regular communication channels to support better understanding of the availability of VAN services through VAN Newsletters, formalised meetings between VAN managers, and the development of working groups and steering committees to implement the IPARVAN Framework. • Almost all Districts/SCHN have reported that staff are guided by a common vision and goals and have a culture of respect, trauma-informed care, and communicate with a common language in mind. To facilitate better integration between VAN services, one District/SCHN has implemented a central intake team so that clients access a 'no-wrong door' into its VAN services. Some Districts/SCHN reported the application of a 'no wrong door' referral process for clients with complex needs– staff from different VAN services meet together to determine the best pathway for these clients. 3 Districts/SCHN reported co-location of some, but not all of their VAN services.
Ensuring VAN Services are appropriately resourced	• There has been a small increase in District/SCHN scores in this domain between 3.2 in 2019-20 and 3.4 in 2020-21. However, Districts/SCHN reported continuing to experience difficulties with meetings resourcing requirements to deliver high quality services. Districts/SCHN reported that 24/7 services are not consistently available across different regions of the district. A number of Districts/SCHN consistently highlighted that child protection and DFV responses (particularly DV screening in the ED) were not readily available to clients.
Ensuring that processes are in place for compliance with standards and use of protocols	• Some Districts/SCHN are actively monitoring the implementation of VAN service standards and have identified where there are gaps in compliance with the VAN service standards. In some instances, Districts/SCHN have developed implementation plans to respond to identified gaps. • 2 Districts/SCHN are yet to commence implementation of the VAN Service Standards. 3 Districts/SCHN noted that they were awaiting feedback from the Ministry of Health on their policies and procedures before they could be implemented.
Engaging effectively with consumers, including through journey mapping	• Overall District/SCHN SAT scores on consumer engagement increased slightly from 2.3 in 2019-20 to 2.4 in 2020-21. • Further work is still needed across all Districts/SCHN to develop strategies to involve consumers in the implementation of the IPARVAN Framework. 3 Districts/SCHN reported administering surveys to clients to seek feedback on their service experience • Most Districts/SCHN reported limited progression of patient journey mapping since 2018-19. It is unclear why things have not progressed in this space, but lack of progress may be attributed to disruptions from COVID-19.

Undertaking local evaluations, quality assurance and service improvement activities	• District/SCHN scores on local evaluations, quality assurance and service improvements increased from 2.8 in 2019-20 to 3.3 in 2020-21. However, based on the SAT qualitative responses, is unclear which activities has enabled Districts/SCHN to progress against this domain, as SAT qualitative responses appear to be similar to previous years. • Districts/SCHN reported a number of initiatives were in place to ensure compliance with processes. This includes auditing clinical documentation, conducting quality and safety meetings and undertaking evaluations of service initiatives. Some Districts/SCHN noted that they seek staff feedback as part of their service improvement activities. • These themes are consistent with what was previously reported in the SAT.

Figure 24 | Average Self-Assessment Scores for progress towards Making it Happen indicators for IPARVAN Objective 3: Expand VAN services to ensure they are coordinated, integrated and comprehensive between 2017/18 and 2020/21

