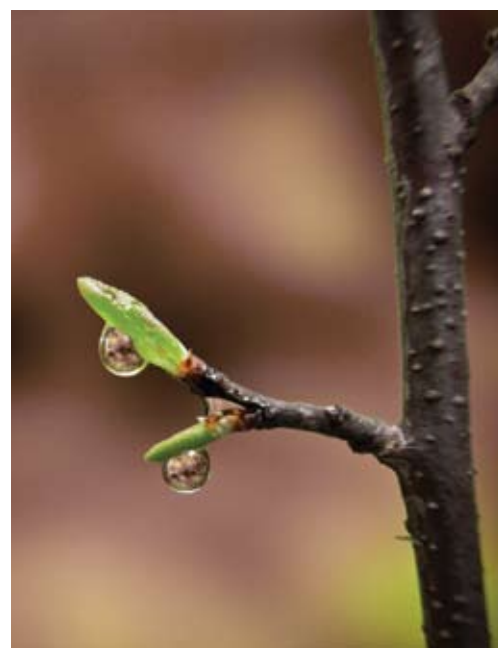


September 2009

# Responding to sexual violence **Environmental scan of New Zealand agencies**



  
MINISTRY OF WOMEN'S AFFAIRS  
MINITATANGA MŌ NGĀ WĀHINE

Authors: Elaine Mossman, Lesley MacGibbon,  
Venezia Kingi and Jan Jordan



CRIME AND JUSTICE RESEARCH CENTRE

*Te Puni Rangahau Taihara, Ture*



Commissioned by  
The Ministry of Women's Affairs

Responding to sexual violence:  
Environmental scan of New Zealand  
agencies

Elaine Mossman, Lesley MacGibbon,  
Venezia Kingi, and Jan Jordan

## Disclaimer

This report was commissioned by the Ministry of Women's Affairs. The views, opinions and conclusions expressed in the report are intended to inform and stimulate wider debate. They do not represent government policy.

Published in September 2009  
by the Ministry of Women's Affairs | Minitatanga Mō Ngā Wāhine  
PO Box 10 049, Wellington, New Zealand

Phone: 0064 4 915 7112  
Fax: 0064 4 916 1604  
Email: [mwa@mwa.govt.nz](mailto:mwa@mwa.govt.nz)  
Website: [www.mwa.govt.nz](http://www.mwa.govt.nz)

ISBN 978-0-478252-45-3

This document is available on the Ministry of Women's Affairs website:  
[www.mwa.govt.nz/news-and-pubs/publications](http://www.mwa.govt.nz/news-and-pubs/publications)

# Contents

<b>List of tables</b> .....	<b>v</b>
<b>List of figures</b> .....	<b>vi</b>
<b>Acknowledgements</b> .....	<b>vii</b>
<b>Executive Summary</b> .....	<b>ix</b>
<b>Part one: Introduction</b> .....	<b>1</b>
<b>1 Background</b> .....	<b>1</b>
1.1 Project overview .....	1
1.2 Rationale for the environmental scan .....	2
1.3 Aim of the environmental scan.....	2
1.4 Structure of the report .....	2
<b>2 Methodology</b> .....	<b>5</b>
2.1 Research objectives.....	5
2.2 Survey instruments .....	5
2.3 Ethical issues .....	5
2.4 Samples .....	6
2.5 Recruitment strategies and response rates .....	7
2.6 Methodology for Māori .....	9
2.7 Data analysis.....	10
2.8 Limitations of the research .....	11
<b>Part two: Survey respondents – roles and characteristics</b> .....	<b>13</b>
<b>3 Community service provider survey respondents</b> .....	<b>13</b>
3.1 Types of community service provider .....	13
3.2 Specialisation in relation to groups of victim/survivors .....	17
3.3 Geographical location of survey respondents.....	19
3.4 Summary.....	20
<b>4 Criminal justice survey respondents</b> .....	<b>21</b>
4.1 Police .....	23
4.2 Doctors for Sexual Abuse Care regional liaison doctors .....	24
4.3 Crown prosecutors .....	28
4.4 Court victim advisers.....	29
4.5 Summary.....	31

<b>Part three: Environmental scan of community service provision.....</b>	<b>33</b>
<b>5 Characteristics of community services .....</b>	<b>33</b>
5.1 Victim/survivors’ service needs .....	34
5.2 Types of services provided .....	37
5.3 Access to services .....	40
5.4 Survey respondents’ views on how service delivery could be improved .....	45
5.5 Summary.....	49
<b>6 Views on community capacity .....</b>	<b>51</b>
6.1 Perceived gaps in service provision for victim/survivors.....	51
6.2 Meeting emotional and medical needs .....	58
6.3 What works – effective interventions .....	63
6.4 Summary.....	65
<b>Part four: Environmental scan of criminal justice system processes .....</b>	<b>67</b>
<b>7 Phases of the criminal justice system .....</b>	<b>67</b>
7.1 Initial reporting of sexual violation.....	67
7.2 Police processing of report (initial call for service).....	71
7.3 Forensic medical examination .....	72
7.4 Formal interview.....	75
7.5 Decision to prosecute (lay charges against the defendant).....	79
7.6 Court hearings.....	80
7.7 Summary.....	84
<b>Part five: Criminal justice system and attrition .....</b>	<b>87</b>
<b>8 Criminal justice system and attrition.....</b>	<b>87</b>
8.1 Survey respondents’ views of the criminal justice system .....	87
8.2 Attrition points .....	92
8.3 Factors contributing to low rates of conviction.....	100
8.4 Survey respondents’ suggestions for change.....	109
8.5 Summary.....	123
<b>Part six: Key findings .....</b>	<b>125</b>
<b>9 Key findings .....</b>	<b>125</b>
9.1 Victim/survivors’ access to services.....	126
9.2 Capacity of victim/survivor services .....	127
9.3 ‘What works’ to promote recovery and resilience .....	128
9.4 Criminal justice system – access and attrition .....	130
9.5 Concluding comment .....	132

**Glossary of Māori terms..... 135**

**References..... 137**

## List of tables

Table 1: Response rate across different surveys or respondents .....8

Table 2: Survey sample characteristics .....9

Table 3: Categories of service provider that responded to the survey .....17

Table 4: Specialisation in services for a particular client group .....18

Table 5: Regional breakdown of service providers.....19

Table 6: Location of service providers (rural, provincial, urban).....20

Table 7: Proportion of regional liaison doctors' time spent on therapeutic and forensic services, by service type .....26

Table 8: Frequency of information requests by (n=166).....35

Table 9: Identifying additional needs .....36

Table 10: Types of services provided (n=167) .....38

Table 11: Most common methods of referral to service provider (n=166).....40

Table 12: Survey respondents' views on how they can be assisted to provide better services .....46

Table 13: Types of service providers perceived as being good at inter-agency collaboration .....49

Table 14: Proportion of respondents viewing the range or level of service provision to be inadequate .....52

Table 15: Service providers' views on factors affecting victim/survivors having their needs met.....59

Table 16: Recommendation to a close friend or family member whether to report to police or go through the criminal justice system .....88

Table 17: Proportion of respondents with concerns about the criminal justice system's ability to respond to or deal with diverse groups of victim/survivors .....91

# List of figures

Figure 1: Police districts (12) used for regional analysis ..... 11

Figure 2: Involvement of different groups in the phases of the criminal justice system .....22

Figure 3: Survey participation of CIB detectives, number by police district.....24

Figure 4: Ability to disclose to a formal agency – gaps in services by region .....55

Figure 5: Emotional support needs – gaps in services by region.....56

Figure 6: Medical (non-forensic) needs – gaps in services by region .....56

Figure 7: Reports of poor or no service delivery for specific groups of victim/survivors .....58

Figure 8: Frequency of attrition during police processing (police estimates) .....93

Figure 9: Mean ratings of how well aspects of the criminal justice system are delivered  
to victim/survivors ..... 120

# Acknowledgements

We would like to acknowledge the help and support we have received from members of our research team: Dr Tess Moeke-Maxwell, who provided Māori expertise and support throughout the project; Associate Professor Peggy Fairbairn-Dunlop, who provided quality assurance and advice from a Pacific perspective; and our two research assistants, Lana Moriarty and Lynzi Armstrong.

We would also like to acknowledge and thank the Ministry of Women's Affairs staff with whom we had a working relationship over the life of the project: Dr Denise Lievore, Research Manager; Nicole Benkert, Research Co-ordinator; and Lynda Byrne, Senior Policy Analyst. All provided valuable guidance, support and feedback on methodology and various drafts of the report.

Feedback on research instruments and draft reports was also provided by the members of the project advisory group and this was greatly appreciated. This group was made up of representatives from the Ministry of Justice, the New Zealand Police, the Secretariat of the Taskforce for Action on Sexual Violence, the Accident Compensation Corporation, Te Puni Kōkiri, the Ministry of Pacific Island Affairs, the Ministry of Social Development, Te Ohaakii a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST) and the National Collective of Rape Crisis. In particular our thanks go to Paulette Benton-Greig and Sandz Peipi from TOAH-NNEST who provided support, information and guidance to the researchers. We would also like to acknowledge the advice and support provided by the members of the project steering group.

We also greatly appreciated feedback provided by several other individuals who generously gave their time to review early versions of the survey instruments: Hayley Samuel, National Manager of Doctors of Sexual Assault Care; Grant Burston, Wellington Crown Solicitor; Mike Arnerich and Neil Holden, New Zealand Police; Margaret McGregor, Regional Victim Adviser Co-ordinator; and Tae Tu-inukuafe, Ministry of Justice. We are also very grateful to the individuals and services that assisted us with the distribution of surveys.

We would like to acknowledge and thank Liz Olle for her valuable and insightful feedback on the report in its final stages.

Finally, we would like to extend a very special thank you to all those who completed a survey, an extra demand during busy and often pressured working days. They have provided valuable information and insights on those agencies that are tasked with the critically important work of responding to adult victim/survivors of sexual violence.





# Executive Summary

## Part one: Introduction

Researchers from the Crime and Justice Research Centre, Victoria University of Wellington, were contracted by the Ministry of Women's Affairs to undertake four work streams relating to effective interventions for adult victim/survivors of sexual violence. This report presents the findings of an environmental scan of agencies and key informants that respond to victim/survivors of sexual violence.

The objectives of the environmental scan were to identify key informants' views on:

- factors influencing victim/survivors' access to the criminal justice system and non-criminal justice services
- victim services' capacity to meet victim/survivors' needs, including gaps in services
- victim services' views on what works to promote recovery and resilience
- the impact of location on victim/survivors' ability to disclose sexual violence, particularly in respect of the level of services available locally, and have their needs met
- police and prosecutors' views on attrition of recorded sexual violation offences and the effect of systemic, organisational and other contextual factors on investigating and prosecuting sexual violation offences.

The key informants for this environmental scan are the individuals and agencies that respond to adult victim/survivors of sexual violence.

- **Community service providers:** specialist sexual violence agencies, women's refuges, Victim Support offices, mental health counselling services, medical service providers, and other community agencies. These service providers respond to the needs of victim/survivors who do not access criminal justice services, as well as those who report their assault to police.
- **Criminal justice groups:** police, sexual assault doctors who perform forensic medical examinations, court victim advisers and Crown prosecutors.

Survey instruments were developed in consultation with the Ministry of Women's Affairs and reviewed by the project advisory group. The nature of contact between the different key informants and victim/survivors varied greatly, requiring five individually tailored surveys to be developed for the community service providers, sexual assault doctors, police, court victim advisers and Crown prosecutors. A range of different recruitment methods were used to invite the different groups of key informants to participate. Over 1,300 surveys were sent out, and 458 completed surveys were returned. Response rates for different groups ranged from 10 percent for Māori providers to 78 percent for specialist sexual violence services. The low response rate from Māori providers means their view has not been comprehensively

represented in this report. Comments from some Māori providers suggested a kaupapa Māori research methodology (i.e. a methodology underpinned by Māori philosophies and practices) would have been more appropriate.

It is important to note that this report is not a stocktake of services, because the characteristics of those who did not respond to the survey are unknown.

## Part two: Survey respondents – roles and characteristics

Descriptive information on survey respondents provides important details about the research sample and is a useful summary of the main groups in New Zealand who respond to victim/survivors of sexual violence.

### Community-based service providers

A good coverage of community-based services was achieved from 12 regions across New Zealand. The majority of service providers who participated in the survey came from a major urban centre or provincial town (82 percent); only 8 percent indicated they were located in a rural area, although a further 9 percent reported that their service covered a range of locations, including rural areas. Service providers who participated in the survey were grouped into the following six categories. The number of respondents in each group appears in brackets.

- **Specialist sexual violence agencies (SSVA) (n=27)** are the primary group that provides specialist support and services to victim/survivors of sexual violence, typically including 24-hour crisis support. They are the only type of service provider that specialises solely on victim/survivors. Providers within this group include Rape Crisis centres, HELP Foundation centres, and other independent sexual violence and/or sexual abuse centres.
- **Women's refuges (n=11)** provide specialist 24-hour support, advocacy and accommodation for women and their children who are experiencing domestic violence. A significant proportion of these women have also been sexually victimised by their partner or husband. Women's refuges play an important role in supporting these women, many of whom do not report their sexual violence to other formal agencies.
- **Victim Support (n=42)** is a nationwide organisation staffed by volunteers that offer support to all victims of crime, including victim/survivors of sexual violence. While Victim Support accepts self-referrals, most victim/survivors they support are those who have reported the violence to police.
- **Mental health counselling services (n=66)** are the individual counsellors or service providers that provide counselling and emotional support services to victim/survivors. This includes Accident Compensation Corporation registered counsellors who provide government-subsided counselling to victims of sexual abuse (including sexual violation).

- **Medical providers (n=15)** are family planning agencies, sexual health clinics and university health centres. These service providers respond to victim/survivors who are seeking medical treatment after a sexual violation.<sup>1</sup>
- **Other community agencies (n=18)** are Māori community social service agencies, women's health centres, sex-worker organisations, and stopping violence organisations.

There was considerable variation across the different groups of survey respondents in the level of specialisation, the volumes of victim/survivors of sexual violence seen, and the types of services offered. These differences are likely to affect service providers' views and understanding of the needs of the victim/survivors with whom they work.

### **Criminal justice survey respondents**

The following key members of the criminal justice system participated in the environmental scan. Their main roles and responsibilities within the criminal justice system are highlighted.

- **Police (n=206)**. Their responsibilities include processing initial reports of sexual violation, investigating complaints, and deciding whether it is appropriate to prosecute the offender by laying charges in court. They are then involved in ongoing liaison with the victim/complainant<sup>2</sup> and Crown prosecution as the case progresses through the court system.
- **Doctors for Sexual Assault Care (DSAC) regional liaison doctors (RLDs) (n=10)**. In cases of recent sexual violation, forensic evidence can be an important element of an investigation. Ideally, this is collected as soon as possible after the assault by a specialist sexual assault doctor. The doctors who conduct the medical examination can be called on to interpret the evidence and act as expert witnesses at trial. DSAC RLDs participated in this research. They co-ordinate a roster of doctors (including themselves) who can conduct these examinations. The forensic work of sexual assault doctors can overshadow their primary role, which is to provide therapeutic care (e.g. assessment and treatment of injuries, and pregnancy and sexual health checks).
- **Crown prosecutors (n=46)**. Once a sexual violation charge has been laid in court and a judge has committed the case to trial, the case is taken on by Crown prosecutors. They review the file and lay the indictment. Crown prosecutors then present evidence against the accused at the jury trial, where they must prove against a set standard the case against the accused.

---

<sup>1</sup> For the purposes of this research, medical practitioners did not include another key group providing medical care, the specialist sexual assault doctors (DSAC-trained/accredited doctors)). This group completed a survey that was tailored to their dual role of providing both therapeutic and criminal justice services, the responses from which are dealt with alongside those of criminal justice agencies.

<sup>2</sup> The term 'victim/survivor' has been replaced with the term 'victim/complainant' in relation to criminal justice personnel. This is to more accurately reflect their status within the criminal justice system before any court outcome.

- **Court victim advisers (n=17):** This group are employed by the courts to support victims of crime through the court process. This support is available from the time charges are first laid against the defendant through to the completion of the court process. The services they provide include the provision of case information; facilitation of victim/survivors' safety whilst in court; and liaison with police, prosecutors, the judiciary, and community organisations. They also inform the court of the victims' views and ensure victims of crime are informed of their rights under the Victims' Right Act 2002.

It is important to note that families/whānau and friends, together with the support agencies also play significant roles in supporting a victim/survivor through the criminal justice system.

### Part three: Environmental scan of community service provision

#### Characteristics of community service providers

Summarised below is descriptive information about the community service providers that participated in the survey. This is based on self-reported information provided by representatives from agencies or individual service providers (i.e. counsellors) and looks at the characteristics of the clients they see, the services they provide, and their views on what could assist them to improve service delivery.

**Victim/survivor service needs:** The majority of clients seen by community service providers were seeking help for historical sexual violence (violence occurring over 12 months ago). Victim Support and women's refuges were the only type of service providers where recent sexual violence cases were more frequent – half or more of their caseloads (82 percent and 70 percent, respectively).

The most frequent requests to service providers from victim/survivors were for information on counselling, followed by a related request on 'how to feel better'. However, only those who recognised, and were able to name, their experience as 'rape', were likely to seek assistance. Information on court processes, reporting to the police, and victims' rights were also frequently requested. Service providers identified that victim/survivors that came to them had high levels of complex needs. Of particular concern was the low number of support services available to assist victim/survivors with immigration, English language and accommodation issues.

**Types of services provided:** Agencies such as SSVAs provide a wide range of services, whereas other agencies have particular areas of focus (e.g. medical services or mental health counselling services).

- **Sexual violence support services:** SSVAs and women's refuges were most likely to provide 24-hour crisis intervention, advocacy and support, and sexual violence education and prevention services.
- **Health and medical services:** Medical practitioners provided victim/survivors with crisis medical services, including assessment and treatment of injuries, and pregnancy, sexually transmitted infection and or other tests. SSVAs or

ACC-registered counsellors were most likely to provide services related to long-term mental health such as counselling.

- **Criminal justice related services:** SSVAs, women's refuges, and Victim Support were most likely to provide victim/survivors with support to report to the police.

Survey respondents identified limited service availability as a barrier to meeting the needs of victim/survivors and called for increased numbers of providers, including those providing specialist sexual violence services and doctors qualified to conduct forensic medical examinations. Respondents also saw the need for restorative justice services for victim/survivors of sexual violence.

**Access to services:** The most common method of referral to service providers was self-referral by the victim/survivor, except for Victim Support where most referrals came from the police. Māori have comparatively higher rates of referral from the victim/survivor's family/whānau and friends. High levels of self-referral point to the importance of service providers and their respective services being well publicised.

Service providers perceived that they were better able to deliver services to some groups of victim/survivors than others, which suggests some groups of victim/survivors have better access to effective services than others. Service providers felt least able to deliver services well to the following client groups:

- ethnic, migrant, refugee clients (65 percent of service providers rated their service delivery as average or worse)
- Pacific peoples (49 percent of service providers rated their service delivery as average or worse)
- people with disabilities (47 percent of service providers rated their service delivery as average or worse).

Just under a third of service providers had concerns about their ability to deliver services to Māori (30 percent) and male victim/survivors (29 percent), and around a quarter in relation to victim/survivors who were sex-workers (24 percent).

Improvements in service delivery for certain groups of victim/survivors were suggested, including making ACC funding available for those now living in New Zealand but experienced an assault overseas (e.g. Pacific peoples, and ethnic minority, migrant and refugee groups). Services to these later groups were also felt to be limited by providers' inadequate knowledge of relevant languages and cultures.

#### **Survey respondents' views on how they could improve service delivery:**

- **Increased funding** was identified as one of the top two needs by four out of the seven types of service providers. SSVAs appeared to be the least well resourced with 96 percent of SSVAs calling for more funding to enable them to improve service delivery. The increased funding would be used to increase workforce capacity and improve facilities and equipment.
- Another major issue for SSVAs related to **improved access to services**. Over two-thirds of SSVAs indicated this as a way to provide better services, compared

to around one-third or fewer respondents from other services. This reflected a concern over a relatively low level of awareness of SSVAs in the community and communities' lack of awareness about the meaning of 'rape' and barriers associated with the stigma of 'rape'.

- Māori service providers indicated that addressing **workforce issues** would improve their service delivery, with 10 out of 13 Māori providers needing more qualified and experienced staff and 8 needing more staff.
- Service providers recognised the importance of **inter-agency collaboration** for the effective delivery of services. While many service providers, particularly SSVAs, were considered to be collaborating well with other agencies, there is still room for improvement. Only around 30 percent of survey respondents had any formal agreements with other agencies for such collaborative work.
- Other ways to improve service delivery included improving the responsiveness of ACC services and systems, improving access to funding for practical support (i.e. childcare and transport) and ensuring adequate coverage of services to all regions.

## Views on community capacity

The views of a wide range of survey respondents (community service providers and criminal justice groups) were sought on the capacity of their community to respond to the needs of victim/survivors. In contrast to the previous self-reports about the services agencies delivered, this section asked them to stand back and comment more broadly on the overall level of service provision in their community.

Survey respondents were asked whether the range or level of services in their area:

- enabled victim/survivors to disclose to a formal agency
- meet victim/survivors' emotional support needs
- meet victim/survivors' medical (non-forensic) needs.

Nationally, the greatest concern was an insufficient level of service provision to ensure victim/survivors could have their emotional support needs met. Community service providers appeared to have greater concerns over gaps in services than criminal justice groups. Particular concerns were the costs and delays in accessing ACC-funded counselling and the inadequacy of resources for SSVAs to provide these services efficiently.

Some areas appeared to be better resourced than others. Bay of Plenty was the region seen to be most lacking in services, and Canterbury was seen as one of the better resourced regions.

Service providers were also asked to rate the extent of service provision for specific groups of victim/survivors within their community. Half of service providers identified gaps in services for new migrants and refugees, and over a third identified gaps in services to Pacific peoples. Few services for sex-workers, people with disabilities and men were also noted. These findings very much mirrored concerns from the service providers about their ability to respond to these particular groups.

**Service providers' perceptions of barriers that prevent victim/survivors having their needs met:**

- **Shame and self-blame:** Forty-four percent of service providers identified shame and self-blame as barriers to victim/survivors accessing services in order to have their emotional support needs met. Shame and self-blame were also seen to be a barrier to victim/survivors accessing medical services, although this was noted by a smaller proportion of respondents (15 percent).
- **Lack of information about available services:** Forty-one percent of service providers stated that a lack of information for victim/survivors about the availability of services limited their ability to access emotional support services, particularly those who were victim/survivors of historical sexual violence. Concerns were raised about the lack of information about ACC entitlements and how to access suitable counsellors. A lack of information was also seen as a barrier to victim/survivors accessing services to meet their medical needs (noted by 39 percent of respondents). Victim/survivors were often unaware of available services other than the hospital emergency department or their family doctor.
- **Costs:** Forty percent of service providers identified the cost of services as a factor preventing victim/survivors accessing services to have their emotional needs met. A slightly higher proportion noted this as a barrier to their accessing services to get their medical needs met (50 percent).
- **A lack of services:** Twenty-five percent of respondents saw the lack of services as a factor limiting victim/survivors access to emotional support services. Gaps in services for specific groups such as young people (16–25 years) and Pacific peoples were seen as being particularly problematic. The inadequacy of services in rural areas was also noted.
- **Geographical isolation:** This was identified as a problem in relation to victim/survivors accessing emotional support services (14 percent) and medical services (8 percent).

**Service providers' perceptions of factors that assist victim/survivors to have their needs met:**

- **The availability of good quality services** was identified by 98 service providers (63 percent) as a key to ensuring victim/survivors can have their emotional support needs met. The key characteristics of good quality services included being immediately accessible, being affordable or free, offering a choice of services, and being widely advertised. Quality services were also seen as important in ensuring victim/survivors were able to have their medical needs met (40 percent). A quality medical service was identified as one with approachable, knowledgeable, non-judgemental doctors and nurses who were supportive of victim/survivors of sexual violence.
- **Good inter-agency collaboration and referral systems** were seen as crucial for services to be able to meet victim/survivors' emotional support needs (n=60, 38 percent) and medical needs (n=50, 42 percent).



- **Provision of practical support** such as childcare and transport was noted by 6 percent of respondents as assisting victim/survivors to be able to access the services they require.
- **Workforce issues:** One-third of Māori services reported being able to provide services effectively to Māori victim/survivors. However, along with non-Māori services, their capacity to respond effectively is impeded by a lack of a highly skilled mental health workforce to provide specialist counselling services.

**What works – effective interventions:** Seventy-six percent of community service providers identified interventions or aspects of service delivery that, in their view, were working well in their community. Key themes were the need for competent and consistent support services, and the ability to meet the need of diverse groups.

- **Effective counselling:** The most frequently cited intervention that was seen to promote recovery and well-being in victim/survivors was effective counselling (65 percent, n=39). Initiatives that enhanced access to effective counselling included counsellor co-ordination across the region, counselling models that include whānau, group counselling, free counselling after ACC funding expires, and culturally matched counselling.
- **Effective crisis support:** The second most frequently cited effective intervention was effective crisis support (58 percent, n=35). Service providers that were perceived as providing effective crisis support included HELP centres, sexual abuse centres, rape crisis centres, Māori agencies, women's refuges, women's centres, and abuse prevention agencies. In one region, an online service for victim/survivors was seen to be showing promise.

Other effective interventions included providing follow-up support, effective interventions for specific groups, good inter-agency collaboration, police specialisation and good liaison, and rape prevention and education programmes.

## Part four: Environmental scan of criminal justice processes

### Phases of the criminal justice system

The criminal justice system consists of the police and the network of courts and legal processes that deal with the enforcement of criminal laws, including the laws that prohibit sexual violation. Victim/survivors who enter this system can experience it in diverse ways: highly validating and supportive or inflicting secondary victimisation (Herman, 2005; Jordan, 2004). Survey respondents revealed a system both complex in nature and involving protracted processes that victim/survivors had to negotiate.

The key phases through which a victim/survivor might typically progress are:

- initial disclosure of sexual violation to police
- police processing of initial report (initial call for service)

- forensic medical examination
- formal interview by police
- decision to prosecute
- court hearings.

There were several points where seeking justice was seen to be re-traumatising for victim/survivors and many respondents raised concerns about the system's ability to deliver justice for all victim/survivors. While the majority of respondents were supportive of victim/survivors reporting sexual violation to the police, fewer said they would advise a friend or family member to go through the criminal justice system (only 20 percent of DSAC RLDS, 38 percent of service providers, 39 percent of Crown prosecutors, and 59 percent of police).

Of particular note were the number of respondents who said their advice would depend on the individual circumstances of the case (e.g. if there was no corroborating evidence and the case relied on disproving consent, vulnerability of victim/survivor, or if they had been under the influence of alcohol or other drugs at the time of the assault). Such replies suggested a clear recognition among respondents that some types of victim/survivors are less likely to receive justice.

## Part five: Criminal justice system and attrition

In New Zealand and overseas, it is understood that there is a high rate of attrition of reported sexual violation offences (i.e. a high rate of reported cases that do not proceed from one phase of the criminal justice process to the next).

Survey respondents were able to identify factors that contributed to high rates of attrition, some related specifically to certain points in the process, while others could occur at various stages (e.g. victim/complainant withdrawal).

### Non-reporting of sexual violation

The point of greatest attrition in sexual violation cases occurs before the criminal justice system because of non-reporting. It is estimated that only one in ten victim/survivors report their sexual violation to police. Community service providers identified the following factors as barriers to reporting.

- **Shame and self-blame:** Shame was identified as a particular factor inhibiting Māori, Pacific women and Asian women, and male victims from reporting. Self-blame was also seen as a problem for victim/survivors when alcohol or other drugs were involved and for victim/survivors who were in a relationship with the abuser. In rural communities, police may be known to the victim/survivor, which can cause embarrassment, which was an issue identified in Māori rural communities.
- The **fear of not being believed** was seen as a barrier to not reporting for most victim/survivors, and was a particularly strong barrier for victim/survivors who were sex-workers, victim/survivors with mental health issues, victim/survivors

who had made a previous sexual violation complaint, male victim/survivors, and women raped by their partners.

- **Disbelief in criminal justice system:** One-third of service providers stated that a major factor in victim/survivors not reporting to the police was their belief that they would not get justice through the criminal justice system. Historical poor relations between police and Māori were also seen to increase levels of distrust.
- **Fear of the consequences,** including fear of retribution or reprisal by the perpetrator, was a strong factor for victim/survivors who were in continuing relationships with offenders and associated with gangs. The fear of publicity or exposure also played a part in the decision whether to report to the police.
- **Family or community pressures** were identified as a particularly strong factor related to non-reporting by Māori and Pacific victim/survivors.

### **Attrition during police processing of complaint**

Police survey respondents perceived victim/complainant withdrawal to be more common than a police decision to discontinue with a case at all points in the process except 'during investigation'. During the investigation a decision by the police not to proceed was seen as more likely than the victim/complainant withdrawing.

