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EVIDENCE CENTRE
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Support for child victims of sexual crimes

Evidence Brief 2021

MARTIN JENKINS

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Executive summary

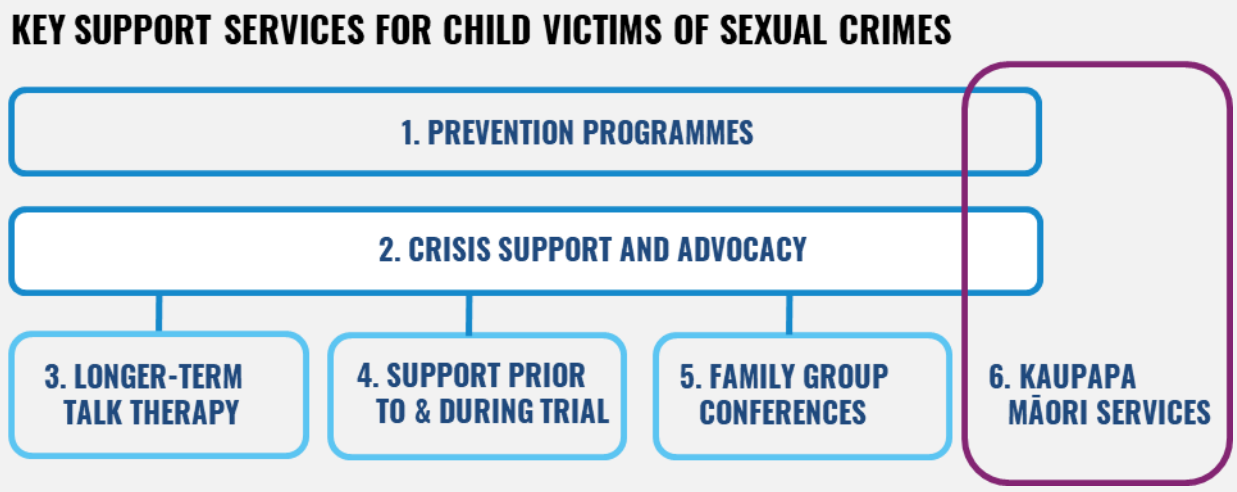
This Evidence Brief summarises the types of support available for children (including adolescents) who are victims of sexual crimes in New Zealand and internationally, to help them recover from their experiences and move through the judicial system, including the court process.

Sexual abuse affects many children in New Zealand, but it is unclear how prevalent it is. Based on New Zealand and international studies its estimated that around one in five females and one in ten males have experienced some form of sexual abuse before turning 16. This abuse can have significant effects on brain development, psychosocial development and overall life trajectory, and it has a large social and economic cost.

The negative effects of abuse can be minimised if people receive effective, specialised support, early on. In New Zealand, most support services are provided by non-governmental organisations that specialise in supporting victims of sexual crimes. A minority of providers specifically cater for the needs of child and youth victims, and an even smaller subset offer Kaupapa Māori services for tamariki and rangatahi.

The core supports offered include prevention programmes; crisis support; talk-based therapy; referrals to other agencies (such as the Police and medical specialists); and advocacy for victims when they are engaging with the Police, the medical system and the justice system (Mossman et al., 2009). A small range of additional supports are offered through the court system and through Oranga Tamariki: these are also summarised below and then discussed in more detail later in this Evidence Brief.

Types of support available: A snapshot of key findings



Prevention programmes

These indirectly support victims – by increasing their knowledge of sexual abuse, promoting disclosure of abuse and inappropriate behaviour early or soon after an event, and reducing self-blame.

Crisis support

This includes crisis counselling, referrals to relevant services (such as medical specialists and the Police), and advocacy when engaging with other formal institutions or agencies.

- For young people, it is most important that they are heard, believed and supported by specialised providers.
- Helplines are particularly valuable – offering anonymous, accessible and potentially cost-effective support.
- Independent Advocates can improve people's experiences with the Police and medical specialists, and the quality of the services received.
- Early support may be offered through the "shopfront" of a Child Advocacy Centre (CAC), which brings government agencies under one roof, and which connects into the specialist NGO sector. The CAC model is more focused on the investigation of abuse than on support for victims of abuse, but victims treated through CACs appreciate the child-centric environment (compared to a standard Police station, for example), and they are more likely to be referred on to mental health services.

Longer-term talk therapy

This plays a key role in helping children to recover from abuse.

- Trauma-focused cognitive behavioural therapy is the therapy with the strongest evidence base for efficacy. The involvement of a supportive caregiver is a critical success factor.
- Group therapy is a promising format for education about abuse and for recovery from it, particularly for adolescents. The group dynamic helps to build connection and reduce shame.
- There is also a growing evidence base for the effectiveness of a range of other therapies that help people to recover from trauma, including:
  - Eye Movement Desensitisation and Reprocessing therapy (EMDR), with some studies showing that results can be achieved quickly and sustained over the longer term
  - play and art therapies, which enable children to share their experiences in a developmentally appropriate way, and which are associated with significant positive effects (Cohen's *d*=.8),[1] and

[1] Cohen's *d* is an expression of a standardised difference between two mean measures, often used to express effect size. In this example *d*=.8 is a large effect size, whereas *d*=.5 is medium, and *d=.2* is small, for example.

  - mindfulness-based Acceptance and Commitment Therapy (ACT), which helps victims to treat thoughts as harmless, and to engage in committed action to help them to move toward their goals.

Support before and during trial

This is offered by specialist NGOs and, later in the process, by the courts.

- Victims appreciate the support offered by Independent Advocates during the lengthy lead-up to trial. This waiting process is considered by many to be the worst part of the criminal justice process.
- Shortly before trial, court preparation services are offered by the court and by specialist NGOs. These services help to reduce the child's stress and anxiety in court, and enable them to give evidence more effectively.
- In-court support services are offered by Court Victim Advisors and by Victim Advisors from specialist NGOs. Their role is to keep children safe at court (for example, away from the defendant), and to provide practical information and emotional support. Research indicates that the independence of Victim Advisors is particularly valuable, because they can challenge the court system when they need to. They may also have more established connections with the victim, if they have provided support in the lead up to trial.
- Communication Assistants (or Intermediaries) help to improve how questions are posed to child witnesses, thus reducing their stress and improving the quality of the evidence gathered.
- Specialist interviewers, combined with full pre-recording of testimony, cross-examination and re-examination, significantly improves the court experience for young witnesses. This model has been adopted in Australia, the UK, Ireland, Norway and Austria.

Family group conferences

Child victims of sexual crimes can be involved in family group conferences (FGCs) in two different contexts. At a **Care and Protection** FGC the child's safety and wellbeing are the paramount focus of the conference, while at a **Youth Justice** FGC they may be involved as the victim of the young person whose offending is the focus of the conference.

- **Care and Protection FGCs** involve the child and their whānau, hapū, iwi or family group, communities and government agencies, working together for the safety and wellbeing of the child. The FGC brings the victim and their family together – enabling the child to share their experiences of sexual crime, and the family to develop a plan to keep the child safe. This plan should draw on the family's strengths and resources, and the process of producing the plan should be empowering for whānau and the child.
- **Youth Justice FGCs** are supported by the Police and the courts where a young person has, or allegedly has, committed an offence. These types of FGCs have four primary, and equal, considerations of:
  - interest of the victim
  - public interest

- accountability
- wellbeing of the child or young person.

A Youth Justice FGC aims to develop a plan addressing these four considerations to reduce likelihood of reoffending. Victims are entitled to participate in these FGCs as part of a restorative effort or to have their say.

The evidence suggests that key factors contributing to the success of Care and Protection FGCs (and Youth Justice FGCs) are preparation, where the conference is held and how it is conducted, and the strength of the relationships between coordinators, social workers, whānau and the child or young person. Further research is needed on the extent to which Care and Protection FGCs enable longer-term policy goals to be achieved, as well as meaningful outcomes as defined by children and their families.

A key criticism of Youth Justice FGCs and the involvement of the victim is the high risk of re-traumatisation. However, the New Zealand and international research suggests that when victims do engage, they are extremely satisfied with the Youth Justice FGC process and its outcomes. Unfortunately, there have been few studies that focus on outcomes and impacts for child victims of sexual crimes. Therefore, it is unclear to what extent the benefits of Youth Justice FGCs for victims can be generalised to a younger and sexual crime victim cohort.

Project Restore NZ is a nationwide provider of a restorative justice conferencing approach tailored to victims of sexual violence. Evaluative studies have found good outcomes for victims, as well as offenders.

Kaupapa Māori services

Kaupapa Māori services may be defined as “Indigenous, localised, whānau-centred solutions designed by Māori, with Māori, underpinned by tikanga and delivered by providers who identify as Māori, primarily for Māori, but available to all” (ACC, 2021).

Among Kaupapa Māori providers, the range of services and supports offered is comparable to “mainstream” NGOs, but the approach to healing is more whānau-centric and holistic. For Māori, these culturally appropriate support services are likely to be more effective than mainstream services. More research and evaluative activity would help to build the case.

What makes support effective

Across the research, this Evidence Brief finds that support is effective when it adheres to these key principles:

- **Specialised** – delivered by people and organisations that understand sexual trauma and how to work with young victims.
- **Accessible** – in terms of location and ease of entry into a service. Services should be based in locations where children are, or be available through other channels such as helplines. Barriers to access, such as eligibility requirements for services, should be removed. Settings should be relatively informal, or at least not clinical or overly judicial.

- **Supportive** – with victims feeling heard, believed and empowered, rather than judged.
- **Well integrated** – with strong connections between the various government agencies that respond to abuse, and also between those agencies and the specialist NGO sector.
- **Stable and continuous** – young people value continuity in their relationships, and the ability to access services when they need them, including over the long term.
- **Culturally responsive** – abuse and recovery should be framed in ways that resonate with young people, and services for Māori should be holistic and engage the wider whānau.
- **Supportive of people's wider network** – support that enables non-offending caregivers and whānau to participate is particularly important, and is associated with better experiences and outcomes for young people. Services should strengthen ties to the victim's peer network.
- **Early** – young people experience fewer symptoms of trauma when they have early access to effective treatments and services.

Further research and evaluation are required

The Evidence Brief primarily considers the **type** of supports available, not the **level** of support. However, there is a shortage of specialised support for young victims of sexual crimes, and a significant shortage of Kaupapa Māori services. This is problematic, given that early access to effective support services is vital for children to recover from abuse.

The Evidence Brief identified gaps in the research base. The following areas should be prioritised for further research and evaluation:

- Working in partnership with providers to adopt culturally appropriate evaluation and monitoring mechanisms into existing Kaupapa Māori services. This would ensure there is more formal tracking of the outcomes achieved by these services, opportunities for continuous improvement, and greater ability to build a case for additional investment.
- Assessing the extent to which Youth Justice FGCs, and other restorative justice approaches, are used in Aotearoa for child victims of sexual crimes, and evaluating their short-term and long-term impacts on the wellbeing of child victims of sexual crimes (and other adverse experiences).
- Putting in place monitoring and evaluation measures to routinely capture the experiences of young witnesses who engage with the justice system, the types of "special measures" used to protect children, the short-term impacts of those measures on the child's experience, and long-term wellbeing outcomes.
- Understanding the barriers to developing and delivering specialist Kaupapa Māori services for child victims of sexual crime, understanding how to remove those barriers, and evaluating the extent to which removing them would lead to

an increase in the number of high-quality providers and wellbeing outcomes for tamariki and rangatahi.

Part 1.
Introduction and context

Purpose of this Evidence Brief

This Evidence Brief summarises the types of support available for child victims of sexual crime, and the efficacy of those supports

Oranga Tamariki plays a key role in protecting vulnerable children in New Zealand. Young victims of sexual crime are uniquely vulnerable, because their traumatic experiences can affect their long-term development, and because they are at risk of secondary trauma as they move through a justice system that has been designed for adults.

This Evidence Brief summarises the types of support available for children (including adolescents) who are victims of sexual crimes in New Zealand and internationally, to help them recover from their experiences and move through the judicial system, including the court process. The brief considers the effectiveness, strengths and limitations of different types of support, including specific supports that are available for tamariki and rangatahi Māori.

This Evidence Brief will be used to inform a policy response

At the outset, this brief had a working hypothesis that there is a lack of specialised services and funding available for sexually abused children in Aotearoa.

For instance, in 2019 the Ministry of Social Development (MSD) received $90.3 million of funding over four years to invest in specialist services for adult victims of sexual violence (MSD, 2020), but there is no equivalent funding available for child victims. This is in the context of one in seven children growing up in violent homes (Ministry of Justice, 2015), and high rates of sexual abuse of children in New Zealand. Prevalence will be further discussed in *The rationale for support services* on page 12.

Oranga Tamariki intends to use this Evidence Brief to inform a policy proposal, for the development of support services for child victims of sexual crimes.