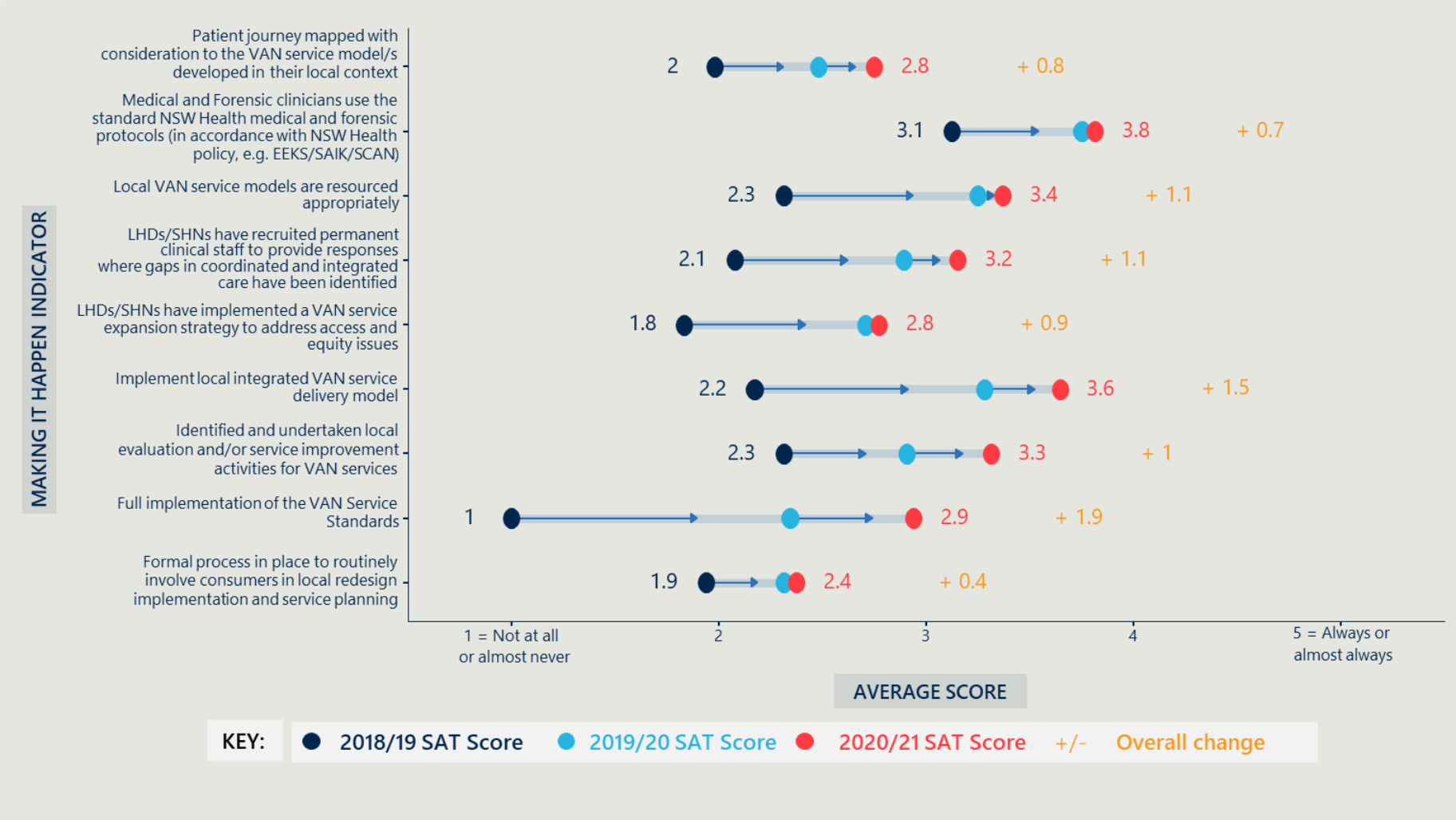
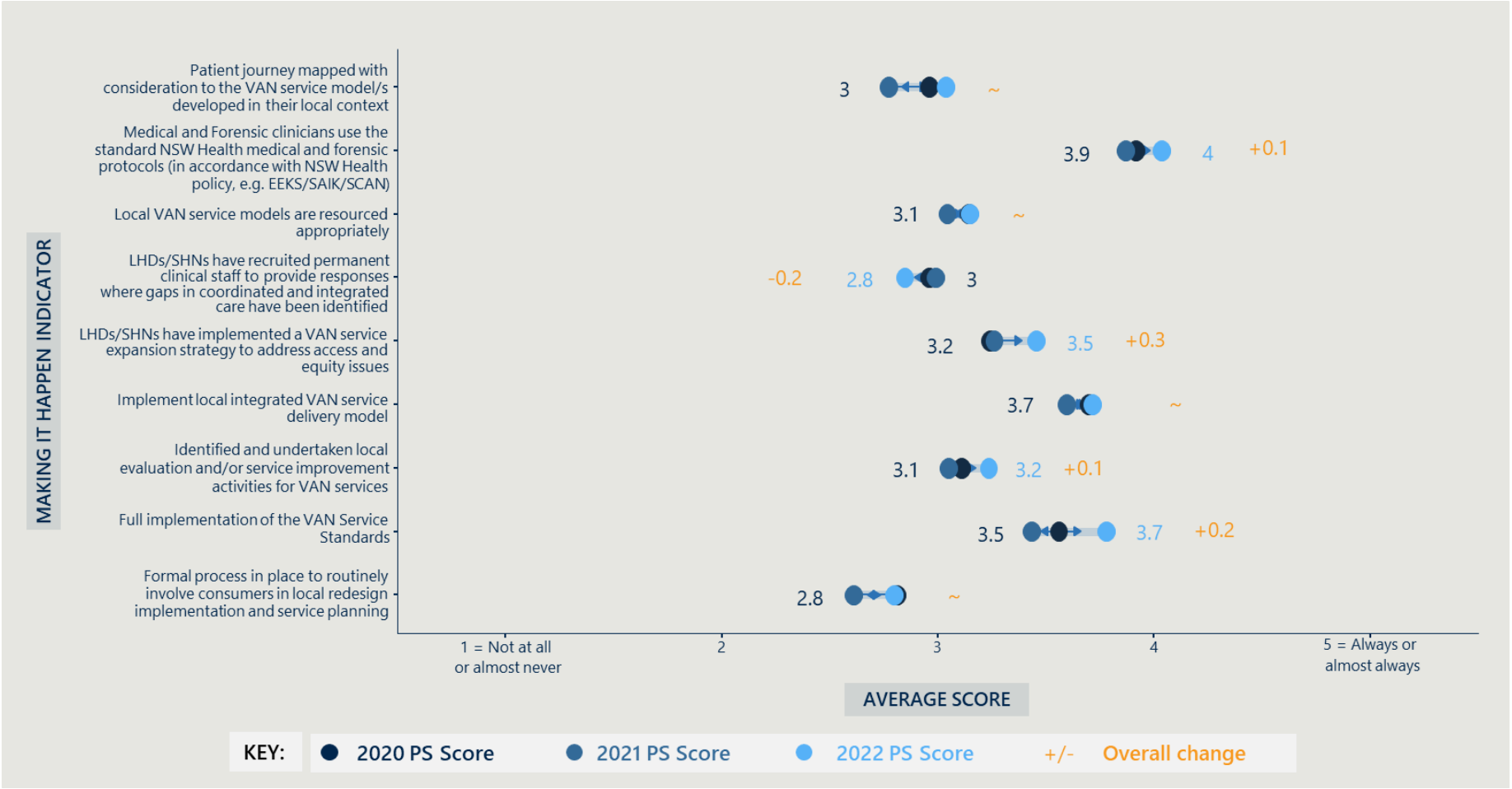