**Reasons for not proceeding to a full investigation:** Police explained the main reasons why cases might not proceed following an initial call for service, focusing on why a victim/complaint would withdraw their complaint, including:

- fear of the legal process
- relationship with the defendant – they could be partners or acquaintances and victim/survivors might not want them to be convicted or go to jail, and some victim/survivors feared retribution
- initial third-party pressure on the victim/complainant to make the complaint, which the victim/survivor subsequently withdrew
- alcohol or other drug consumption – either the complainant decided after sobering up that they did not want to continue, or were concerned that the level of intoxication might have contributed to the situation
- reporting solely to inform police – some victim/complainants just want the police to know what happened (or want safety or medical assistance) but for various reasons do not want to make a complaint.

A case also might not continue if early indications were that the evidential threshold would not be met; for example:

- the evidence collected is contradictory (i.e. evidence of a false complaint)
- there is insufficient evidence because of the impaired memory of the victim/complainant as a result of the influence of alcohol or other drugs
- there is a lack of corroborating evidence

- the victim/complainant has misunderstood the law, and when it is clarified it is established that sexual violation did not occur.

**Attrition during or following an investigation:** Police descriptions of why cases do not proceed beyond the investigation phase to where charges are laid, also included that the evidential threshold had not been met (the most common scenario), closely followed by the victim/complainant deciding to withdraw. As the case progressed, a factor contributing to the victim/complainant's decision to withdraw was the likely lengthy delays before the case would be heard. Other factors included the suspect not being identified, victim/complainants not being capable of giving evidence (because they have absconded, have died, cannot be located, or are mentally or emotionally unfit to withstand trial), concerns about victim credibility, and the poor prospects of getting a conviction.

### **Attrition during court proceedings**

Where a police investigation has concluded there is sufficient evidence to proceed with a prosecution, police lay charges in court against the defendant.

Police and Crown prosecutors were asked to describe why attrition in sexual violation cases occurs during the court process.

**Plea bargaining before depositions:** Responses from police indicated that plea bargaining was not common with sexual violation charges. In the few cases where plea bargaining occurred it appeared it was more likely for sexual violation charges to be amended to lesser sexual offences, than it was for sexual violation charges to be not pursued at all. In such cases the decision to negotiate appeared to be the result of weighing up the likelihood of getting a conviction against what was in the best interests of the victim/complainant.

**Attrition after depositions, before trial:** Once a case has been committed to trial, Crown prosecutors review the case file, and then 'lay an indictment'. It is possible this re-assessment can result in charges being re-formulated (i.e. either different or additional charges). It is also possible for the Crown to elect not to file an indictment. Neither were seen to be common occurrences, but electing not to file an indictment was seen as even less probable than the amendment of sexual violation charges. The most likely reason for an indictment not to be laid is when the Crown 'offers no evidence' because the victim/complainant wishes to withdraw the complaint. This would result in a section 347 discharge under the Crimes Act 1961, with the judge dismissing the case from court.

Other reasons for the case not proceeding could be that the defendant enters a guilty plea or, in rare cases, the defendant dies or disappears. It is also possible for the judge to dismiss the case over concerns for the welfare of the victim/complainant (e.g. after repeated suicide attempts).

**Trial discontinued before a final verdict is reached:** Once a case makes it to trial it may be discontinued before a verdict is reached by a jury (e.g. a 'stay of proceedings' or the judge can dismiss the case).

Examples of where a 'stay' might occur were predominantly cases where there had been lengthy delays in the case getting to trial or previous hung juries. Reasons

given for a dismissal were similar to those applicable in earlier stages of the proceedings – the court process being seen as too traumatic for the victim/complainant, or the victim/complainant not wanting to give evidence, so the Crown offering no evidence.

**Accused acquitted:** The final point of possible attrition is where, based on the evidence presented, the jury fails to find the accused guilty ‘beyond reasonable doubt’ and there is an acquittal.

For a conviction to be handed down, the jury must decide beyond reasonable doubt that the accused is guilty of the sexual violation. An over-riding theme that arose from respondents was that achieving the evidential threshold required to convince jurors beyond reasonable doubt was particularly problematic in cases of sexual violation.

Police and Crown prosecutors pointed to several factors associated with sexual violation cases that made meeting the criminal standard of proof particularly difficult. These factors included:

- the nature of the evidence, in particular the lack of corroborating evidence
- cross-examination tactics – the ability of the defence to discredit the victim/survivor as a reliable witness
- the rights of the accused – the inability of the prosecution to challenge an accused using their right to remain silent
- jury members’ lack of understanding about the nature of rape/sexual violation (and issues of consent).

A few suggestions were made about factors specific to certain groups of victim/survivors (e.g. Māori, Pacific, young people, or people with an intellectual disability): credibility issues, prejudices of juries against certain groups, and family and community pressures not to report or follow through (e.g. Māori, Pacific, and other ethnic, migrant, and refugee groups).

## Survey respondents’ suggestions for change

Many of the criticisms made and concerns identified by respondents were not new, resulting in a confirmation of issues rather than new insights. While there was a recognition of changes that had been made (e.g. legislative reforms), it was clear most respondents were still waiting for more to be done. Their suggestions are summarised below.<sup>3</sup>

**Change the way a complainant gives evidence:** A number of suggestions for improvement centred on the way victim/complainants are required to give evidence, in particular, the cross-examination of their evidence by defence counsel. There were calls for:

---

<sup>3</sup> Views are based on what would improve conditions for the victim/complainant. This research did not include views of those concerned with the rights of the accused to a fair trial (i.e. defence lawyers).

- greater judicial control over the nature and content of cross-examination of victim/complainants
- the use of alternative provisions for giving evidence, including considering whether it would be appropriate for evidence-in-chief to be given via a video recording.

**Change the availability and presentation of evidence by the accused/defence:**

Several suggestions related to increasing the availability of defence evidence, including:

- abolishing the accused's right to silence
- increasing the admissibility of propensity evidence (i.e. evidence about similar convictions and previous similar behaviour)
- requiring the full disclosure of defence evidence
- placing the onus on the accused to prove that consent had been given.

**Educate juries and the public on the nature of sexual violation/rape:** Comments throughout this report made it clear that the dominant stereotype of 'rape' as an act committed by strangers is still pervasive. This greatly affects the ability of those whose sexual violation experience does not fit this stereotype to access justice. This was reflected in the number of survey respondents who said they would not necessarily recommend to a close friend or family member that they go through the criminal justice system. In response, there were suggestions that jurors should be educated on the nature of sexual violation, either by being given information before evidence is presented, through the use of expert witnesses, or more generally, through a public education campaign.

**Consider alternative systems of criminal justice:** Several suggestions were made around more fundamental changes to the criminal justice system, including:

- judge-only trials (either a single judge or panel of judges)
- whether an inquisitorial system of justice would be more appropriate
- different options for verdicts
- expediting trials
- restorative justice as an option in addition to existing criminal justice processes
- specialist courts.

**Other suggestions:** Suggestions were made about how to improve the experience of victim/complainants.

- More specialisation by police and other criminal justice professionals. Reports indicated responses from police were variable, some good and some not so good. Increasing the availability of detectives who have specialist training in adult sexual violation was one suggestion for improving consistency.
- Ongoing provision of information for victim/survivors, including the provision of written material so information can be accessed when victim/survivors are ready and able to take it in.

- Earlier and more involvement or contact with Crown prosecutors for victim/survivors (and other agencies).
- Improved environment and facilities for victim/survivors when reporting to police and during court hearings.
- More doctors qualified to conduct forensic medical examinations to reduce travel and delays for some victim/survivors, and increased resourcing for these doctors to reflect the time involved.

### **Concluding comment**

The strength of this report is in the bringing together of information about all the agencies, services and systems with which victim/survivors may come into contact. The roles and responsibilities of the various groups have been described and an outline provided of many of the processes a victim/survivor must negotiate. Consequently, our understanding of the capacity of these groups to respond effectively to victim/survivors and the factors that affect their ability to do so have been enhanced.

Findings have revealed a range of community service providers, with varying levels of specialisation that offer a variety of services and support to victim/survivors throughout New Zealand. However, just because services exist, it does not mean victim/survivors can access them or that the services have the capacity to meet the all the needs of victim/survivors. Questions were raised about the adequacy of existing services in particular to meet the needs of victim/survivors in more remote rural areas and from diverse groups.

To improve service delivery it was clear service providers required increased funding in order to employ a sufficient number of experienced and qualified staff, and ensure services were delivered in appropriate facilities. There was also a pressing need to increase qualified, experienced staff to work with Māori victim/survivors. Societal misunderstanding of the nature of sexual violation/rape was also seen as a significant barrier to all victim/survivors being able to identify their experiences as sexual violation and to access appropriate support and justice.

Many of the concerns and criticisms identified in relation to the treatment of victim/survivors within criminal justice system were not new. While there was recognition of improvements in some areas (e.g. legislative reforms and increased specialisation and training within police), there was a strong sense that more needed to be done before victim/survivors could be guaranteed a fair and just system.

Key challenges are:

- deciding what needs to be done to ensure there is consistently good practice among all those who respond to victim/survivors
- gaining a better understanding of what is effective and fair practice to diverse groups of victim/survivors.

In relation to the criminal justice system a further challenge to making any changes will be achieving the right balance between the needs of victim/survivors and the evidential needs of a justice system that has been designed to determine the criminal liability of the accused.

The objectives and intended scope of this report were very broad. In attempting to present such a complete picture of all the agencies, services and systems that victim/survivors may come in contact with, there has been a trade-off in the inability to explore all the complexities of the information provided by survey respondents. Therefore, rather than providing all the definitive answers, this report should be seen as providing a starting point for identifying issues requiring more attention.





# Part one: Introduction

## 1 Background

This report responds to a request by the Ministry of Women's Affairs to conduct an environmental scan of agencies and key informants that respond to victim/survivors<sup>4</sup> of sexual violence.<sup>5</sup>

### 1.1 Project overview

This report comes out of one of the four interrelated work streams of the Effective Interventions for Adult Victim/Survivors of Sexual Violence research project. This project has been led by the Ministry of Women's Affairs in partnership with the Ministry of Justice and New Zealand Police. The four interrelated work streams are:

- a study of pathways from crisis to recovery, focusing on individuals who have experienced sexual violence as adults and their experiences with a variety of support sources (Kingi et al., 2009)
- an environmental scan of agencies and key informants who respond to victim/survivors, focusing on systemic, organisational and other contextual factors that influence systems and agency responses (the environmental scan)
- a retrospective analysis of attrition of sexual violation incidents recorded by the New Zealand Police (Triggs et al., 2009)
- a literature review of good practice in service delivery for services that respond to adult victim/survivors of sexual violence (Mossman et al., 2009a).

The findings from the environmental scan together with the findings from the other three work streams will contribute to the Government's considerations for policy and practice responses for victim/survivors of adult sexual violence in New Zealand. The project also has critical links with the work programme of the Taskforce for Action on Sexual Violence.

---

<sup>4</sup> The term 'victim/survivor' has been used to reflect that experiencing sexual violence is an act of victimisation that must be acknowledged as such. However, being victimised does not mean those raped should have to assume the 'victim' label with all its negative connotations; conversely, survival is neither assured nor necessarily immediately apparent: some women may always deem it a 'work in progress' (Mossman et al., 2009a: 7).

<sup>5</sup> 'Sexual violence' is a broad term that covers a continuum of sexual offending behaviours. The focus of this review is on services for victim/survivors specifically of 'sexual violation'. For the purposes of this review, we have used the legal definition of sexual violation from section 128 of the Crimes Act 1961, which covers rape and unlawful sexual connection. However, we have used the two terms 'sexual violence' and 'sexual violation' interchangeably.

## **1.2 Rationale for the environmental scan**

High-quality service delivery is crucial for meeting the crisis and longer-term needs of victim/survivors to minimise the harm experienced and to promote their future safety and well-being. International research has shown that victim/survivors' engagement with formal justice and support systems can exacerbate the harm of sexual violence and result in secondary victimisation (Campbell and Raja, 1999; Herman, 2005; Jordan, 2004; Lievore, 2005). There is a growing body of research assessing the impacts of victim/survivors' engagement with the criminal justice system, but few studies have been conducted into how well support services meet victim/survivors' needs (Campbell, 2006; Lievore, 2005; Lovett et al., 2004)

Understanding which agencies are available to respond to victim/survivors and the level and type of services they can provide is important in the development of policies and strategies that aim to ensure effective service delivery for victim/survivors.

It is also important to identify how best to support victim/survivors who want to engage with the formal justice system. A clear picture of the phases of the criminal justice system that victim/survivors must negotiate and the role of different members of the criminal justice system with whom they may come into contact, will help us to understand what might be done to ensure victim/survivors can access justice without being revictimised.

Overseas this type of information had been gathered through environmental scans of the services and agencies that respond to victim/survivors, for example, in Alberta, Canada (Tutty et al., 2005) and Australia (Lievore, 2005; NSW Violence against Women Specialist Unit, 2006). This current research is the first environmental scan for New Zealand.

## **1.3 Aim of the environmental scan**

The Ministry of Women's Affairs believes an environmental scan can assess systemic, organisational and other contextual factors that affect systems' and agencies' capacity to respond effectively to the needs of victim/survivors.

The scan entailed the in-depth surveying of key informants from systems, agencies and groups that are accessible and available to adult victim/survivors across New Zealand. These included representatives of sexual violence services and other victim service providers, medical and other helping professionals, and umbrella and advocacy organisations, and criminal justice personnel.

## **1.4 Structure of the report**

Part one introduces the background to the environmental scan (chapter 1) and outlines the methodology used to carry out the scan (chapter 2).

Part two describes the roles and characteristics of the respondents from the community service providers' survey (chapter 3) and the criminal justice survey (chapter 4). Descriptive information about the survey respondents provides

important details of the research sample and a useful summary of the main groups in New Zealand who respond to victim/survivors.

Part three is the environmental scan of community service provision. Chapter 5 is based on the self-reported information provided by representatives from agencies or individual service providers (i.e. counsellors) and looks at the characteristics of the clients they see, the services they provide, and their views on what could help them to improve service delivery. Chapter 6 describes survey respondents' comments on the overall level of service provision in their community. Where possible, the views of other key informants (Doctors for Sexual Abuse Care (DSAC) regional liaison doctors (RLDs), police, court victim advisers, and Crown prosecutors) were included alongside those of community service providers in order to gain a broader perspective on the overall level of service provision across New Zealand.

Part four (chapter 7) is the environmental scan of criminal justice system processes. Key phases of the criminal justice system are reviewed from initial entry point (i.e. the reporting of sexual violation) to court hearings. This provides a useful platform from which to consider how things might be improved.

Part five (chapter 8) looks at the attrition of sexual violation cases within the criminal justice system and reviews survey participants' views on the factors that might affect the reporting and successful prosecution of sexual violation offences.

Part six (chapter 9) brings together the key findings of this environmental scan and summarises them in relation to each of the research objectives.

The report concludes with a glossary of te reo Māori used in the report and references.



## 2 Methodology

### 2.1 Research objectives

The environmental scan focused on systemic, organisational and other contextual factors that influence systems and agency responses to victim/survivors.

The objectives of the environmental scan were to identify key informants' views on:

- factors influencing victim/survivors' access to the criminal justice system and non-criminal justice services
- victim services' capacity to meet victim/survivors' needs, including gaps in services
- victim services' views on what works to promote recovery and resilience
- the impact of location on victim/survivors' ability to disclose sexual violation, particularly in respect of the level of services available locally, and have their needs met
- police and prosecutors' views on attrition of recorded sexual violation offences and the effect of systemic, organisational and other contextual factors on investigating and prosecuting sexual violation offences.

### 2.2 Survey instruments

The survey instruments were developed in consultation with the Ministry of Women's Affairs and reviewed by the project advisory group. Five surveys were developed, one for community service providers, one for DSAC RLDs, and three for criminal justice professionals (i.e. police, Crown prosecutors, and court victim advisers).<sup>6</sup>

The Ministry of Women's Affairs and the New Zealand Police and Ministry of Justice progressively signed off the research instruments from mid-August to mid-September 2008.

### 2.3 Ethical issues

An application for ethical approval for the survey was submitted to the Human Ethics Committee, Victoria University of Wellington. The committee granted ethics approval in June 2008.

---

<sup>6</sup> Separate surveys were developed for each group to take into account the different type and timing of contact each group has with victim/survivors. For example, Crown prosecutors have contact only with victim/survivors whose case goes to trial, while community service providers are the only group that works with the victim/survivors who might not have reported their assault to police. Where possible, core questions were included to allow for comparisons across all groups.

The provisions of the Privacy Act 1993 with respect to confidentiality and methods of obtaining, storing and destroying information were adhered to.

An information letter was included with the survey. The letter described the research and told potential participants about their right not to answer any questions and the confidential nature with which their responses would be treated. Participation was voluntary and informed consent was inferred from the return of a completed survey form. All surveys were sent out with a covering letter from the Ministry of Women's Affairs that described the project and validated the survey.

## 2.4 Samples

### 2.4.1 Identifying areas for survey distribution

Service agencies and key informants were targeted in areas that had courts that held jury trials and in which Crown solicitors were located.

### 2.4.2 Identifying key informants

The aim was to survey the agencies and key informants from around New Zealand that respond to victim/survivors of sexual violence. A list of possible survey respondents was developed with assistance from the Ministry of Women's Affairs that included:

- community service providers, such as specialist sexual violence agencies (SSVAs), women's refuges, other generic victim support groups, and health professionals (e.g. counsellors and medical practitioners), and other advocacy and community groups
- criminal justice groups, such as police, judges, Crown prosecutors, and other court staff (e.g. court victim advisers).

Different strategies were used to identify and locate contact information for these groups.

On 21 May 2008 the Ministry of Women's Affairs sent out an email message informing people on its workshop and hui (meeting) contact lists that the Crime and Justice Research Centre had been awarded the contracts for the sexual violence research. Any individual or organisation interested in taking part in the research was invited to communicate their interest to the Ministry of Women's Affairs. With permission, these details were then passed to the research team. This resulted in a small number of service provider and practitioner self-referrals.

Other community service providers that responded to victim/survivors were identified from lists of those who had participated in the Ministry of Women's Affairs' workshops and hui around the research, the national register of trauma recovery agencies (i.e. SSVAs), lists of generic community agencies that might respond to victim/survivors of sexual violence, the national register of the National Collective of Independent Women's Refuges, and lists of Māori community organisations.

Most criminal justice professionals were identified and accessed through the national office of their particular organisation; for example, police and court victim advisers.

An application was made to the Judicial Research Committee to include judges in the survey. The committee declined the request for ethical reasons.

## 2.5 Recruitment strategies and response rates

Different recruitment methods were used to invite the different groups of key informants to participate in the scan. Recruitment methods included:

- a mass mail-out of surveys with a covering letter inviting those identified as responding to victim/survivors to participate
- a mail-out of surveys following an expression of interest by key informants (e.g. Accident Compensation Corporation (ACC) counsellors, university health centres and sexual health clinics)
- the distribution of surveys by the national office of various organisations to eligible parties (e.g. police, court victim advisers, Victim Support, New Zealand Family Planning)
- the distribution of surveys through regional offices to eligible parties (e.g. Crown prosecutors); some offices elected for the survey to be distributed by email
- sending an extra 105 surveys to Māori community social/health services with a covering letter in te reo Māori (Māori language) from the research team in an attempt to boost the sample size of Māori providers.

Recruitment strategies were selected on the basis of what was practical, possible and appropriate for the different groups of informants.

Response rates for the different surveys are in Table 1. More than 1,300 surveys were distributed, so it was not practical to follow-up all non-respondents. However, to maximise response rates from groups with small numbers of possible participants (SSVAs, Family Planning, DSAC RLDs, and Crown prosecutors), up to three reminders were given (by email and/or telephone phone). These reminders improved response rates, particularly for the SSVAs.

In general, response rates overall were higher than the average expected rate for self-complete surveys.<sup>7</sup> Response rates for the service provider survey ranged from almost 75 percent for SSVAs to about 10 percent for Māori service providers. Response rates for the criminal justice groups ranged from 68 percent for Crown prosecutors to 28 percent for police.

---

<sup>7</sup> Oppenheim (1992) puts the response rate for postal surveys at less than 40 percent.



**Table 1: Response rate across different surveys or respondents**

Survey or respondent	Number sent	Number received	Response rate (%)
Service provider survey			
Specialist sexual violence agencies	38	27	71
Women's refuges	47	11	23
Victim support	54	42	78
Mental health counselling services	113	66	58
Medical services	29	15	52 <sup>1</sup>
Māori providers	105	10	10
Other advocacy and community groups	32	8	25
Overall	418	179	43
Doctors for Sexual Abuse Care survey	22	10	46
Police survey	748 <sup>2</sup>	206	28
Crown prosecutor survey	70 <sup>3</sup>	46	65
Court victim adviser survey	53	17	32

## Notes

- 1 This is likely to be an over-estimate, because it was unknown how many individual family planning offices were sent a survey.
- 2 A total of 874 Criminal Investigation Branch detectives were eligible to complete the survey, but 126 were out of the office during the survey period, leaving an initial sample of 748.
- 3 Information on the number of Crown prosecutors in each office who were eligible to complete a survey was incomplete. This number is an estimate based on the offices that supplied this information.

### 2.5.1 Characteristics of survey respondents

Table 2 shows the demographics of survey respondents and reflects typical characteristics of the different workforces.

Ninety-three percent of community service providers' respondents were women, reflecting the high numbers of women who work in the social services. In contrast police work is male dominated. Police and Crown prosecutors were the only groups of respondents that had a greater representation of males (78 percent and 56 percent, respectively) than females. Police and Crown prosecutors also had the greatest representation of survey respondents who identified as New Zealand European (86 percent and 91 percent, respectively) rather than as other ethnicities. Community-based service respondents had the greatest representation of Māori across the different groups of respondents (18 percent).

More details on the characteristics of survey participants are in the main body of the report (see chapter 3 for community service providers' characteristics and chapter 4 for criminal justice groups' characteristics).

**Table 2: Survey sample characteristics**

Characteristic	SP (n=179)		Police (n=206)		CP (n=46)		VA (n=17)		DSAC (n=10)	
	n	%	n	%	n	%	n	%	n	%
Gender <sup>1</sup>										
Male	10	6	160	78	24	56	1	6	2	20
Female	150	94	45	22	19	44	15	94	8	80
Age <sup>2</sup>										
20–29	3	2	5	3	3	7	–	–	–	–
30–39	14	9	108	53	22	49	3	19	1	11
40–49	40	25	80	39	12	27	5	31	4	44
50–59	67	42	9	4	7	16	6	38	3	33
60 and over	35	22	1	1	1	2	2	13	1	11
Ethnicity <sup>3</sup>										
NZ European	114	71	175	86	41	91	12	75	7	78
Māori	29	18	13	6	2	4	2	13	–	–
Pacific	2	1	4	2	1	2	–	–	–	–
Other <sup>4</sup>	15	9	12	6	1	2	2	13	2	22

Notes: CP = Crown prosecutor; DSAC = Doctors for Sexual Abuse Care; SP = service provider; VA = court victim adviser. Percentages should be interpreted with caution because base numbers are low.

- 1 Data on gender were missing for 24 respondents (SP n=19; Police n=1; VA n=1; CP n=3).
- 2 Data on age were missing for 26 respondents (SP n=20; Police n=3; CP n=1; VA n=1; DSAC n=1).
- 3 Data on ethnicity were missing for 24 respondents (SP n=19; Police n=2; CP n=1; VA n=1; DSAC n=1).
- 4 'Other' includes Chinese, English, Irish, Australian, and New Zealander.

## 2.6 Methodology for Māori

Response rates for Māori service providers were low – less than 10 percent. This low response rate means the views of Māori service providers cannot be comprehensively represented in the survey findings. Comments from Māori providers and Māori advisers suggested that the generic nature of the data collection method did not allow for more appropriate methods to be used with Māori participants. It was felt the postal survey method and content did not encourage Māori interest and participation and did not reflect the way Māori organisations, particularly kaupapa Māori services (services based on Māori philosophies and practices), conduct their mahi (work). Hui or focus group interviews with Māori services probably would have increased participation rates, and appropriate cultural terms of engagement would have inspired greater involvement from the whole community and all services. A postal survey tends to be individualistic in approach and utilisation. A kaupapa Māori research method takes a more holistic approach

and incorporates a broader whānau (extended family) perspective, which would have reflected the aims and aspirations of Māori services more accurately.

Māori services' staff and resources are often stretched, with their priorities dedicated to their core business. Participating in this research project may not have been considered a high priority by Māori services. Some kaupapa Māori services distrusted the research kaupapa, agenda and process, which related to historical grievances about mainstream research with Māori. Some providers indicated they would have had a greater interest and investment in the project had their partnership and participation been sought to a greater extent in the initial stages of the project's development.

Given that a relatively low number of Māori services participated in this study, it may be advisable for future research to be undertaken regionally with Māori. This research would need to involve local iwi (tribes) and hapū (sub-tribes) and Māori services in the design, implementation and analysis of the research. This would ensure a kaupapa Māori or Māori research-centred approach would be used, which would maximise local buy-in, increase recruitment rates, and ensure culturally appropriate research.

## 2.7 Data analysis

Surveys were structured and included predominantly questions with tick-box options for answers. Some open-ended questions were included to allow survey respondents more flexibility in their responses.

Quantitative data were entered into a Microsoft Excel 2003 spreadsheet for checking, and then imported into SPSS software for analysis. Frequencies were produced for numerical data. Thematic analysis of qualitative data (e.g. the responses to open-ended questions) was limited, but where such data existed they were coded around key themes. Quotations from respondents are used to illustrate these themes throughout the report.

### 2.7.1 Presentation of results

Where appropriate, data were analysed by the 12 New Zealand Police districts to maintain consistency and comparability of results (see Figure 1).

Data presented in tables are usually self-explanatory, but, at times they are summarised in the body of the report. In general, throughout the report data have been presented as percentages. Raw data have been reported where the numbers involved are very small and it is misleading to report percentages, except with some comparisons across groups when it was easier to use percentages. Note too that base numbers in tables vary, because the number of respondents who answered each question varies. (For example, questions were not always applicable, comments were voluntary, and respondents could choose not to respond.)

Figure 1: Police districts (12) used for regional analysis



## 2.8 Limitations of the research

Three caveats should be noted in relation to the findings from this research.

First, we were reliant on community service providers (i.e. SSVAs, Women's Refuge), individuals (e.g. ACC counsellors) and criminal justice professionals completing and returning the surveys. Therefore, the views of key informants that we describe may not be typical of all those within a particular sector. Those who returned the completed survey might have been positively or negatively influenced in one way or another by the degree and nature of their experiences and views.

Second, this research focuses on the needs of victim/survivors of sexual violence. Therefore, the findings do not present a complete picture of the process; they exclude the views of those who work predominantly with the perpetrator, such as defence lawyers.

Third, the sampling of criminal justice sector agencies is incomplete, because we were unable to obtain the views of judges.

## **Part two: Survey respondents – roles and characteristics**

### **3 Community service provider survey respondents**

This chapter describes the respondents to the community service providers' survey. For information about those who completed one of the four individually tailored criminal justice system surveys (police, Doctors for Sexual Abuse Care (DSAC) regional liaison doctors (RLDs),<sup>8</sup> Crown prosecutors, and court victim advisers), see chapter 4.

#### **3.1 Types of community service provider**

Sexual violence results in a range of adverse physical, mental and emotional effects. Some consequences become apparent immediately after an attack, while others surface after a delay. To minimise the harm experienced by and to promote the future safety and wellbeing of victim/survivors, it is important they have access to different types of interventions that can address both their crisis and longer-term needs.

Victim/survivors need access to services that provide:

- crisis intervention and support in the immediate aftermath of sexual violence
- assessment and treatment of mental and/or physical injuries that result from sexual violence
- support and advice about accessing the criminal justice system, including undergoing a forensic medical examination
- ongoing support and advocacy following the assault
- support and assistance for the families/whānau or friends who may be seeking assistance on how to support a victim/survivor, or help for themselves to come to terms with the negative consequences of the assault.

A range of community service providers respond to victim/survivors in New Zealand. To better understand which service providers offer what types of services, a survey was sent to all agencies and services across New Zealand that had been identified as responding to adult (aged 16 and over) victim/survivors of sexual violence. A total

---

<sup>8</sup> DSAC RLDs have a dual role, providing both therapeutic medical services and criminal justice forensic services. Therefore, they were asked to complete a survey that was tailored to this dual role and the results have been included with those from criminal justice groups in chapter 4.

of 418 agencies and individuals were invited to participate, and 179 responses were received.<sup>9</sup>

The level of specialisation, types of services offered, and nature and extent of interactions with victim/survivors varied considerably across survey respondents. To capture the different views of those providing these wide-ranging services, service providers were categorised into the six main groups:

- specialist sexual violence agencies (SSVAs)
- women's refuges
- Victim Support
- mental health counselling services
- medical service providers
- other community agencies.

The composition and characteristics of each group of community service providers are described below.

#### **3.1.1 Specialist sexual violence agencies**

SSVAs are the primary agencies providing specialist support and services to victim/survivors, typically including 24-hour crisis support. This is the only group of community service providers that works solely with victim/survivors of sexual violence. Statistics are unavailable on the relative uptake by victim/survivors of the different types of services. However, because of their specialisation, it is likely SSVAs work with the greatest volume of victim/survivors, so have the opportunity to develop the greatest expertise in understanding the needs of this group.