Meaning and scope of key terms

- **Support** is generally used in this Evidence Brief to mean a service that enables the psychological recovery of young victims, or that prevents further psychological harm and re-traumatisation within the justice system. The brief focuses primarily on support offered by specialist sexual violence services and by independent advocates within these organisations. For ease of reading, the term “specialist NGOs” is used rather than “specialist sexual violence services”.
- **Terms referring to children and young people**: The UN Convention on the Rights of the Child defines all people under the age of 18 as “children”. The Oranga Tamariki Act 1989 defines a child as a person under the age of 14 years, and a young person as a person of or over the age of 14 years but under 18 years (section 2). In this Evidence Brief, “tamariki” will also be used to refer to people under the age of 14, and “rangatahi” to refer to those aged 14 to 18. In some instances, the use of child and young person will be used interchangeably to refer to a person under the age of 18.

- **Sexual abuse:** Sexual abuse and violence covers a spectrum of activity. This includes:
  - Non-contact abuse: unwanted exposure of genitalia, public masturbation, unwanted sexual propositions, forcing a person to watch pornography, sending sexually explicit content to a person who has not consented
  - Contact abuse: unwanted touching of a sexual nature, or pressure to touch someone else or perform sexual acts; attempted or completed oral, anal or vaginal intercourse (that is, rape)
  - Sexual exploitation: when a child is forced to engage in sexual activity, in exchange for money or another payment or benefit.

  Most of the studies discussed in this Evidence Brief focus on child victims who have experienced contact abuse.
- **Victims** has been used as the default term for child victims of sexual crimes. Victims may prefer to be called "survivors", and researchers and providers often use the term "victim-survivor".

Topics out of scope

These topics are out scope for this Evidence Brief:

- Tailored support for child victims of commercial sexual exploitation, including sex trafficking
- Support services targeted at people with harmful sexual behaviours (although that can be a consequence of experiencing sexual abuse as a child)
- In-depth commentary on how the judicial system might be reformed to improve the experience of child victims within that system
- In-depth commentary on the availability of different support services.

Method

Evidence was drawn from a desktop review and interviews with a small number of key informants

The Evidence Brief was compiled through a desktop review of academic databases and grey literature. Interviews were also held with five key stakeholders – three from the specialist NGO sector, including one Kaupapa Māori provider; one stakeholder from a peak body in the social services sector; and one former Oranga Tamariki social worker who had provided support for child sexual abuse victims.

Wherever possible, this brief has drawn on insights from systematic reviews and meta-analyses.

The evidence base has a range of limitations – but it is still possible to draw useful insights from it

Across the social services, it can be difficult to identify causal links between a support service and a beneficial outcome for a particular cohort of people, for the following reasons:

- Support services vary. They differ according to the ethos of the organisation and the skillsets and approaches of its individual staff, and services also adapt to respond to the service user's unique needs and context.
- Service users vary. This includes, but is not limited to, differences in age, gender, the nature of the abuse (for example, within or outside the family), and the duration of the abuse.
- It can be difficult to define what a good outcome looks like for child victims of sexual crimes, so research is frequently confined to quantitative measures (for example, a reduction in symptoms of post-traumatic stress disorder).
- Victims may not want to engage in longitudinal studies that track their improvement over time.
- There have been relatively few randomised controlled trials, and so researchers cannot state with confidence whether a person's improvement is due to the support service provided, or merely due to the passing of time.

As a result, the evidence base on the effectiveness of support services for victims of sexual crimes is weak (Potter et al., 2002), and particularly so for young victims in New Zealand (Woodley et al., 2013).

> *"We know from our experience that these services help people to recover – but it's very hard to get gold-standard research that compares the life outcomes of people who receive services with those that don't." (Stakeholder from Specialist Sexual Violence Service)*

The rationale for support services

We know that sexual abuse affects many New Zealand children – but it is difficult to get an accurate picture due to variations in studies' definitions of sexually abusive behaviour and issues with under-reporting. It's estimated that around one in five females and one in ten males have experienced some form of sexual abuse before turning 16.

It is difficult to estimate the prevalence of sexual abuse of children. Different studies and countries use different definitions of child sexual abuse, and under-reporting is common. Stevenson (2017) draws on local and international literature and concludes that its prevalence in New Zealand is similar to overseas – with experiences of child sexual abuse reported by one in five women and one in ten men (see Table 1 for details of findings from New Zealand studies). The median age at which abuse tends to start has been reported as nine years old (Fanslow et al., 2007).

Table 1: Estimates of the prevalence of childhood sexual abuse in New Zealand

Study type and cohort	Estimated prevalence of abuse		Source
	Females (%)	Males (%)	
Longitudinal cohort study: Dunedin Multidisciplinary Health and Development Study	30%	9%	van Roode et al (2009)
	Birth cohort study of over 1,000 people born in Dunedin and members are still being studied. Sexual abuse defined as unwanted involvement with any of the following activities before age 16. At the age 26 assessment, study members were asked "Before you turned 16, did someone touch your genitals when you didn't want them to?" If the study member reported this, they were asked about the frequency of the abuse, their age at first and last abuse, the gender and age of the abuser, and their relation to the abuser. Similar questions were asked about being forced to touch someone else's genitals, attempted intercourse, completed intercourse, and any "other" unwanted sexual activity. Study members who indicated they had experienced "other" abuse, were asked to select from exposure, pornography, sexual talk, oral sex, or other.		
Longitudinal cohort study: Christchurch Health and Development Study (CHDS)	17.3%	3.4%	Fergusson et al (2000)*
	Birth cohort study of 1,265 people born in Christchurch in 1977 and members are still being studied. Child sexual abuse is defined as, whether before the age of 16, anyone had ever attempted to involve them in any of a series of sexual activities when they did not want this to happen. These activities spanned: (a) non-contact episodes, including indecent exposure, public masturbation by others and unwanted sexual propositions or lewd suggestions; (b) incidents involving sexual contact in the form of sexual fondling, genital contact or attempts to undress the respondent; (c) incidents involving attempted or completed vaginal, oral or anal intercourse.		

Study type and cohort	Estimated prevalence of abuse		Source
	Females (%)	Males (%)	
National survey of high school students	20%	9%	Clark et al (2013)
	Survey of students from 125 randomly selected schools. 91 schools and 8,500 students participated. Sexual abuse defined as "Ever been touched in a sexual way or made to do unwanted sexual things".		
National survey of 9–13-year-olds	11% across sample		Carroll-Lind et al (2011)
	A representative sample of 2,077 children from 28 randomly selected schools of various sizes, geographic areas and socioeconomic neighbourhoods. Sexual abuse defined as "unwanted sexual touching or being asked to do unwanted sexual things".		
Retrospective survey of women in Auckland and Waikato	23.5% Auckland 28.2% Waikato		Fanslow et al (2007)
	Random sample of 2,855 women aged 18-64 years old in Auckland and north Waikato. Face-to-face interviews with one randomly selected woman from each household were conducted. Sexual abuse defined as unwanted sexual touch, or being made to do something sexual that they did not want to do.		
Survey of women in Otago	26% before age 12 32% before age 16		Anderson et al (1993)
	Otago Women's Health Survey. Sample of 3,000 women who were randomly selected from the electoral rolls in Otago and Dunedin. Sexual abuse defined as an unwanted sexual experience. Sexual abuse was grouped into three categories: non-genital, genital but not penetrative, and attempted or completed intercourse.		

Note: * Modelling by the authors based on reports at age 18 and at age 21 suggests that the estimated true prevalence of child sexual abuse is in the range of 24.3%–26.5% for females and 3.6%–8.6% for males.

Child sexual abuse is reported at a higher rate among Māori than non-Māori. For instance, official statistics cited by researchers using data from the Christchurch Health and Development Study put the rate of substantiated abuse (physical, sexual or emotional) per 1,000 children under 17 years at 11.9 for Māori children versus 5.9 for non-Māori children (Marie et al., 2009). Among adult females, experiences of child sexual abuse were more commonly reported by Māori women in Auckland and Waikato than among non-Māori women (Fanslow et al., 2007). Data from Oranga Tamariki indicates that amongst children in their care, 37% of all sexual abuse cases affect Māori tamariki or rangatahi (cited in Te Puni Kōkiri, 2017).

Under-reporting of abuse is common and happens for a variety of reasons. For example, survivors may not trust Police or government agencies; think they won't be believed; feel shame and a (misplaced) sense of responsibility for their experiences; feel trauma from previous unsuccessful disclosure attempts, or fear that reporting the abuse will make things worse for them.

Under-reporting happens more in certain populations – for example among males and people with communication difficulties (Carne, 2020; Ministry of Justice, 2020; New Zealand Family Violence Clearinghouse, 2017a).

Using statistical models and reports at two points in time (at age 18 and at age 21), New Zealand researchers estimate that the true prevalence of abuse is at least 10 percentage points higher than stated in cross-sectional studies that ask people only once about their experiences (Fergusson et al., 2000, p. 529; see also note to Table 1):

> *"Approximately 50 percent of those exposed to abuse do not report these experiences when questioned on a single occasion."*

As evidence of this under-reporting, research on New Zealand secondary school students found that 53% of abused teenage girls had not told anyone about the abuse, and this figure rose to 71% among teenage boys (Adolescent Health Research Group, 2013; Clark et al., 2013).

The majority of abusers are male, and known to the victim

In most instances, young victims know their abuser. For instance, Otago-based research found that among women who had been sexually abused as a child, 38% were abused by another family member and 46% by an acquaintance, while only around 15% were abused by a stranger (J. Anderson et al., 1993). Carroll-Lind et al's (2011) study of 9–13 year olds found that 'other known adults' were most frequently the perpetrators of abuse (in just under half of cases involving adult abusers), followed by strangers and then parents.

The Christchurch Health and Development Study, which included 106 study members who reported child sexual abuse, reported that 94% of the reported perpetrators were male and 6% female (Fergusson, Lynskey, et al., 1996). The finding that males are more likely to be the perpetrator is consistent with administrative data from Oranga Tamariki, New Zealand Police and the criminal courts (New Zealand Family Violence Clearinghouse, 2017b).

Child sexual abuse can have significant effects in the short and long term

Sexual abuse is a form of trauma that can adversely affect the developing brain and the person's ability to form healthy relationships (Briere & Elliott, 1994; Putnam, 2006), with significant long-term effects.

> *"You are basically changing that child's entire trajectory in terms of their capacity to concentrate, to attend in school, their capacity to manage their internal emotions – and we know that self-regulation is one of the key skills in life – and their ability to have trusting relationships." (Stakeholder from sexual violence service)*

The following list summarises the key impacts of child sexual abuse:

Mental health impacts

- Post-traumatic anxiety and fear (Briere & Elliott, 1994; Kaplow et al., 2005)
- Feelings of helplessness and hopelessness, self-blame, low self-esteem, and reduced trust in others (Briere & Elliott, 1994)
- For ages 16–25, increased risk of depression, anxiety, substance abuse, anti-social disorders or conduct disorders, suicidal ideation and attempted suicide (Fergusson et al., 2008; Fergusson, Horwood, et al., 1996)
  - In New Zealand, child victims of rape or attempted rape are 2.4 times more likely than other victims to have one of the mental health disorders listed above
  - It is estimated that child sexual abuse underpins 13% of all mental health problems
  - The Christchurch Health and Development Study found that the association between psychotic experiences and child sexual abuse was the strongest when the abuse was severe (C. J. Bell et al., 2019).
- Child sexual abuse victims are 18 to 21 times more likely to abuse substances, according to some international researchers (discussed in Putnam, 2006a).

Social and economic impacts

- Reduced ability to form strong attachments with others
  - Child sexual abuse victims tend to have fewer friends and less satisfying relationships, greater discomfort with others and the tendency to withdraw from relationships, and a greater sense of isolation (Briere & Elliott, 1994)
- More sexualised and abusive relationships
  - Abused girls are likely to have more sexual partners, and are at a greater risk of sexually transmitted diseases, and a four-times greater risk of unwanted pregnancy (Putnam, 2006)
  - People who were victims of sexual abuse as children are twice as likely to experience violence from their intimate partners (Fanslow et al., 2007)
  - Data analysis from the Christchurch Health and Development Study suggests that the extent of child sexual abuse exposure is related to adolescent risk-taking, which in turn leads to early and more frequent cohabitation, risk of intimate partner violence, and lower satisfaction with, and investment in relationships (Friesen et al., 2010).
- More likely to enter prostitution (Bagley & Young, 2009; Farley & Barkan, 1998)
- Higher levels of stress and unemployment
  - The combined impact of psychotic experiences and child sexual abuse can set off a chain of effects, in that those who reported higher rates of psychotic

experiences and reported severe child sexual abuse were also more likely to report higher levels of life stress and unemployment (C. J. Bell et al., 2019).

Intergenerational impacts

- There is some evidence that children who are sexually abused are at greater risk of being abusive towards others.
  - A study of 280 young sexual abuse perpetrators found that 71% had been sexually abused themselves (Vizard, 2013).
  - In a study of 747 male subjects in a forensic psychopathology clinic, 35% of sexual abuse perpetrators had been child victims, whereas among those who did not go on to abuse the rate of victimisation was 11% (Glasser et al., 2001).

The social and economic costs of child sexual abuse are significant – sexual violence is **the most costly** of all crimes

When aggregated across victims and over time, the social costs of sexual abuse are highly significant.