Figure 25 | Average Provider Survey Scores for progress towards Making it Happen indicators for IPARVAN Objective 3: Expand VAN services to ensure they are coordinated, integrated and comprehensive between 2020 and 2022



Objective 4 | The least progress was made under objective 4, however some Districts/SCHN undertook activities that supported better information sharing processes

There were some efforts to progress activities under strategic objective 4, although this was not an area of focus for two core reasons:

1. Many activities within objective 4 align with Phase 2 implementation.
2. Objective 4 is focused on integration beyond VAN services, which requires greater collaboration with other parts of the health system where VAN services have less ability to drive progress and influence change.

Table 35 provides an overview of progress made against the strategic priorities of Objective 4.

Table 35 | Assessment of average progress against IPARVAN Framework objective 4 strategic priorities for SAT scores between 2018/19 and 2020/21, and provider survey scores between 2020 and 2022

Strategic priority under each objective	Assessment of progress across all Districts/Networks	Average change in scores from baseline to current						
		SAT	1	2	3	4	5	Overall change
		PS	1	2	3	4	5	
Identification, response, referral and coordination	• Linkages between VAN services have progressed well with the establishment of standardised and documented referral pathways. • Collaboration and coordination between VAN services and other health and interagency services progressed through the development of informal relationships and attendance at interagency meetings. There was limited evidence of formal mechanisms to better link these services			2.5	3.3			+0.8
					3.9	4.0		+0.1
Integrated electronic clinical information systems	• Progress against this priority was bound by LHDs/SCHN interpretation of relevant legislation and Ministry policies. • VAN service staff reported interest in identifying ways to better share information with other health services but were cognisant of legislative requirements and the need to maintain privacy and confidentiality. This was particularly important in regional, rural and remote LHDs. • Good progress was made by some LHDs/SCHN to implement better information sharing processes through updated VAN forms.			2.8	3.4			+0.6
						4.1 | 4.2		+0.08
System improvement – trauma-informed care and child safe organisations	• All LHDs/SCHN acknowledged the importance of trauma-informed care, but there was very limited evidence available to show what activities were undertaken to implement trauma-informed care, outside of formal training opportunities. Progress against this strategic objective was hindered by delays from the Ministry in finalising and distributing the Trauma Informed Care Framework. • Efforts to ensure LHDs/SCHN are child safe was progressing. Over half of all LHDs/SCHN reported they have begun embedding Child Safe Standards in their districts.		1.6 | 1.9					+0.3
					3.5 | 3.6			+0.11

Key areas of progress under objective 4 include:

- **Building referral pathways between VAN and broader health services.** VAN services managers and staff reported efforts to build relationships with broader health services and non-health organisations. VAN services staff and managers in most Districts/SCHN noted challenges with creating partnerships with mental health and whole family teams units.
- **Enhancing sharing of client records between VAN services and broader health services.** All Districts/Network noted that it was important to balance access to information with respecting client privacy and confidentiality. This was particularly important in rural, regional and remote Districts.
- **Implementing child safe standards.** SAT responses indicated that some Districts/SCHN had not commenced implementation as they were still waiting for guidance from the Ministry. Other Districts/SCHN reported undertaking preparatory activities such as gap analyses to understand areas of their work that did not comply with the standards.
- **Participating in interagency meetings to coordinate responses to violence, abuse and neglect.** Districts/SCHN reported a number of activities which aimed to support coordinated responses to clients who were presenting to multiple services across health and non-health agencies. These meetings typically involved representatives from multiple services reviewing client files, assessing the client's risk, and determining opportunities to provide a seamless and coordinated response. These include Safety Action Meetings (SAMs), Safe Start, and Joint Child Protection and Response Program (JCPRP).

> I think its advantageous to know the vulnerabilities and difficulties for [a client]. It's part of thinking about how to manage that care, and how that trauma Is manifesting.
>
> *VAN services staff*

> "Information sharing is a big issue. VAN files sit on a different system and are locked down. It makes sense for client confidentiality, but the ability to share more patient information would improve patient experience and safety."
>
> *VAN services staff*

Districts and SCHN also reported attendance at a number of other interagency initiatives such as Making a Safer Home (MASH) and Safer Pathways.

The average SAT score against the strategic objective *involvement of staff from relevant health services in VAN interagency initiatives* dropped from 3.9 to 3.7 between 2019-20 and 2020-21. This drop may reflect some services not attending these meetings during the COVID-19 pandemic.

District/SCHN workers who provide a psychosocial response to people experiencing violence, abuse and neglect and VAN services staff reported that interagency meetings were often useful, but some raised concerns about the effectiveness of these meetings, including due to:

- Limited time spent on each case, as there were often a high number of cases to review in each meeting.
- Interagency meetings being attended by staff with limited authority, so actions were not being progressed.
- Limited formal processes in place to track attendance, meaning staff were not accountable for progressing key activities.

> "Need to revise governance arrangements to gauge the level of participation [for] health and non-health staff and how the arrangements support effective case coordination."
>
> *LHD/SCHN SAT response*

Table 36, Figure 26, and Figure 27provide additional detail on progress made against objective 4 Making It Happen indicators

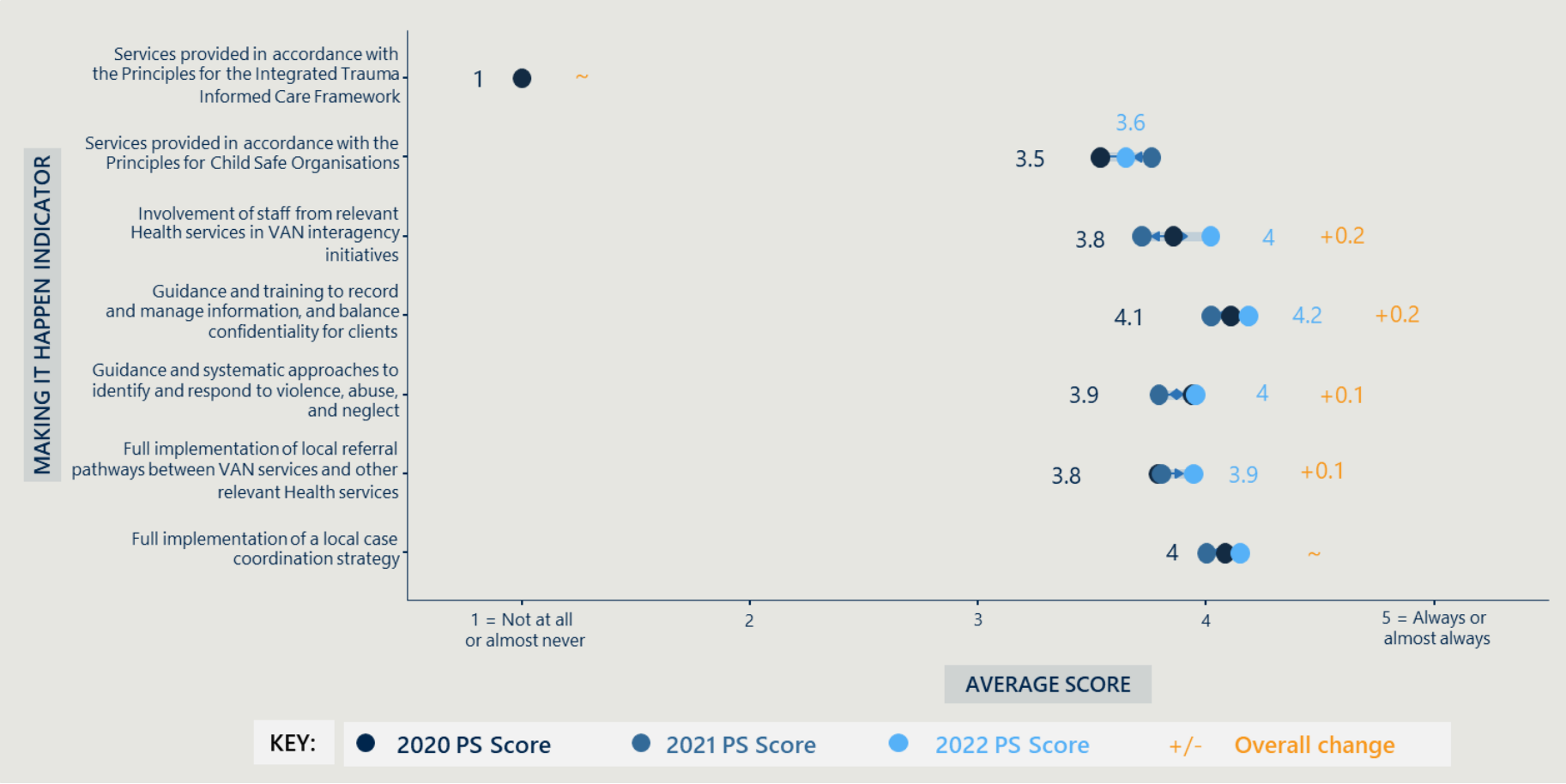
Table 36 | Assessment of progress against Making it Happen Indicators for IPARVAN objective 4