SSVAs include Rape Crisis centres, HELP Foundation centres, and other independent sexual violence and/or sexual abuse centres. These agencies work with victim/survivors of recent and historical sexual violence; some provide services only to women, others work also with men and children who have been victims of sexual violence. As will be seen in chapter 5, SSVAs provide a wide range of specialist services, typically 24-hour crisis intervention, ongoing support and advocacy, specialist counselling services, and sexual violence education and prevention programmes.

SSVAs work with victim/survivors regardless of whether they report their assault to police. SSVAs and many police stations have formal agreements to ensure victim/survivors who do report still have access to support services.

Thirty-eight SSVAs were identified across New Zealand, from which 27 survey responses were received (15 percent of the total sample of community service providers). Most surveys were completed by the SSVAs' manager. Only one survey respondent was male. Two-thirds of respondents identified as New Zealand

---

<sup>9</sup> See section 2.4.2 for details on the identity of key informants and Table 1 for response rates.

European and 22 percent as Māori. Respondents were aged from 20 to over 60, with two-thirds being aged over 40.

### **3.1.2 Women's refuges**

Women's refuges provide specialist 24-hour support, advocacy and accommodation for women and their children who are experiencing domestic violence. The focus of women's refuges is ensuring the safety of those who come to them. A significant proportion of women who go to a refuge have also been sexually victimised by their partner or husband. Women's refuges play an essential role in supporting these women, many of whom do not report their sexual violence to other formal agencies.

The National Collective of Independent Women's Refuges is the umbrella organisation for about 50 women's refuges across New Zealand. Other women's refuges, not affiliated with the national collective, are funded by the Government and church and community groups (Lievore and Mayhew, 2007).

Surveys were sent to 47 women's refuges, and responses were received from 11. Survey respondents were all women. Five respondents identified as Māori and six as New Zealand European. All respondents were aged 40–59.

### **3.1.3 Victim Support**

Victim Support is a nationwide organisation that offers support to all victims of crime, including those who have been victim/survivors of sexual violence. Victim Support offices are staffed by volunteers and located in police stations around New Zealand. While lacking the specialist sexual violence expertise of SSVAs, in areas where there are no SSVAs, Victim Support can be heavily relied on to support victim/survivors. Victim Support accepts self-referrals, but most clients come through agreed referral mechanisms with police, so most victim/survivors Victim Support helps have reported the violence to police.

There are 54 Victim Support offices around New Zealand, and representatives from 42 offices responded to the survey. Not all of these respondents supplied demographic details, but of those who did most were women (90 percent). Seventy percent of these respondents identified as New Zealand European, 17 percent as Māori, 3 percent as Pacific, and 10 percent as another ethnicity. Respondents were aged from 20 to over 60, with the most frequent age group being 50–59 years.

### **3.1.4 Mental health counselling services**

The largest group of community service provider respondents in our research sample were those providing mental health counselling services (n=66). These services included individual counsellors and representatives from agencies that provide counselling and emotional support services to victim/survivors. The majority of respondents in this category (n=61, 92 percent) indicated they were Accident Compensation Corporation (ACC) registered counsellors, which means they can provide government-subsidised counselling services to victims of sexual abuse.



All but four respondents were women. In terms of the ethnicity of respondents, 82 percent identified as New Zealand European, 5 percent Māori, 2 percent Pacific, and 9 percent as another ethnicity. Respondents were aged over 30, with the most frequent age group being 50–59 years (46 percent).

### 3.1.5 Medical providers

The medical providers group of survey respondents included representatives from New Zealand Family Planning agencies (n=6), district health board sexual health clinics (n=4), and university health centres (n=5). These service providers tend to respond to victim/survivors who are seeking medical treatment after sexual violation (e.g. for the assessment and treatment of injuries, emergency contraception, and tests for sexually transmitted infections). Victim/survivors of sexual violence would make up a relatively small proportion of these providers' total client workload.

This category did not include the DSAC-trained and -accredited doctors who provide specialist medical services to victim/survivors. This group completed a survey that was tailored to their dual role of providing both therapeutic and criminal justice services, and their responses are dealt with alongside those of criminal justice agencies in chapter 4.

All survey respondents were women and aged 30 or over. All but two respondents identified as New Zealand European.

### 3.1.6 Other community agencies

The other community agencies category included community service providers that had been identified as responding to victim/survivors of sexual violence, but that did not fit into any of the above categories. These agencies included Māori community social service agencies (n=8), women's health centres (n=5), New Zealand Prostitutes Collective regional offices (n=3), and stopping violence organisations (n=3).<sup>10</sup> These service providers do not specialise in working with victim/survivors, but sexual violence can be disclosed to them in their course of working with clients from their community.

Of the 17 survey respondents who provided demographic details, 15 were women. These respondents were aged 30 or over, with three-quarters aged 40–59. Eight respondents identified as Māori, six as New Zealand European, and two as another ethnicity.

#### ***Relative proportion of different services within the total sample***

Table 3 shows a breakdown of the survey respondents from each of the six categories, their relative proportion within the total sample of community service providers, and estimated response rates (only one individual from each specific

---

<sup>10</sup> Stopping violence organisations specialise in treating sexual violence offenders. However, they were included in this survey because many of the offenders they work with have also been victim/survivors, and, whilst not a basis for excusing their offending, issues related to their victimisation may require intervention.

agency completed a survey). Numbers of respondents in each group varied according to their relative numbers in the community (e.g. there are only about 38 SSVAs across New Zealand, compared with many more mental health counsellors, including over 500 ACC-registered counsellors). Different recruitment strategies and corresponding response rates also affected the relative sample sizes of each group.

Despite a very high response rate, SSVAs represented a relatively small proportion of the research sample (15 percent). This is unfortunate because they see the greatest volume of victim/survivors of sexual violence, so are likely to have a better understanding of the needs of this group than some other agencies have. In recognition of their expertise, extra attention has been given to comments they offered.

**Table 3: Categories of service provider that responded to the survey**

Service provider category	Frequency	Percentage (%)	Response rate (%)
Specialist sexual violence agencies <sup>1</sup>	27	15.1	71
Women's refuges	11	6.1	23
Victim Support	42	23.5	78
Mental health counsellors	66	36.9	58
Medical <sup>2</sup>	15	8.4	52
Other community agencies	18	10.1	13
Total	179		100

Notes: Percentages should be interpreted with caution because base numbers are low.

- 1 The 'specialist sexual violence agencies' category includes one service provider that provides specialist services to ethnic, migrant, refugee women who are victims of domestic violence. It is not a specialist in providing sexual violence support services, but has been included in this category because it is recognised as a sexual violence national trauma recovery agency.
- 2 The 'medical' category does not include the 10 specialist sexual assault doctors (from Doctors for Sexual Assault Care) who completed a different survey. The characteristics of this group are reviewed in chapter 4.

## 3.2 Specialisation in relation to groups of victim/survivors

Survey respondents were asked to indicate if their agency/service specialised in providing services for any particular group or groups of client. Responses appear in Table 4. This information highlights the special interest groups of survey respondents. However, the specialisation of client group of those service providers who did not complete a survey is unknown, so data should not be interpreted as the community-wide measure of the level of specialist service provision for particular groups.

To some extent, the types of specialisation appearing in Table 4 reflect the purposeful sampling of survey respondents. For example, the 6 percent specialising in domestic violence are women's refuges, and the 5 percent specialising in students and youth are university health centres.

Overall, there appeared to be very little specialisation in client group across survey respondents, with the majority (61 percent) indicating they provide services to all victim/survivors of sexual violence. The main exceptions to this were the women's refuges that provided services only to women and their children and SSVAs of which around half offered services only to women. Sixteen service providers specialised in providing services for Māori.

**Table 4: Specialisation in services for a particular client group**

Client group	Total	
	n <sup>1</sup>	%
None specified	117	61.0
Women <sup>2</sup>	27	14.0
Māori	16	8.0
Domestic violence	11	6.0
Students/youth	9	5.0
Male victims	3	2.0
Sex-workers	3	2.0
Pacific peoples	2	1.0
Male offenders	2	1.0
Ethnic, migrant, refugee peoples	2	1.0
Gay, lesbian, transgender, bisexual, intersex people	1	0.5
People with disabilities	1	0.5
Total	193	100.0

Notes: Percentages should be interpreted with caution because base numbers are low.

- 1 Numbers do not total 179 because some service providers were counted more than once if they specified more than one area of specialisation (e.g. ethnic, migrant, refugee status and women; and Māori who were male or female).
- 2 Seven of the specialist sexual violence agencies and all of the women's refuges also provided services to children.

#### 3.2.1 Māori service providers

Sixteen of the community service providers who responded to the survey reported that they specialised in providing services to Māori, this included over half of the community agencies. To identify the particular characteristics of the services for Māori victim/survivors and to better understand the needs of this group of victim/survivors it was decided to present responses from these agencies as a specific group (i.e. Māori providers). However, so as not to lose the views of Māori providers in relation to the type of service they provide (e.g. SSVAs) their responses are also included with other service providers who provide the same type of services (e.g. SSVAs, Victim Support, mental health counselling services, and other community agencies). Therefore, the responses from these agencies are presented

twice, but to avoid skewing results, each service provider is counted only once when total frequencies and percentages are calculated.

### 3.3 Geographical location of survey respondents

Table 5 shows the geographical location of survey respondents. The table illustrates that in terms of the distribution of survey respondents a good coverage of services and agencies across New Zealand was achieved.

**Note:** It is important to note that the geographical breakdown reflects those who responded to the survey, which may or may not reflect the level of service provision that is available in these regions.

**Table 5: Regional breakdown of service providers**

Region	SSVA	Ref	VS	MH	Med	CA	Total		Māori
							n	%	
Wellington	5	3	5	5	3	4	25	14.0	4
Waitemata	–	1	4	4	1	1	11	6.1	–
Waikato	1	1	4	7	1	2	16	8.9	2
Tasman	1	–	3	6	–	1	11	6.1	1
Southern	2	–	5	8	1	3	19	10.6	1
Northland	4	–	3	–	1	1	9	5.0	1
Eastern	2	2	2	5	–	–	11	6.1	1
Counties Manukau	1	2	3	3	2	1	12	6.7	2
Central	2	1	6	4	1	2	16	8.9	1
Canterbury	5	1	2	12	2	2	24	13.4	2
Bay of Plenty	1	–	–	4	2	1	8	4.5	1
Auckland City	3	–	5	8	1	–	17	9.5	–
Total	27	11	42	66	15	18	179	100.0	16

Notes: CA = other community agencies; Med = medical; MH = mental health counselling service; Ref = women's refuges; SSVA = specialist sexual violence agency; VS = Victim Support. Percentages should be interpreted with caution because base numbers are low.

#### 3.3.1 Rural compared with urban services

New Zealand has relatively few large urban centres, with most of the country being made up of relatively isolated rural areas. Hence, it is important to consider the extent to which service provision is influenced by location – rural compared with urban. Table 6 provides a breakdown of the location of survey respondents. The majority of service providers who participated in the survey came from a major urban centre or provincial town (82 percent), with only 8 percent from a rural area, although a further 9 percent reported that their service covered a variety of

### 3 Community service providers

locations, including rural areas. This indicates that the majority of views presented in this report will be from non-rural service providers.

Based on those who responded to the survey, it appeared that Victim Support and the community agencies had the greatest rural representation. However, it must be acknowledged that the location of those who did not respond to the survey is not known.

**Table 6: Location of service providers (rural, provincial, urban)**

Location	SSVA	Ref	VS	MH	Med	CA	Total		Māori
							n	%	
Major urban area (M)	15	5	16	44	11	14	104	58.2	12
Provincial town (P)	8	5	9	17	4	–	43	24.0	–
Rural (R)	1	1	8	4	–	–	14	7.8	1
Variety (M, P & R)	2	–	9	1	–	4	16	8.9	2
Not applicable or not specified	1	–	–	–	–	–	2	1.1	1
Total	27	11	42	66	15	18	179	100.0	16

Notes: CA = other community agencies; Med = medical; MH = mental health counselling service; Ref = women's refuges; SSVA = specialist sexual violence agency; VS = Victim Support. Percentages should be interpreted with caution as base numbers are low.

### 3.4 Summary

There is a wide range of service providers in communities across New Zealand that are available to respond to victim/survivors of sexual violence. However, only one group of providers (SSVAs) works solely with victim/survivors. The volume of clients seen by, and the focus of, different agencies (whether sexual violence, domestic violence, victims of crime, mental health or medical needs, or Māori or other groups) is likely to affect an agency's views and understanding of the needs of the victim/survivors with whom they work.

## 4 Criminal justice survey respondents

The criminal justice system consists of the police and the network of courts and legal processes that deal with the enforcement of criminal laws, including the laws that prohibit sexual violation. In New Zealand it is estimated that just one in ten victim/survivors chooses to report their sexual violation, so has any experience with the criminal justice system (Mayhew and Reilly, 2007). Those victim/survivors who do enter this system can experience it in diverse ways; the experience can range from being highly validating and supportive to inflicting secondary victimisation (Herman, 2005; Jordan, 2004). A victim/survivor's experience of the criminal justice system is greatly influenced by the individual criminal justice representatives with whom they come in contact. This chapter describes their characteristics and roles in relation to victim/survivors of sexual violence:

The members of the criminal justice system who participated in this research were:<sup>11</sup>

- police (see section 4.1)
- Doctors for Sexual Abuse Care (DSAC) regional liaison doctors (RLDs) (see section 4.2)
- Crown prosecutors (see section 4.3)
- court victim advisers (see section 4.4).

It is important to note that families/whānau and friends, together with the support agencies described in chapter 3, also play significant roles in supporting a victim/survivor, including supporting them in the criminal justice system.

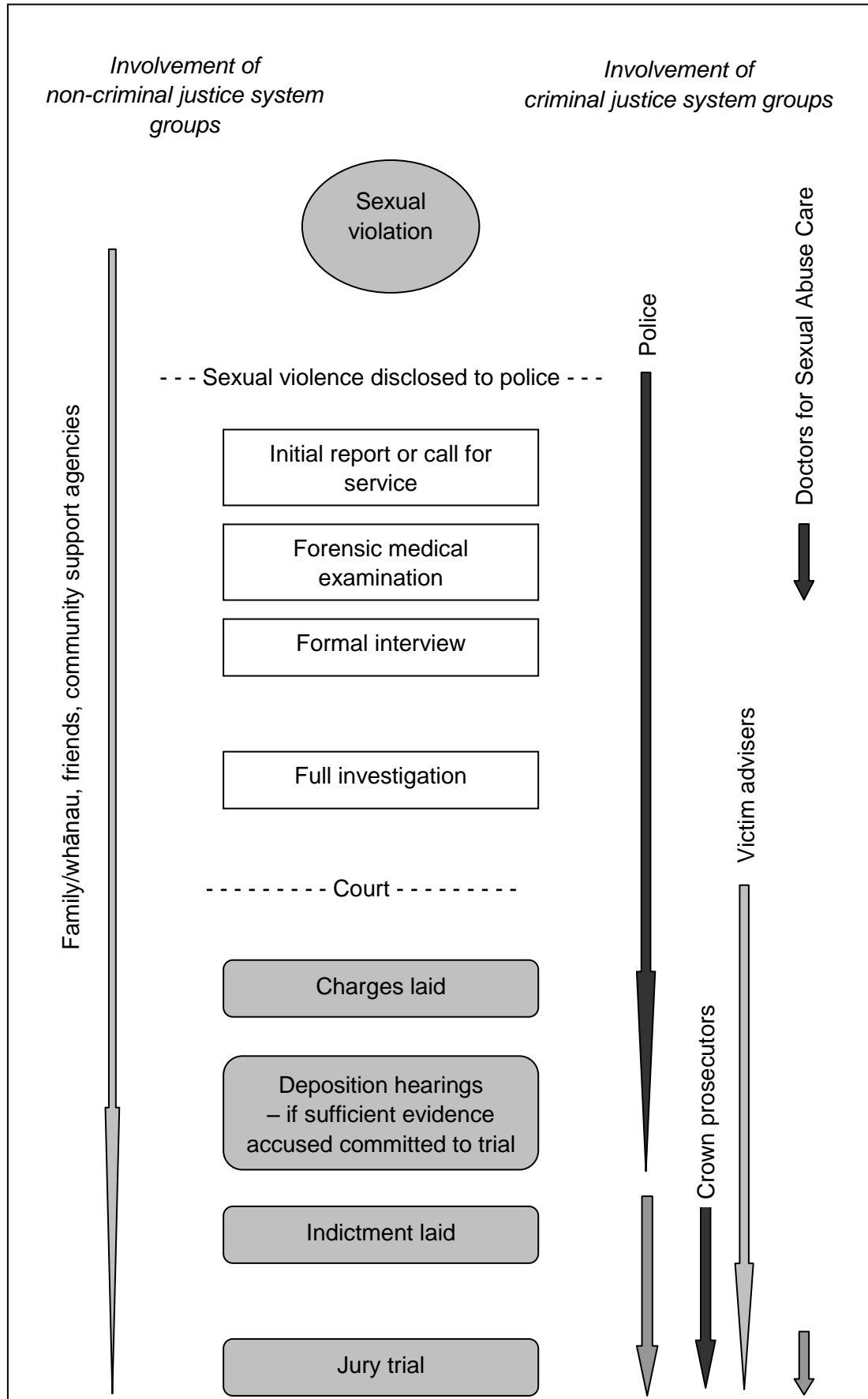
Figure 2 is a flow diagram showing the criminal justice phases through which a victim/survivor must progress, and the involvement of the different groups at different phases.<sup>12</sup>

---

<sup>11</sup> The initial research design also proposed surveying the views of judges. However, an application to the Judicial Research Group to access judges was not approved.

<sup>12</sup> Changes to the Summary of Proceedings Act 2008 came into force on 29 June 2009 and have changed the court processes around preliminary hearings or depositions. The preliminary hearings in indictable proceedings have now been replaced a standard committal procedure. This standard committal will not involve a hearing or consideration of oral evidence, unless the judge grants a special application, in which case there will be a committal hearing.

Figure 2: Involvement of different groups in the phases of the criminal justice system



## 4.1 Police

Police play a pivotal role in the criminal justice system as the first agency that the reporting victim/survivor encounters. Their role then extends to the investigation of the report made and, depending on the outcome of their investigation, the decision whether to bring a prosecution before the court (i.e. to lay charges of sexual violation against offender).<sup>13</sup> Based on an initial presentation of evidence, the judge decides whether there is a case to answer and, if there is, commits the case to trial. From this point, police oversee the case as it progresses through the court system, with ongoing liaison with the victim/complainant<sup>14</sup> and Crown prosecutor.

A survey was developed and sent to all Criminal Investigation Branch (CIB) detectives who had been involved in, investigated or supervised an adult sexual violation case in the previous 12 months.<sup>15</sup> Responses were received from 206 CIB detectives.

### 4.1.1 Characteristics of police survey respondents

Of the 206 detectives who responded, 22 percent were women (n=45) and most identified as New Zealand European (85 percent).<sup>16</sup> These detectives ranged in age from their 20s to over 60, with the most frequent age group being 30–39 (53 percent).

Sixty-two percent (n=127) of these detectives had undertaken the Adult Sexual Assault Investigation<sup>17</sup> course and 11 percent (n=22) had undergone Investigative Interviewing, Level 3 Specialist Adult Witness, training.<sup>18</sup>

Attendance on Adult Sexual Assault Investigation courses varied across police districts from 100 percent participation among survey respondents in Northland to 42 percent in the Southern district. The Southern district also had the lowest level of participation in Investigative Interviewing, Level 3 Specialist Adult Witness Training (no respondents); Tasman had the highest (30 percent).

---

<sup>13</sup> In other countries, such as the United Kingdom, Crown prosecutors are involved with the investigation and decision-making around whether to prosecute. In some cases in New Zealand the Crown deals with a case from the start until the committal process. This is at the Crown and the police's discretion.

<sup>14</sup> The term 'victim/survivor' has been replaced with the term 'victim/complainant' in relation to criminal justice personnel. This more accurately reflects their status within the criminal justice system before any court outcome.

<sup>15</sup> A survey was developed for police that was tailored to their roles and responsibilities.

<sup>16</sup> Other ethnic groups included 13 who identified as Māori (6 percent) and two who identified as Pacific (1 percent). The remaining 8 percent identified as another ethnicity or did not specify their ethnicity.

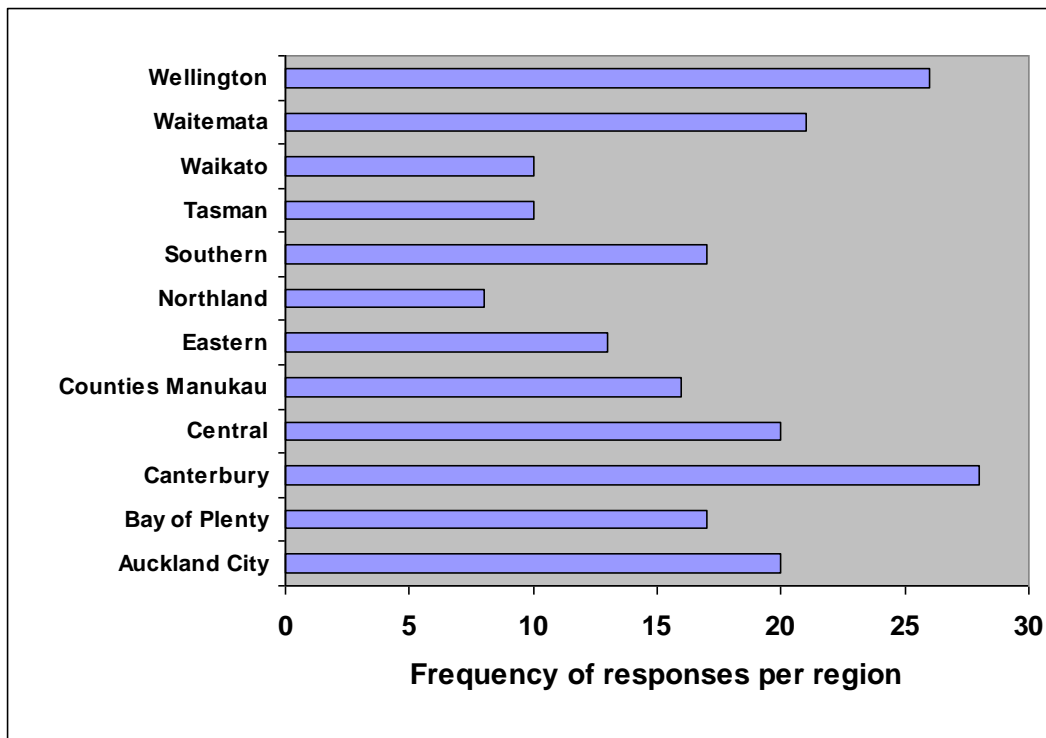
<sup>17</sup> The New Zealand Police delivers a variety of Adult Sexual Assault Investigation courses, including a five-day course; an Initial Complaint course; Investigative Interviewing courses; and support services and external training.

<sup>18</sup> The New Zealand Police is rolling out a national training programme in investigative interviewing. The level 3 course, specialist adult witness training, is the highest level of training.



Figure 3 shows which police districts respondents came from, and illustrates representation across all police districts. The districts containing main centres were particularly well represented (i.e. the Auckland districts (Waitemata, Counties Manukau, and Auckland City), Wellington and Canterbury). Fourteen percent of respondents described their working environment as rural.

**Figure 3: Survey participation of CIB detectives, number by police district**



The role played by police from receiving the initial report of sexual violation, to completing the investigation, to laying charges in court is described in chapter 7.

## 4.2 Doctors for Sexual Abuse Care regional liaison doctors

In New Zealand, forensic medical examinations are carried out by medical practitioners who specialise in sexual assault care. These doctors make themselves available for forensic medical examinations via on-call rosters co-ordinated at a regional level. Many of these doctors have received training through DSAC and/or are DSAC accredited. These doctors are often referred to as ‘DSAC doctors’, but DSAC is a professional organisation, not a service provider per se.<sup>19</sup> DSAC also publishes a national directory of sexual assault doctors around New Zealand who can provide specialist services for child and adult victim/survivors.

<sup>19</sup> Doctors formed DSAC in the late 1980s to provide education and support to medical practitioners to ensure internationally recognised standards of best practice were maintained in the medical and forensic management of sexual assault (for adults and children).

DSAC-trained or -accredited doctors are well recognised for their role in performing forensic medical examinations, interpreting findings, and acting as expert witnesses in cases that go to court. Their primary work providing specialist therapeutic medical care (crisis and longer-term) is often under-recognised.

The regional liaison doctors (RLDs) co-ordinate the on-call rosters of sexual assault doctors. Surveys were sent to an RLD from each of the 22 regions covered by DSAC, seeking information on the medical and forensic services provided to adult victim/survivors by the sexual assault doctors in their region.<sup>20</sup>

Replies were received from 10 RLDs: eight female and two male doctors, all of whom were New Zealand European.<sup>21</sup> These RLDs commented on the services provided by 38 individual adult sexual assault doctors on the roster in their particular regions.<sup>22</sup>

#### **4.2.1 Characteristics of doctors who perform forensic medical examinations**

The 10 RLDs provided the following information about the 38 sexual assault doctors in their regions.

- The number of sexual assault doctors available to conduct adult sexual assault medical examinations in each region ranged from 2 to 11 (the most frequent number being 2). Auckland, Christchurch and Hawke's Bay had the largest numbers per region.
- Seventy-four percent of the 38 doctors (n=28) had received training through DSAC.
- Sixty-eight percent of the 38 doctors (n=26) had been through the DSAC accreditation process to conduct forensic and medical examinations.
- Of the 38 doctors, 10 were police medical officers, 3 were hospital-based doctors, and 13 were community-based practitioners. The employment status of the remaining 12 doctors was not specified.
- Six out of the 10 RLDs said that, in their region, if a victim/survivor requested a female doctor this would be possible, although four qualified this, saying it would not be possible in every circumstance (e.g. the female doctors might be on leave or have other commitments). One RLD commented that in their region all doctors were women, but that was not always the most important criterion.

---

<sup>20</sup> A survey was developed especially for DSAC RLDs that took into account the particular services they provided. We were advised by DSAC to keep the survey length to an absolute minimum in recognition of their typically busy schedules.

<sup>21</sup> A comment by one of the DSAC RLDs suggested that the quality of responses from DSAC RLDs might not be as complete as they would have liked because of the time pressures these doctors work under.

<sup>22</sup> Regions represented were Northland, Auckland, the Coromandel, Tauranga, Hawke's Bay, Taranaki, Wanganui, Nelson, Christchurch, and Queenstown.

*In our opinion it is the training and attitude of the doctor which is the most important factor and not the gender.*

RLDs were asked how well they thought their region was able to respond to the cultural needs of adult victim/survivors of sexual violence. Half of the RLDs (5 out of 10) said cultural needs were met ‘very well’; three said ‘satisfactory’; two did not comment. However, none of the 10 RLDs said their region could guarantee to match the ethnicity of the doctor and the victim/survivor: ‘We do not have the ethnic choice in our workforce.’

RLDs identified groups who posed particular challenges for sexual assault doctors when providing therapeutic and forensic services. The groups were:

- men (n=2)
- people with mental illness (n=1)
- people from remote locations (n=1)
- people with disabilities (n=2)
- people with limited English language skills (n=2).

#### 4.2.2 Therapeutic compared with forensic work

The forensic work of sexual assault doctors can overshadow their therapeutic role (e.g. the assessment and treatment of injuries, and pregnancy and sexual health checks). To better understand the characteristics of their work, we asked RLDs to estimate what proportion of work with adult victim/survivors was therapeutic and what proportion was forensic. We asked them to estimate this for acute cases (i.e. referrals immediately following a sexual violation) and for non-acute cases (i.e. where there had been a delay following the sexual violation or historical cases of sexual violation). Mean estimates are presented in Table 7.

**Table 7: Proportion of regional liaison doctors’ time spent on therapeutic and forensic services, by service type**

Service	Therapeutic		Forensic	
	Mean (%)	Standard deviation	Mean (%)	Standard deviation
Acute services	37	27.3	64	27.3
Non-acute services	91	10.0	9	10.0

Notes: Caution must be taken in interpreting these figures; there was considerable variability in individual responses. Percentages should be interpreted with caution because base numbers are low.

Responses were most consistent for non-acute cases where work was clearly more therapeutic (individual responses ranged from 75 percent to 100 percent of time).

*All consults involve discussing possible forensic or legal options regardless of presentation or time since assault and allowing for patients to change their mind and report at a later date in the future. (DSAC RLD)*

As seen in Table 7, a much greater proportion of time was spent on forensic services in acute cases than in non-acute cases (an average 64 percent of time compared with 9 percent). However, in acute cases responses varied widely; individual estimates of the proportion of therapeutic work ranged from 10 percent to 80 percent. RLDs suggested the question might have been too simplistic, assuming that the type of referral would influence the type of service provided (i.e. whether referral was from police or not). However, even when a referral came from police specifically for a forensic medical examination, therapeutic services were still provided.

*It takes 90% of the time to do the forensic and approximately 10% of the medical tacked on the end. (DSAC RLD)*

RLDs listed other services that doctors typically provide to victim/survivors in addition to the forensic medical examination. These services included:

- safety assessments
- the prescription of medication for physical symptoms (e.g. insomnia, nausea and vomiting, and pain relief)
- advice on the risk of sexually transmitted infections and HIV prophylaxis (post-exposure medication)
- counselling and mental health services (which could be assessment, treatment, information and/or referral)
- support with investigation and legal processes and case co-ordination with police
- advice and information (e.g. about ACC services, criminal process, and ongoing care)
- administrative tasks (e.g. completing ACC forms and off-work certificates).