Sexual violence (of all types) makes up only 1% of reported criminal acts, but sexual violence is estimated to be **the most costly crime**[2] in New Zealand (as estimated in The Treasury working paper by Roper & Thompson, 2006). Each incident of sexual violence is estimated to cost over $72,000 in 2013 terms, and when aggregated, these crimes cost around 0.85% of GDP each year (MSD, 2013). With the New Zealand economy valued at $325 billion in 2021 (Stats NZ, 2021), and assuming no inflation and the same prevalence of abuse over time, the estimated cost of sexual offences would be $2.76 billion.

More recent estimates for child sexual abuse in care contexts put the average life-time cost for an individual abused in care at approximately $857,000 (in 2019 dollars) (MartinJenkins, 2020). Of this figure, $184,000 is financial cost to the economy from increased spending on healthcare, state costs in responding to negative outcomes from abuse, and productivity losses. The remaining $673,000

[2] The study estimates the full cost, in net present value (NPV), to society of all criminal acts committed in New Zealand during 2003/04. This includes the cost of crime prevention activity. Per criminal act, sexual offences are by far the most costly sub-category, primarily reflecting the impact on victims. The number of sexual offences used as a basis for calculating cost is determined by using the number of recorded crimes or incidents and applying a multiplier to reach the estimated number of criminal acts. The multiplier is based on that used in a similar UK study.

Sexual violence is defined as sexual violation and other sexual offences (i.e., sexual attacks and affronts, acts of immoral behaviour, etc).

Crime has been broken down into three main categories:

- offences against the person: violent offences, sexual offences and robbery;
- offences against private property: burglary, theft, property damage and fraud;
- offences with no direct or intended victim: drug offences, serious traffic offences and all other offences.

reflects the pain and suffering, and in some cases premature death, of the child sex abuse victim.

The long timeframe for these costs is also significant. Recent research has found that the time delay between abuse and exposure averages around 15 years (Rajan et al., 2021). That finding is supported by NGOs, who observe that most people who seek help are adults who were victimised as children.

> *"The people who are flooding through the doors, about 1 in 5 is the result of a recent assault, but the bulk are coming for child sexual abuse that they didn't get treatment for." (Stakeholder from specialist NGO)*

The negative impacts of abuse can be lessened if people receive early, effective, specialised support

Trauma from sexual abuse stems both from the abuse and from how other people respond to it (Hester & Lilley, 2018).

Children experience fewer symptoms of trauma when they are able to share their experiences with a trusted adult, when their story is believed and they are not blamed, and when they are given support to recover (Briere & Elliott, 1994; McNeish et al., 2019), including early access to effective treatments (Vizard, 2013).

> "*Although maltreatment and adversity may negatively affect a child's developing brain and general wellbeing, recovery is possible when effective interventions are delivered as early as possible." (Vizard, 2013, p. 512)*

The academic literature consistently finds that effective supports and treatments are those delivered by specialised providers who understand the impact and trauma of sexual abuse (Gekoski et al., 2020; Hester & Lilley, 2018; Leary & Hay, 2019; Mossman et al., 2009). When it comes to child victims, providers would also ideally be skilled in providing developmentally appropriate services.

> *"People often treat children as little adults – but they are quite different." (Stakeholder from specialist NGO)*

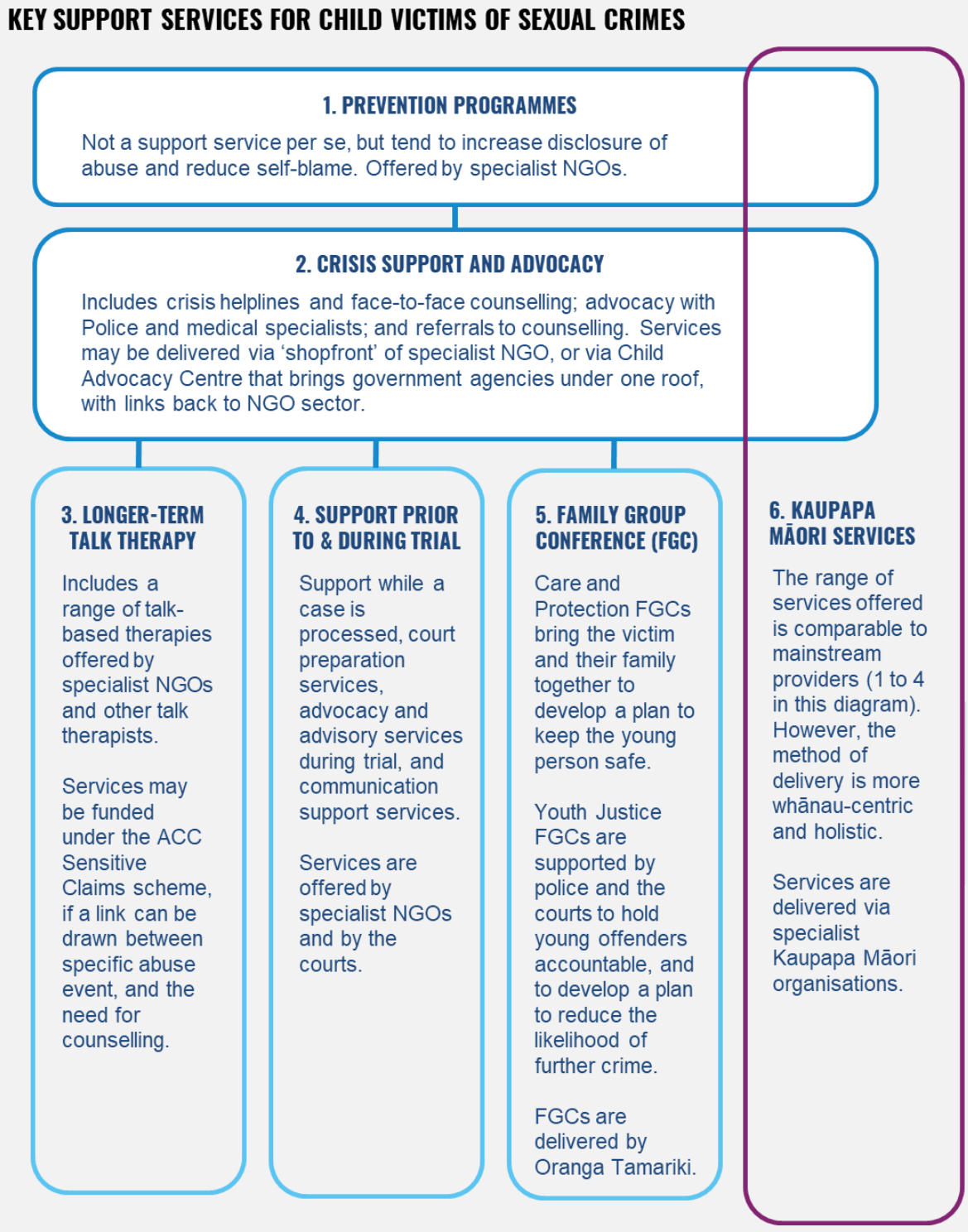
Therefore, the rationale for providing these support services is that (1) abuse is common, with wide-ranging negative impacts for individuals, families and society, and (2) it is possible to lessen the impacts of abuse, by providing specialised, effective services for young victims.

Part 2. Support to recover and move through the justice system

Overview of key support services

A range of **organisations** are involved in responding to instances of child sexual abuse. These organisations are described in Appendix 1.

The following diagram summarises the key **support services** offered to young victims of sexual crimes. The rest of this Evidence Brief is structured using these six headings.



1. Prevention programmes

Prevention programmes indirectly support child victims – by increasing their knowledge, promoting disclosure, and reducing self-blame

Education programmes that seek to prevent child sexual abuse are not specifically within the scope of this Evidence Brief; however, they are included here because they often lead victims to disclose abuse, and they help young victims avoid blaming themselves for their experiences (Finkelhor, 2009).

Programmes are typically delivered by the specialist NGO sector, or by the wider NGO sector (for instance, Barnardos). Sessions are run in schools or in community-based settings such as churches and youth clubs. Content and delivery vary according to age:

- Programmes for younger children typically use puppets, music, movement and stories to teach children body awareness and boundaries, how to recognise and say no to unwanted touching, and how to share with a safe adult if they have been touched inappropriately (Finkelhor, 2009; Point Research, 2011). Programmes are most effective when they focus on behavioural skills, and when parents and teachers are involved in the delivery (Artus & Niemi, 2016).
- Programmes for teenagers tend to focus on the elements of healthy relationships, including intimate relationships, and how to seek help if necessary (e.g., Empowerment Trust, 2021).

An international meta-analysis has found that participants in these programmes absorb the messages effectively, are 6 to 7 times more likely to act in self-protective ways compared to non-participants, and are more likely to disclose abuse (Finkelhor, 2009). Some evidence also suggests that the programmes reduce self-blame, which is associated with better psychological outcomes (Finkelhor, 2009).

In New Zealand, an evaluation of the “We Can Keep Safe” programme for pre-schoolers found that participants were far more likely to tell an adult about touching that they didn’t like (from 57% at baseline, to 91% after the course, sustained at 88% after 1 year) (Point Research, 2011). Parents also noted a marked increase in their children’s knowledge, and stakeholders from the programme frequently receive at least one disclosure of abuse after their sessions (HELP Auckland, personal communication, August 2021).

2. Crisis support and advocacy with Police and medical staff

Crisis support is offered by specialist NGOs and other social workers

Work to prepare this Evidence Brief included a brief stock-take of specialist sexual violence services in New Zealand. The stock-take showed that many providers offer crisis support, in the form of helplines, in-person crisis counselling, and urgent referrals to the Police, medical specialists, and Oranga Tamariki if necessary. Some crisis counselling services or drop-in centres are based in schools.

Social workers may also provide crisis support, particularly if they are the first person to become aware of abuse – for instance, through the Social Workers in Schools service. In these instances, the crisis support will include emotional support and referral to other services such as the Police, medical specialists and counsellors (Leary & Hay, 2019; Prior et al., 1999).

It is positive when services can be easily accessed, as young people's awareness of support services is low and they "tend not to know about services unless they 'trip over' them" (Woodley et al., 2013). As another stakeholder explained, "there has to be a very easy way in the door" (stakeholder from specialist NGO).

Young people value being heard, believed and supported by specialised providers

A wide range of qualitative research has demonstrated that young people who disclose abuse want to be heard, believed and supported by non-judgmental, empathetic adults, ideally those who specialise in supporting young victims of sexual abuse (Gekoski et al., 2020; Leary & Hay, 2019; Lester et al., 2020; Potter et al., 2002; Prior et al., 1999). For instance, this finding came through clearly in the UK's Independent Inquiry into Child Sexual Abuse (Gekoski et al., 2020), and a systematic review of children who had Adverse Childhood Experiences, including sexual abuse (Lester et al., 2020).

Victims appreciate the independence of NGOs, which enables services to be less prescriptive and to adopt a "needs-led approach" (Isham et al., 2021, p. 3). NGOs can create an environment in which the shame of abuse is understood, addressed and minimised (Isham et al., 2021).

Helplines are particularly valuable. They offer anonymous, accessible and often cost-effective support

Crisis helplines offer young victims accessible, 24-hour support, including counselling and referrals to other providers. The services are anonymous and confidential, they are often staffed by trained counsellors, and they are increasingly

multi-modal, allowing people to communicate by free phone, free text, email, or webchat (Finn & Hughes, 2008; Superu, 2018).

New Zealand has a relatively wide range of helplines available, including the national Safe to Talk helpline for sexual violence; national helplines for children and teenagers (including 0800 What's Up, Kidsline and Youthline); and regional helplines offered by specialist NGOs.

Studies from New Zealand indicate that young people value the anonymity of helplines and digital services over face-to-face counselling (Malatest International, 2018; Youthline, 2008). This anonymity is particularly valuable for child victims of sexual crimes, given that young people are often reluctant to share their experiences because they are embarrassed or ashamed.

Young people also appreciate the accessibility of crisis helplines compared to face-to-face counselling, as there are no associated time and travel costs, and no need to arrange discussions around school and other commitments (Superu, 2018). Helplines also save time for those providing support. One study estimated that talk-based therapy delivered over the phone takes 40% less therapist time, which equates to significant cost savings (Youthline, 2008).

Despite these upsides, many young people in vulnerable demographics may still not have access to a personal phone or device (Former social worker from Oranga Tamariki, personal communication, September 2021). Helplines also often face greater demands than they can meet – for instance, the 2008 review of Youthline found that of 232,000 calls made to the service, counsellors could service only 20,000 (less than 10%).

Independent Advocates can improve victims' experiences with the Police and medical specialists – and the quality of the service received

A child may be supported by an advocate when they engage with the Police, or with sexual health services to receive a therapeutic medical check or a forensic check.[3]

Advocates support victims by explaining key processes, answering questions, and speaking up for the victim's interests. The advocates are usually from specialist NGOs; however, advocacy services appear to be less common than other services (such as counselling), and it isn't clear to what extent these advocacy services are available to child victims, as a matter of course in New Zealand.