Making it Happen indicator	Assessment of progress between 2018/19 and 2020/21
Promoting and implementing the Integrated Trauma-Informed Care Framework and the Principles for Child Safe Organisations	• Further steps have been taken to implement the Child Safe Standards. Two Districts/SCHN reported undertaking a gap analysis to identify areas of further work needed to implement the Standards. Three other Districts/SCHN have reported that the standards have been fully embedded within their organisation. • While Districts/SCHN indicate that their model of care is underpinned by trauma-informed principles, this does not appear to be guided by the implementation of an overarching Framework. The Integrated Trauma Informed Care Framework was only recently released by the Ministry.
Supporting linkages between VAN Services and other health services including case coordination	• There has been further progress to support linkages between VAN services through the development of service protocols and procedures. At least half of Districts/SCHN reported that clear, standardised and documented referral pathways have been developed to support referrals between VAN services. • Districts/SCHN have had different experiences with effectively establishing linkages between VAN and non-VAN services. Some Districts/SCHN reported continued difficulties with establishing linkages with non-VAN staff, particularly with mental health and Emergency Department services. These Districts/SCHN attributed these difficulties to non-VAN staff having limited visibility of the available VAN services, the available pathways into VAN, or lack of buy-in to IPARVAN. Conversely, other Districts/SCHN reported that they had established very clear referral pathways between ED and VAN services.
Ensuring NSW Health is represented on relevant interagency committees	• District/SCHN scores in this domain decreased overall from 3.9 in 2019-20 to 3.7 in 2020-21. It is unclear why this may be the case as many Districts/SCHN reported their involvement in a number of interagency committees and meetings which include with JCPRP and Department of Communities and Justice (DCJ). • Three Districts/SCHN highlighted that it would be useful to have better visibility of which interagency meetings VAN services can be involved in. One Districts/SCHN indicated there was a lack of formal processes to track attendance at interagency meetings, which may impact on agency accountability to the meetings, and the progression of key actions.
Developing and implementing clinical systems to support information sharing whilst maintaining patient safety and confidentiality	• Districts/SCHN scores suggest limited progression in this domain since 2019-20 SAT. • A number of initiatives are in place to maintain patient safety and confidentiality such as training packages and guidance to document information in new forms. Most Districts/SCHN reported continuing to work within Ministry policies and legislative requirements in relation to information exchange and confidentiality.

- Some Districts/SCHN noted that further work is needed to fully implement access to secure information and ensure that relevant services had appropriate access to client information.

Figure 26 | Average Self-Assessment Scores for progress towards Making it Happen indicators for IPARVAN Objective 4: Extend the foundations for integration across the whole NSW Health system between 2018/19 and 2020/21

Figure 27 | Average Provider Survey Scores for progress towards Making it Happen indicators for IPARVAN Objective 4: Extend the foundations for integration across the whole NSW Health system between 2020 and 2022



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