### **4.2.3 Types of referrals**

All RLDs indicated referrals were made from sexual assault doctors to other services; most commonly this was done by giving clients the relevant contact details. Referrals could be made to:

- counselling and mental health services
- support services (e.g. SSVAs (such as Rape Crisis), Victim Support, women's refuges, and women's centres)
- the victim/survivor's own doctor
- sexual health clinics
- alcohol and other drug clinics
- emergency departments

- the police.

RLDs said that their being provided with more information about available services and regular inter-agency meetings would help them to make referrals.

### 4.2.4 Funding

In the past, there was no dedicated national funding to employ doctors to conduct forensic medical examinations. However, early trials of a dedicated model of funding began in 2008, and in 2009 funding became available nationally under Sexual Abuse Assessment Treatment Service contracts. The funding is provided by the New Zealand Police, ACC and Ministry of Health, and is optional for district health boards and individual providers to sign up to. The aim of this national funding is to enable regions to establish and support a more robust sexual assault service rather than relying on the goodwill and efforts of a small group of doctors.

RLDs were unsure of the number of practitioners who operated under a Sexual Abuse Assessment Treatment Service contract, but estimated 18 out of the 38 practitioners. These practitioners came from three of the 10 regions (Northland, Canterbury, and Auckland City).

## 4.3 Crown prosecutors

In New Zealand, sexual violation offences are designated as indictable offences (i.e. serious charges requiring a jury trial). Prosecution of indictable offences is carried out by Crown solicitors or Crown prosecutors on behalf of the Crown, either in the High Court or District Court. Crown prosecutors' involvement begins once police have laid charges against the offender and a judge has committed the case to trial. Crown prosecutors review the case before laying the indictment against the defendant, and then proceed to prosecute the case at trial on the Crown's behalf. Crown solicitors and Crown prosecutors are independent of the police.

A network of Crown solicitors has been appointed on the recommendation of the Attorney-General and by warrant of the Governor-General. These Crown solicitors are partners of private law firms that are typically based in the High Court centres around New Zealand. They are responsible for overseeing all Crown prosecution work within that region. Crown solicitors may delegate work to individual Crown prosecutors, lawyers working for or on behalf of the Crown solicitor.

Surveys were sent to all 15 Crown solicitors for their completion and for them to distribute to the Crown prosecutors in their firm who had had experience in prosecuting sexual violation cases in the last two years.<sup>23</sup>

---

<sup>23</sup> There are 16 High Court centres around New Zealand, but only 15 Crown solicitors, because the same Crown solicitor oversees the Gisborne and Napier High Courts.

### **4.3.1 Characteristics of Crown prosecutor survey respondents**

Prosecutors completed 46 surveys from 11 out of the 15 Crown solicitor law firms. The majority of respondents were New Zealand European (91 percent), and just over half were women (57 percent). Of the 46 respondents, nine indicated they were Crown solicitors. The number of years' experience these 46 respondents had had as prosecutors for the Crown ranged from 1 year to 30 years, with an average of 9.6 years. The number of adult sexual violation cases the Crown prosecutors had led in the previous two years ranged from none to 20 (the average was 7). Seven prosecutors had not led an adult sexual violation case, but had assisted in a junior role.

## **4.4 Court victim advisers**

Court victim advisers are specialist court staff employed to provide information and support to victims of crime through the court process, which can include victim/survivors.<sup>24</sup> They may provide case information, ensure victim/survivors' safety during court proceedings, and liaise with police, prosecutors, the judiciary and community organisations. They also inform the court of the victims' views and ensure victims of crime are informed of their rights under the Victims' Rights Act 2002.

At the time of this research, 53 court victim advisers were located in the 21 District Courts around New Zealand. (These court victim advisers also service the High Court, as required.) A survey developed specifically for court victim advisers was sent to all 53. Replies were received from 17.

### **4.4.1 Characteristics of court victim adviser survey respondents**

All 17 court victim advisers said that whilst carrying out their role they had advised adult sexual violation victim/complainants.

Six of the 17 noted that other groups also provided advice to victim/complainants of adult sexual violation during court proceedings: Victim Support, SSVAs, sexual abuse counsellors, and other support agencies such as Barnardos and the Salvation Army. However, 11 out of the 17 were not aware of any other agencies providing these services in their courts. This suggests the degree of involvement of court victim advisers varies across the country.

### **4.4.2 Role of court victim advisers**

In developing a survey for court victim advisers it became apparent that the role and involvement of court victim advisers with victim/survivors was not well understood.

---

<sup>24</sup> Court victim advisers should not be confused with the Victim Support personnel discussed in chapter 3. Court victim advisers are court staff the Ministry of Justice employs, whereas Victim Support is a non-government organisation that offers support to victims of crime regardless of whether the case goes to court.

Therefore, in the survey court victim advisers were asked to describe their main role. Responses have been grouped into three functions.

- Providing information to the victim/complainant about, for example:
  - court processes, the progress of a case, and the timing of court appearances
  - available support services/agencies (e.g. SSVAs, refuges, counselling services, Housing New Zealand services, and applications for protection orders and ACC sensitive claims)
  - court outcomes or details of any appeals, and, if the offender is sentenced to prison, details about the Victim Notification Register.
- Acting as a court liaison person, which includes:
  - informing the court of victim/complainants' views (e.g. in relation to bail conditions and name suppression, how victim impact statements might be presented, and other relevant considerations for the court such as a victim/complainant's pregnancy or need to sit important exams)
  - being a contact person for the Crown prosecution and police officer in charge of the case.
- Preparing and supporting the victim/complainant for court appearances (e.g. court orientation, preparing victim/complainants to give evidence, facilitating safety measures for victim/complainants, and ensuring a support person is present).

One court victim adviser described their role as working behind the scenes, making sure victim/survivors had the appropriate information and support. A more direct role supporting victim/survivors was typically provided only when requested or unavailable from other sources.

### 4.4.3 Training

Court victim advisers were asked if they had received any special training for dealing with adult victim/complainants. Few court victim advisers (3 out of 17) said they had received any special training. Of these three, two referred to training they had received before becoming court victim advisers, only one referred to Ministry of Justice training, where in her first year of job-related training there had been some role-playing and discussions about the specific needs of victims of sexual violence. All those who had not received any specialised training were supportive of the idea, with some indicating they thought this was very important.

*Absolutely essential – I don't think we should be working with these victims without specialised training.*

Two court victim advisers also commented on a need for specialised training to respond to diverse ethnic groups. Three court victim advisers were more ambivalent about the need for specialist training.

*Possibly. It's most important for the victim adviser to provide the actual, generic service of court services for victims properly and consistently, than having in-depth training of a particular victim group.*

One court victim adviser reported that the first dedicated training for court victim advisers in this area is being developed and is due to be delivered in May 2009.

## **4.5 Summary**

This chapter described the characteristics of the criminal justice survey respondents and outlined the roles of four key groups. The role of police extends from an initial report to the end of any court hearing. Sexual assault doctors collect forensic evidence, but also provide important therapeutic services. Support from court victim advisers is available from the first court appearance. Police make the initial decision about whether to lay charges, and Crown prosecutors become involved only after a judge rules at a preliminary hearing that there is a case to answer.





# Part three: Environmental scan of community service provision

## 5 Characteristics of community services

This chapter describes the community service providers that participated in the survey. This is based on self-reported information provided by representatives from agencies or individual service providers (i.e. counsellors) and looks at the characteristics of the clients they see, the services they provide, and their views on what could assist them to improve service delivery.<sup>25</sup> A broader look at community capacity, including survey respondents' views on how well their community as a whole is able to deliver effective interventions, is presented in chapter 6.

As illustrated in chapter 3, a broad range of services in the community respond to victim/survivors of sexual violence, including specialist sexual violence agencies (SSVAs), women's refuges, Victim Support, mental health counselling services, medical services, and other community agencies. These providers vary considerably in the types of services they offer, and the nature and extent of their interactions with victim/survivors. Their level of specialisation also varies, and SSVAs are the only group that specialises solely in responding to victim/survivors of sexual violence.

This chapter aims to clarify which agencies provide what services and their views on their ability to meet the needs of victim/survivors who come to them.

Information is presented about:

- the service needs of victim/survivors (section 5.1)
- the types of services provided (section 5.2)
- the factors that influence access to services, including to people from diverse backgrounds (section 5.3)
- service providers' views on ways to improve service delivery (section 5.4).

Note: Findings presented in this chapter are not a stocktake of services, because the characteristics of those who did not respond to the survey are unknown.

---

<sup>25</sup> Data in this chapter are based on 168 survey respondents who provided services to victim/survivors. Eleven of the 179 agencies who completed a survey (see chapter 3) indicated that they did not provide services to victim/survivors (e.g. those providing services to sexual violation offenders). However, these agencies had views on the capacity of their community to respond to victim/survivors, so completed the second part of the survey; the results of which are presented in chapter 6.

## 5.1 Victim/survivors' service needs

Survey respondents were asked questions about the needs and characteristics of the victim/survivors that came to them. This is a useful starting point before moving on to consider how well service providers feel they respond to such needs.

### 5.1.1 Client characteristics (recent compared with historical sexual violence)

The length of the period between when an assault occurred and treatment-seeking has implications for the needs and types of services required (e.g. crisis intervention or longer-term support and counselling). Some victim/survivors seek assistance from services soon after an assault, others do not. Some will only ever seek help from family/whānau or friends, and some may never tell anyone. Multiple factors influence an individual's decision to disclose, including the fear of not being believed, a lack of trust in the criminal justice system, or not recognising what happened as sexual violation. Delays in reporting can also be because of a change in the a victim/survivor's life circumstances, such as leaving a violent relationship and wanting to break the cycle of violence or being no longer able to cope with the affects of the assault and/or previous victimisations, including childhood sexual abuse.

The majority of service providers reported that they worked mostly with clients who were victims of historical sexual violence (i.e. violence occurring over 12 months ago).<sup>26</sup> Nearly two-thirds of the service providers reported that 'most' or 'all' of their clients were seeking help in relation to historical sexual violence. This was particularly true with mental health agencies (91 percent) and SSVAs (76 percent). Victim Support and women's refuges were the only type of service providers where recent sexual violence cases were more frequent – half or more of their caseloads (82 percent and 70 percent, respectively).

### 5.1.2 Information requests

Access to information is one of the key requirements of victim/survivors (and/or their family/whānau). The type of information they are seeking indicates the type of needs they are seeking help with.

Survey respondents were asked to indicate which of the seven information requests listed in Table 8 were commonly made by victim/survivors who came to their agency/service. Responses in Table 8 are presented in order of frequency (from most to least frequent).

---

<sup>26</sup> There is no accepted definition for what constitutes historical sexual violence. Violence occurring over 12 months ago was an operational definition decided on by the researchers in conjunction with the Ministry of Women's Affairs. The aim was to differentiate the types of service needs of those at different stages of recovery. For example, the acute crisis needs of those seeking help more immediately, compared with those who delayed their help-seeking and had moved beyond the acute crisis stage (e.g. those who had experienced childhood sexual abuse).

The most frequent requests from victim/survivors were for information on counselling (made by 84 percent of respondents), followed by a related request on 'how to feel better' (67 percent). Information on court processes, reporting to the police and victims' rights were also frequently requested.

**Table 8: Frequency of information requests by (n=166)**

Type of information request	Frequency	Percentage (%)
Counselling	139	84
How to feel better	112	67
Reporting to police	73	44
Victims' rights	73	44
Court processes	72	43
Pregnancy, sexually transmitted infections or injury	19	11
Forensic medical examinations	8	5

Some information requests were higher for certain types of service providers. Victim Support agencies reported receiving a particularly high level of requests for information on victims' rights (90 percent of Victim Support respondents). Information on pregnancy, sexually transmitted infections or injuries were far more commonly made of medical services (82 percent of medical services survey respondents).

Other common information requests respondents mentioned related to:

- accessing financial support if unable to work because of trauma
- understanding why the sexual violence occurred
- managing day-to-day relationships.

A semi-rural Māori service provider commented that victim/survivors need information about the services available and the definition of sexual violation/rape.

*Because it's amazing really the number of clients who still say 'I'm not sure if it is rape' ... They know something was wrong but they don't want to go so strong as to say it was rape; especially when it's a partner, 'I love somebody who raped me'. It's easier to say, 'I love someone who likes rough sex'.*

Other SSVAs also described how it is relatively common for clients who have been sexually abused as children to not realise that what is happening to them in their marriage is sexual violation.

A few suggestions were offered on what would assist in providing information to victim/survivors. These included:

- written information on victims' rights, reporting to police, and court processes
- a directory of procedures and relevant service providers.

### 5.1.3 Additional services required by victim/survivors

In addition to coping with the direct consequences of the sexual violence, victim/survivors can often have other needs they require assistance with. Survey respondents were asked to indicate whether victim/survivors who contacted their agency/service had any of the 11 additional needs listed in Table 9.

Service providers identified a high number of additional needs, suggesting victim/survivors have high and complex needs. Over three-quarters of the service providers identified mental health issues, family/domestic violence, alcohol and other drug counselling, and suicide and self-harm as additional needs.

**Table 9: Identifying additional needs**

Additional need	Need identified (n=166)	
	n	%
Mental health issues	136	82
Family/domestic violence	132	80
Drug and alcohol counselling	128	77
Suicide and self-harm	126	76
Family law/legal advice	113	68
Accommodation	107	65
Medical assistance	105	63
Cultural support	100	60
Needs related to disability	74	45
Language translation	60	36
Immigration issues	55	33

Some survey respondents noted other types of needs that victim/survivors had presented with: financial support (n=8), childcare (n=2), transport (n=2), assistance around personal safety issues when working as a sex-worker (n=2), managing work-related issues (n=1), relationship issues (n=1), sexuality issues (n=1), and historical abuse (n=1).

Survey respondents were also asked to indicate, in their area, where they feel increased service capacity is required to ensure victim/survivors can get appropriate responses to their needs. The three areas most frequently noted as needing more services were in relation to:

- immigration issues
- language translation
- accommodation.

Immigration issues and language translation, while less common among those victim/survivors who sought assistance from service providers, appeared to have the highest levels of perceived unmet need.

## 5.2 Types of services provided

To better understand which type of agencies provides what types of services, survey respondents were asked to indicate which of the services listed in Table 10 they provided to victim/survivors. Note they were *not* asked whether they had adequate funding to deliver these services or to comment on how well they felt they were able to deliver them.

The data presented provide some indication of where victim/survivors are likely to be able to access the different types of assistance they require. However this is not a stocktake of services and is representative of only those service providers that participated in the research.

As illustrated in Table 10, some agencies provide a wide range of services (e.g. SSVAs), whereas other agencies have particular areas of focus (e.g. medical services and mental health counselling services).

The SSVAs, women's refuges and Victim Support are most likely to provide crisis intervention, advice and advocacy. Education and prevention work was also identified as part of most (93 percent) SSVAs, and almost two-thirds (64 percent) of refuges. SSVAs and Māori agencies were the most frequent providers of family/whānau support.<sup>27</sup>

Pregnancy, sexually transmitted infection and other tests were most frequently provided by medical services, although a small number of integrated community health centres (in the other community agencies group) reported they offered these services. Surprisingly, not all medical services reported that they assessed and treated injuries (most health centres did, some sexual health clinics, but few family planning centres). However, the findings may well reflect differences in how an injury is defined. Interestingly, 36 percent of mental health counselling services also indicated they assessed and treated injuries, which for this group presumably was interpreted to include emotional, psychological and other mental health effects. This would most likely be applicable to all counsellors.

Counselling was provided, as expected, by all mental health counselling services and most SSVAs (93 percent). It was also provided by 62 percent of Māori providers. Four medical providers (36 percent) also provided counselling. These were all university health centres that provided integrated health services.

---

<sup>27</sup> Working with families/whānau is central to the holistic way Māori providers work. Only one Māori provider did not work with families/whānau and this was an ACC counsellor who provided individual counselling.

**Table 10: Types of services provided (n=167)**

Services	SSVA (n=27) (%)	Ref (n=11) (%)	VS (n=39) (%)	MH (n=66) (%)	Med <sup>1</sup> (n=11) (%)	CA (n=13) (%)	Māori (n=13) (%)
<b>Support services</b>							
Crisis intervention	89	91	69	32	18	23	31
Advocacy & support	100	100	100	36	45	62	69
Education & prevention	93	64	10	46	45	39	54
<b>Health/medical-related services</b>							
Assessment & treatment of injuries	11	9	3	36	45	23	23
Pregnancy, sexually transmitted infection or other tests	4	10	–	–	100	31	15
Family/whānau support	93	46	46	18	–	31	92
Social work	67	64	5	3	–	31	46
Counselling	93	18	8	100	36	46	62
<b>Criminal justice-related services</b>							
Forensic medical examinations	7	–	–	–	8	–	–
Support for reporting to police	89	73	80	18	36	39	54
Court preparation & support	85	36	90	26	9	23	39

Notes: CA = other community agencies; Med = medical; MH = mental health counselling service; Ref = women's refuges; SSVA = specialist sexual violence agency; VS = Victim Support. Percentages should be interpreted with caution as base numbers are low.

1 One medical survey had missing data for this variable.

The principal service providers that offered support to victim/survivors when reporting to the police were SSVAs, Victim Support, and women's refuges. Assistance in preparing for court and support during court was most likely to be provided by Victim Support or SSVAs.

Community service providers were also asked if they provided any additional services. Many of the responses given were examples of categories of assistance already indicated (e.g. types of counselling such as telephone counselling and family violence counselling). Other additional services were kaupapa Māori services, emergency housing, food, and youth education programmes.

### 5.2.1 Perceived shortfalls in types of services

Survey respondents were asked to indicate the types of services they felt were not being delivered.

Among the most frequently cited shortfalls were insufficient specialist sexual violence services to deliver crisis interventions, sexual violence education and prevention, and specialist social work and counselling services (n=13).

*Anyone who works with sexual violence survivors must have extensive and specialised training in the specifics of crisis intervention. A local specialised, integrated, professional, fully funded, sexual assault service is needed. (Mental health counsellor)*

Survey respondents from three areas reported there being no SSVAs (Kapiti Coast in the Wellington region, Hastings in the Eastern region, and South Otago in the Southern region). Three service providers noted there were no SSVAs for Māori in their region (Christchurch, Canterbury; Rotorua, Bay of Plenty).<sup>28</sup> One service provider commented there were no SSVAs for men in their area (Waitakere City in Waitemata).

These areas should be seen as the minimum and not total number of areas requiring SSVAs, because survey responses were received only from areas where there was at least some level of service provision. Areas where there are no agencies/services are not represented.

One survey respondent elaborated on why it was important for victim/survivors to have access to specialised sexual violence services.

*If sexual abuse is not dealt with properly and with specialised people, it can turn very quickly for the victim, including feelings of shame, disappointment, filth and anger. (Women's refuge)*

There were also shortfalls in forensic medical services (n=13). Concerns centred around the lack of doctors qualified to conduct examinations and the resulting delays when victim/survivors had to travel to where forensic medical examination services were available.

*the lack of medical staff to do the forensic tests in the outlying areas, resulting in the need to travel sometimes more than 200 km. (Victim Support)*

A lack of restorative justice services for victim/survivors of sexual violence was also noted by several respondents (n=14).<sup>29</sup>

*Many survivors of sexual violence ask – 'why'. Restorative justice conferencing is one way to give survivors an opportunity to ask this and other questions and*

---

<sup>28</sup> Māori services do not necessarily work on the premise that sexual violence requires specialist services. This is more characteristic of a Western approach to intervention.

<sup>29</sup> The appropriateness of restorative justice in cases of sexual violence is an area in urgent need of research attention, particularly considering the difficulties faced by victim/survivors who seek justice through the current criminal justice system.



*empowers them to begin the healing process by telling the offender the effects and what is needed. The offender may begin rehabilitation by hearing the effects, take responsibility and make amends. (Mental health counsellor)*

Māori providers also requested availability of restorative justice conferencing, with the proviso that conference facilitators were Māori. One Māori provider requested that marae (Māori meeting place) justice be recognised.

### 5.3 Access to services

Survey respondents were asked to describe how clients came to access their service or agency (i.e. what the referral mechanism was). They were also asked to give their views on how well they were able to deliver services to diverse groups of victim/survivors, providing some indication of particular groups that might experience difficulties in accessing services to fully meet their needs.

#### 5.3.1 Referral mechanisms

Survey respondents were asked to indicate how common it was that clients came to them through the four referral mechanisms listed in Table 11. Data presented are the proportion of survey respondents who indicated the referral mechanism listed was how clients 'mostly' or 'always' came to them.

As can be seen in Table 5.4 self-referral by victim/survivor was the most common form of referral for all service providers except for Victim Support, where 85 percent came from police referrals. High levels of self-referral point to the importance of service providers and the services they offer being well publicised.

**Table 11: Most common methods of referral to service provider (n=166)<sup>1</sup>**

Method of referral	SSVA <sup>2</sup> (n=26) (%)	Ref (n=11) (%)	VS (n=39) (%)	MH (n=66) (%)	Med <sup>3</sup> (n=11) (%)	CA (n=13) (%)	Māori (n=13) (%)
Self-referral	54	55	10	64	91	85	85
Police referral	19	27	85	3	9	15	8
Referral from other agency	12	–	5	35	9	31	38
Family/whānau or friend	15	9	–	17	9	38	38

Notes: CA = other community agencies; Med = medical; MH = mental health counselling service; Ref = women's refuges; SSVA = specialist sexual violence agency; VS = Victim Support. More than one method of referral was possible. Percentages should be interpreted with caution because base numbers are low.

- 1 Survey respondents indicated if clients came to service provider 'never', 'sometimes', 'mostly' or 'always' via the different methods of referral. Data presented are the proportion of respondents who reported the method of referral was used 'mostly' or 'always'.
- 2 One SSVA survey had missing data for this variable.
- 3 One medical survey had missing data for this variable.

Some of the differences in the method of referral across types of service reflect agency policies and agreements; for example, Victim Support is located in police stations, so the high level of referral from police reflects this proximity and agreed referral protocols between the police and Victim Support. Survey respondents from women's refuges indicated they only 'sometimes' accepted referrals from other service providers, which may reflect their policy of working directly with clients, even if initial information comes from another source. Community agencies and Māori providers have comparatively higher rates of referral from the victim/survivor's family/whānau or friends (38 percent), perhaps reflecting their close links to their communities.

Referral from another agency was generally less common, and where this had occurred the most common referral routes were through a victim/survivor's doctor (n=10). Other referral agencies mentioned included Plunket,<sup>30</sup> a midwife, the Community Probation Service, social workers, counsellors, and a church.

For rural Māori, referrals were more likely to be made by victim/survivors and whānau or from a variety of services including Child, Youth and Family<sup>31</sup> and Barnardos. Mental health counsellors also pointed out referrals often came through the ACC list of registered counsellors

### **5.3.2 How well service providers perceived they could provide services to diverse groups**

Service providers were asked to rate how well they felt their agency (or themselves in the case of counsellors) provides services to victim/survivors from a range of diverse groups (responses were given on a five-point scale from 1 (not very well) to 5 (very well)). Groups with lower ratings (services perceived to be delivered less well) are indicative of those groups more likely to experience difficulties in accessing services to fully meet their needs.

The groups of clients that service providers felt least able to deliver services well to were victim/survivors who were:

- ethnic, migrant, refugee peoples (65 percent of service providers rated their service delivery as average or worse)
- Pacific peoples (49 percent of service providers rated their service delivery as average or worse)
- people with disabilities (47 percent of service providers rated their service delivery as average or worse).

Just under a third of service providers had concerns over their ability to deliver services to Māori victim/survivors (30 percent) and male victim/survivors (29 percent), and around a quarter in relation to victim/survivors who were

---

<sup>30</sup> The Royal New Zealand Plunket Society is New Zealand's leading provider of Well Child and family health services.

<sup>31</sup> Child, Youth and Family is the government agency that has legal powers to intervene to protect and help children who are being abused or neglected or who have behavioural problems

sex-workers (24 percent). Some service providers commented on factors they felt limited their ability to deliver effective services to these groups. These are reviewed below.

### **Factors limiting service providers' ability to meet the needs of specific groups of victim/survivors**

An open-ended question invited survey respondents to describe the factors they felt limited their ability to meet the needs of specific groups of victim/survivors (Māori, Pacific peoples, youth, and other specific groups). Identifying such factors points to ways access to effective service delivery might be improved for these groups. Responses were analysed and the findings are presented below.

#### **Māori victim/survivors**

Factors perceived to be limiting service providers' ability to deliver effective services to Māori victim/survivors have been separated out, according to whether the providers were Māori or non-Māori.

**Māori service providers:** Of the 16 Māori service providers that completed the survey, six agencies commented on factors that limited their ability to meet the needs of Māori. Two Māori mental health counselling services stated that their workers had to cover large geographical distances, which meant it was difficult to get to some clients. A lack of ongoing specialist support for Māori victim/survivors and their whānau and a lack of resources were also issues for them.

*Getting access to clients who live out of [the] city centre and can't travel. Finding resources to meet their practical and social support needs before they can be stable enough to make good use of counselling. Lack of people to work with in teams to work with whānau and social needs. (Māori mental health counsellor)*

Three of the ten Māori community agencies stated that they did not have enough Māori counsellors. One Māori community agency commented on difficulties experienced working with other agencies.

*Non-Māori services thinking of referring to Māori services too late. Protocols not being followed. Ignorance, and non-Māori assumptions about Māori behaviour. (Māori community agency)*

**Non-Māori service providers:** Forty-eight (30 percent) of the non-Māori service providers commented on some of the limitations they felt they had in meeting the needs of Māori clients. Twenty-four (15 percent) service providers identified a lack of Māori counsellors and/or staff as a limitation.

*We do not have Māori workers. We have been unable to employ any as they either don't apply or do not have enough skills (we would be prepared to train but we need basic skills). Most Māori workers with skills are in demand with Māori services. (Women's refuge)*

*There is a real shortage of Māori counsellors in the [Tasman] areas, let alone those also trained to work with effects of rape/sexual abuse. (Mental health counsellor)*

Three respondents specifically commented on the need for Māori men to work with Māori male victim/survivors of sexual violence.

Twenty (13 percent) service providers identified their lack of tikanga Māori (customs, rules, principles) and te reo Māori (language) as limitations for working with Māori clients.

*Although I have high levels of awareness of Māori culture and the effects of colonisation I am not Māori so am limited in connecting on a deeper cultural level. (Mental health counsellor)*

Interestingly, comments from one-third (n=54) of non-Māori service providers indicated they did not perceive themselves to have any problems delivering services to Māori clients. Explanations for this were that:

- agencies refer Māori clients to Māori service providers (n=11)
- the agency provides staff and counsellors with cultural supervision (n=11)
- the agency has Māori staff (n=7).

Six providers said that this was not an issue for them because they did not get referrals for Māori clients.

*We generally don't get Māori clients. It's because we don't have any Māori counsellors working here. (Mental health counsellor)*

### **Pacific clients**

Almost half of the survey respondents rated their service delivery to Pacific peoples as being average or less. Sixty-one (34 percent) service providers, including 63 percent of SSVAs (17 out of 27), commented on the factors they felt limited their ability to meet the needs of Pacific clients who came to them.

Fifty-five (31 percent) service providers identified their lack of knowledge of Pacific languages and cultures as limiting their ability to provide effective services to this group. This is particularly challenging because Pacific people are not a homogenous group, coming from different islands with their own languages and cultures.

*We are a very Pākehā organisation that cannot provide fully culturally appropriate services for Pacific women. Also Pacific and migrant women aren't accessing our service. We are working on what the barriers are for both parties – agency and potential client. (SSVA)*

A further 13 (7 percent) service providers identified the lack of Pacific services as a problem.

*A difficulty is that there is no local Pacifica service to collaborate with regards sexual abuse. We do collaborate with generic Pacifica services, however this has limitations. (SSVA)*

Three mental health counsellors identified an additional issue for Pacific victim/survivors – ACC does not cover abuse that occurred in the Pacific Islands, so counselling is too expensive for many Pacific victim/survivors.

### **Young clients**

Comments from the majority of service providers indicated they believed they were able to deliver effective services to youth (aged 16–25), with only 28 (15 percent) commenting on perceived limitations.

Seven service providers identified issues with working relationships with other organisations in their communities. Two stated they were unable to work with young survivors in schools, and others talked of poor inter-agency links and clumsy referral processes.

*Sometimes there is interference from other agencies e.g. child, family and mental health services that refuse to work alongside ACC sensitive claims or private practitioners. (Mental health counsellor)*

Five mental health counsellors commented on the difficulty of meeting the level of need of some young clients who had been sexually assaulted.

*I have concerns regarding young people who have no adult supervision in their lives and who are not connected to other services. With such clients, mobility, poverty, drug abuse, not showing for appointments and suicidality are big issues. (Mental health counsellor)*

Other issues specific to counsellors were that they were not trained to work with young clients (n=7) and had difficulty establishing rapport 'across the generation gap' (n=3).