Although the evidence base is limited and generally focused on adults, research from the US and the UK indicates that victims who are supported by an advocate receive better-quality service, and have better experiences (Campbell, 2006; Hester & Lilley, 2018). Campbell's study of 81 victims of sexual violence compared care given in matched hospitals, one with a victim advocate present and one without. The presence of the advocate meant victims received more thorough medical treatment (for example, they were more likely to be prescribed emergency contraception), had

[3] Note: Victims may connect with medical services and the Police at about the same time, and have the same advocate present in both settings, or there may be a significant time lag between accessing medical support and reporting abuse to the Police (with some abuse never reported).

more Police reports taken, were less likely to experience negative interactions with medical staff and Police, and were less distressed (Campbell, 2006; Mossman et al., 2009).

Child Advocacy Centres offer crisis support and statutory agencies under one roof. Young people appreciate the child-centric environment, and are more likely to be referred to mental health services

Child Advocacy Centres (CACs) are designed to serve as a "one stop shop", allowing child victims to access support services and agencies that will investigate abuse, under one roof. The services offered typically include:

- **Medical examinations** – to check the victim's physical health, and in some instances, to collect forensic evidence
- **Mental health assessments and services** – which typically includes trauma-focused therapy
- **Child protection services** – for instance, social workers from Oranga Tamariki, who assess the child's safety needs
- **An advocate for the victim** – who is often from an NGO and who serves as the primary point of contact for the child and for a non-offending caregiver
- **Law enforcement and justice services** – who will investigate the abuse, conduct forensic interviews with the victim, and potentially take the case to trial (Herbert & Bromfield, 2016; Stevenson, 2017).

These services are provided by multi-disciplinary teams (MDTs), who provide a child-friendly environment, and ideally are culturally competent (Herbert & Bromfield, 2016). The MDTs work together on cases, regularly reviewing and tracking to ensure that children receive appropriate referrals and support, and that cases progress through the Police and justice systems (Herbert & Bromfield, 2016).

Evaluations of the CAC model have typically focused on whether investigations run by CACs lead to better justice outcomes. There are few studies seeking to understand whether CACs lead to improvements in the physical and mental wellbeing of child victims (Herbert & Bromfield, 2016; Stevenson, 2017).

Though the evidence base is small, victim-focused studies suggest that children appreciate the child-centric CAC model, including the lack of uniforms and the warm treatment from staff (Rasmusson, 2011). Caregivers are also significantly more satisfied with services delivered through CACs rather than through stand-alone agencies (Jones et al., 2007).

> *"I think it is great that it is not located at the police station, because police officers are scary to children." (Parent of child served by a CAC, cited in Rasmusson, 2011, p. 312)*

Victims treated by MDTs within a CAC are also more likely to be referred to mental health services than those treated by a less integrated team (Herbert & Bromfield, 2019, 2021).

In New Zealand, Puawaitahi is the country's first CAC, established in 2002 in Auckland (Stevenson, 2017). A 2017 evaluation found Puawaitahi to be a well-functioning CAC, with effective coordination of cases, and the provision of child-focused and culturally competent services in a welcoming physical environment (Stevenson, 2017).

It is interesting to note that, even under the CAC model, 20% of children felt "scared or worse" after a forensic interview within a CAC (Jones et al., 2007). This finding highlights the value of victim advocates (described above) or specialist interviewers (described in section 4), within CACs.

The CAC "one-stop shop model" is considered best practice among adult victims of sexual abuse, though there can be challenges with implementation

The Ministry of Social Development (MSD) recently published a literature review of the best court support models for adult victims of sexual violence (Slade, 2020). The review identifies a range of international delivery models that are comparable to the Child Advocacy Centre (CAC) – including Sexual Assault Response Centres in the UK, Sexual Assault Response Teams in the US, Thuthuzela Care Centres in South Africa, and the Sexual Assault Reform Program in ACT Australia (Slade, 2020).

Those integrated, victim-centric services are considered best practice, as they "enable victims-survivors to access a range of services and support at one location, including medical care, legal advice, counselling and advocacy, thus increasing access to justice and helping to reduce re-victimisation" (Slade, 2020, p. 1).

However, MSD observes that running multi-agency support programmes can be more resource-intensive and expensive than operating stand-alone services (Slade, 2020). A lack of resourcing in rural areas may also lead to poorer service delivery.

3. Longer-term talk therapy

Talk-based therapies play a central role in helping young people to recover from sexual abuse, and specialised services are highly valued

Being able to talk to a trusted and supportive adult is hugely important for young people's recovery from sexual abuse (Gekoski et al., 2020; Lester et al., 2020; Potter et al., 2002; Prior et al., 1999). This support is frequently provided in the context of talk-based therapy – which may also be referred to as "counselling", "psychosocial intervention", "supportive psychotherapy", working with a psychologist, and other terms or phrases (e.g., Beutler et al., 1994; Kim et al., 2016).

There is strong evidence in support of the value of talk-based therapy for child victims of sexual abuse. For instance, in their comprehensive review of psychosocial interventions that had been studied through experimental and quasi-experimental methods, Kim et al (2016) reported the following headline finding:

> *"The retrieved studies reported positive results with respect to improvements in the negative psychosocial sequelae of child sexual abuse following the use of a diverse set of treatment strategies." (Kim et al., 2016, p. 597)*

Victims particularly value talk-based therapy provided by specialists trained in understanding trauma and treating sexual abuse victims (Gekoski et al., 2020; Mossman et al., 2009). For instance, counselling services provided by NGOs specialising in child sexual abuse or rape support were rated more highly than any other support service, by victim respondents for the UK Independent Inquiry into Child Sexual Abuse (Gekoski et al., 2020).

While it focuses on adults, an Australian evaluation also found that victims valued support from specialist sexual victim services over all other helping agencies, including mental health services and more generalist NGOs offering counselling (Lievore, 2005, cited in Mossman et al, 2009).

In New Zealand, ACC used to require talk-based therapists to be trained to work with children and young people, before they could receive funding for working with children and youth/rangatahi. This prerequisite has now been removed (HELP Auckland, personal communication, August 2021).

Trauma-focused cognitive behavioural therapy (TF-CBT) has the strongest evidence base, and the involvement of a supportive caregiver is a critical success factor

Therapy overview

Trauma-focused cognitive behavioural therapy (TF-CBT) aims to reduce children's stress, anxiety and shame following sexual abuse. This is achieved through:

- Psycho-education – teaching children about abuse, typical reactions to abuse, and safety skills
- Progressive exposure to traumatic memories, alongside stress-management techniques
- Reframing – enabling children to think differently about the abuse, their role in it (that is, they are not responsible), and their recovery from it
- Engaging supportive caregivers in each of these steps, with the aim of strengthening the relationship between child and caregiver (de Arellano et al., 2014; Saunders et al., 2003; Vizard, 2013)

Evidence of efficacy over the long term, even in young children

TF-CBT has the strongest supporting evidence base of all the talk therapies. A wide range of randomised controlled trials have found that it is more effective than other therapies at reducing symptoms of anxiety, depression, posttraumatic symptoms such as dissociation, and sexual problems, with results sustained over time (Cohen et al., 2005; Vizard, 2013).

US Guidelines for the treatment of child sexual abuse categorise TF-CBT as a "well-supported and efficacious treatment" (classification 1 of 6), whereas many other talk-based therapies are described as "supported and acceptable treatments" (classification 3 of 6) (Saunders et al., 2003).

TF-CBT has also achieved positive results in very young children (ages 3 to 6) (discussed in Vizard, 2013). This is most likely because the therapy is adapted to ensure that it is developmentally appropriate, and because non-offending caregivers are involved in the therapeutic process (Celano et al., 1996; de Arellano et al., 2014).

Although the evidence base for TF-CBT is strong, it is not "water tight". A gold-standard Cochrane Library Review found that the benefits of TF-CBT were not often statistically significant, and certain studies have questionable methodology, such as selective reporting of data (Macdonald et al., 2012).

Those authors concluded that "There is nothing in this review to detract from the general consensus that cognitive-behavioral approaches, particularly those that are trauma-focused, merit consideration as a treatment of choice for sexually abused children who are experiencing adverse consequences of that abuse". They said that closer attention should be paid to how studies are designed and run (Macdonald et al., 2012, n.p.).

Group therapy is a promising format for abuse education and recovery; the group dynamic helps to build connection and reduce shame

Group therapy tends to include two key components (Brown et al., 2013; Wanlass et al., 2006):

- psycho-education about the nature of abuse and its impacts

- support to address traumatic feelings and coping behaviours that may stem from abuse, including low self-esteem, anger and sexualised responses

Group therapy is considered to be particularly relevant for adolescents, given the importance of peer relationships at this age (Corder, 2000, cited in Avinger & Jones, 2007).

A meta-analysis of group treatment for child victims of sexual abuse, including both younger children and adolescents, suggests that these treatments can have the intended effects. Group therapy reduced psychological distress and negative coping mechanisms, and increased self-esteem and knowledge about how to prevent abuse (Reeker et al., 1997). This is a qualified finding, given the significant variation between studies in the nature of the group and the type and duration of treatment. More recent studies are also positive. For instance, Avinger and Jones (2007) found that group therapy led to reduced anxiety and increased self-esteem in adolescent girls, and Hébert and Tourigny (2010) found that group therapy for 6–12 year-olds led to reductions in anxiety and PTSD symptoms.

The format of group therapy can benefit victims. As people share their abuse and have their shame understood by others (Wanlass et al., 2006), and experience “a testing ground for constructing healthy behaviors including boundary setting, communication skills, and self-advocacy” (Brown et al., 2013, pp. 145–146). However, some studies suggest that young people would prefer to be treated individually rather than through group therapy (discussed in Brown et al, 2013), which highlights the importance of understanding and responding to a victim’s unique needs.

There is a growing evidence base for a range of other trauma-informed therapies

EMDR therapy can effectively reduce the effects of trauma. Studies suggest that results may be achieved quickly and sustained over the longer term

Eye Movement Desensitisation and Reprocessing (EMDR) is a therapy designed to help people to tolerate and process trauma (Edmond & Rubin, 2004).

Participants are asked to recall their traumatic memories at the same time as they attend to another visual stimulus – for instance, the therapist’s fingers clicking alternately on the left and right (Edmond & Rubin, 2004). This dual focus (of the memory and the motor activity) is thought to help people process their memories, so that they are no longer traumatic.

Three meta-analyses have found that EMDR effectively reduces trauma symptoms in children with post-traumatic stress (Lewey et al., 2018; Moreno-Alcazar et al., 2017; Rodenburg et al., 2009). Along with TF-CBT, EMDR is recommended by the World Health Organization as a treatment for children with post-traumatic stress disorder (World Health Organization, 2017). However, the relative efficacy of EMDR and TF-CBT is not clear-cut. For instance, the Rodenburg et al. (2009) meta-analysis found EMDR to be more effective than TF-CBT, while Moreno-Alcazar et al. (2017) placed them as equally effective, and Lewey et al. (2018) found that EMDR is

marginally less effective than TF-CBT. Given that TF-CBT has the strongest evidence base at present, these results should be seen as a general endorsement of EMDR.

Looking more narrowly at EMDR for child victims of sexual abuse, there is a growing evidence base. EMDR therapy has been associated with reduced trauma symptoms in adult females who had been child victims of sexual abuse, with results maintained after 18 months (Edmond & Rubin, 2004). Likewise, EMDR reduced trauma symptoms in sexually abused Iranian adolescents, in one of the few, perhaps only, randomised trials of EMDR in sexually abused children (Jaberghaderi et al., 2004).

EMDR is notable in that in some instances it may be delivered over a short time. US guidelines for treating child physical and sexual abuse note that EMDR therapy usually lasts two to three sessions, while most talk-based therapies are offered for 12 sessions (Saunders et al., 2003). The EMDR International Association notes that therapy sessions typically take 60 to 90 minutes, and that "it could take one or several sessions to process one traumatic experience" – with the caveat that the length of therapy will differ according to the client's needs and the depth of trauma (*Experiencing EMDR Therapy*, 2021).

The 2009 meta-analysis mentioned above found that children who received fewer EMDR sessions achieved better treatment outcomes (Rodenburg et al., 2009). This finding "might reflect that children with less deeply engraved trauma respond faster to EMDR" (Rodenburg et al., 2009, p. 604). This is a topic worth examining in the New Zealand context.

Mindfulness-based Acceptance and Commitment Therapy is a promising and empowering therapy for children

Acceptance and Commitment Therapy (or ACT) is a relatively new therapy that combines mindfulness with goal setting (Smout, 2012). Participants are first taught how to mindfully observe their thoughts and feelings, rather than suppressing them. Through psycho-education and interactive exercises, people learn how to treat thoughts as harmless – creating distance between the thought or feeling and the person observing that thought or feeling. Participants then work to articulate their values and what is important to them, and engage in actions that move them toward their goals (Smout, 2012).

A systematic review of ACT in children with various psychological challenges found that the therapy led to a reduction in negative symptoms, increased psychological flexibility, and improved quality of life (Swain et al., 2015). However, the authors noted that methodological issues were common in many studies, and that there would be value in larger, more robust studies.