### **Other groups of clients**

Fifty-eight (32 percent) service providers commented on difficulties they experienced in delivering effective services to other groups of clients, including ethnic minority, refugee and new migrant victim/survivors; male victim/survivors; and victim/survivors with disabilities.

**Ethnic minority, refugee and new migrant victim/survivors:** Ethnic minority, refugee and new migrant victim/survivors were the group that survey respondents felt most challenged to deliver effective services to, with 65 percent rating their service delivery to this group as average or worse). Twenty-one survey respondents commented on the limitations they had experienced in meeting the needs of this group because of their lack of knowledge about the cultures and languages of these clients. They also identified a lack of networks or links into these communities, along with the lack of culturally appropriate services to refer clients to.

Ten service providers stated that a major concern for refugee and new migrant clients was that no ACC funding for counselling is available if the sexual violation occurred outside New Zealand.

*ACC regulations state that if the historical abuse of an immigrant occurred outside of NZ, they are not eligible for funding for counselling. This does not make sense if we are wanting them to become fully functioning, healthy members of our society. (Mental health counsellor)*

**Male victim/survivors:** Just under a third (29 percent) of the survey respondents identified their service delivery to male victim/survivors as being average or worse.

The main factor identified as limiting this group's ability to have its needs met was lack of services, raised by ten service providers. Four of these services were SSVAs that had been set up specifically to support women, so did not provide services to male victim/survivors.

*Our ... constitution papers [state we don't deal with men]. (SSVA)*

*We are a feminist organisation, with a women-centred empowerment philosophy of valuing the need to have a 'woman and child only space'. This limits men being able to come to the centre, however we have begun to offer info and support to men over the phone. We are not experts on the impact sexual violence has on men, and we are all women. We are not altering the 'women only' aspect of our service, but would love to see a specialist service for male survivors run by men. (SSVA)*

**Victim/survivors with disabilities:** Just under half of the survey respondents identified their service delivery to victim/survivors with disabilities as being average or worse (47 percent). Eleven (6 percent) service providers identified factors that limited their ability to meet the needs of victim/survivors with disabilities. Limitations centred on access difficulties for this group such as:

- no wheelchair access to the building (n=6)
- no access to Deaf interpreters (n=2)
- no professional development for working with people with intellectual disabilities (n=2)
- no information in Braille (n=1).

## 5.4 Survey respondents' views on how service delivery could be improved

Survey respondents were asked to identify which of the factors listed in Table 12 would assist their agencies (or themselves) to deliver better services to the victim/survivors that come to them. The top priorities were more funding for agencies and more appropriately skilled and experienced practitioners in the field, and ensuring existing practitioners had access to professional development.

Increased funding was identified as the top need for the majority of respondents from SSVAs, women's refuges and mental health counselling services. The first two of these three service providers are those most likely to deliver crisis intervention and the third is most likely to be responding to the impacts of sexual violence.

Funding appeared to be a particular issue for SSVAs with all but one identifying a need for increased funding (96 percent).

*Current service delivery levels are not indicative of resource levels. Our agency has repeatedly been on the verge of financial collapse and required government assistance every time. The way we have managed money has been closely scrutinised and the conclusion every time has been that actually we run the services on the equivalent of 'the smell of an oily rag'. (SSVA)*

**Table 12: Survey respondents' views on how they can be assisted to provide better services**

What would help to provide better services	SSVA <sup>1</sup> (n=26)	Ref (n=11)	VS (n=39)	MH (n=66)	Med <sup>2</sup> (n=11)	CA (n=13)	Māori (n=13)
Increased funding	96	73	67	53	36	54	54
Access to more training	54	73	69	23	64	38	38
More qualified and experienced staff	62	45	41	23	27	62	77
Increased levels of staffing	73	64	26	14	45	38	62
Better inter-agency collaboration	42	45	56	41	45	62	62
Better access to information	23	45	46	18	27	31	31
Improved facilities & equipment	58	18	10	8	36	23	31
Improving access to service	69	9	31	29	27	38	38
Nothing	–	–	8	8	18	–	–

Notes: Notes: CA = other community agencies; Med = medical; MH = mental health counselling service; Ref = women's refuges; SSVA = specialist sexual violence agency; VS = Victim Support. Percentages should be interpreted with caution because base numbers are low.

1 One SSVA survey had missing data for this variable.

2 One medical survey had missing data for this variable.

The majority of SSVAs identified a range of funding-related needs that could also improve their service delivery: workforce issues such as increased level of staffing (73 percent of SSVAs), more qualified and experienced staff (62 percent), and improved access to training (54 percent), and improved facilities and equipment (58 percent).

Another major issue for SSVAs related to improved access to services. Over two-thirds of SSVAs indicated this as a way to provide better services compared with around one-third or fewer respondents from other services. This reflected a concern about communities' relatively low level of awareness of SSVAs and communities' lack of awareness about the meaning of sexual violation/rape and barriers associated with the stigma of rape.

*The services are there but there is an accessibility thing – they will hesitate to come to Rape Crisis, it's that 'R' word. Also, misinformation in [the] community about rape is hard to combat. (SSVA)*

*Several pathways are needed for survivors to get to services that are easily accessible and transparent to all i.e. through [doctors], Police, CAB [Citizen's Advice Bureau], Health, Education etc. (SSVA)*

Workforce issues (access to more training, more qualified and experienced staff, or increased levels of staffing) were identified as a top priority by six types of service providers (SSVAs, women's refuges, Victim Support, medical providers, other community agencies and Māori providers). This appeared particularly pressing for Māori service providers, with 10 out of 13 Māori providers indicating they needed more qualified and experienced staff and 8 needing more staff.

Rural areas also needed additional staff to compensate for the travel time required to cover wide geographical areas to see clients, and to assist clients to undertake forensic examinations in town. As one Māori counsellor pointed out, they are at risk of feeling overwhelmed by the volume, and complexity, of work.

*In [name of rural area] I'm the only Māori one. And if I knew that before I went there I wouldn't have probably gone there ... Well there were times when I thought ... 'Geez, I'm "it" and I'm "it", and I'm "it". And there's times that I thought, 'Well, I'm not going to be "it" forever'.*

The same counsellor also noted that specialist counsellors were needed to cover the specific needs of different age groups (i.e. rangatahi (youth), koro (elderly men) and kuia (elderly women)). In particular, counselling elderly people may invoke tuakana-teina (in this context, meaning roughly 'inter-generational'; see explanation in glossary) dynamics that can require specialist cultural knowledge.

*Well the difficulty was ... I felt that I needed more training ... I need exposure to that. Like I've only had one [kuia] up the [name of rural place] and ... most of our kuia's say they've sorted out [effects of abuse]. You know, they cope well with it or they've just lived like that for so long that this is what it is now ... But this one that did [talk] ... I sat and listened to her and she could talk about it to me and the story you know – that was all I could do.*

Additional comments from service providers on how to improve services highlighted the three following themes.

- **Responsiveness of ACC services and systems:** ACC-registered counsellors identified issues with inadequate subsidies, delays in processing claims, poor information flows, and high compliance costs (i.e. paperwork).

*There is a gap when working for ACC between assessment sessions and waiting for approval to continue treatment that is potentially distressing for those clients in need of continuous and immediate treatment. (Mental health counsellor)*

*Difficulty with ACC red tape and ongoing assessments of the client and the work means I significantly limit the number of ACC clients I am willing to see at any one time. These difficulties mean most experienced psychotherapists either do not work with ACC clients at all or limit the number. (Mental health counsellor)*

- **Childcare and transport:** Service providers reported that childcare and transport are a problem for some clients in terms of accessing services.

*Serious poverty and/or lack of social support is an ongoing problem for many of my clients – for example they may not have alternative child-care*



*and, if their car breaks down, cell phone has no funds etc ... they cannot get to sessions or, in some [cases], even advise that they are unable to attend [at all]. Poor health is also an issue and sometimes clients do not attend because they are sick. (Mental health counsellor)*

- **More services or better access to other services:** Some service providers commented that they could provide better services to their clients if additional services were available in their community for referral (e.g. SSVAs, services for men, specialist Māori services, specialist counselling for refugees, and alternative treatments, such as massage, to assist with body integration). One medical provider commented that access to medical services was limited because of short, fixed appointment times.

*More time available to see client in consultation [and to potentially] discover if client has been a victim of abuse. Currently we have very strict 10 and 20 min appointments. (Medical provider)*

### 5.4.1 Inter-agency collaboration

Inter-agency collaboration is recognised as an important aspect in the delivery of effective services. Cross-agency referrals and the sharing of information are crucial to a well-functioning support system. This appeared to be recognised by service providers with 42–62 percent indicating that improved inter-agency collaboration would assist them to deliver better services to victim/survivors (see Table 12). This need was particularly evident among more generalist service providers (community agencies, 62 percent; Māori providers, 62 percent; and Victim Support agencies, 56 percent).

To explore this issue further, survey respondents were asked to rate on a scale from 1 (very poor) to 5 (very good), the level of inter-agency co-operation they experienced with each of the agencies listed in Table 13. Table 13 presents the proportion of agencies that felt there was 'good' or 'very good' inter-agency collaboration with those agencies listed.

SSVAs were rated most frequently by survey respondents as good collaborators (rated by 61 percent). Other types of agencies received similar recognition as being good collaborators: DSAC-trained and -accredited doctors (57 percent); community agencies (54 percent); police (53 percent); health services (52 percent); and Māori providers (49 percent). While inter-agency collaboration was perceived to be good among many agencies, there appears to be plenty of opportunity for greater numbers of agencies to participate.

One way to increase inter-agency co-ordination and collaboration is to have written protocols or agreements in place for service providers working with any other agency that responds to victim/survivors. Just 49 of the service providers (30 percent) stated that they had such written agreements in place.

**Table 13: Types of service providers perceived as being good at inter-agency collaboration**

Service provider	Service providers receiving ratings of good inter-agency collaboration <sup>1</sup>	
	n <sup>2</sup>	%
Specialist sexual violence agencies	73 out of 120	61
DSAC-trained and -accredited doctors	60 out of 105	57
Other community agencies	72 out of 134	54
Police	77 out of 145	53
Health services (mental health, general practitioners, family planning)	81 out of 156	52
Māori community providers	69 out of 142	49

Notes: DSAC = Doctors for Sexual Abuse Care. Percentages should be interpreted with caution because base numbers are low.

- 1 The number of survey respondents that rated having 'good' or 'very good' inter-agency collaboration with these service providers.
- 2 The total number of survey respondents varied because some agencies decided not to comment or felt unable to comment (i.e. they had no experience of working with particular agencies).

## 5.5 Summary

### 5.5.1 Characteristics of services and their clients

Community service providers who participated in the survey offered different types of services, which meant the nature and extent of their interactions with victim/survivors varied. Levels of specialisation also varied, with SSVAs being the only group responded solely to victim/survivors.

The majority of clients seen by community service providers were seeking assistance in relation to historical sexual violence.

Information on counselling and how to feel better were the most common requests victim/survivors made to service providers. However, only those who recognised and were able to name their experience as 'rape' were likely to seek assistance.

Service providers identified the high and complex needs for some victim/survivors, which required enhanced service capacity. Issues included assistance with immigration matters, language and accommodation.

Some agencies provided a wide range of services (e.g. SSVAs), whereas other service providers had particular areas of focus (e.g. medical services and mental health counselling services).

Gaps were identified in the availability of specialist sexual violence services, doctors able to perform forensic medical examinations, and access to forms of restorative justice for victim/survivors.

### 5.5.2 Access to services

Most clients were self-referrals, although Victim Support received most of its clients through referrals from police. High levels of self-referral point to the importance of service providers and their services being well publicised.

Survey respondents had concerns about their ability to deliver services to certain groups, particularly victim/survivors who were from an ethnic minority including Pacific peoples, migrants and refugees, and victim/survivors with disabilities. Of particular concern, was the ineligibility for ACC funding for those living in New Zealand who had experienced sexual violence outside New Zealand.

### 5.5.3 Effectiveness of service delivery

Increased funding was identified as the top need by three out of seven service providers (SSVAs, women's refuges and mental health counselling services). SSVAs appeared to be the least well resourced with 96 percent calling for more funding to improve service delivery. Increased funding could be used to increase workforce capacity and improve facilities and equipment.

Workforce issues were identified as a top priority for six out of the seven service providers. Increasing the number of experienced and qualified staff was seen to be particularly pressing among Māori agencies.

Other ways identified to improve service delivery included improving the responsiveness of ACC services and systems, increasing access to funding for practical support (such as childcare and transport), and ensuring adequate coverage of services in all regions.

Ways to improve service delivery for certain groups of victim/survivors included making ACC funding available for people living in New Zealand but who had experienced sexual violence overseas (e.g. Pacific and other ethnic minority, migrant and refugee victim/survivors). Services to these groups were also felt to be limited with services providers having inadequate knowledge of relevant languages and cultures. Appropriate services for victim/survivors who were male or had disabilities were also needed.

Service providers recognised the importance of inter-agency collaboration for the effective delivery of services. Many service providers were considered to be good collaborators, particularly SSVAs, room for improvement existed. Only about 30 percent of survey respondents had any formal working agreements with other agencies.

## 6 Views on community capacity

This chapter presents the views of a wide range of survey respondents on the capacity of their community to respond to the needs of victim/survivors. This contrasts with the previous self-reported information about the nature and types of services agencies delivered, and resulted from respondents being asked to stand back and comment more broadly on the overall level of service provision in their community.

To gain a broader perspective on the overall level of service provision across New Zealand, the views of other key informants (e.g. Doctors for Sexual Abuse Care (DSAC) regional liaison doctors (RLDs), police, court victim advisers, and Crown prosecutors) have been included alongside those of community service providers.

This chapter presents survey findings on:

- gaps in service delivery – views on inadequate service provision nationally and regionally and the gaps in services for particular groups of victim/survivors (section 6.1)
- the factors influencing a victim/survivor's ability to have their needs met – factors limiting and enabling victim/survivors emotional support and medical needs to be met (section 6.2)
- what works – interventions and ways of working that community service providers think are effective in their communities (section 6.3).

### 6.1 Perceived gaps in service provision for victim/survivors

This section begins with an overview of the perceived gaps in service provision across New Zealand, according to agencies that respond to victim/survivors of sexual violence and participated in this survey (Table 14). This is followed by a regional breakdown of these perceived gaps (Figures 4–6). Perceived gaps in service provision for specific groups are then presented.

Note: The findings in this chapter should be viewed only as an indication of the minimum gaps in services and not the total number. Survey responses were received from those who were providing at least some level of service provision. Hence, areas without agencies/services responding to victim/survivors could not be represented.

### 6.1.1 Perceived gaps in services nationally

Survey respondents were asked whether there was a sufficient range or level of services in their area to:

- enable victim/survivors to disclose to a formal agency
- meet victim/survivors' emotional support needs
- meet victim/survivors' medical (non-forensic) needs.

Most victim/survivors do not disclose to police, so only community service providers were asked about the adequacy of service provision to enable victim/survivors to disclose to a formal agency. However, both community service providers and criminal justice groups were asked about the adequacy of services to meet victim/survivors' emotional and medical needs. The proportions of respondents who perceived the range or level of service provision to be inadequate are presented in Table 14.

**Table 14: Proportion of respondents viewing the range or level of service provision to be inadequate**

Lack of service provision	Service providers (n=179) %	DSAC RLDs (n=10) %	Court victim advisers (n=17) %	Crown prosecutors (n=46) %	Police (n=206) %
Ability to disclose to a formal agency	27	Not asked	Not asked	Not asked	Not asked
Emotional support	47	29	9	12	21
Medical support	22	40	8	8	9

Notes: DSAC RLDs = Doctors for Sexual Abuse Care regional liaison doctors. Don't knows and no comments were excluded when calculating percentages. Percentages should be interpreted with caution because some base numbers are low. Exact question asked to criminal justice groups varied from service providers, but results have been included in same table for purposes of comparison.

As can be seen in Table 14 four out of five groups of survey respondents perceived the provision of emotional support to be the greatest unmet need; the DSAC RLDs reported medical support as most lacking. This difference may reflect the particular needs of the victims/survivors that DSAC RLDs come into contact with (i.e. only those requiring medical treatment or a forensic medical examination) or perhaps indicate the pressure they feel because of the lack of experienced specialised sexual abuse doctors.

Service providers and DSAC RLDs are likely to have a high familiarity with service responses in relation to emotional and medical needs and observed higher levels of inadequate service provision than the criminal justice groups (court victim advisers,

Crown prosecutors and police). Again, these differences could reflect the differences in the types of interactions each group has. Criminal justice groups interact only with those victim/survivors who have reported to police, so are likely to be less familiar with others in the community who have not reported.

Community service providers were invited to elaborate on their responses in relation to the adequacy of service provision. Responses are presented below.

### ***Ability to disclose – gaps in services***

Disclosing sexual violence is traumatic for most victim/survivors, and the decision to disclose can be affected by the availability of services and whether these services provide an environment conducive to reporting (e.g. a safe and respectful environment). Only 27 percent of service providers felt there were insufficient services available in their area for those who wished to disclose sexual violence. Seventy-nine respondents provided additional comments. Many of those who had indicated there were sufficient services qualified their response, noting that while services might be available, they might have waiting lists or be under-funded to provide those services.

*I am unsure of the capacity of the available agencies and waiting times for people wanting these services (Victim Support)*

*Yes but – very under-funded – much of this work is done on a voluntary basis, as an adjunct to provided services (SSVA)*

Concerns were also raised about whether victim/survivors and providers were aware of the specialist services that existed.

*Survivors who have contacted [a high-profile rape victim/survivor], who didn't know who else to go to. Not visible – communication breakdown. Don't know who to ring. ... Fear of who it is safe to talk to. (SSVA)*

*Whether all GPs [general practitioners] know what agencies these are is another matter (Mental health counsellor).*

Where services were seen to be insufficient to enable victim/survivors to disclose, the following issues were mentioned.

- The availability and high cost of counsellors in some areas (often referred to in relation to ACC-registered counsellors) (n=13).

*ACC must respond more quickly with approvals for counselling – survivors often need immediate support, and having disclosed (as the forms require) should not have to wait several weeks for funded help. As an ACC counsellor – a recognition that ACC fees are inadequate would be helpful – I do not surcharge although many of my colleagues do and because of the fragmentation and poverty in the lives of many of my clients the non-attendance rate is very high. I do not get paid for non-attendance and accountability costs are corrosive. Financial stress on top of the difficulties of this kind of work tends to reduce the duration of many counsellors' working life. (Mental health counsellor)*

- The availability of specialist services appropriate to special groups: Māori (n=7); men (n=5); ethnic minorities (n=3); gay, lesbian, transgender, bisexual, intersex people (n=2); people with disabilities (n=1).
- The existence or availability of an SSSVA (n=7).

*There is no specialised formal agency. Survivors can disclose to police, and many would not seek to do this. There is a local Victim Support agency, but they are associated with the police and this compromises their availability. Some disclose to Women's Refuge, their GP [general practitioner], or seek out a counsellor independently. This area is well resourced with sensitive claims counsellors, but their working brief may need to be expanded to include other family members who are in distress (Mental health counsellor).*

### **Emotional support needs – gaps in services**

Table 14 indicates the greatest gaps in services are those to meet victim/survivors' emotional support needs. Eighty service providers elaborated on their response, with issues centred on the lack of counselling and crisis support options. In terms of counselling support, issues were raised around costs and delays in ACC approval. In terms of crisis support, there were concerns about SSSVAs' ability to respond because of resource constraints, and the pressures placed on service providers when they attempted to respond without sufficient resources.

*Yes – But only because the two crisis counselling agencies are extremely committed to their role. The agencies and their staff are very stretched, under-funded and staff underpaid (especially the after-hours support counsellors). This area of support requires major funding investment. (DSAC RLD)*

### **Medical needs – gaps in services**

Overall, most service providers were happy with the level of medical services available in their area, with just 22 percent reporting insufficient services in terms of pregnancy and sexually transmitted infection checks, and assessment and treatment of injuries incurred during the sexual violence. Those with concerns identified the lack of access to doctors, no 24-hour service, the costs of after-hours services, and a shortage of female doctors.

These concerns were echoed by DSAC RLDs who pointed out that most victim/survivors attend after-hours services or hospital emergency departments, which provide a variable level of care. They also stated that some doctors in general practice have poor knowledge or understanding of the needs of victim/survivors, so cannot provide good care. However, they said if victim/survivors attend sexual health clinics they receive good care.

### **6.1.2 Regional breakdowns of perceived gaps in services**

To explore whether certain locations around New Zealand were perceived to have more gaps in services than other areas, the data presented above were broken down by region. Data from criminal justice groups have been aggregated to enable an easier comparison with community service providers.

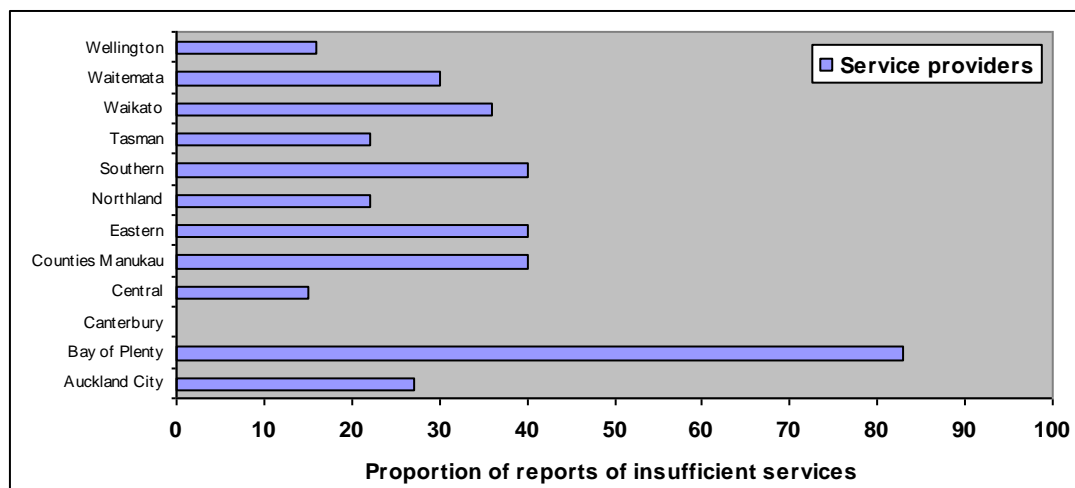
The percentage of respondents in each region who reported that in their view services were insufficient to enable victim/survivors to disclose to a formal agency is shown in Figure 4, to have their emotional support needs met is shown in Figure 5, and to have their medical (non-forensic) needs met is shown in Figure 6. In the figures, the regions with comparatively longer bars are the regions where more respondents from that region perceived there to be gaps in services.

Percentages in Figures 4–6 must be interpreted with caution because the number of responses per region varied and was often small. Responses for service providers ranged from 6 in the Bay of Plenty to 21 in Wellington. Similarly with criminal justice groups, responses ranged from 7 in Canterbury to 41 from the Southern Region.<sup>32</sup>

Figures 4–6 reveal the regions perceived to have the greatest need for increased service provision. Data presented also reinforce the pattern of findings observed in Table 14. Figures 5 and 6 clearly show that community service providers perceived greater gaps in services than criminal justice groups, although the regional breakdown reveals variations in the degree of this difference. For example, Tasman and Auckland showed large discrepancies, whilst there appeared to be greater agreement in Waitemata and Northland.

The provision of emotional support was perceived to have the greatest unmet need across regions by both service providers and criminal justice groups (see Table 14). Bay of Plenty was the region both groups identified as having the greatest unmet need.

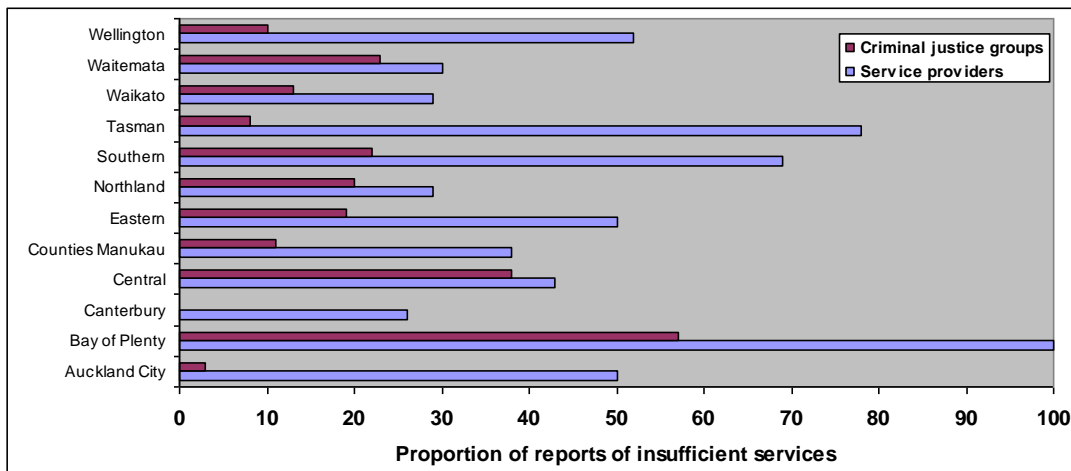
**Figure 4: Ability to disclose to a formal agency – gaps in services by region**



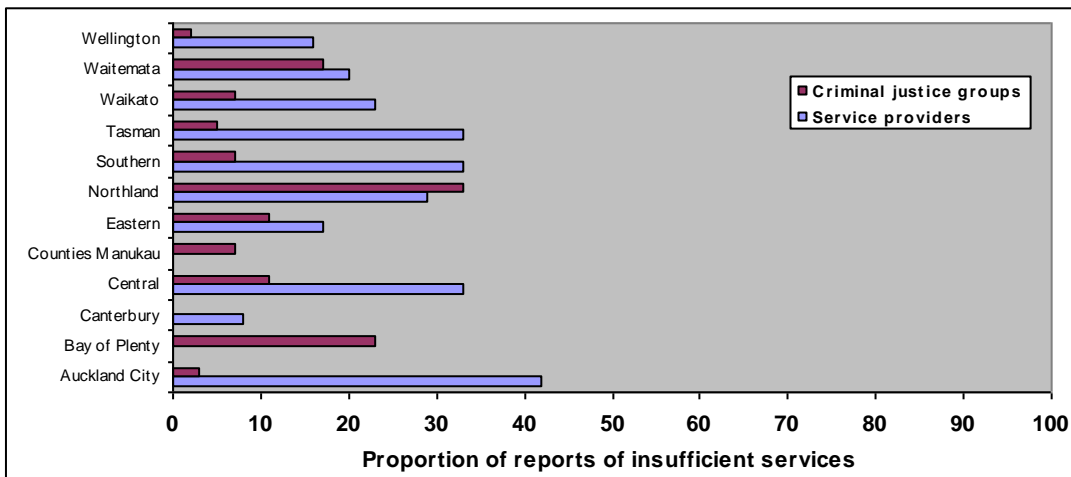
<sup>32</sup> Not all survey respondents replied to this question, further reducing numbers in some regions. For an idea of the maximum number of total number of survey responses per region, see Table 5 in chapter 3, and Figure 2 in chapter 4.



**Figure 5: Emotional support needs – gaps in services by region**



**Figure 6: Medical (non-forensic) needs – gaps in services by region**



**Ability to disclose**

Bay of Plenty was identified by the greatest number of respondents as having insufficient services to enable victim/survivors who wished to disclose sexual violence to a formal agency to do so (five out of six respondents; 85 percent). Canterbury was perceived to be the best-resourced region, with no reports of insufficient services (n=17).

**Emotional support needs**

Bay of Plenty was identified by most respondents as the region having insufficient services to enable victim/survivors to have their emotional support needs met: all six community service providers and six out of ten criminal justice respondents (60 percent). Other areas community service providers identified as having particularly high ratings of gaps in emotional support services were Tasman (78 percent), Southern (69 percent), and Wellington, Eastern, and Auckland City (all about 50 percent). In contrast, criminal justice groups ranked Central as having the

second greatest level of unmet need (38 percent,) followed by Waitemata (23 percent). Canterbury was again perceived to be the best resourced by both groups.

### ***Medical (non-forensic) needs***

The regions identified by most community service respondents as having insufficient services to enable victim/survivors to have their medical needs met were Auckland City (5 out of 12 respondents; 42 percent) followed by Central, Tasman and Southern (all 33 percent). Reports of insufficient services in Auckland City were unexpected. Closer examination of responses revealed concerns about existing services not being available 24 hours a day and also problems travelling to medical services in Auckland City.

*Services offered in only a few sites across a large city. Public transport can be difficult to face following sexual violence (SSVA).*

In contrast, criminal justice groups identified Northland, Waitemata and Bay of Plenty as having the greatest unmet medical needs.

### **6.1.3 Perceived gaps in services for particular groups of victim/survivors**

Community service providers (but not criminal justice groups) were asked to rate the extent of service provision for specific groups of victim/survivors on a scale from 1 (very poor) to 5 (very good). Figure 7 shows the percentage of community service providers who reported that services in their community were 'not available' or 'poor' for specific groups.

Figure 7 shows that half the service providers identified gaps in services for new migrants and refugees, and over a third identified gaps for Pacific peoples. Few services for sex-workers, people with disabilities, and men were also noted. These findings very much mirror service providers' concerns about their ability to respond to these particular groups (see section 5.3.2).

Respondents were also invited to comment on the needs of specific groups of victim/survivors in their communities. Not many commented on gaps in relation to specific groups; more commented on gaps in core services in their areas that affected all groups. For example, three service providers from Northland commented that their region lacked services across the board.

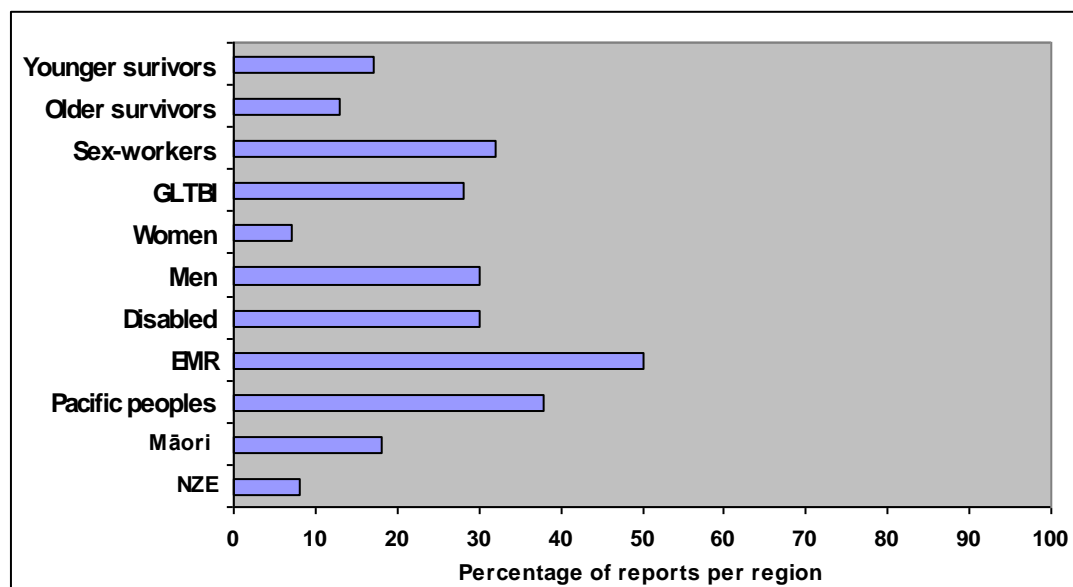
*There aren't enough services in our community. Those that do have resources are often inundated and struggle to cope with the demand. (Victim Support)*

The key issues service providers identified for Māori concerned gaps in crisis services, services that are inaccessible to Māori and services that can respond adequately to cope with the volume of Māori clientele. Māori social service providers do not necessarily have staff with specialist counselling skills (or ACC registration) and there is a shortage of Māori counsellors generally. For some, the issues are compounded by multiple barriers.

*Very poor availability of follow-up counselling services. Waiting lists for ACC-registered counsellors between six months and two years. No crisis*

*service. Non-specialist services often offering unhelpful advice/service. (Māori mental health counsellor)*

**Figure 7: Reports of poor or no service delivery for specific groups of victim/survivors**



Note: EMR = ethnic, migrant, refugee peoples; GLTBI = gay, lesbian, transgender, bisexual, intersex people; NZE = New Zealand European.

## 6.2 Meeting emotional and medical needs

Community service providers (but not criminal justice groups) were asked to comment on the factors that assisted or limited victim/survivors having their emotional and medical needs met. These were open-ended questions, and the comments were content analysed. The themes that emerged are presented in Table 15.

As can be seen from Table 15 there was considerable overlap in the factors seen as important for ensuring victim/survivors could have both their emotional and medical needs met. Some factors related to attitudes about sexual violence that society holds and the resulting misattributions these cause in victim/survivors themselves (e.g. shame and self-blame), which acted as barriers to accessing services. Other factors related to the characteristics and availability of services.

**Table 15: Service providers' views on factors affecting victim/survivors having their needs met**

Factors	Emotional needs		Medical needs	
	n=169	%	n=125	%
Limits needs being met				
Shame and self-blame	74	44	24	15
Lack of information on services	69	41	49	39
Costs	68	40	63	50
Lack of services	42	25	–	–
Geographical isolation	24	14	10	8
Helps in meeting needs	n=156	%	n=118	%
Quality services	98	63	47	40
Inter-agency collaboration & liaison	60	38	50	42
Practical support (transport and childcare)	9	6	–	–

Note: The numbers of respondents represent those who thought to mention these factors. If survey respondents had been specifically asked about the impact of each factor identified, it is likely the percentage of survey respondents who agreed would have been higher.

### 6.2.1 Service providers' perceptions of barriers that prevent victim/survivors from having their emotional and medical needs met

Views on barriers that prevent victim/survivors having their emotional support needs met were provided by 169 service providers. There were also 125 suggestions on barriers preventing victim/survivors having their medical needs met. The factors identified are reviewed below.

#### **Shame and self-blame**

Seventy-four service providers (44 percent) identified shame and self-blame as barriers to victim/survivors accessing services to meet their emotional needs. They were also seen to be limiting factors in victim/survivors having their medical needs met, although fewer respondents noted this (n=24; 15 percent).

It was commented that many victim/survivors believe common rape myths, for example, that their actions contributed to the sexual violation.

*They experience shame, guilt, denial (that it's rape), or that it was serious enough. Guilt because the victim was drunk or drugged or it was 'date rape', and the victim blames herself or himself. (SSVA)*

Although service providers identified that shame and self-blame are a major hindrance to all victim/survivors accessing assistance to meet their emotional needs, they noted that they are a particular difficulty for male victim/survivors.

*For male survivors it is difficult. Males are indoctrinated from a young age to believe that males cannot be victims, expressions of anger and aggression are*

*acceptable but other emotions (sadness, grief etc) must be suppressed. Shame and homophobia limit males seeking help. (SSVA)*

One service provider acknowledged the courage it takes for victim/survivors to overcome their shame and seek help.

### **Lack of information about available services**

Sixty-nine service providers (41 percent) noted a lack of information for service providers and victim/survivors about the availability of services to meet emotional needs.

Victim/survivors of historical sexual violence who did not make police reports often found it more difficult to know what services were available for them than those who had reported.

*In our area there is no single point of contact e.g. crisis centre – so nobody knows where to go. (Medical provider)*

*There is a lack of information, no adequate referral system, and no direct accessibility for help. (Victim Support)*

Information about ACC entitlements and access to and the availability of counsellors were also identified as factors that limited victim/survivors accessing the emotional support services they needed. This was also a significant limiting factor noted in relation to medical needs (n=49; 39 percent).

*There is insufficient information regarding which counsellors will accept ACC clients at any specific time. Some who start with the 'list' are also desperate by the time they get to me. (Mental health counsellor)*

Respondents commented that victim/survivors were often not aware of services other than the hospital emergency department or their family doctor.

*Lack of information of services available unless contact is made through the police and this is not always an option for some victims. (Victim Support)*

### **Costs**

Sixty-eight service providers (40 percent) identified the costs of services as a factor preventing victim/survivors from accessing emotional support services. A slightly higher proportion noted this was a barrier to their getting medical needs met (n=63, 50 percent).

The cost of counselling was often referred to, with many ACC counsellors noted to be charging a surcharge because their services were not fully covered by ACC funding. As mentioned previously, there is no provision for ACC-funded counselling for victim/survivors who were sexually assaulted outside New Zealand.

The use of after-hours medical centres was also noted as expensive. If victim/survivors prefer to have ongoing medical treatment from a doctor other than the one with whom they are registered, they incur considerable costs for each visit.

*Some family doctors may also be treating the perpetrators. (SSVA)*

Other costs that limited access to services were the costs of transport and childcare.

### ***Lack of services***

A lack of services for victim/survivors was commented on by 42 service providers as negatively affecting victim/survivors' ability to have their emotional support needs met (25 percent). This mirrors the data presented in Table 14. Gaps in services were particularly problematic for specific groups of people, for example, young people and Pacific people (see section 5.3.2). Inadequate services in rural areas were also noted.

### ***Geographical isolation***

Geographical isolation was identified as limiting access to emotional support services (n=24; 14 percent) and medical services (n=10; 8 percent).

Victim/survivors in isolated places were less likely to have services in their area, so would need to travel to other areas. Geographical isolation was also identified as contributing to confidentiality difficulties.

*Being a small town everyone knows everyone. Survivors don't want family/friends to know. Survivors have to travel up to two hours to receive help at the various agencies/counsellors. (Victim Support).*

The perceived lack of confidentiality in rural and small communities was also viewed as a barrier to accessing medical care.

*Confidentiality – they tend to go out of town for diagnosis and medical treatment. (Women's refuge)*

Ten service providers identified that some rural areas had no general practitioner services or only very limited access, for example, a monthly visit by a general practitioner to the area. Transport to medical services was a related issue six service providers identified. One service provider summed up the difficulties faced in accessing medical services in an isolated community.

*Local people have to travel to Gisborne to have checks, whānau take them and their children, but there are lots of issues – money for petrol, reliable car, child minding, mental health issues and whakamā [embarrassment or loss of mana]. There are differences in culture ... people don't want to go to town and be examined by someone different. (Mental health counsellor)*

## **6.2.2 Service providers' perceptions of factors that help victim/survivors to have their needs met**

Suggestions about what factors help victim/survivors to having have emotional support needs met were given by 156 service providers. There were also 118 service providers who had suggestions about factors that help victim/survivors' medical needs to be met. Factors included the availability of good quality services, good inter-agency collaboration and referral systems, and practical support for victim/survivors.

### **Availability of good quality services**

The availability of good quality services was identified by 98 service providers (63 percent) as a key to ensuring victim/survivors have their emotional support needs met. Good quality services were seen to be those that:

- had immediate access (n=18)
- were affordable or free (n=14)
- offered a choice of counselling services (n=10)
- were visible or widely advertised (n=13).

*Excellent services that are free of charge to users, with ease of referral/access, and out of office appointments for workers. Diverse service provision/choice for users and access to transport assistance. (SSVA)*

Forty-seven service providers (40 percent) stated that the availability of quality medical services was important for ensuring victim/survivors can access services to meet their medical needs. A quality medical service was identified as one with approachable, knowledgeable, non-judgemental doctors and nurses who were supportive of victim/survivors of sexual violence.

*GPs [general practitioners] being approachable and knowledgeable enough to ask the right questions and pick up on the non-verbal language being displayed. (Mental health counsellor)*

Accessibility is a criterion for a quality service and was identified by 30 service providers (25 percent) as a key factor in enabling victim/survivors to have their medical needs met. Accessibility included not only geographical access to services, but also affordable or free and culturally appropriate services.

Other aspects of quality medical services included having female doctors available (n=3), guaranteed confidentiality (n=3), and doctors able to offer extended consultations with victim/survivors (n=2).

### **Good agency collaboration and referral systems**

Good inter-agency collaboration and referral systems were seen as crucial for services to be able to meet victim/survivors emotional support needs (n=60; 38 percent) and medical needs (n=50; 42 percent).

*Good liaison between services really helps. This includes good education of health professionals about available services. (Medical provider)*

The need to have general practitioners 'in the loop' was specifically noted by 16 service providers.

### **Practical support**

Nine service providers also noted that victim/survivors need practical support, such as childcare and transport, to enable them to access the services they require.

## **6.3 What works – effective interventions**

Service providers were asked to identify interventions or other aspects of service delivery that they felt were working well in their communities to promote the recovery and well-being of victim/survivors. Sixty service providers offered their views, with many of their responses overlapping with those reviewed above.

Unfortunately, one limitation of a self-complete survey is that the depth of information sought is not always forthcoming. For example, although service providers identified services they believe offer effective interventions, typically they did not describe what these services did or what made them effective. This is an area that warrants future research, so we can better understand why these interventions were viewed as effective. In the following sections, we refer to the agencies named and, where details have been given, provide examples of effective practice.

### **6.3.1 Effective counselling**

The most frequently cited intervention that was seen to working to promote recovery and well-being in victim/survivors was effective counselling (n=39; 65 percent). Initiatives that were seen to be enhancing access to effective counselling included counsellor co-ordination across the region, counselling models that include whānau, group counselling, free counselling after ACC funding expires, and culturally matched counselling.

### **6.3.2 Effective crisis support**

The second most frequently cited effective intervention was effective crisis support (n=35; 58 percent). Examples of service providers that were perceived as providing effective crisis support were HELP centres, sexual abuse centres, Rape Crisis centres, Māori agencies, women's refuges, women's centres, and abuse prevention agencies. In one region, an online service for victim/survivors was seen to be showing promise.

### **6.3.3 Follow-up support**

Several successful interventions for follow-up support were identified (n=29; 48 percent): a survivor's support group initiated by a survivor, an empowerment group and course for victim/survivors, outpatients groups at Dunedin Hospital, and community mental health nurses providing support in the community.

### **6.3.4 Effective services for specific groups**

The importance of providing for the needs for specific groups of victim/survivors has been reiterated throughout this report. Examples of effective interventions for specific groups was mentioned by 46 percent of respondents (n=28).



### ***Pacific peoples***

Pacific peoples' church meetings were seen as an effective way of working with Pacific victim/survivors. The Pacific Health Trust in Canterbury was also identified as working well.

### ***Young people (16–25 years)***

Examples of interventions working well for young victim/survivors included the resilience model used in Waitakere; the Auckland HELP youth team working in schools; START in Christchurch; the Safer Centre and teen parent mentoring unit in the Central region; the Life Trust (youth) and Uri o Hau (Māori youth) in Northland; and Kapiti Youth Support, Evolve and VIBE youth centres in Wellington.

### ***Māori***

Culturally matched services and whānau-based programmes were seen to be effective for Māori victim/survivors. Specific services perceived by service providers as working well in their communities were Te Puna Oranga in Christchurch; Parakatia Te Piri for Māori women in Dunedin; Te Rata Awhina Trust in the Tasman region; and Horo te Pai, Orongomai Marae, Wānanga Marae, Māori Women's Refuge, and Kōkiri Marae in Wellington.

It is interesting to note that non-Māori service providers often identified local iwi and marae services and hauora (local Māori health services) as providing effective interventions for Māori. However, Māori service providers generally identified their services lacked a specialised workforce to respond to the highly complex needs of adult victim/survivors. Rural services were particularly short of specialist counsellors, particularly when hauora aim to treat the whole whānau.

Only one Māori provider indicated their service provided long-term counselling beyond that provided by ACC and they provided whānau interventions. Clients were also referred to this provider's Māori peer-based educational programmes to build 'a sense of whanaungatanga [relationships and connection] and resilience'.

## **6.3.4 Good inter-agency collaboration**

Inter-agency co-operation, inter-agency collaboration, and cross-agency co-ordination were mentioned by 38 percent of respondents (n=23) as a key to effective services and has been highlighted throughout this report (see section 5.4.1).

Effective networks that met regularly, shared information and looked for solutions to problems, were identified by service providers in Canterbury, the Central region, the Eastern region, Northland, the Southern region, Waitemata and Wellington. The Tairāwhiti Abuse Intervention Network in Gisborne (Eastern region) was also cited as an effective model of inter-agency collaboration.

### **6.3.5 Police services**

Good police liaison was mentioned positively by eight community service providers. Police specialisation in adult sexual assault was also seen as an effective police intervention. One SSVAs described the changes to its work that having a specialist Adult Sexual Assault Team in the area made.

*It is not like the old days. When I am meeting with survivors I have confidence in saying to them, 'If you are thinking about it and you are not sure what you want to do, how about we just go and meet the police'. With ASAT [the Adult Sexual Assault Team] I have the confidence that I'm going to get a good response. It is not like the crime squad, where you don't know what you are going to get. I wouldn't do it, and crime squad wouldn't have the time or space or energy. (SSVA)*

*Sexual assault work is unpleasant work, it has a low resolution rate and an even lower conviction rate, so it is not feel-good work for the police. So when it is in the general pile, everything can and does take priority. It is hard to investigate and it takes a long time. Whereas when you have a team, and that is their work, they need to get satisfaction out of making it work. It is quite a shift. (SSVA)*

### **6.3.6 Education**

Rape prevention and date rape programmes in schools and the community were identified as effective education interventions, as was raising the issue of sexual violence with all clients to Family Planning (n=8).

## **6.4 Summary**

### **6.4.1 Community capacity – gaps in services**

Nationally, the greatest concern was an insufficient level of services to ensure victim/survivors can have their emotional support needs met. Particular concerns were the costs, delays and eligibility criteria for accessing ACC-funded counselling and the inadequacy of resources for SSVAs to provide these services efficiently.

Regionally, Bay of Plenty was the area seen to be most lacking in services, and Canterbury was seen to be one of the better resourced regions.

Gaps in services for diverse groups mirrored service providers' concerns about their ability to respond to particular groups (see section 5.3.2). Half the service providers identified shortfalls in services for migrants and refugees, and over a third identified gaps in services to Pacific peoples. Few services for sex-workers, people with disabilities and men were also noted.

### **6.4.2 Meeting emotional and medical needs**

There was considerable overlap in factors seen as important for ensuring victim/survivors could have their emotional and medical needs met. These included

addressing barriers caused by shame and blame experienced by victim/survivors, a lack of services and information about services that do exist, the cost of services, and problems caused by geographical isolation.

Factors seen to be helpful included the provision of quality services, practical support to enable victim/survivors' to access these services (e.g. childcare and transport), and encouraging good inter-agency collaboration among providers.

### **6.4.3 What works**

Examples of interventions or aspects of service delivery that were seen to be working in survey respondents' communities included counselling, crisis support, follow-up support, effective services for diverse groups, good inter-agency collaboration, police liaison and specialisation, and rape prevention education.

# Part four: Environmental scan of criminal justice system processes

## 7 Phases of the criminal justice system

This chapter presents an overview of some of the key phases or components of the criminal justice system from the victim/survivors' initial entry point (i.e. the reporting of sexual violation) to court hearings. This provides a useful platform from which to then consider how things might be improved (see chapter 8). Responses are predominantly from criminal justice groups, but responses from community service providers have also been included.

The phases reviewed in this chapter are organised into the chronological stages through which a victim/survivor who enters the criminal justice system might typically progress.<sup>33,34</sup> The stages are:

- the initial reporting of sexual violation to police (section 7.1)
- police processing of the report (initial call for service) (section 7.2)
- the forensic medical examination (section 7.3)
- the formal interview (section 7.4)
- the decision to prosecute (lay charges against the defendant) (section 7.5)
- court hearings (section 7.6).

### 7.1 Initial reporting of sexual violation

An initial report of sexual violation can be made through a third party, but because of the intimate nature of sexual violation, the decision to report usually rests with the victim/survivor.

Of all the key informants who participated in this research, the community service providers were most familiar with the dilemmas faced by victim/survivors in deciding whether to report the sexual violation to police. Criminal justice groups have contact only with those who have reported.

---

<sup>33</sup> The specifics of the case influence the progression and relevance of different phases. For example, whether the assault was recent or historical, whether a forensic medical examination is appropriate, and whether there is sufficient evidence to lay charges.

<sup>34</sup> Changes to the Summary of Proceedings Act 2008 that came into force on 29 June 2009 have changed the court processes around preliminary hearings or depositions. Preliminary hearings in indictable proceedings have been replaced with a standard committal procedure. This standard committal will not involve a hearing or consideration of oral evidence, unless the judge grants a special application for a committal hearing. (For more details about this and other legislative changes, see McIntosh, 2009).

One hundred and fifty-three service providers responded to the question, 'In your area what are the factors that prevent/discourage survivors from reporting sexual violence to the police?'. Most answered this question with multi-factor responses.

*Shame, fear of being blamed, fear of retaliation, fear of making a fuss in the family, fear of not being believed, wanting to move on and thinking/hoping they can just forget it, believing they won't get justice anyway. (Mental health counsellor)*

The factors commented on can be grouped into the five main themes of:

- shame and self-blame (34 percent)
- fear of police and the criminal justice system (33 percent)
- fear of not being believed (29 percent)
- fear of the consequences (19 percent)
- family or community pressures (13 percent).

A large proportion of service providers (n=71) also noted factors specific to certain groups of victim/survivors; these have been integrated into the discussion below.

### 7.1.1 Shame and self-blame

Fifty-two service providers (34 percent) identified victim/survivors' feelings of shame and self-blame as reasons they do not report to the police. This is consistent with earlier findings in this report that shame and self-blame are major factors preventing victim/survivors from disclosing and seeking emotional support from community service providers (see section 5.2). Embarrassment and loss of mana were identified as factors for Māori, Pacific and Asian women. Self-blame was also a factor for victim/survivors who had been under the influence of alcohol or other drugs at the time of the sexual violation. Shame and self-blame were also strong factors for victim/survivors who were or had been in relationships with the abusers and where deciding whether to report to the police.

Ten service providers identified that the sense of shame is particularly strong for male victim/survivors because of society's attitudes about masculinity.

*Gay men have been told by some professionals that they 'deserved it' or other such discrimination. (Mental health counsellor)*

Six service providers also commented that not all victim/survivors recognise the sexual violation as a crime. They suggested that some young people saw it as just 'part of life'.

### 7.1.2 Fear of police and criminal justice system

One-third of service providers (n=50) stated that a major factor in victim/survivors not reporting to the police was their belief that they would not get justice through the criminal justice system. They feared they would:

- not be believed by the police or judge and jury
- be revictimised during a court case, and have their character assassinated by the defence counsel
- have to confront the offender in court
- have to put their lives on hold for an indeterminate time while waiting for the trial
- see the perpetrator walk free.

*Fear of how distressing it will be, knowing the chances of conviction are low, fear of facing offender in court. (Mental health counsellor)*

A further 33 comments related directly to victim/survivors' fear or mistrust of the police that influenced their decision to report to the police. Victim/survivors who had had previous negative experiences with the police or who had criminal records were reluctant to report. In small communities where the victim/survivors knew the police in a variety of contexts or were related to them, they were less willing to report the sexual violation.

Service providers also reported that the lack of trust in the police by all non-European ethnic groups and the lack of ethnic diversity within police were also factors that inhibited reporting. The lack of a separate Māori criminal justice system was identified as a factor for Māori victim/survivors not reporting, as was the lack of Māori victim support workers. According to one service provider, not being able to physically access the police station was the reason why victim/survivors with physical disabilities were not reporting.

### **7.1.3 Fear of not being believed**

Service providers (n=45; 29 percent) identified the victim/survivor's fear of not being believed as a major factor in their not reporting to the police. In addition to their fear that they would not be believed, they felt the police would not take them seriously or treat them with respect. Although this was a fear of most victim/survivors it was a particularly strong reason for sex-workers, people with mental health issues, people who had made a previous sexual violation complaint, male victim/survivors, and women raped by their partners.

### **7.1.4 Fear of the consequences**

Victim/survivor fear of retribution or reprisal was mentioned by 30 service providers (19 percent) as a factor when deciding whether to report to the police. This was an important consideration for victim/survivors who were in continuing relationships with the offender, because they were often financially or emotionally dependent on the perpetrator or his family. The fear of reprisals for women associated with gangs was a strong disincentive to report to the police.

*Utu [revenge or retaliation] arranged from prison for disclosing. For example, one survivor was gang raped five times for disclosing. (Mental health counsellor)*

Another consequence of reporting to the police is the fear of publicity or exposure. This factor was identified by 26 service providers (17 percent) as a barrier to reporting, particularly in rural areas and small towns.

### 7.1.5 Family pressure

Family pressure not to report to the police was identified by 20 service providers (13 percent). They believed this was a particularly strong factor in Māori and Pacific communities, with their collective ways of seeing the world and strong belief in loyalty to family.

*Sometimes it's having whānau who don't think that anything's really happened. You know, like the whānau prefer not to have it exposed and that's common, that is really common up here ... When someone discloses ... it affects not only just [the victim] ... it's the whole hapū really because ... they're all related. If [offender's] from the hapū ... that has complications for [the victim] to disclose ... And sometimes they're up against it, like it it's a tuakana-teina [situation]; if it's the old kaumātua who speaks on the marae then they're not going to ever come out and say that 'My papa did this to me; my papa'. (Māori SSVA)*

Communities can also provide pressure.

*And what happened, the mother complained to the police that her daughter was being sexually molested and it ended up going to court. Now ... half of the family supported the [offender] and not the young girl ... and so what happened was a big wrangle over here at the court. When it ended up in court, the courtroom had to be cleared because the [offender] got her relations or whānau ... to try and get this young girl to say it didn't happen ... so what happened was it split the community. (Māori SSVA)*

Shame would also be brought on to the whānau by reporting to the police.

*Whakamā about talking to police, talking about sex, about making trouble within iwi/whānau. Can't say bad things about kaumātua. (Medical provider)*

### 7.1.6 Other factors affecting Māori

Several key areas were identified that affected Māori victim/survivors' decision to report sexual violence. The historic relationship between police and Māori victim/survivors and their whānau and the perception of institutional racism created difficulties. Victim/survivors may not feel believed or feel unsupported by police and strong cultural alliances may result in them protecting their whānau from police involvement. Personal (emotional and social) issues create barriers because Māori reportedly fear negative repercussions from whānau (e.g. rejection and blame). In some cases, Māori may resist disclosing to reduce the negative impacts disclosures might have on their whānau and community and to prevent shame and embarrassment.

Cultural barriers also prevent reporting.

*Māori have been known in [name of rural area] to be less likely to follow through with the process because of lack of Māori support, i.e. no Māori police locally or Māori victim support workers. (Victim Support)*

Māori service providers identified several barriers to reporting, many of which were similar to those presented above. Māori victim/survivors also fear they will not be believed by the police, fear becoming revictimised and fear historical offences may be too difficult to investigate. They may also fear potential recrimination from perpetrators ('gangs') against their whānau. The process of documenting sexual violation ('form filling') and repetitive questioning was also viewed as a barrier because Māori 'need to see someone face to face' (Māori SSVA)

## 7.2 Police processing of report (initial call for service)

When incidents of adult sexual violation are disclosed to police, the initial report may be from the victim/complainant<sup>35</sup> or from a third party (e.g. a friend, family member or support agency) reporting an assault or suspected assault on the victim/complainant's behalf. The information from either source can arrive through several possible routes. It may be through a phone call to a call centre, someone coming into a police station and reporting to watch-house staff, someone flagging down and/or alerting police officers on patrol, or by way of an online report or a written letter. The method of contact, time of day, day of the week and location of police station all influence who is likely to receive the initial report or, as the police say, 'the initial call for service'.

After the initial call for service, a 'scoping interview' ascertains the immediate facts of the case, identifies witnesses, ensures evidence is preserved and, where appropriate, arranges for a forensic medical examination. This should not be confused with the formal interview (or statement-taking) that is conducted later (see section 7.4).

Police were asked which individual from their station was most likely to conduct the scoping interview. Responses varied within and across regions but most (90 percent) indicated it would be a Criminal Investigation Branch (CIB) detective on duty. The remaining 10 percent reported it was most likely to be a general duties officer.

Around 13 percent of police responses indicated the person conducting the scoping interview would vary depending on the circumstances. For example, it was noted that while ideally the scoping interview would be carried out by a CIB detective, in smaller police stations there might be only one detective. If that detective is on leave or another call, a general duties constable would have to conduct the interview.

---

<sup>35</sup> Within this report, the term 'victim/survivor' has been replaced by 'victim/complainant' once they enter the criminal justice system. This is how they are referred to by criminal justice personnel and it more accurately reflects their status within the criminal justice system before any court outcome.



Other circumstances that might influence who undertook the interview included the time and day of the call, which would predict who was on duty at the time (i.e. crime squads are more likely to be on duty over a weekend, while detectives with specialist sexual violation experience may be available only Monday to Friday). Who was available to be on duty also depended on the resources in an area. Increased resources are required for specialist detectives or specialist Adult Sexual Assault Teams (currently available only in Auckland City and Henderson (in Waitemata)). In rural areas it is more likely that one CIB detective is responsible for all types of crime.

### 7.3 Forensic medical examination

When the reported sexual violation is recent, it is likely that a forensic medical examination will be carried out. However, if the report is of an historical sexual violation this is less likely to be the case. As noted in section 6.2, special medical expertise is required to conduct these examinations. A roster lists those qualified and available in different regions around New Zealand to conduct these examinations. Some doctors must cover large regions, and it is often necessary for victim/survivors to travel to locations where this expertise is available.

Police survey responses suggested in most cases (n=161; 79 percent) the officer who conducted the scoping interview was the person who assessed the need for a forensic medical examination and, where appropriate, made a referral for this examination to be carried out. Exceptions to this were when the scoping interview was carried out by a general duties officer; in these cases an on-call CIB detective would be contacted, advised of the circumstances, and would make the decision. In some cases, the decision would be made in consultation with a supervisor or team leader, in a few cases detectives said decisions would be made in consultation with the sexual assault doctor, and in one case decisions would be made in consultation with the SSVA.

#### 7.3.1 Location where examination is carried out

The location where the forensic medical examination is conducted depends on the local circumstances and, according to 11 responses, more than one option may be available. It appeared the most common location was a community medical centre (n=92; 45 percent). The next most common location was a hospital (n=77; 37 percent), in some cases this was a specialist sexual assault unit within a hospital (e.g. Pohutakawa Clinic at Greenlane Hospital and Te Puaruruhau: Starship Hospital, both of which are in Auckland). Other locations included community-based specialist sexual and child abuse investigation centres (e.g. Kimiora CSAT<sup>36</sup> in New Plymouth), at the police station (10 – predominantly in the Waikato) and in specialist facilities within an SSVA (e.g. in Wellington).