Play and art therapies enable children to share their experiences in a developmentally appropriate way – and there is strong evidence of their effectiveness

Play therapy and art therapy allow abused children to make their thoughts, feelings and experiences visible to others – and then to receive support to process that material, in order to move forward (Saunders et al., 2003). Play therapy is more

common among younger children (aged 3 to 12) (Association for Play Therapy, n.d.), and art therapy is appropriate for all ages.

Play therapists typically offer a range of different "stations" that children can interact with – for instance, puppets, sand, props, arts and craft material (Gil, 2003). Puppets and props may be chosen for their symbolic value – for instance, puppets that look scary and dominant, and breast shields that symbolise self-protection (Gil, 2003).

In the session, the child plays or creates art, and the therapist observes, reflecting on what they are doing, and asking gentle questions to get them to expand or clarify an issue. This process usually leads children to share their experiences in a vivid way. For instance, one girl painted her room with a black cloud in it. "I don't like my room because my abuelito [grandfather] would do bad things to me in my bed" (Gil, 2003, p. 158). Once children share their experiences, the therapist will offer more typical therapeutic support.

A meta-analysis of 93 studies of play therapy found that this treatment is effective for children with various presenting challenges (such as internalised anxiety, or externalised aggression) – and reported a large treatment effect size (Cohen's *d* = 0.8)[4] (Bratton et al., 2005). Therapy appears to be more effective when a non-directive approach to play is used (rather than a directive approach, such as a board game). It is **most** effective when delivered by parents ($p<0.01$ vs delivery via mental health professionals). In some instances, parents may need to be offered "collateral therapy" to address their own experiences of abuse, so that they can then support their child (Saunders et al., 2003). Finally, play therapy is more effective when offered in a residential setting, rather than a clinical setting (Bratton et al., 2005).

When it comes to psychodynamic therapy for the treatment of child sexual abuse, there is a significant evidence gap

Psychodynamic or psychoanalytic therapy stems from Freudian theory, and is based on the idea that previous experiences and relationships can distort how people think, feel, act and relate to others in the present (Parker & Turner, 2014). This causes psychological pain and can lead to unhealthy coping mechanisms. The goal of therapy is to "help people have a better understanding of unconscious difficulties about which they may previously have been unaware and this is thought to allow resolution of their problems" (Parker & Turner, 2014, p. 2).

A relatively recent Cochrane review found that no randomised or quasi-randomised trials have been conducted on the use of psychodynamic therapy, for child victims of sexual abuse (Parker & Turner, 2014). Those authors could therefore not conduct a meta-analysis. This finding is not proof that psychodynamic therapy does not work – it means that, given the current evidence base, it is not possible to know whether the treatment is effective or not. More research is needed in this area.

[4] Cohen's *d* is an expression of a standardised difference between two mean measures, often used to express effect size. In this example *d*=.8 is a large effect size, whereas *d*=.5 is medium, and *d=.2* is small, for example.

Duration and cost: Therapies typically run over 12 sessions, but young people value long-term support that they can access as needed

The duration of talk-based therapy will vary according to the child's needs, and the type of therapy provided. However, therapy is commonly offered for 12–16 sessions, with the notable exception of EMDR which, as noted above, may require only two or three sessions (Saunders et al., 2003).

Under the ACC Sensitive Claims scheme, victims are fully funded for 16 initial sessions (ACC, 2015). This includes two sessions to get started, 12 core sessions, and then two sessions to plan next steps (ACC, 2020). Victims can also receive longer-term support, which includes up to 48 sessions over 12 months, and up to four sessions per year, over three years (ACC, 2020). Clients can 'return' to ACC cover throughout their lives.

Therapeutic costs funded by ACC vary from $95 per hour to just over $370 per hour, depending on the provider's qualifications (ACC, 2020). For instance, therapy provided by a counsellor has a lower per-hour rate than therapy provided by a psychiatrist.

Putting funding to one side, the research indicates that sexually abused children value strong, continuous relationships with trusted adults, and forms of support they can access over the long term (Lester et al., 2020; McNeish et al., 2019).

> *"There are a million triggers for children. A new teacher might wear the same perfume as the abuser, and that brings everything up again. Or a perpetrator might get out of jail, and they see them at the local mall. Knowing they can come back [to a support service] is reassuring for the child." (Stakeholder from the specialist NGO sector)*

4. Support before and during trial

A wide range of literature demonstrates that justice processes and court experiences can retraumatise victims, particularly young victims of sexual crimes. For instance, Randell et al (2018, 2020, 2021) and McGregor (2017) deftly summarise the challenges that young victims in New Zealand face, both in the lead up to trial, and during trial processes – particularly cross-examination.

In response to these issues, a suite of systemic changes has been adopted, trialled or proposed in New Zealand. It is outside the scope of this Evidence Brief to describe and evaluate these changes in depth.[5] However, Table 2 summarises key changes and proposals and provides a snapshot of the evidence base.

Table 2: Summary of child-centric reforms to the justice system

Key stressor	Potential responses	Snapshot of evidence base
Engagement with Police	Victim Advocate present	Positive – see section 2
	Services delivered via Child Advocacy Centre (CACs)	Positive – see section 2
Lack of progress with case, delays in the lead up to trial, and during trial	Full recording of child testimony, including cross-examination, before the trial (victim can then exit justice system)	Positive – see Case study on Specialist Interviewers and full pre-recording
	Case progression coordinated via CAC, bringing response agencies under one roof (Police and justice – plus child protection, physical and mental health services)	Positive, CACs associated with faster case progression (and some indications of a higher conviction rate) (Herbert & Bromfield, 2019, 2021)
	Victim Advocate or Social Worker provides updates and support	Positive – see below in section 4
	Court sessions timed to reduce waiting for young witnesses	Positive results noted in the Whangārei Child Witness Protocol (McGregor, 2017; Randell et al., 2016)
Intimidating court environment	Court preparation services	Positive – see below in section 4
	Introduced to judge and lawyers before the trial; less formality (no wigs for example); child-friendly waiting areas	Positive results noted in the Whangārei Child Witness Protocol (McGregor, 2017)
Risk of contact with perpetrator	Evidence given via CCTV, or from behind a screen	Generally positive – viewed positively by vast majority of victims in UK research, but potential challenges with CCTV technology and some views that CCTV testimony is less impactful (Fairclough, 2020)
	Protection Order requiring perpetrator to keep distance from victim	Not reviewed here, but proposed by Auckland Sexual Abuse HELP in submission on alternative trial processes (Auckland Sexual Abuse HELP, 2011)

[5] Interested readers are directed to: (1) a previous Evidence Brief which examined strategies for maximising young people's participation and engagement in justice systems, including restorative justice systems (Oranga Tamariki Evidence Centre, 2020a); (2) commentary and research on experiences of justice for all victims of sexual crime (Gravitas Research, 2018), for child witnesses specifically (McGregor, 2017), and for child witnesses in investigations and trials related to sexual abuse (Davies et al., 2000; Randell et al., 2018, 2021); (3) specific evaluations of the Whangārei Young Witness Court Protocol and the Sexual Violence Court Pilot (Gravitas Research, 2018; Randell et al., 2016); and (4) HELP's submission on alterative pre-trial and trial processes for young witnesses (Auckland Sexual Abuse HELP, 2011).

Key stressor	Potential responses	Snapshot of evidence base
	Victim Advocate or Court Victim Advisor keeps victim away from perpetrator	Positive – see below in section 4
Stress during cross-examination	Full testimony, including cross examination, conducted by specialist interviewer and using narrative style	Positive – see Case study on Specialist Interviewers and pre-trial recording of cross examination
	Training of judges and lawyers in child-centric questioning methods	Mixed – New Zealand researchers suggest this intervention alone would not be sufficient to improve children's experiences of questioning (discussed in Auckland Sexual Abuse HELP, 2011)
	Communication Assistant to improve questioning and enable responses from the victim	Positive – see below in section 4

Specialised support is valued in the (long) lead-up to trial

At present, there is a significant time lag between when a criminal charge is brought and when a case appears before the New Zealand courts – 15 months on average (Hanna et al., 2010), and in some cases, up to two-and-a-half years (Randell et al., 2018). Even in New Zealand's recent pilot of a specialised Sexual Violence Court, all children and caregivers thought that the length of time between reporting abuse and trial was "far too long" (Randell et al., 2021, p. 7).

For young victims and their families, this delay period can be **the most negative aspect of the whole trial process**, described as "nerve-wracking", "harrowing" and "horrendous" (Randell et al., 2018, p. 361). It makes it difficult for children to process their experiences, and to move on with their lives.

During this extended waiting period, victims appreciate the emotional support and information provided by independent advisors from specialist NGOs. For instance, UK research on female sexual abuse survivors has demonstrated these advisors play a key role in "holding" victims in the system, during the long wait for trial and the "mental torture" of trial adjournments (Hester & Lilley, 2018). Advisors can offer personalised and responsive services in a way that statutory mental health agencies cannot.

Preparation support offered by the court and specialist NGOs can reduce children's stress and anxiety in court, and help them to give evidence more effectively

Specialist NGOs and the court system both offer information and support to young witnesses in the lead-up to a trial. The service often includes education about processes (for instance, about what to expect at court and during questioning), and preparation techniques (for instance, how to respond to questions, and how to manage anxiety and stress). Services are typically provided over a short time – for instance, in 1–3 preparatory sessions.

- Court-led services include the "Court Education for Young Witnesses" programme in New Zealand, which allows young people to visit the court and to learn about typical court processes (Barker, 2003). The service is run by Court Victim Advisers in the three weeks before a trial, and the educational components are tailored to the child's age and cultural background.
- Specialist NGOs offer tailored support to victims. This can include explaining court processes, giving advice about how to respond to questions (particularly during cross-examination), developing strategies to cope with the stresses of the experience, and even setting up a mock trial (HELP Auckland, n.d.; *Interview with Kaupapa Māori Provider of Specialist Sexual Support Services*, personal communication, August 2021; McGregor, 2017; Peterson, 2020). Some pre-trial support services are run by mental health professionals, and draw on evidence-based approaches to minimising trauma (Peterson, 2020).

Studies from the US have indicated that pre-trial preparation services can lead to significant reductions in how anxious child witnesses feel about going to court (Nathanson & Saywitz, 2015; Peterson, 2020).

Pre-trial services can also enable young children to understand and respond to legal questioning more effectively. Researchers have shown that after training, children as young as 5 to 8 can better understand "legalese" questions and make it clear when they do not understand, and children aged 12 can better resist questions that challenge their credibility, if this training is delivered within one week of the trial (outlined in McGregor, 2017).

The Court Education for Young Witnesses programme was seen as positive by children and by prosecution and defence lawyers when it was piloted in 2004 (Davies et al., 2004). However, uptake of the programme appears to be patchy, and there is value in assessing whether it is still consistent with best practice (McGregor, 2017).

Court support services are offered by specialist NGOs and the courts – but there is particular value in the independent, long-term support that NGOs offer

Specialist NGOs and the New Zealand courts both offer young people a form of support in court – through Independent Victim Advisors (or advocates) from the NGO sector, and through Court Victim Advisors.

The role of the Independent Victim Advisors is largely comparable to those of the Court Victim Advisors employed by the Ministry of Justice. They keep children safe and away from the defendant while at court; explain what to expect; ensure that the child has access to relevant "special measures" such as giving evidence by CCTV; and serve as a contact person for stakeholders involved with the trial (such as the Police, prosecuting lawyers, and judges) (Gravitas Research, 2019; HELP Auckland, personal communication, August 2021; Slade, 2020).

In addition to these "core" support services, Independent Advisors play a broader role. They provide support in the lead-up to the trial (as discussed earlier), supporting the child's family during trial, and are available to provide ongoing counselling after the trial, if needed (Gravitas Research, 2019).

While both court-led and specialist NGO-led supports will improve children's experiences within the justice system, there appears to be greater value in the independent support that NGOs can offer – as noted by both the Court Victim Advisors and Independent Advisors (Gravitas Research, 2019; HELP Auckland, personal communication, August 2021; Slade, 2020). Independent Advisors can more effectively challenge the court system, in the best interests of the child.

Support for families is another key differentiator. Children may feel responsible for protecting their family from the abuse, but when Independent Advisors provide support for the family, it takes this weight off children.

> *"Children in these families will disclose bit by bit, because they are trying to look after their families. We need to take that weight off of them. Our services need to acknowledge that there are always (at least) two parties – the child and their needs, and the family and their needs." (Stakeholder from specialist NGO)*

Finally, the longer-term support that Independent Advisors can provide is appreciated. In 2015 the Law Commission observed that:

> *"One way to ensure victims-survivors are adequately supported throughout the justice process is to provide a specialist advocate who creates a centralised, single liaison point between the victim-survivor and the CJS [criminal justice system]. That person would provide ongoing support and information to a victim-survivor from their first point of contact with police, medical officer, and other support agencies, right through to the end of the justice process."* (Law Commission, 2015, cited in Slade, 2020, p. 9)

Communication Assistants can reduce stress for child witnesses, and improve the quality of testimony

Courts in England, Wales and New Zealand have introduced Communication Assistants to help facilitate effective communication between young witnesses, lawyers and judges (Fairclough, 2020; McGregor, 2017). Communication Assistants are usually trained speech language therapists who assess the child's communication needs before the trial, and give advice about how to ask questions and engage with the witness to get useful testimony (McGregor, 2017; Talking Trouble Aotearoa NZ, 2021). Communication Assistants may also provide support in the courtroom – for example, letting the judge know when questions to the witness are problematic, and checking when the witness needs a break (McGregor, 2017).