---

<sup>36</sup> This centre is run by the New Plymouth Police Child Sexual Assault Team and works with adult and child victim/survivors. It is located in a house separate from the police station and works in an integrated way with the DSAC service and local SSVAs.

### 7.3.2 Waiting time for a forensic medical examination

Police and Doctors for Sexual Abuse Care (DSAC) regional liaison doctors (RLDs) were asked to estimate how long on average it takes for an acute forensic medical examination to be arranged. This was the average triage or waiting time for a victim/complainant before the doctor arrived or they were taken to the doctor for the examination to be conducted, not the time it took to perform the examination.

Estimates from both groups varied greatly, from less than an hour to, in one case, up to 12 hours. Most of the estimates provided were ranges of time (e.g. 1–4 hours) as the period was reported to vary, depending on whether:

- travel was involved – particularly in larger regions where the victim/complainant had to travel some distance to be brought to the sexual assault doctor
- doctors were available – delays could be expected if the sexual violation occurred during the day because sexual assault doctors are only available to conduct forensic examinations after hours.

Police, DSAC RLDs, and community service providers were asked whether they felt the time taken to arrange the examination was acceptable. Most police (81 percent) and DSAC RLDs (90 percent) felt that the time was acceptable. In contrast, although few community service providers were aware of how long it took to arrange (n=40; 25 percent), of those who felt able to comment, just over half felt the time was unacceptable (n=21; 52 percent).

Many of the respondents who felt the timing was acceptable qualified their comments in relation to the limited specialist expertise available and the remote locations that needed to be covered (i.e. delays were acceptable considering the circumstances).

*A number of these occur at night or in the early hours of the morning e.g. 3 am so it takes time to wake doctors and nurses up, open medical rooms and travel into medical rooms. (Police)*

*Most delays occur during business hours when the DSAC doctor is working in their own surgery. After hours is very quick. (Police)*

*This is too long for anyone to have to wait (6 to 10 hours, Hawke's Bay), but location and availability of qualified doctor (only one in province) dictate terms. (Victim Support)*

One RLD acknowledged that travel time was unavoidable, but felt doctors should also be available during daytime hours.

Those who felt the time taken was unacceptable focused on the adverse impact of longer delays on a victim/complainant.

*It is not acceptable if the victim reports the assault at 4 am and we can't get them examined until 5 pm. That means they can't shower etc, revictimising them. (Police)*

*After sitting through the interview the victims are tired and just want to shower and sleep. However, they are not allowed to do anything until after the*

*examination (4 to 8 hours). They have to carry what they see as filth and shame for longer than they want to. I suggest examination first then interview. (SSVA)*

Police also had concerns that delays could affect the collection of useful evidence.

*The longer the wait the more chance for loss of forensic evidence, also requirement for urine/blood samples re sexual violation/stupefaction offences means these should be taken asap. (Police)*

*Sometimes takes longer, and can make the difference as to whether victim wants to continue; I do not like advising victims there is an undue delay for a medical examination. Delays are usually due to 'no doctor available'. (Police)*

### 7.3.3 Follow-up medical care

DSAC RLDs were asked if follow-ups with victim/survivors were routinely carried out after an acute forensic examination. Six out of ten said follow-up was routine. Who carried out the follow-up varied: it could be the sexual assault doctor who conducted the forensic medical examination, a sexual assault nurse, or the victim/complainant's doctor (it is not uncommon for victim/survivors to travel elsewhere for the forensic medical examination (i.e. away from their home town)). The number of follow-ups also varied. One RLD said it was from one to an indefinite number; others suggested it was two or three, and another reported two to three face-to-face follow-ups, followed by three to six phone call follow-ups.

### 7.3.4 Ways to improve forensic medical examination

RLDs were asked to comment on what might enable sexual assault doctors to deliver better services to the victim/survivors they see. In decreasing order of frequency, the following were their responses to a list of 11 possible factors.

- Increased infrastructure or support from district health boards or primary health organisations (8 out of 10).

*In Auckland we have acute space issues with our office and patient areas. We have no time or resources to attend to, for example, setting up a website, advertising the service as we are at capacity already. (DSAC RLD)*

- Increased levels of staffing to cover the acute daytime service (7 out of 10).
- Improved facilities and equipment (7 out of 10).
- Increased levels of staffing for the acute after-hours roster (6 out of 10).
- More funding for doctors to access relevant training (6 out of 10).
- Better interagency collaboration (6 out of 10).
- More qualified/experienced staff (5 out of 10).
- Availability of more specialist training (4 out of 10).
- Better availability of relevant sources of information for doctors (3 out of 10).

- Increased funding for patients to pay for services (2 out of 10).
- Increased support from DSAC (1 out of 10).

Many comments focused on ways to increase the availability of qualified sexual assault doctors. This related not only to the number available, but also to their availability during working hours when many doctors have other work commitments.

One RLD had concerns about the unrealistic demands made on sexual assault doctors, which was seen to affect those prepared to commit to this type of work.

*Acute examination and care of victims of sexual assault is an unpleasant, time consuming and disruptive activity for doctors. It may involve court appearances which are always very time consuming (time wasting) and negatively impact on our own practices. For these reasons there is understandably little interest from GPs [general practitioners] to do this work. This makes it very difficult for the few who are available. We used to have three female GPs in our region who did this. They are scarred by the experience and won't be returning. (DSAC RLD)*

There were also some concerns expressed about the possible effect of the new Sexual Abuse Assessment Treatment Service funding model, which is being introduced: contract funding being inadequate to cover all the work required; funding of services being structured for police acute-referred patients, which are a minority of caseloads; a fee-for-service payment structure that meant there is no income if patients do not turn up, which was not uncommon.

Service providers had a few practical suggestions for improving the process for victim/survivors, including that the process needed to take account of Māori customs, that victim/survivors needed adequate support throughout the process, and that victim/survivors needed to be reminded to take a spare change of clothes. One service provider commented favourably on 'one-stop shops' for sexual violence services.

## 7.4 Formal interview

After the initial scoping interview, and usually after the forensic medical examination (if applicable), a formal interview is conducted to get a fuller statement from the victim/complainant that records key evidence. This evidence will form a crucial part of any case that goes to court.

The recording of the formal interview can take a range of formats. Most commonly it was reported to be a written statement (50 percent), followed by video (36 percent), and less frequently it was an audio recording (14 percent). Around one in ten responses indicated a combination of formats.

According to police respondents, in all but one case a CIB detective carried out the formal interview.<sup>37</sup> In the one case a Child Abuse Team-trained general duties officer carried out the formal interview.

As for the scoping interview, the timing and circumstances of the reported incident were important. In some cases, if the incident occurred over the weekend, the case might be passed on to specialist CIB on the Monday morning to progress the investigation, particularly if protracted enquires were called for. However, if those on duty over the weekend (e.g. the CIB crime squad) have made good progress with the case and have the offender 'in sight' they may have already conducted a formal interview and kept the file themselves.<sup>38</sup>

Officers who carry out this formal interview tend to have attended the Adult Sexual Assault Investigation course (79 percent) and around a third were reported to have undergone Investigative Interviewing, Level 3: Specialist Adult Witness Training (30 percent).<sup>39</sup>

As noted above most CIB detectives had received specialist training in interviewing victim/complainants of sexual violation. Community service providers were not asked their views on interviewing techniques, but a few SSVAs offered comments. The use of narrative interviewing techniques where the victim/complainant gets to tell their story in their own way, rather than facing a barrage of questions from the interviewing officer was viewed positively. However, one SSVA expressed concern at the latest strategy of using the psychological approach of 'advanced cognitive interviewing'.

*In cognitive interviewing, which is done by level three interviewers, they take the victim back and live the experience through their senses. That process is likely to re-traumatise the person. The police explained to me that they use it because, 'She wants to get a conviction, we want to get a conviction, you want to get a conviction, and yes it might cause a bit of harm, but at the other end you're going to come out with a conviction'. It is OK to harm them here, for a better outcome down there.*

It may be that differences in opinion over the use of investigative interviewing could be related to misunderstandings over the use and purposes of the new interviewing techniques the police use. Opinions could also reflect the different roles and objectives of SSVAs and police. While the police must weigh up the welfare of the victim/complainant against collecting the best evidence in order to maximise the chance of getting a conviction, SSVAs can focus solely on what is best for the welfare of the victim/complainant.

---

<sup>37</sup> This included 44 percent who were investigative interviewing level 'specialist interviewers' (44 percent), 38 percent with adult sexual assault training, and 19 percent who were Child Abuse Team members.

<sup>38</sup> In 85 percent of cases this person will be the same for both recent and historical sexual violation.

<sup>39</sup> The New Zealand Police advised that the number of people who have undergone investigative interviewing, level 3: specialist adult witness training has intentionally been kept to a small number. This is to ensure a small groups of specialist staff are conducting all interviews to build expertise and experience in this area.

*Our job is their care when they are so traumatised. The police have another job to do, and they can be very kind and very gentle, and they can care a lot, but they have still got to ask the questions. They are still gathering the evidence; they've still got to find this dude. Whereas what we are there for is to look after her.*

In most cases (85 percent) if a victim/complainant requested that a woman conduct the formal interview this would always be possible.

*The victim's view re: gender of interviewing member are paramount to enable a successful interview. (Police)*

In cases where such a request could not be accommodated, this was typically because a suitably qualified female officer was not available and arranging one would result in undesirable delays. However, a few comments indicated that some detectives did not always feel such a request was appropriate.

*Don't agree with this situation regardless. If a complainant is not prepared to talk to any officer in relation to a complaint of sexual violation, how is she expected to give evidence about it in court? (Police)*

*yes ... but if the best interviewer available was male we would discuss this with the victim. (Police)*

However, one SSVA made the point that there is something fundamentally different for victim/survivors of sexual violation disclosing to female officers rather than male officers.

*Most of the police force is male, and they don't know what it is to be raped. They don't know what it is like living your life in fear of being raped, and now the worst thing that you thought could ever happen to you has happened to you.*

Only 7 percent said, if requested, it would be possible to match the ethnicity of the victim/complainant and police officer. Many pointed out the impracticality of such requests, while some felt it was inappropriate or unnecessary.

*This request would be an impossible one to meet. This ethnic officer required would have to be on duty [have] training, have knowledge and understand the issues of such an interview. How can this be accomplished? (Police)*

*Given the racial mix in Counties Manukau it would not always be possible to match ethnicity with some complainants. (Police)*

*Wouldn't be seen as a necessity in the taking of the interview. (Police)*

*I believe that the standard and ability of the interview is more important. (Police)*

Other comments indicated ethnicity and cultural issues were considered.

*Cultural aspects are considered and any need for interpreters etc is taken into account. (Police)*

*Almost impossible in a small station/office, we only have one non-European female in the station who is very junior and I would not use her for such an interview. However, we would certainly be arranging for a Victim Support*

*woman (of the same ethnicity if possible) to be present during interview if victim requested/indicated that they wanted one – we ask victims about this before interview even now. (Police)*

### 7.4.1 Who takes the case on after the formal interview?

Fifty percent of police who responded said that the same person who carried out the formal interview takes the file on and becomes the officer in charge of the case. In cases where this did not occur, several factors might indicate who took over the case including workloads of different officers, the location of the incident, who first attended the incident, and whether the offender was apprehended. In general, the person most likely to be the case holder (if it is not the formal interviewer) was the detective who took the initial complaint or a member of the squad on duty at the time the complaint was laid. A comment by one officer suggested this was a strategic choice because it reduced the number of people the victim/complainant had to work with.

Sometimes the police officer interviewer and case holder were different people because of, for example, practical considerations.

*It really depends on the circumstances of the case and the case load/availability of staff to continue with the matter. (Police)*

More recently, with the introduction of specialist training in investigative interviewing, there is a more intentional decision to have the interview conducted by those most qualified (i.e. those who have undergone Investigative Interviewing, Level 3: Specialist Adult Witness Training, whose primary responsibility is to conduct such interviews).

*Now level 3 interviewing is underway the interviewer is generally separate to the investigation and is not the file holder. (Police)*

### 7.4.2 Availability of specialist support

The formal interview involves the victim/complainant recalling in detail the sexual violation. It is recognised that this is likely to be traumatic for victim/complainants, so efforts are made to ensure a support person is available for the interviewee.

Most police (73 percent) reported that there were written protocols or agreements in place in their area to provide specialist support for victims of sexual violence who have made a report to the police. There were no agreements or protocols for 12 percent of the sample, and a further 15 percent were unsure of their existence.

Where agreements existed, this was most commonly with an SSVA (n=103; 64 percent). Other agencies with agreements included Victim Support (n=30), counselling services (n=14), and women's refuges (n=5).<sup>40</sup>

---

<sup>40</sup> Twenty-two respondents indicated there were agreements with more than one agency.

The only occasions where a person from the agency named in the agreement was not used as a support person was when this was the wish of the victim/complainant.

Although police do contact SSVAs to support victim/survivors, one SSVAs noted that they do not always do this at the initial call for service stage. There can often be a delay between the initial call for service and forensic medical examination, and the formal interview to ensure the most experienced and qualified officer is available to conduct the interview. Victim/complainants may be sent home to rest and then be contacted the next day to do the formal interview. It is at this point when most protocols indicate a support person be contacted. However, a concern mentioned by one SSVAs was that they were not always being contacted at the first instance, which is when the victim/complainant is likely to be most traumatised and in need of support. It could also affect a victim/complainant's decision to continue with their complaint.

*If we are not there when the preliminary statement is made, it has a huge impact, because there can be a huge attrition at that point. It will be taken by officers on the desk who may not be well trained in the area of sexual violence. They could ask the incorrect questions, and could make judgements around the story. (SSVA)*

## **7.5 Decision to prosecute (lay charges against the defendant)**

Once an investigation has been completed, the police are responsible for deciding whether there is sufficient evidence to prosecute (i.e. lay charges against) the perpetrator. They must decide whether a case is well founded and the nature of the charge.

In making this decision only one in five survey respondents (21 percent) reported they would usually or always ask for advice. In cases where advice was wanted, most sought help from the Crown solicitor (63 percent) or the Police Legal Section (27 percent) or a combination of the two. Senior police or supervisors were also consulted in one out of ten cases. Others occasionally consulted included the victim/complainant, the family, Rape Crisis and medical experts. In 40 percent (n=49) of cases, respondents indicated they sought advice from multiple sources.

Ninety-five percent (186 out of 196 who commented) said they felt they had access to sufficient legal advice to make good decisions about whether to lay charges – whether this was around the nature of the charges or whether the case was well founded. Several comments illustrated the ease of access to such advice.

*We have a very good relationship with Crown Law and Police Legal Section. They are always keen to give advice or guidance. (Police)*

*The Crown prosecutors in Christchurch are very proactive relating to offering advice. (Police)*

*We have a very approachable Crown solicitor's office who is always willing to go over a file with us which is often easier than consultation by phone with legal section. (Police)*



*If help is sought outer-office, the Crown solicitors make themselves available at just a phone call away and are very helpful. In addition to that they explain things in a manner which can be translated to victims also if required. (Police)*

A couple of comments indicated that locality could affect the availability of advice.

*Yes, most of the time [it's available], once again isolation can cause delays which can hinder progress. (Police)*

*Don't have a legal officer on tap. Have to ring Christchurch. Each major district should have a legal officer. (Police)*

A couple of comments suggested more involvement from Crown prosecutors at this stage would be advantageous.

*I have found in general the PPS [Police Prosecution Service] and Crown are not involved in the investigation and evidence obtained before charges are laid. I feel a closer relationship would provide a better success rate of conviction. (Police)*

*If I had my way I would recommend use of the Crown at all times vs seeking a legal opinion via our own District Legal Adviser. (Police)*

## 7.6 Court hearings

For sexual violation cases that make it to court there are several possible stages in the court process. Police are responsible for the early stages, including:

- the laying of charges when the defendant first appears in court<sup>41</sup>
- presenting the facts of the case at initial court appearances when pleas are first sought from the defendant<sup>42</sup>
- presenting evidence at preliminary or deposition hearings where a judge must decide whether there is a 'case to answer' and whether to issue a 'committal for trial'.

This is the point where Crown prosecutors take over. They have two key responsibilities.

- Crown prosecutors review the evidence presented at the preliminary hearings and lay the indictment (the final charges the accused<sup>43</sup> will face at trial).
- Crown prosecutors lead the prosecution against the accused on the Crown's behalf at trial. Crown prosecutors decide which witnesses to call, what questions

---

<sup>41</sup> Unless the case has been fully prepared, remand is requested the accused. If the case has been prepared, then the accused may enter a plea at this stage.

<sup>42</sup> If the plea entered is 'not guilty' and the defence wishes to contest the charges laid, a date for a depositions hearing is set. If the charge is accepted by the defence lawyer, the case can be referred for trial without a depositions hearing.

<sup>43</sup> Before a committal to trial the legal term for the person being charged is the 'defendant'. After they have been committed for trial they become the 'accused'.

to ask, and how to present the case to the jury. They aim to prove to the jury 'beyond reasonable doubt' that the accused is guilty of the charges in the indictment.

### 7.6.1 Information on court procedures and processes

The above sequencing reveals some of the complexities of the court process a victim/complainant must understand. Survey responses from criminal justice groups suggested that information on court procedures and processes was offered from all three criminal justice groups: police, Crown prosecutors and court victim advisers, as described below.

#### **Police**

All but one detective said police provided victim/complainants with information on court procedures and processes. This was typically done face to face in the first instance, but was often supplemented by written information and updated with phone calls as the case progressed.

*I would speak to them face to face after formal interview and tell them what to expect in the next while and keeping them updated by phone or by letter. Face to face during a court orientation in the week before the trial. (Police)*

*Face to face and often many more times over the phone during the process. I have drafted a document [and] planned to give [it] to victims to take away and read, however, have not had this approved for use yet in our station. A universal pamphlet would be great to give to victims of sexual assault as they often don't digest it all when you tell them. (Police)*

Most provided information to the victim/complainant throughout the investigation, but particularly during the time leading up to the deposition hearing and the trial. However, the timing could depend to some extent on the victim/complainant. For instance, information is provided when the victim/complainant asks for it or it appears they can cope with it:

*In the first instance when they quite often solicit this information. On occasions this is one of the concerns of victims when first making the allegation. (Police)*

*[At the] beginning and middle – stress can make people forget. Depends on vulnerability of complainant and time frame of police contact and offence occurring, but in my case always after obtaining statement and before commencing investigation. (Police)*

The provision of written information for victim/survivors to take away with them would be one way to ensure that information is available at a time when they are ready and able to comprehend it.

### **Crown prosecutors**

Nearly all Crown prosecutors (n=43; 96 percent) reported that they provided complainants with information about court procedures and processes face to face when they first met the complainant.<sup>44</sup> This would occur at a later stage than with the police, as any meeting would not occur until after the preliminary or depositions hearings, most commonly just shortly before the trial (over half said in the week or days leading up to the trial). However, service providers commented that it was not unusual for the victim/complainant to first meet the Crown prosecutor on the day of the trial. If this were the case, the victim/complainant would not have sufficient time, or be in the right frame of mind to better process any information provided.

### **Court victim advisers**

A key role of court victim advisers is to provide information to victim/complainants about court procedures and processes (see section 5.3). However, their role extends beyond the provision of information to making more direct support available.

**Stage of initial contact:** The point of initial contact of court victim adviser with victim/complainants was reported to be at the first court appearance of the defendant (9 out of 17) or following the defendant's first appearance (8 out of 17). Initial contact depended on the court victim adviser receiving referral information.

*As long as police have completed a CSV1 (court services for victims form), it can be from the time the defendant first appears in court. This is preferable as you have had lots of contact with them before trial date. (Court victim adviser)*

**Mode of initial contact:** Initial contact could be face to face, by phone, or by letter or email. This varied depending on circumstances, for example, the type of contact details provided to the court victim adviser (postal address and/or phone number), whether the complainant lived locally or overseas, and whether the complainant came to the defendant's first court appearance, making face-to-face initial contact possible.

One court victim adviser signalled the high priority placed on cases involving victims of sexual violation.

*These [adult sexual violation] cases are treated as High Priority so contact is made ASAP. If [the] victim is attending court the initial contact is face to face. If [a] contact phone [number is] provided by the police then contact is by phone otherwise a letter is sent explaining the CSV [court services for victims] and my contact details are included which includes an 0800 number so there is no cost to the rural victims. If no referral is received from the police then I contact them for a referral to be faxed to the court. (Court victim adviser)*

A phone call followed by a letter appeared to be the most common scenario (8 out of 17), unless phone details were unavailable. Face-to-face contact was more likely to occur later on, although the preference expressed by the victim/complainant could influence this.

---

<sup>44</sup> One Crown prosecutor reported also providing written information.

*[Initial contact is] usually over the phone and then followed up in writing, however, they are welcome to meet face to face, it is up to them. Usually meet them face to face nearer the trial date regarding court familiarisation. (Court victim adviser)*

**Level of contact:** It is not surprising that the level of contact made was often dictated by the needs and wishes of the victim/complainant (9 out of 17).

*It's hard to say 'typically'. It varies and depends on the victim's needs and other supports available. (Court victim adviser)*

*Depends on the needs of each client, we will be in contact each time the accused appears in court to advise what is happening and explain the process, some victims will only want contact towards the end of the process, just before trial. (Court victim adviser)*

*Depends on the level of contact they want. But usually when something 'significant' happens, e.g. a plea, or substantive movement, e.g. to depositions/trial. (Court victim adviser)*

Other comments suggested a minimum amount of contact would occur at each court appearance, and that contact would increase if and when the case went to trial.

Most court victim advisers (15 out of 16) made referrals to other agencies, usually in cases where the complainant was not already seeking or receiving support from other agencies.<sup>45</sup>

Some court victim advisers accompanied victim/complainants to court (5 out of 17). Those that did indicated that this was not common, but, in particular, might occur if the judge requested it or the victim/complainant's support person was unavailable.

Court victim advisers reported having a limited role in relation to victim impact statements. The police were seen to be the primary group responsible for collecting victim impact statements. Examples of when a court victim adviser had a greater involvement were only if victim/complainants chose to write their own and where relationships between the victim/complainants and police had broken down. Six court victim advisers mentioned that they checked files to make sure a victim impact statement had been completed by the police, and two said they would discuss with the victim/complainant how the victim impact statement would be presented to the court.

Court victim advisers were asked if they did anything different for adult victim/complainants of sexual violation compared with victims of other crimes. Seven of the court victim advisers said they did not treat adult victim/complainants of sexual violation any differently. Ten said they did do things differently in four areas.

- **Higher priority:** Three court victim advisers indicated that adult victim/complainants of sexual violation were given a high priority. This was because of the seriousness of the crime and the length of time they were likely

---

<sup>45</sup> These agencies included:- SSSV, women's refuges, Victim Support, ACC sensitive claims, Housing New Zealand, Work and Income New Zealand (WINZ) emergency assistance.

to be in the court system. However, adult victim/complainants of sexual violation were treated similarly to other victims of serious crime.

*I give high priority to victims of sexual violence because of the seriousness of the charge. Just as I give high priority to the families of victims who have been killed or victims of other serious charges. I try to respond to any victim sensitively and give consideration to the nature of the offence and the surrounding circumstances of the offence. (Court victim adviser)*

- **More support:** Five court victim advisers suggested they offered more support, in court or by ensuring victim/complainants were engaged with appropriate support agencies or counsellors.
- **Type of contact:** Three court victim advisers said that the type of contact they had varied. One said they made extra efforts to talk with the victim/complainant over the phone. One said they felt it was particularly important to provide details such as dates in writing. Two mentioned that they were extra-vigilant with these victim/complainants and made sure they updated them promptly on the progress of the case.
- **Crime-specific treatment:** Two court victim advisers commented on special rights and services they discussed with adult victim/complainants of sexual violation (e.g. victims' views on name suppression and bail conditions, using a screen when giving evidence, and programmes and services related to victims of sexual violence).

## 7.7 Summary

### 7.7.1 Initial disclosure of sexual violation to police

Service providers identified several factors that prevented or discouraged victim/survivors from reporting to police: shame and self-blame, fear of not being believed, fear of police and the criminal justice system, fear of the consequences, and family or community pressures. Several of these factors were more significant for certain groups.

### 7.7.2 Police processing of report (initial call for service)

The initial call for service could be made by the victim/complainant or a third party, and could be made known to police via several routes. The time of day the call was made together with the resources in any particular area can influence who is likely to be available to receive and process the initial call for action.

### 7.7.3 Forensic medical examination

Delays in conducting a forensic medical examination could occur when travel was involved or a doctor was not available. Delays could be reduced, if more sexual assault doctors were available, including during working hours.

#### **7.7.4 Formal interview**

The formal interview is when essential evidence is collected from the victim/complainant. This interview is nearly always carried out by an experienced CIB detective. This can be a traumatic experience for the victim/complainant because they are asked to recall details of the sexual violation. Written agreements and protocols ensured a specialist support was contacted in most cases (75 percent). SSVAs would like to be contacted when the assault is first made known to police. Opinions about the most appropriate interviewing techniques differed.

#### **7.7.5 Decision to prosecute**

Nearly all police (95 percent) felt they had access to sufficient legal assistance to make good decisions about whether a case should be prosecuted.

#### **7.7.6 Court hearings**

Information for victim/complainants about court processes and procedures is available from police, Crown prosecutors and court victim advisers. The latter group can also offer more direct forms of support.



## **Part five: Criminal justice system and attrition**

### **8 Criminal justice system and attrition**

In New Zealand and overseas, it is understood that there is a high rate of attrition of reported sexual violation offences (i.e. a high rate of reported cases that do not proceed from one phase of the criminal justice process to the next). This section focuses on survey respondents' (criminal justice and community service provider groups) views on the factors that might affect the reporting and successful prosecution of sexual violation offences.

The chapter begins with survey respondents' overall views on and ratings of the criminal justice system (section 8.1). This is followed by a description of possible points of attrition, with examples of why cases might fail to proceed at these points (section 8.2). Section 8.3 takes a closer look at factors that were seen to contribute to a low rate of conviction for sexual violation offences. The chapter concludes with survey respondents' views on what could be done to increase rates of conviction in cases of adult sexual violation and improve the experience for victim/survivors (section 8.4).

#### **8.1 Survey respondents' views of the criminal justice system**

##### **8.1.1 Advising a close friend or family member to become involved with the criminal justice system**

To ascertain survey respondents' views on the criminal justice system they were asked, 'If you had a close friend or family member who was a victim of sexual violence, would you recommend they go through the criminal justice system?'. They were also asked whether they would recommend reporting the offence to the police, without it necessarily going to court.

As can be seen in Table 16, the majority of respondents said they would recommend that a close friend or family member who was a victim of sexual violence report to the police. This ranged from 76 percent of service providers, to 90 percent of Doctors for Sexual Abuse Care (DSAC) regional liaison doctors (RLDs). Conversely, a smaller proportion (20–59 percent) of respondents said they would advise a close friend or family member to go through the entire criminal justice system, and 25–60 percent were unsure what they would advise in this regard.



**Table 16: Recommendation to a close friend or family member whether to report to police or go through the criminal justice system**

Recommendation	SP (n=173) (%)	Police (n=206) (%)	CP (n=46) (%)	DSAC (n=10) (%)
Reporting to police				
Yes	76	88	85	90
No	3	8	2	–
Don't know	20	3	13	10
Going through the criminal justice system				
Yes	38	59	39	20
No	17	16	28	20
Don't know	45	25	33	60

Notes: CP = Crown prosecutor; DSAC = Doctors for Sexual Abuse Care; SP = community service provider. Percentages exclude those who did not comment. Caution should be used in interpreting percentages because some groups have low base numbers.

### ***Reasons for recommending not going to the police***

Community service providers and Crown prosecutors were slightly less likely to recommend that victim/survivors report to the police than the other groups. This was largely because of their concerns that victim/survivors might be pressured by the police to take further action against their wishes or that they did not see it as their role to make recommendations.

Most of the police who said 'no' to this question were adamant that, *'There is no point unless they are prepared to go to court'*.

*What's the point, police investigate crime for the purpose of prosecuting offenders. Why report it if you don't want anything done about it. (Police)*

On the other hand, police who would recommend that victim/survivors report, even if they did not want to go through the court system, said that it was useful to record the matter as intelligence in case complaints were made against the same offender in the future.

### ***Reasons for recommending not going through the criminal justice system***

The reasons given by service providers, police, Crown prosecutors and DSAC RLDs for not recommending that close friends or family members go through the criminal justice system were similar. The consensus among those who responded 'no' was that the criminal justice process is harrowing for victims of sexual violation and can re-traumatise the complainant. This is because the system is not set up to support the victim, but to ensure a fair trial for the accused. Hence, the complainant is subject to intense scrutiny under cross-examination, the rate of conviction is low, and sentences for those proven guilty are perceived to be light.

*In my view the process for complainants in sexual violence cases is brutal, every aspect of the complainant's character and conduct is questioned and exposed, and the likely outcome is not guilty. (Crown prosecutor)*

*I wouldn't put myself through this and certainly would let a friend or family know how degrading it is and that they will be revictimised and the chances of a guilty verdict are very, very low. (Police)*

The proportion of respondents who stated 'don't know' was high (DSAC RLDs 60 percent; service providers 45 percent; Crown prosecutors 33 percent; and police 25 percent); all said it would depend on the situation. If their friend or family member had been assaulted by a stranger and/or there was corroborating evidence, and they believed the victim/complainant was resilient and had good support, they would recommend proceeding through the criminal justice system. If, on the other hand, the victim/complainant was vulnerable, there was no corroborating evidence, and the case relied on 'consent', or the victim had been under the influence of alcohol or other drugs at the time of the assault, they were far less likely to say they would recommend that person become involved with the criminal justice system.