Communication Assistants are not, strictly speaking, a support for child victims, as they are neutral parties who serve the interests of the court by improving the quality of evidence that is gathered (Fairclough, 2020; McGregor, 2017). This intent is being achieved, in both the UK and New Zealand (Fairclough, 2020; Gravitas Research, 2019; McGregor, 2017). However, improving the process of questioning, particularly cross-examination, has significant benefits for young witnesses. Children gain increased access to justice as they are better able to express themselves (McGregor, 2017; Plotnikoff & Woolfson, 2007), and cross-examination is less stressful. This finding is noted by judges, victim advocates and the parents of child witnesses, in research from the UK and New Zealand:

> *Mother of child witness: "My five year old was physically sick the night before court. The intermediary helped settle him because he was worried about not being able to answer questions. He knew he could tell her if he didn't understand." (cited in Plotnikoff & Woolfson, 2007, p.61)*
>
> *Victim advocate: "[Communications assistants] are so beneficial. They are a good use of resources absolutely. Imagine a little one sitting in front of the screen and not knowing how to answer a question, and knowing that their support person cannot say anything? They need an advocate, someone who can help them express themselves." (cited in Gravitas Research, 2019, p. 48)*

The role of Communication Assistants has also been endorsed by defence lawyers in early evaluations. They observed that Assistants improve questioning and are truly independent, rather an advocate for the child (Plotnikoff & Woolfson, 2007).

Concerns about the cost of this service have been raised. However, New Zealand's Chief Victims Advisor has noted that research from Northern Ireland found that the cost per trial was "not excessive", and these costs need to be weighed against the benefit of improved questioning and potential savings of time (see McGregor, 2017).

Success factors for Communication Assistants: involved early, independent, informed about the law, and ideally accredited

Communication Assistants can perform their role most effectively when they meet a victim ahead of the trial, to determine their communication needs. They are less effective when they are brought into the court on the day of the trial (Gravitas Research, 2019).

Communication Assistants need to remain independent in their role, or there is a risk of a mistrial, and it is useful if they have some understanding of the law, so that they can suggest alternative ways of phrasing a question without changing the substance of that question (Gravitas Research, 2019).

In other jurisdictions, Communication Assistants are accredited. The service is currently unregulated in New Zealand (McGregor, 2017); however, "[d]evelopment of NZ protocols, processes, codes of ethics and conduct is underway" (Talking Trouble Aotearoa NZ, 2021).

Specialist Interviewers and the model of "full pre-recording"

One final support worth noting is that provided by Specialist Interviewers, when combined with full pre-recording of testimony, cross-examination and re-examination. This involves the following key steps:

- A specialist forensic interviewer captures a child's testimony on video, using a narrative style of questioning, soon after disclosure. This is already permitted under New Zealand law (Hanna et al., 2010), and standard practice at Puawaitahi, the Auckland-based CAC (Stevenson, 2017).
- Cross-examination and re-examination are conducted at a pre-trial hearing, and questioning may be performed by a specialist, court-appointed intermediary. These interactions are all recorded.

- Special measures are usually put in place as well – for example, children giving evidence by CCTV recording, and Court Victim Advisors or Independent Victim Advisors present to support the child and keep them away from the defendant (Hanna et al., 2010).
- There is a judge present, but no jury (McGregor 2017).

The "full pre-recording" model has been standard practice in Western Australia since 1992 (with subsequent roll-out to other states), adopted in Norway and Austria (Auckland Sexual Abuse HELP, 2011; McGregor, 2017), and recently rolled out across England and Wales (Fairclough, 2020; Flury, 2021).

Both researchers and advocates from the specialist NGO sector cite a range of benefits from this set-up:

- Children can "exit" the justice system much faster, as pre-recorded hearings can be held within a relatively short time (Hanna et al., 2010; McGregor, 2017; Tinsley & McDonald, 2011). For instance, Hanna et al observe that in Western Australia, pre-recorded hearings must occur within six months of a charge being laid, but that most hearings occur within three months (Hanna et al., 2010). (Recall that standard processes in New Zealand result in a lead-time of 15 months on average (Hanna et al., 2010), and 2.5 years in some instances (Randell et al., 2018)). Once they exit the system, children can receive counselling which is focused primarily on recovery – not on preparing for trial (Tinsley & McDonald, 2011).
- Giving evidence sooner means that young people are likely to give better, more accurate evidence (Hanna et al., 2010; Tinsley & McDonald, 2011) – although there is less consensus on this point (Fairclough, 2020).
- The cross-examination process is less stressful for young witnesses (Auckland Sexual Abuse HELP, 2011; Fairclough, 2020; Hanna et al., 2010; McGregor, 2017; Tinsley & McDonald, 2011).
- The absence of a jury means the court can be more responsive to a child's needs – for example, by allowing bathroom breaks when needed (McGregor, 2017).

As a result of all these factors, child witnesses have a significantly improved experience in the justice system. For instance, when the full pre-recording model was available in Western Australia but not elsewhere, researchers asked young witnesses if they would ever be willing to report sexual abuse again or go through the courts as a witness. Willingness to disclose abuse was much higher in Western Australia (64%) than in Queensland (44%) or New South Wales (33%). The proportion of children who said they would never testify again was lower too: at 17% in Western Australia, versus 39% in Queensland and 56% in New South Wales (Eastwood & Patton, 2002, cited in Hanna et al., 2010).

The changes outlined above are strongly recommended by both specialist advocates and researchers (Auckland Sexual Abuse HELP, 2011; Hanna et al., 2010), as the following quotes illustrate:

> *"Pre-recording is highly regarded by judges, counsel, other practitioners and commentators, all of whom cite numerous advantages for both children and the trial process" (Hanna et al., 2010, p. 150).*

> *"We think there is **most merit** in a system that adds pre-recorded cross and re-examination by a court-appointed specialist child examiner to our current forensic interviewing processes" (Hanna et al., 2010, p. 5).*

The practices have been enacted in at least two cases for adults in the High Court in New Zealand (Tinsley & McDonald, 2011). At the very least, this process "warrants consideration" as a less stressful way of giving evidence, which will in turn help to support child witnesses.

5. Family group conferences (FGCs)

Family group conferences (FGCs) were established in the Oranga Tamariki Act 1989 and Children's and Young People's Well-being Act 1989. FGCs are administered by Oranga Tamariki and are a statutory process, rather than a specialist support service. They are meetings for the purposes of Care and Protection or Youth Justice.

- **Care and Protection** involves the child and their whānau, hapū, iwi or family group, communities and government agencies working together for the safety and wellbeing of children, tamariki and rangatahi. The child's safety and wellbeing are the paramount focus.

  If a child has been the victim of a sexual crime, a Care and Protection FGC may be used when the perpetrator is an adult and a whānau member, or a non-whānau member. The FGC would usually follow a Report of Concern and the perpetrator would proceed through court processes, and the child would also be supported by Court Victim Advisors.

  Care and Protection FGCs bring the victim and their family together – enabling the child to share their experiences of sexual crime, and the family to develop a plan to keep the child safe. This plan should draw on the family's strengths and resources, and the process of producing the plan should be empowering for whānau and the child.

  Care and Protection FGCs can have a restorative practice element to them, but are ultimately about the wellbeing and best interests of the child. The FGC coordinator may decide to exclude the offending whānau member from the FGC if they believe this would be beneficial for the victim.

- **Youth Justice** is for children who have, or allegedly have, committed an offence.

  Youth Justice FGCs are supported by the Police and the courts, and these types of FGCs have four primary, and equal, considerations:

  - Interest of the victim.
  - Public interest.
  - Accountability.
  - Wellbeing of the child or young person.

  A Youth Justice FGC aims to develop a plan addressing these four considerations to reduce likelihood of reoffending. Victims are entitled to participate in these FGCS as part of a restorative effort or to have their say.

  A Youth Justice FGC may be used when the perpetrator is 12–17 years old. They may be charged and go through a Youth Justice FGC.

  If the victim is a child, they can choose to be present at the FGC to talk about the impact of the sexual crime on them, or they can send through a Victim Impact Statement to be read out at the FGC. This may help the victim to heal.

  Youth Justice FGCs are considered to be a restorative justice approach.

The following section explains the evidence base for each of these, in terms of the potential benefits for child victims of sexual crimes.

Care and Protection FGCs bring the victim and their family together – enabling children to share their experiences, and families to develop a plan to keep the child safe

Plans for the long-term safety and wellbeing of the child developed during a Care and Protection FGC should draw on the family's strengths (Kanyi, 2013; Knoke, 2009) and keep the child connected to their whānau in some way. These connections are central for improving outcomes for vulnerable children (M. Bell & Wilson, 2006).

The plan is then reviewed by child protection agencies (like Oranga Tamariki in New Zealand), and ideally will be monitored over time to ensure it is implemented and the child is kept safe.

With Care and Protection FGCs it's important to get the processes right and for coordinators and social workers to have good relationships with the family

A review of New Zealand evaluative literature in 2013 found a number of challenges to the successful implementation of Care and Protection FGC plans (Kanyi, 2013):

- Families lacked resources to implement plans
- There was a lack of support from social workers in implementing the plans
- There was a lack of follow-up on the progress of the plans
- The making of the plan is often seen as a sign of success, rather than the outcomes the plan seeks to achieve.

New Zealand research indicates that the benefits of Care and Protection FGCs are that they strengthen families, they lead to more placements in kinship arrangements, and they foster partnerships with families, but it is unclear to what extent positive outcomes for children, much less for child victims of sexual crime, have been achieved (Connolly, 2006; Kanyi, 2013). Kanyi (2013) also raised concerns about the lack of valid and reliable evaluation of the outcomes of Care and Protection FGCs.

Carswell et al (2014) evaluated Care and Protection FGCs in partnership with the then-Child, Youth and Family (CYF) and Te Awatea Violence Research Centre at the University of Canterbury. The evaluation was based on statistical analysis of CYF administrative data, a CYF internal review, and consultation and interviews at five CYF sites, including 9 children, 16 of their whānau, and caregivers and CYF staff.

A central finding of the evaluation was that Care and Protection FGCs are "an important and valuable decision making process for children and their whānau **if implemented well**" (Carswell et al., 2014, p. 6, emphasis added). This is consistent with evaluations of Care and Protection FGCs overseas. For example, a recent evaluation of Care and Protection FGCs in Scotland found that good experiences of the FGC process tend to lead to positive perceptions of outcomes, and that the relationship between coordinators/social workers and families is pivotal to

understanding how, why and whether positive long-term outcomes are realised (Mitchell, 2020).

Care and Protection FGCs need to have their objectives clearly defined at the outset, for all parties

Mitchell's (2020) evaluative work on 11 cases from 5 local government areas across Scotland stressed the importance of defining Care and Protection FGC objectives according to what matters to children and families, alongside what matters to welfare agencies. Personally meaningful outcomes relate to:

- Process – for example, feeling recognised, listened to and respected
- Change or learning – for example, improved communication skills, and a sense of positive progress
- Quality of life – for example, feeling safe and settled, feeling a sense of control about what happens, and enjoying stronger relationships with people who are significant in their lives.

Best practices for FGCs in the case of sexual crimes

If Care and Protection FGCs are to be used for young victims, including victims of sexual crimes, a range of best practices should be adopted (Carswell et al., 2014). These include:

- engaging with whānau before the Care and Protection FGC, to give them more time to develop an appropriate plan
- hosting the conference in a neutral and comfortable venue
- adequately preparing victims for the process and giving them time to share their experiences
- involving victims in developing the protection plan
- providing follow-up support to victims
- taking steps to ensure that the plan is implemented.

Te Awatea Violence Research Centre specifically highlights the value of there being a supportive and communicative social worker throughout the Care and Protection FGC process (Carswell et al., 2014). These good practice findings from the evaluation are consistent with Oranga Tamariki's family group conferencing practice standards (Oranga Tamariki Practice Centre, 2019).

It is timely to review how Care and Protection FGCs have been implemented over time, and their effect on long-term outcomes for child safety and wellbeing

FGCs originated in New Zealand, and to date, the focus of most research has been on FGC processes, rather than their long-term outcomes (Sundell & Vinnerljung, 2004; the RTK, 2016). There has not been any significant evaluation or monitoring of Care and Protection FGCs in New Zealand since the early 2010s.

This is problematic, as noted by multiple authors. “For the FGC to maintain its credibility, the critical need for evaluative research in the New Zealand care and protection FGC needs to be addressed” (Kanyi, 2013, p. 35). In 2014, researchers from Te Awatea Violence Research Centre noted the need to capture better data on the long-term outcomes for children and families after an FGC. In 2019, a report on iwi-led FGCs noted “some degree of whānau transformation” following the FGC process, but no further details were given (Roguski, 2019, p. iv).

The international evidence suggests that, overall, FGCs are about as effective as standard child welfare practices in preventing the maltreatment of children. However, this high-level finding obscures the complexity of the research to date.

- Knoke (2009) notes a small number of studies in which children who engaged in Care and Protection FGCs felt safe, cared for, and happy, because their views were heard and they could shape the care plan; and one study in which FGC participants were less exposed to child abuse, neglect, and out-of-home placements (Knoke, 2009).
- A number of randomised controlled trials from the Netherlands and the US have found that FGCs are no more or less effective than care-as-usual for reducing instances of child maltreatment (Berzin et al., 2008; Dijkstra et al., 2019; Hollinshead et al., 2017), a result supported by meta-analysis (Dijkstra et al., 2016).
- The impact of Care and Protection FGCs on the likelihood of children being placed out-of-home is not clear.
    - Two US studies found the rate of out-of-home placements was comparable between FGCs and care-as-usual (Berzin et al., 2008; Hollinshead et al., 2017).
    - A study from the Netherlands found that out-of-home placements were more common among families that participated in a Care and Protection FGC rather than care-as-usual, and these placements were also more common among minority groups (Dijkstra et al., 2016).
    - A three-year Swedish study found that 22% of children engaged in a Care and Protection FGC were then cared for by their extended family, compared with 3% of children who had received care-as-usual (Sundell & Vinnerljung, 2004). However, children in the FGC group were also significantly more likely to be re-referred to child protection services.

Commentators argue that the international research base needs to be interpreted carefully (eg Sanders, 2019). First, the rate of out-of-home placements tends to be low, and when dealing with small numbers there is an increased risk of finding a false positive that links a treatment condition (Care and Protection FGCs) with an outcome (out-of-home placement) (for example, in Dijkstra et al, 2016, discussed by Sanders, 2019).

Second, the cultural context in which Care and Protection FGCs occur is also likely to influence how they are rolled out and received by children and their families (Levine, 2000; Sanders, 2019; Sundell & Vinnerljung, 2004). For instance, the three-year Swedish study described above did not include any people from a “native minority”, whereas “the few studies with encouraging long-term outcomes of FGCs included a substantial part of families from indigenous minorities” (Sundell &

Vinnerljung, 2004, p. 283). The Swedish welfare state is also strongly "paternalistic", which may "make Swedes unfamiliar with participation in the CPS decision process" (Sundell & Vinnerljung, 2004, p. 283). This contrasts sharply with the focus on self-determination and agency among Māori, and with kinship placements tending to be frequent in the New Zealand model (Connolly, 2006; Kanyi, 2013).

Taken together, these findings highlight the need for evaluation of Care and Protection FGCs in New Zealand, moving beyond research that focuses on short-term outcomes and FGC processes, and on to studies of long-term outcomes that focus on meaningful outcomes for children and families.

Youth Justice FGCs are designed to help victims to feel heard and to recover. Yet, very few peer-reviewed studies have been conducted among victims of sexual abuse

Youth Justice FGCs focus on repairing the harm caused by a young offender, and reintegrating that person into their whānau and wider community. *(For a more in-depth description of youth justice FGCs and victim engagement and participation, see Oranga Tamariki Evidence Centre, 2020a.)*

An earlier Evidence Brief noted that there is debate about whether FGCs are appropriate for certain crimes, including sexual assault (Oranga Tamariki Evidence Centre, 2020a). Some jurisdictions do not permit the use of Youth Justice FGCs for cases involving sexual abuse, while others permit them in cases where the non-abusive caregiver and wider family believe and support the young victim (Knoke, 2009).

Victims are usually very satisfied with Youth Justice FGCs, but there are few studies of children's participation in them or of Youth Justice FGCs specifically in the area of sexual abuse

Victim "satisfaction" is measured in various ways in different studies and different jurisdictions. Questions usually relate to the process, whether needs are met, and/or whether they are satisfied with the outcome. Various studies in the US, Australia, Canada, England and Northern Ireland have found uniformly high victim satisfaction with Youth Justice FGCs – ranging between 83 and 90% (Barnes, 2013; House of Commons Justice Committee, 2016; Trimboli, 2000; Umbreit et al., 2000; Wagland et al., 2013; Youth Justice Agency, 2019).

There are a few factors that appear to moderate victim satisfaction:

- Victims who provide written submissions to a Youth Justice FGC are likely to be less satisfied than those who attend in person (Shapland et al., 2007).
- Victims are likely to be less satisfied if they are not offered sufficient support to feel safe and not be intimidated by the offender (M. Anderson & Parkinson, 2018; Wemmers & Canuto, 2002).
- The potential for revictimisation needs to be examined and mitigated. Victims should be offered the option of having a representative attend in their place, or of

writing a letter to be read out by the youth justice coordinator (O'Driscoll, 2008; Slater et al., 2015).

New Zealand data analysis has found that victims who engage in restorative justice processes are generally satisfied with their experiences. Satisfaction rates are particularly high among young victims (aged under 19), and among Māori and Pacific peoples (Ministry of Justice, 2016). It is unclear to what extent child victims of sexual crime have participated in Youth Justice FGCs and how satisfied they are with the processes and the outcomes achieved.

New Zealand research and models of restorative justice in sexual violence cases are showing good benefits – for victims, perpetrators and the justice system

While attendance at Youth Justice FGCs and their overseas equivalents has been linked to improved victim wellbeing (Becroft, 2017; Blecher, 2011; Daly, 2002), there is a surprisingly thin evidence base for restorative justice and Youth Justice FGCs in the context of sexual violence.

Researchers recently sought to systematically review previous peer-reviewed studies of the use of restorative justice methods for sexual offences and family violence, but identified only one eligible study (Gang et al., 2021). The authors concluded that there was an urgent need for evaluations of restorative justice programmes that accept sexual and family violence cases (Gang et al., 2021, p. 1).

The eligible study was an evaluation of the RESTORE programme (Responsibility and Equity for Sexual Transgressions Offering a Restorative Experience) in Arizona in the United States. The programme linked a conferencing model with community-based therapy services to process adult misdemeanour and felony sex crimes cases referred by the courts.

Notable features of the RESTORE programme include the following (Koss, 2014; Lopez & Koss, 2017):

- The perpetrator and victim prepare for the conference independently. The preparation addresses safety concerns, ground rules for participation, the conference agenda, development of written statements, discussion of what a redress plan might include, and preparation of support networks.
- The conference takes place in a local police station, led by a trained RESTORE facilitator, and with a prepared agenda.
- There is a focus on the accountability and re-integration of the perpetrator. Over 12 months, the perpetrator was required to complete the redress plan, maintain regular telephone and in-person contact with a case manager, attend quarterly meetings with a Community Accountability and Reintegration Board (CARB), comply with stay-away orders, and present a written statement of apology at the final CARB meeting.
- In cases where victims did not want to attend the conference, community members were trained as Victim Representatives and attended the conference, read written statements, and stated the impact of the offence on the victim.

Inspired by the Arizona RESTORE programme and the research of Associate Professor Shirley Jülich at Massey University, Project Restore NZ was launched in 2005 (Jülich, 2016). It is a national provider of restorative justice designed specifically for harmful sexual behaviour and sexual violence.

Project Restore NZ is a specialist sexual violence restorative justice service that has merit

Project Restore NZ's model is a modified Youth Justice FGC. It consists of (Jülich, 2016; Jülich et al., 2009, 2010; Jülich & Landon, 2013):

- a restorative justice facilitator who has an in-depth understanding of the dynamics of sexual violence. These are Project Restore NZ staff.
- two community specialists – a survivor specialist and an offender specialist with in-depth understanding of restorative justice.
  - If the victim was a child when the sexual violence occurred, a therapist from the SAFE Network is contracted as the offender specialist (Jülich et al., 2010).
  - If the victim was an adult when the sexual violence occurred, Project Restore NZ contracts a therapist in private practice working with offenders who offend against adults.
- a clinical psychologist – this is a clinical consultant who has a background in and understanding of working with both survivors and offenders. They provide professional supervision and act as team leader, but have no face-to-face contact with victims or offenders.
- Referrals come from the criminal courts and from the community.
- If the victim chooses not to participate in the conference, a surrogate is sent in their place, and these cases are called "community panels".
- There is careful on-going assessment during the extensive preparation phase and the case review process.
- Follow-up work is done by the Project Restore NZ team to ensure that the outcomes identified in the plan are achieved (Jülich & Landon, 2013). Project Restore NZ asks for feedback from stakeholders on all cases by using evaluation forms. The feedback is regularly reviewed, practices are reflected on and changes made as required.

Compared to Youth Justice FGCs, Project Restore NZ puts the victim at the centre. The process is reviewed and tailored to the needs of the victim. The model seeks to provide a "sense of justice" for victims, to maximise the opportunity for healing, and to minimise chances of harm. Ongoing evaluation[6] of the Project Restore NZ model has found evidence that:

[6] The evaluation reports acknowledge the difficulty of undertaking evaluative work in this field. Researchers achieved low response rates to the surveys, telephone interviews and face-to-face meetings, which hindered the ability to make more conclusive statements about the efficacy of Project Restore NZ.

- The model follows the principles of restorative justice best practice as set by the Ministry of Justice.
- It enables financial restitution.
- It addresses the underlying causes of the offending, victims are able to hear the offender admit guilt, relationships are transformed, victims are able to speak about the incident, and victims have a sense of justice.
- Victims have an increased sense of wellbeing, which may minimise their future vulnerability to sexual revictimisation.

Project Restore NZ has estimated on average that the cost to government per case that is conferenced is $3,800, and $1,230 per case for those that do not result in a restorative process. The organisational costs are on average an additional $1,300 per case (Jülich et al., 2010). It is a cost-effective intervention given the estimated cost of $72,000 per incidence of sexual violence as estimated by Treasury officials (Roper & Thompson, 2006).

There appears to be scope to bolster funding for Project Restore NZ and to ensure it is continuously improved through ongoing evaluation and monitoring activities. It would also be beneficial to examine how Project Restore NZ supports child victims and to identify the outcomes achieved. Unfortunately, a baseline survey of adult specialist sexual violence services in New Zealand finds that there is increasing demand by children for specialist sexual violence services (Gregory et al., 2021). Some specialist NGOs indicated that they supported people under 18 years, even though their contract with MSD did not fund them for this, and this was especially so for those where there were no specialist services for young people in the local area. The need for more flexible contracts was voiced by service providers to address this issue.

There have also been calls for “mainstream” specialist sexual violence services, including Project Restore, to consider how it would deliver culturally appropriate restorative and resolution options for minority ethnic families and communities (Shama Hamilton Ethnic Women’s Centre, 2019). In 2013, an MSD review of the specialist sexual violence sector expressed concern about the limited availability of specialist Kaupapa Māori, Pacific and other ethnic-specific sexual violence services (MSD, 2013). Unfortunately, this gap does not appear to have been addressed in the intervening eight years. The following section discusses the contribution of Kaupapa Māori services.

6. Kaupapa Māori services

There is a shortage of Kaupapa Māori services

Kaupapa Māori services may be defined as "Indigenous, localised, whānau-centred solutions designed by Māori, with Māori, underpinned by tikanga and delivered by providers who identify as Māori, primarily for Māori, but available to all" (ACC, 2021).

There is a significant shortage of specialised, Kaupapa Māori support services available for tamariki and rangatahi who have experienced sexual abuse – a fact noted by numerous providers and authors (*Interview with Kaupapa Maori Provider of Specialist Sexual Support Services*, personal communication, August 2021; Malatest International, 2018; MSD, 2013; Te Wiata & Smith, 2016; TOAH-NNEST, 2014) and in a recent Oranga Tamariki Evidence Brief (Oranga Tamariki Evidence Centre, 2020a).

There are fewer than five specialist Kaupapa Māori providers (for adults or children) in the North Island, and only one provider in the South Island, according to stakeholders from the sector and the national umbrella group for specialist sexual violence NGOs, TOAH-NNEST (*Interview with Kaupapa Māori Provider of Specialist Sexual Support Services*, personal communication, August 2021; TOAH-NNEST, 2014).

Te Wiata and Smith (2016) explain that a number of Kaupapa Māori providers have closed over the years, due to the challenges of meeting specific, Westernised criteria as to how services will be delivered, and associated challenges in securing funding.

The lack of Kaupapa Māori services is particularly concerning – given that rates of reported sexual abuse are higher for Māori, and that culturally inappropriate services may revictimise children (Cram et al., 1999) and prevent them from disclosing or discussing their experiences of abuse.

> *"[W]hen I went to a Pakeha counsellor they didn't listen and just made me feel worse so I stopped going, I didn't want to talk about it anymore." (TOAH-NNEST, 2014, p. 5)*

Kaupapa Māori providers have a whānau-centric and holistic view of recovery

A desktop review of Kaupapa Māori providers (conducted for this Evidence Brief) indicates that the range of services offered is similar to other specialist NGOs. It includes community-based prevention programmes, crisis support and helplines, social work, counselling, and advocacy. However, Māori providers tend to define sexual violence and recovery in more holistic terms, and this affects **how** support is delivered.

Definitions of sexual violence, models of healing

A Te Ao Māori view of sexual violence includes the negative effects that abuse has on mana and tapu[7] (TOAH-NNEST, 2014). Like mainstream services, there is an acknowledgement of the impact of abuse on people's physical and emotional wellbeing; however, Kaupapa Māori services will also focus closely on the social and relational effects and the spiritual effects of abuse (TOAH-NNEST, 2014). Abuse is seen to affect not just the individual but the wider whānau, including previous generations and those to come.

> *"Any violation of te whare tangata (house of the people) such as abuse of the genital area and rape, has the potential to create distress amongst Māori women. This distress is not only physical or psychological in origin, but also spiritual and has multiple dimensions to it. Not only is this a violation of the woman herself but also a violation of her tīpuna [ancestors] and future generations. Spiritual distress is often a dimension that is neither recognised nor acknowledged but one that impedes recovery and healing"* (Wilson, nd, as cited by Pihama & McRoberts, 2009).

When abuse is conceptualised in this way, then healing is also defined more broadly. Mason Durie's influential model of "Te Whare Tapa Whā" frames health as a wharenui (meeting house) placed on the whenua (land) (*Te Whare Tapa Whā*, 2021). Holistic health includes the walls of taha tinana (physical health) and taha whānau (family and social health), upon which rests the roof of taha hinengaro (mental and emotional health) and taha wairua (spiritual health) (*Te Whare Tapa Whā*, 2021). This model was the basis for his subsequent counselling model of Paiheretia, which aims to help people achieve stronger connections to their cultural identity, to others, and to their wider context (McLachlan et al., 2017).

Durie's holistic models are reinforced by authors such as Cram et al (1999; Cram & Sauni, 2015), who note the importance of whānau healing and maintenance of wairua (or spirit) as key needs for Māori victims of crime. Likewise, TOAH-NNEST state that part of their service vision is to "strengthen, enhance and increase wairua, mana, tapu, potency and vitality of the whānau" (TOAH-NNEST, 2014, p. 6).

Other models such as Tihei-wa Mauri Ora are frequently used by services focused on health and recovery (Te Wiata & Smith, 2016). The model was developed by Teina Piripi and Vivienne Body and is based on concepts of creation. People move from Te Korekore (a void), through Te Pō (the night), to the turning point of Te Whei-Ao (glimmer of light) and on to Te Ao Mārama (world of light), and finally to Tihei-wa Mauri Ora (the breath of life). So this translates to shifting from the realm of potential being to the world of becoming, moving from darkness and into light, and finally into the realm of being (Te Wiata & Smith, 2016). It is easy to see how this model applies to trauma-focused talk-based therapy, for instance, as people seek to move past the darkness of their trauma, and toward a more hopeful future that they help to shape.

Rigid systems for funding and delivering support services can make it difficult for Kaupapa Māori providers to apply these holistic models. For instance, ACC assessors may claim that the models and related treatments are not evidence-based (discussed in Te Wiata and Smith, 2016). It can also be challenging to include

[7] Mana = prestige, authority, control, power, influence, status, spiritual power, charisma; mana is a supernatural force in a person, place or object. Tapu = sacred, prohibited, restricted, set apart, forbidden (Māori Dictionary, 2021).

whānau healing as a core part of service delivery when institutions are designed on a person-centric, Western model (Te Wiata & Smith, 2016).

Kaupapa Māori services in practice – whanaungatanga, manaakitanga and a strengths-based approach

Kaupapa Māori providers incorporate tikanga (or traditional practices) into their work. This includes whakawhanaungatanga – or establishing links between a person and their wider community, through mihi and pepeha (introductions), and engagement with the wider whānau, including non-offending caregivers.

There is a strong focus on manaakitanga, on making people feel welcomed and comfortable. This may include operating services within home rather than clinical settings, having visible cultural references (Te Wiata & Smith, 2016), and sharing cups of tea and kai together. As one Kaupapa Māori provider explained:

> *"A lot of people talk about concepts like whanaungatanga, manaakitanga, but we actually practice it. And it works. We use those practices for engagement initially – because the engagement is the thing that sets the trust and terms of engagement, for going forward. If you haven't got that right, it's not going to work. Tikanga is really important, so we can get down to business." (Stakeholder from Kaupapa Māori service)*

The Kaupapa Māori approach also tends to be strengths-based and empowering. Providers emphasise that whānau can find their own answers to protect young people and prevent abuse – meaning the provider is a facilitator of change, rather than an expert that the family may become dependent on (*Interview with Kaupapa Māori Provider of Specialist Sexual Support Services*, personal communication, August 2021).

For Māori, culturally appropriate support services are likely to be more effective than "mainstream" services; more research and evaluation is required

To date, there has been very little research on the efficacy of Kaupapa Māori support services, or research into the experiences of Māori victims/survivors of crime, more generally (Cram et al., 1999; Cram & Sauni, 2015; Oranga Tamariki Evidence Centre, 2020b; Te Wiata & Smith, 2016). In terms of talk-based therapies, a previous Evidence Brief noted that "Kaupapa Māori and tikanga continue to be applied by Māori practitioners, despite limited mainstream acknowledgement and validation as effective clinical approaches" (Oranga Tamariki Evidence Centre, 2020b, p. 6).

Although formal studies may be lacking, researchers have highlighted the value of the Kaupapa Māori approach, and culturally informed approaches more generally. For instance, evaluators from Malatest International have observed that:

> *"Kaupapa Māori providers are best placed to support Māori in minimising harm from sexual violence. Across the health and social services, those provided by Māori for Māori have been shown to be successful in identifying and meeting community, whānau and individual needs in ways that mainstream services cannot" (Malatest International, 2018, p. 11).*

Similarly, in research focused on what New Zealand teens want from sexual violence support services, Woodley et al (2013) found:

> *"For most young people, an understanding of, and respect for, their culture was central to the efficacy of support and service delivery. Importantly they want staff and services that are culturally responsive, and that understand the different cultural worlds in which they live" (p. vi).*

There is a need for more specialist NGO services that are by Māori and for Māori (Cram et al., 1999; Malatest International, 2018; TOAH-NNEST, 2014). The organisations delivering these services should be trained in Kaupapa Māori and tikanga, ensure robust quality assurance measures are in place, and use monitoring and evaluation to build the depth of the evidence base for Kaupapa Māori approaches (TOAH-NNEST, 2014).

Conclusion and next steps

Principles of effective support

When it comes to delivering effective support services to young victims of sexual crime, the research base indicates that there are several key principles. Services will ideally be:

- **Specialised** – delivered by people and organisations that understand sexual trauma and how to work with young victims.
- **Accessible** – in terms of location and ease of entry into a service. Services should be based in locations where children are, or be available through other channels such as helplines. Barriers to access should be removed (for example, barriers to the ACC Sensitive Claims scheme). Settings should be relatively informal, or at least non-clinical or non-judicial.
- **Supportive** – with victims feeling heard, believed and empowered, rather than judged.
- **Well integrated** – with strong connections between the various government agencies that respond to abuse, and also between those agencies and the specialist NGO sector.
- **Stable and continuous** – young people value continuity in their relationships, and the ability to access services when they need them, including over the long term.
- **Culturally responsive** – abuse and recovery should be framed in ways that resonate with young people, and services for Māori should be holistic and engage the wider whānau.
- **Supportive of people's wider network** – support for including non-offending caregivers and whānau to participate is particularly important and associated with better experiences and outcomes for young people. To quote a UK review: "It was widely felt by professionals that barriers to achieving the most positive outcomes for younger children are often linked to the engagement of parents or carers" (McNeish et al., 2019, p. 4). Services should strengthen ties to the victim's peer network.
- **Early** – young people experience fewer symptoms of trauma when they have early access to effective treatments and services. There can often be a long lag before child sexual abuse is reported, so early acknowledgement and support is particularly important.

Areas where more support is needed

This Evidence Brief looked mainly at the **type** of supports available, not the **level** of support. However, it is clear that there is a shortage of specialised support for young victims of sexual crimes, and a significant shortage of Kaupapa Māori services. This

is problematic, given that early access to effective support services is vital for children to recover from abuse.

Areas where more research is needed

The Evidence Brief also identified gaps in the research base. Future research should include:

- Working in partnership with providers to adopt culturally appropriate evaluation and monitoring mechanisms into existing Kaupapa Māori services. This would ensure there is more formal tracking of the outcomes achieved by these services, opportunities for continuous improvement, and greater ability to build a case for additional investment.
- Assessing the extent to which Youth Justice FGCs, and other restorative justice approaches, are used in Aotearoa for child victims of sexual crimes. And evaluating their short-term and long-term impacts on the wellbeing of child victims of sexual crimes (and other adverse experiences).
- Putting in place monitoring and evaluation measures to routinely capture the experiences of young witnesses who engage with the justice system, the types of "special measures" used to protect children, the short-term impacts of those measures on the child's experience, and long-term wellbeing outcomes.
- Understanding the barriers to developing and delivering specialist Kaupapa Māori services for child victims of sexual crime, understanding how to remove those barriers, and evaluating the extent to which removing them would lead to an increase in the number of high-quality providers and wellbeing outcomes for tamariki and rangatahi.

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Appendix 1: Overview of the support system

Specialist NGOs provide a suite of key supports for victims

When abuse is disclosed or discovered, a wide range of organisations may be involved in the response. This includes:

- specialist sexual violence support services ("specialist NGOs", for the purposes of this report) and the Independent Sexual Violence Advisor-Advocates (Independent Advisors) that work for these agencies
- social workers from Oranga Tamariki and the NGO sector
- counsellors and mental health services
- medical specialists
- the Police, and
- stakeholders from the legal and justice systems, including lawyers, judges, juries and Court Victim Advisors and other victim-centred supports.

This section briefly summarises the role that these different organisations and individuals play, highlighting the types of support that have been reviewed in the Evidence Brief.

Specialist and generalist NGOs

There are specialist and generalist NGOs that provide support to young victims of crime in Aotearoa. Generalist providers include organisations such as Victim Support and Barnardos. Specialist NGOs include sexual assault referral centres such as HELP Auckland, and rape crisis centres. The umbrella organisation for this sector is TOAH-NNEST.

Specialist NGOs provide a range of support services for victims of sexual abuse, with a minority of providers explicitly catering for the needs of child victims. An even smaller subset of providers offer Kaupapa Māori services for tamariki and rangatahi.

The core supports offered by the specialist NGO sector include the following: crisis helplines; counselling or referrals to counselling; referrals to other agencies (for example to the Police and to medical specialists); and advocacy for victims when they are engaging with the Police, the medical system, and the justice system (Mossman et al., 2009). Davies et al observe that "it is mostly community agencies that provide families with ongoing support, information, and counselling to deal with the effects of the abuse" (Davies et al., 2000, p. 44).

Social workers / Child protection services

Social workers play a key role in responding to disclosures of abuse – by helping to assess a child's needs, referring the case on to the Police if the abuse could be considered a crime, referring children for counselling, and arranging for a child to be removed from their home if necessary.

Social workers can provide emotional support for victims, and in some instances they may also provide counselling or therapeutic services, if specialist counsellors are oversubscribed (Leary & Hay, 2019). However in New Zealand, the involvement of social workers typically ends after the victim has engaged with the Police and with medical services, and been referred on to counselling (Davies et al., 2000).

Counsellors and mental health services

Talk-based therapies for sexually abused young people are offered by counsellors and psychologists from specialist sexual violence services, other NGOs, private practice, and mental health services within the public health system.

These services may be funded through the ACC Sensitive Claims scheme, if a clear link can be drawn between a specific event of abuse, and the need for counselling.

Medical specialists

Specialised medical staff provide health checks for victims of sexual abuse – for instance, to assess and address injury, and to provide prophylaxis to prevent pregnancy and sexually transmitted infection amongst rape victims. These providers can also gather forensic evidence to support criminal prosecution, and refer on to crisis support, counselling and court support services (MEDSAC, 2021).

The Police

The Police investigate allegations of abuse, to determine whether there is sufficient evidence to prosecute someone. Police consult with victims during the investigation stage, and before deciding whether to prosecute (New Zealand Police, 2019).

When a victim first engages with the Police to report an allegation of abuse, the Police arrange for an evidential interview in which the victim shares their experiences. This may be recorded for later use in a court trial. The Police will also connect the victim to specialist sexual violence services, and they may refer the victim on to medical specialists and to counselling services.

The legal and justice systems

Lawyers gather evidence to be presented at trial, either in support of the victim or the defendant.

Judges and juries within the court system are responsible for determining whether the evidence indicates, beyond reasonable doubt, that a crime has been committed. If it has, judges are responsible for sentencing (for example, determining the length of jail time).

A range of victim-centred supports may be offered to improve a child's experiences as they move through the judicial system. This includes Court Victim Advisors, Communication Assistants, and Specialist Interviewers – as described in this Evidence Brief.