*Any advice I gave would depend on the age and personality of the victim in question. The process is certainly a difficult one for victims of sexual crimes and requires them to share with complete strangers' very personal details which is often humiliating. If however, there was more than one complainant, or any other supportive evidence my advice may be different. (Crown prosecutor)*

*Honestly, it would depend on the actual offending, stranger attack and rape then definitely, any violence or random attack then definitely, but in some circumstances I would be hesitant ... I'm not sure, I would have to be guided by the person and their ability to cope with pressure and stress of the whole procedure. (Police)*

Such replies suggested a clear recognition among respondents that some types of victim/survivors are less likely to receive justice.

### **Reasons for recommending going through the criminal justice system**

Respondents who stated that they would recommend a friend or family member go through the criminal justice system, would do so if they could ensure the victim/complainant had excellent support, was familiar with the process, and was prepared for cross-examination.

Other reasons respondents gave as to why they would recommend this course included ensuring the perpetrator was made accountable or punished, reducing the chance of the perpetrator assaulting another victim, and helping the victim/complainant's recovery.

*Only because I feel strongly that people need to be held to account (i.e. the offender) and that everything should be done to ensure this. Knowing the system, cross-examinations they will likely face etc. I know it will be very difficult for them. (Crown prosecutor)*

*Definitely proceed – I've seen too many complainants in historic sex cases that did not, and were emotionally harmed long term by non-disclosure. (Crown prosecutor)*

*I know there is such a low conviction rate, but for some just going through court is healing. By having told their story, having faced him in court – some women can do that. (Specialist sexual violence agency (SSVA))*

### 8.1.2 Criminal justice system meeting needs of diverse groups

Survey respondents were asked to rate on a scale from 1 (not very well) to 5 (very well) how well they felt the criminal justice system responds to or deals with diverse groups of victim/survivors. Table 17 presents the groups of respondents where ratings were given as 1 (not very well) or 2 (not well).

As can be seen in Table 17, about half the court victim advisers believed the criminal justice system does not meet the needs of Pacific peoples, ethnic minorities, migrants and refugees, people with disabilities, and Māori victim/survivors. Around 40 percent of Crown prosecutors expressed identical views in relation to ethnic minorities, migrant and refugees, and people with disabilities. However, they also added gay, lesbian, transgender, bisexual and intersex people; and sex-workers to the list of those whose needs are not met by the criminal justice system. More than half of the police respondents identified men and sex-workers as the least likely groups of victim/survivors to have their needs met by the criminal justice system.

Few of the comments respondents made related directly to specific groups of victim/survivors. Many commented that they saw no difference in the way the various groups were treated by the criminal justice system or that they were all mistreated equally.

*I don't believe that you are treated differently because of the group you belong to – I think the system is equally unfriendly to all victims. (Police)*

Several respondents made general comments about the prejudice and discrimination present in society in general being reflected throughout the criminal justice system.

*People's prejudices are reflected in the process from the beginning (police) to the end (jury verdict). Not enough education in schools, universities, police, courts. There is a real lack of tolerance and of understanding. (Crown prosecutor)*

*The criminal justice system does not deal well with groups that the jury and the community also do not deal well with. (Police)*

**Table 17: Proportion of respondents with concerns about the criminal justice system's ability to respond to or deal with diverse groups of victim/survivors**

Category	VA (n=17) (%)	CP (n=46) (%)	Police (n=206) (%)
New Zealand European	40	14	33
Māori	47	29	35
Pacific peoples	53	31	42
Ethnic, migrant, refugee peoples	50	42	48
People with disabilities	50	41	47
Men	40	24	55
Women	43	20	34
Gay, lesbian, transgender, bisexual, intersex people	43	40	47
Sex-workers	43	40	56
Older survivors (aged over 50)	36	16	34
Younger survivors (aged 16–25)	43	32	36

Notes: CP = Crown prosecutor; VA = court victim adviser.

Survey respondents were asked to rate on a scale from 1 (not very well) to 5 (very well), how well they felt the criminal justice system responds to or deals with diverse groups of victim/survivors.

Percentages represent the proportion of respondents who gave ratings of 1 (not very well) and 2 (not well).

Percentages are based on the number of agencies who provided a rating. This excludes the small number of agencies who had not worked with clients of a particular groups, so were unable to rate themselves.

Percentages should be interpreted with caution because base numbers are low.

One respondent linked the wider justice issues for Māori in relation to the criminal justice system and Māori victim/survivors of sexual violence.

*Most offences of this nature are committed by someone known to the victim; especially Māori. Why would Māori want to engage in a prosecution brought by the Crown when they feel so aggrieved by the Crown. If marae-based justice is employed a national recording system of convictions is still required to prevent repeat offending and offenders getting access to children/vulnerable victims.  
(Police)*

Male victim/survivors were identified as a group whose needs were not well met by the criminal justice system, particularly if they are gay, again because of negative societal attitudes reflected throughout the system. One respondent stated that the way the law is framed discriminates against male victims of sexual violence.

*Men are completely uncatered for, the forgotten, ignored and subsequently invisible crime. How can a man report when 'rape' is a crime that only someone with a vagina can suffer from. A man who is sexually violated feels just as*

*'raped' as a woman does; why a special clause just for women?  
[Section 128(1)(a) of the Crimes Act 1961] (Police)*

Other respondents identified multiple groups they believe the system does not serve well.

*The system is geared to the accused, not the complainant. The complainant is clearly on trial and not the accused. There should have been a column headed 'very poorly' and I would have rated Māori, Pacific peoples, ethnic (etc), gay (etc) and sex workers in this category. (Police)*

*It is just a matter of time before the large number of criminal offences committed against disabled, mentally ill and elderly people comes to the fore, we will then be snowed under trying to deal with these. Provisions need to be made to provide justice to these sections of the community before the public outrage at the inability of the police and justice sector to act equally for the population. (Police)*

## 8.2 Attrition points

This section presents some of the possible points where attrition might occur (i.e. points where a case does not proceed from one phase of the criminal justice process to the next). Where available, the perceived frequency of occurrence and some of the reasons for cases not proceeding are presented. Data presented are based on the perceptions of police within their organisational context. Possible points of attrition are considered first during the police processing of the complaint, and then during the court processing after charges have been laid.

### 8.2.1 Attrition during police processing of complaint

This section presents possible attrition points during the police processing of a sexual violation complaint. It is critical, however, to recognise that the point where there is the greatest attrition in sexual violation cases is before this, as a result of non-reporting.

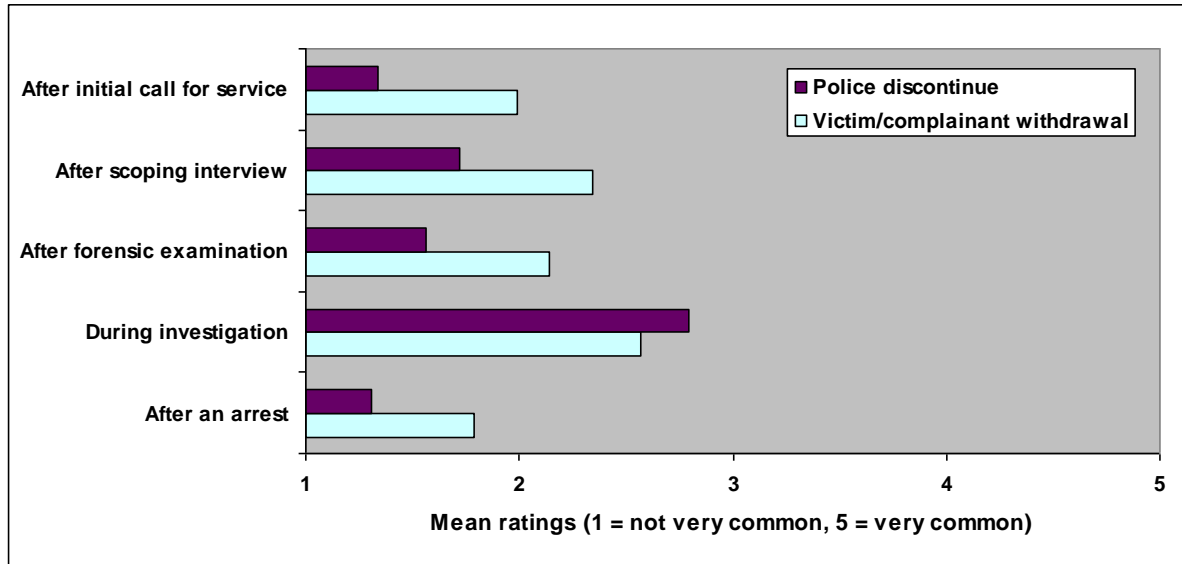
Figure 8 presents police estimates of how common it is for a case to fail to proceed at the five possible points during police processing of a sexual violation complaint. The five points are:

- after the initial call for service, but before the scoping/initial interview
- after the scoping/initial interview, but before the forensic medical examination
- after the forensic medical examination, but before the formal interview
- during the investigation
- after an arrest.

At each of these points a case could discontinue because the victim/complainant withdraws the complaint or because of a police decision not to continue. Police rated

how common each scenario was at each of the five points, on a scale from 1 (not very common) to 5 (very common). Average ratings are presented in Figure 8.

**Figure 8: Frequency of attrition during police processing (police estimates)**



It can be seen from Figure 8 that, on average, perceptions of attrition at any of the five points were not seen as common (all average ratings were below 3).

Victim/complainant withdrawal was seen to be more common than a police decision to discontinue at all points except 'during investigation'. Differences were greatest 'after an initial call', and 'after an arrest'. Perhaps not surprisingly, at these stages it was less likely to be because of a police decision to discontinue. Overall, attrition was perceived to be least likely to happen after an arrest, and most likely to happen during the investigation phase.

### ***Reasons for a case not proceeding to a full investigation***

When asked to explain the main reasons why cases might not proceed after an initial call for service, police referred to reasons why a victim/complainant would withdraw their complaint (119 responses) or gave examples of where there might be early indications that the evidential threshold had not been met (111 responses). Twelve detectives said that, in their experience, after an initial call for service police would investigate all complaints. Cases not proceeding would be those only where a victim/complainant chose not to take it further.

*The complainant changes their mind about the complaint, in almost all of these cases it is because the complainant has not been truthful about the true nature of the incident. In some cases it is because someone other than the complainant is 'driving' the complaint. In NO cases does the complaint ever not proceed due to the police refusing to continue with the initial action phase, through to the investigation phase. (Police)*

One SSVA questioned whether this was case, pointing to the large number of cases where a forensic medical examination is not carried out.<sup>46</sup>

*The official line is we fully investigate the cases and then we make a decision. But 'fully investigate' means you do your forensic kit analysis, and they are not doing that before deciding to stop the investigation.*

Five reasons were given for why a victim/complainant might choose to withdraw at this stage.

- Fear of the legal process.

*Trauma suffered by the victim which is prolonged by the protracted court process. Victims understand that they will have to face their alleged violator in the court room and that every part of their lives will be scrutinised by unscrupulous defence counsels. (Police)*

- The influence of alcohol and other drug consumption – the complainant decided after sobering up that they did not want to continue or was concerned that their level of intoxication might have contributed to the situation.

*Also alcohol often plays a big part in sexual violation complaints. When people sober up and thought is given to the matter they often do not wish to proceed. Some people believe that due to their intoxication level they contributed to the situation and do not wish to proceed. (Police)*

- Third-party pressure to make the complaint – when an initial complaint was made by a third party without the victim/complainant's consent or the victim/complainant had been pressured to make the complaint. This could cover situations where a third party had misunderstood what had happened and sex had been consensual and cases where a victim/complainant was embarrassed because of 'regrettable sex' or simply just did not want to continue.
- Reporting to inform police – some victim/complainants just want the police to know what has happened (or want safety and/or medical assistance) but for various reasons do not want to proceed with a complaint.
- Relationship with the offender – they could be partners or acquaintances, and victim/survivors may not want them to be convicted or go to jail. Some victim/survivors fear retribution.

*Victim requests no further police involvement. Variety of reasons provided, such as fear of offender or his family and associates. 'Talked out of it' by own family or friends. Reconciliation with offender. Fear of court system/publicity. 'Don't want to relive the attack' etc. (Police)*

Cases might not proceed because early indications are that the evidential threshold has not been met.

---

<sup>46</sup> This was an unsolicited observation from one SSVA and it is not known whether other SSVAs have similar concerns.

- Evidence collected is contradictory – in the main these comments implied or stated that the complaint had been false.

*The evidence doesn't support the allegations as in the facts are at odds with the allegation. When this is pointed out to the complainant they generally retract from the complaint. (Police)*

*The victim is not consistent in the initial report, there are witnesses or other information presented to the police who prove the report is inaccurate. The victim has made previous false complaints. (Police)*

*False complaint – I would guess from 16 months on crime squad that about 60–70 percent of reported sex violation cases are false complaints. (Police)*

However, there were concerns from community service providers whether all cases suspected as 'false complaints' were actually false or just inconsistent in some facts.

*She was 18 and it was the first time her mother had gone away and left her on her own. She invited a boy over and though she fought him off, he raped her. The police could not find any evidence of a fight in the kitchen where she had said it happened. She lied about the location because she didn't want her mother to know she had taken a boy into her mother's bedroom. That makes it a non-case. (SSVA)*

- Insufficient evidence because of the victim/complainant's impaired memory as a result of using alcohol or other drugs.
- Lack of corroborating evidence.

*Victims decide that they don't want to go through with their complaints for various reasons such as their word against the offender's, that the complaint is false or there is no corroborative evidence to support the charge. (Police)*

- Misunderstanding the law, and when it is clarified it is established that sexual violation did not occur.

### ***Attrition during or after an investigation***

Police were asked to describe the reasons why cases do not proceed beyond the investigation phase to where charges would be laid. Comments given were similar to those given above: the evidential threshold is not met (most common scenario), closely followed by the victim/complainant deciding to withdraw. As the case progressed, a further factor contributing to the decision to withdraw was understanding the likely lengthy delays before the case would be heard. Other scenarios were:

- the suspect not being identified
- the victim/complainant not capable of giving evidence (e.g. absconded, died, not located, or mentally or emotionally unfit to withstand trial)
- concerns about the victim/complainant's credibility



*I believe that the main reasons that cases do not go on to be prosecuted are the lack of credibility of some complaints or the outright fabrication of them and the evidential requirements not being met, sadly most cases have little or no supporting evidence and it is clear that there is little or no chance of gaining a conviction. (Police)*

- poor prospects of getting a conviction (e.g. in the case of date rape or when the victim/complainant and perpetrator are in a relationship).

*Most common for me are cases where I am sure the victim has been raped but it would be impossible to get past reasonable doubt with a jury e.g. a victim in a relationship with [the accused] ... she is raped but not physically injured and acquiesces without significant protest and then spends the night in the rapist's bed. In a case like that if I am asked by the victim about chance of success at trial I will be honest. In the absence of a confession [it is] very hard to get past consent. (Police)*

### 8.2.2 Attrition during court processing

When a police investigation has found sufficient evidence to proceed with a prosecution, the police lay charges in court against the defendant. Following preliminary court hearings, if the defendant does not plead guilty, a depositions hearing is held before a judge.<sup>47</sup> At this hearing the judge must decide whether there is a case to answer; that is, whether a prima facie case has been established (i.e. whether there is sufficient evidence to proceed to trial). When there is sufficient evidence the judge makes a 'committal for trial'. At this point the case is taken over by Crown prosecutors for trial before a jury.

Police and Crown prosecutors were asked to describe some of the reasons why, after charges have been laid, sexual violation cases do not proceed to trial. Reasons given included the charges being amended, the prosecution offering no evidence, or the judge dismissing the case.

The accused entering a guilty plea is not considered an attrition point, because this results in a conviction. However, guilty pleas are sometimes made through plea bargaining. In such cases, while there is a conviction, there may also have been attrition of individual sexual violation charges.

#### ***Plea bargaining before depositions***

Police were asked how common it was for there to be negotiations over which charges would be laid in cases that involve a sexual violation offence. Responses indicated this was not common.<sup>48</sup>

---

<sup>47</sup> Occasionally, the defence will not dispute the case and will elect to go straight to trial. With indictable offences, such as sexual violation, committal hearings will be before a judge. For summary sexual offences, the committal hearings will usually be heard before two justices of the peace or community magistrates.

<sup>48</sup> Only 27 out of 185 (15 percent) who commented on this said negotiations over charges (e.g. plea bargaining) were 'common' or 'very common'.

*I've never had occasion to reduce charges. I think that would be wrong if you have the evidence to pursue it and the complainant is up to it. (Police).*

*Due to the serious nature of sexual violation charges they are not negotiated over in respect of withdrawing or guilty pleas on other charges etc, or substituted for lesser charges. This is not a fair representation of the circumstances and is not doing the complainant justice. (Police)*

In the few cases where plea bargaining occurred, it appeared it was more likely for sexual violation charges to be amended to lesser sexual offences, than it was for sexual violation charges to be not pursued at all. In these cases the decision to negotiate appeared to be the result of weighing up the likelihood of getting a conviction against what was in the best interests of the victim/complainant.

*A number of sexual violation charges are laid and the guilty plea is to a single representative sexual violation charge covering the period. Victim's reluctance, likelihood of conviction. Best result outcome with victim's interests paramount. (Police)*

*Likelihood of conviction not high and guilty plea offered for lesser charge. The victim hasn't the strength to withstand defence counsel cross-examination. Fear of the accused and associates. (Police)*

Comments also reflected that the police believed it was important that the defendant assumed some proportion of responsibility in relation to the offending, even if a charge was not quite accurate.

*When the evidence available for that charge is particularly light and there are other sexual violation charges that will be pleaded to and there will be no real difference in the sentence received at the end of the day. (Police)*

*To ensure convictions on some offending and to negate the need for victims to go through the court experience and the decision to be relied on the fickle and unpredictable jury process. (Police)*

*Sometimes you just have to be pragmatic. Bear in mind that police can only enter into these deals until depositions stage, after that it becomes a Crown file and they make the calls. They will often lay alternative charges before trial. (Police)*

### **Attrition after depositions and before trial**

Once a case has been committed to trial, Crown prosecutors review the case file, and then 'lay an indictment'. Only evidence presented in the depositions hearing can be used to formulate the charges in the indictment, but re-assessment of the evidence can result in different or additional charges. It is also possible for the Crown to elect not to file an indictment. However, when asked, both Crown prosecutors and police indicated that this was uncommon.

*I am not aware of this happening locally, but clearly the Crown must review the case and the evidence before the laying of the indictments and if they are not satisfied there is sufficient evidence or there are errors in the case then they have an obligation not to proceed; given the experience in our office and of our*

*supervisors this is highly unlikely. We would not put through a case that was not up to standard. (Police)*

*[It is] seldom charges wouldn't proceed. Exceedingly rare for Crown to elect not to file indictment – I can't recall seeing a case where this happened. If enough evidence for committal and complainant willing to continue, Crown will proceed to trial. (Crown prosecutor)*

Electing not to file an indictment was seen as even less likely than amending sexual violation charges. The most likely reason for an indictment not to be laid was when the Crown signalled it would 'offer no evidence' because the victim/complainant wished to withdraw their complaint. This would result in the case being dismissed by the judge (a section 347 discharge under the Crimes Act 1961, where the accused is discharged without conviction by the judge).<sup>49</sup>

Other reasons for the case not proceeding could, again, be where the defendant pleads guilty or, in rare cases, where the defendant dies or disappears. It is also possible for the judge to dismiss the case because of concerns for the welfare of the victim/complainant (e.g. repeated suicide attempts).

Keeping in mind it was considered uncommon for the Crown to offer no evidence, it was interesting to consider, when this did occur, which of the following two scenarios was most likely.

- There was a prospect of getting a conviction, but the complainant wished to withdraw.
- There was no real prospect of getting a conviction, and the complainant agreed to offer no evidence.

If the first option was more common than the second, this would have greater implications in terms of understanding how rates of successful convictions might be increased. Unfortunately, prosecutors' responses suggested this was a difficult question to understand and it was difficult to make such estimations; a range of responses was given. However, overall it appeared, on the rare occasions the Crown was to 'offer no evidence', the first scenario was more common. This suggests more convictions might be possible, if the reasons for the victim/complainant wishing to withdraw at this stage could be resolved.

Other reasons for the Crown not offering evidence included:

- the victim/complainant lacked credibility (n=5), for example, being hostile, failing to give evidence, unable to be located, or has accepted money in return for false testimony
- the perpetrator made a guilty plea to a different charge (n=4), for example, if there was insufficient evidence on the primary count, but a guilty plea was offered to alternatives, or a guilty plea to a more serious charge, or the

---

<sup>49</sup> Under section 347 of the Crimes Act 1961, the judge may in her/his discretion, at any stage of any trial, whether before or after verdict, direct that the accused be discharged.

defendant was already convicted on other charges, the case would require a re-trial

- it was not good for the victim/complainant (n=1), for example, medical experts give strong evidence that the victim/complainant's mental health status is such that they should not be put through the trauma of giving evidence.

### ***Trials discontinued before a final verdict is reached***

Once a case makes it to trial, the trial may be discontinued before the jury reaches a verdict. There can be a 'stay of proceedings' or the judge can dismiss the case (a section 347 discharge under the Crimes Act 1961). With a 'stay' the accused person is free to go, but the charge is not dropped or withdrawn, so proceedings could be reinstated at some future date. A section 347 discharge means the case is permanently dismissed.

Examples of where a 'stay' might occur were predominantly in cases where there had been lengthy delays in the case getting to trial, particularly if the offending had been historical (e.g. witnesses no longer available). In one case a 'stay' was reported after two previous trials had resulted in hung juries. Reasons for a section 347 discharge were similar to those applicable in earlier stages of the proceedings: the court process would be too harmful for the victim/complainant, or the victim/complainant did not want to give evidence and subsequently the Crown offered no evidence:

*Only complainants deciding to withdraw, Crown offering no evidence and s347 being successful. If there is no complainant there is no trial – can't use other evidence to fill a gap as is often the case with other trials. (Crown prosecutor)*

Police and Crown prosecutors agreed that it was rare for a victim/complainant to ask to withdraw their evidence once a trial had started. The reasons given for why this might occur were similar to those relating to earlier stages of the process: reconciliation of the victim/complainant with the accused or pressure from the court process, in particular cross-examination, being too much for the complainant. However, while rare, comments from one detective indicated this was understandable.

*It is only natural for victims to want to withdraw at this stage, understanding this is half the battle. (Police)*

Police and Crown prosecutors were asked to clarify what might happen when a victim/complainant asked to withdraw. Comments indicated that sometimes the trial might continue regardless of the wishes of the victim/complainant, and other times the trial might be dismissed.

It appeared that any decisions were typically the result of discussions between all parties, making sure choices were fully informed.

*A meeting is convened with police and complainant; the pros and cons are traversed; if maintained then complainant either is called in a voir dire [a closed hearing during the trial] to give evidence that she does not wish to continue OR she signs a statement as to the effect not giving evidence will have (i.e. no*

*recourse) and no evidence is offered without complainant appearing in court. Which option depends on circumstance. (Crown prosecutor)*

*Sit down and discuss, giving them time to digest, get assistance for them, and another meeting to check that is what they want. Hold the MEK [evidence from the medical examination kit] for a while and give victim the ability to contact me again but realising that they have made the decision. (Police)*

*Have to do what the complainant requests. Work through it together. Explain the consequences that there will be no second chance. (Police)*

Comments from some indicated they would do their best to resolve concerns and encourage victim/complainants to continue.

*The officer in charge of the case and Crown prosecutor meet with the complainant to resolve the issues which have caused the complainant to want to withdraw his/her evidence. (Crown prosecutor).*

*Generally tend to get them back on track by lots of persuasive discussion, with assistance from victim support group/whānau. (Police)*

*Seek reasons as to why and try and encourage them to continue through. Be in a position to have counselling services present and work with them. (Police)*

One detective spoke of efforts he made to address these anxieties.

*I believe feelings of desperation and fear mount as the trial draws nearer. It is one reason why I have begun to prepare victims for the trial and the rigors of trial earlier in the process so as not to add to this nearer trial. (Police)*

### **Accused acquitted**

The final point of possible attrition is where, based on the evidence presented, the jury fails to find 'beyond reasonable doubt' that the accused is guilty and there is an acquittal.<sup>50</sup> There has been much debate over specific factors associated with sexual violation cases that result in low rates of conviction compared with other types of offences. Survey respondents' views on these factors are reviewed in more detail in section 8.3.

## **8.3 Factors contributing to low rates of conviction**

Crown prosecutors and police were asked if they were aware of specific factors associated with sexual violation cases that contribute to low rates of conviction. Responses confirmed many of the issues that have been raised in other research both here in New Zealand and overseas (Jordan, 2004; Kelly et al., 2005; McDonald, 1997; Temkin and Krahé, 2008).

---

<sup>50</sup> However, considering a 'not guilty' verdict as a point of attrition could be debated because this implies that all accused are guilty of the offences with which they have been charged.

For a conviction to be made, the jury must decide 'beyond reasonable doubt' (i.e. the criminal standard of proof) that the accused is guilty of the sexual violation. An over-riding theme that arose from respondents was that achieving the evidential threshold required to convince jurors 'beyond reasonable doubt' in cases of sexual violation was particularly problematic.

*The burden of proof is simply too high and juries only need a little bit of doubt and won't convict. (Police)*

*The fact that prosecution has to prove the case beyond a reasonable doubt has a huge bearing, all the defence have to do is plant one tiny seed of doubt and the jury have to acquit. (Police)*

*Juries seem to need to have next to no doubt whatsoever before they convict in sexual matters as opposed to beyond reasonable doubt. (Police)*

Police and Crown prosecutors pointed to several factors associated with sexual violation cases that made meeting the criminal standard of proof particularly difficult. These factors included:

- the nature of the evidence, in particular the lack of corroborating evidence
- cross-examination tactics – the ability of the defence to discredit the victim/complainant as a reliable witness
- the rights of accused – the inability of the prosecution to challenge an accused who is using the right to remain silent
- a lack of understanding of the nature of sexual violation (and issues of consent) by jury members.

### **8.3.1 Nature of evidence – lack of corroborating evidence**

The nature of sexual violation means, in most cases, only the accused and the complainant will have been present. A consequence of this is there is no third-party evidence and the case rests on proving 'beyond reasonable doubt' based on one person's word against another's.

*In the vast majority of sexual violation cases, the matter boils down to a complainant's word against the accused's word. Even though juries are reminded that if they accept what a complainant has said is true, then that is sufficient to convict, it appears that juries want other independent or 'corroborating' evidence. Frequently there are no eye witnesses or medical evidence. (Crown prosecutor)*

As noted in the comment above, even though a jury can convict on the strength of the complainant's word, more often than not they want some other form of corroborating evidence (e.g. DNA evidence or medical evidence of physical injuries) in order to be convinced 'beyond reasonable doubt'.

*Lack of 'corroboration' be it forensically or generally i.e. a witness. Even when I explain in closing that [there is] no need for corroboration, or DNA testing etc, juries (anecdotally) still want such evidence, even in circumstances where there*

*cannot be any eyewitnesses given the nature of the allegation. (Crown prosecutor)*

The unavailability of corroborating evidence, in conjunction with jurors wanting such evidence, was the most common problem commented on by Crown prosecutors (58 percent), and was also raised by several police respondents (n=23).

The situation can be further complicated by jury members' unrealistic expectations created through watching crime programmes on television. There were both police and prosecutors who described this as the 'CSI effect' (after the television series *CSI: Crime Scene Investigation*).

*High threshold of proof considering there is unlikely to be independent witnesses. The 'CSI effect' where juries seem to believe there will always be compelling forensic evidence, or admissions from the offender. Crown prosecutors need to be hammering this point with juries, CSI is not reality and the case must be proved beyond a reasonable doubt, not 'all doubt'. (Crown prosecutor)*

Unrealistic expectations of the place of forensic evidence could apparently also extend to cases where it was not even relevant (e.g. where sexual intercourse was not disputed but consent was).

One Crown prosecutor described how, in his experience, the situation could be made worse by judges giving contradictory directions to the jury.

*Juries like corroboration – many won't convict without it. They feel that the word of a complainant is not enough, Some [area] judges tell juries that while corroboration is not required 'a wise and prudent jury' would look for supporting evidence before convicting. (Crown prosecutor)*

### **Difficulties in proving consent had not been given**

The unavailability of corroborating evidence was particularly problematic in cases where the complainant knew the accused. The main defence arguments in these cases tend to be that the accused believed consent had been given by the complainant. However, when it is one person's word against another's, it is perhaps not surprising that police and prosecutors found it difficult to be able to prove beyond reasonable doubt that the complainant did not consent to the sexual act.

*Juries find the concept of consent very hard to comprehend, particularly when confronted with the ever present hurdle of 'beyond reasonable doubt'. (Police)*

As is discussed later, several felt that to some extent the onus should be on the accused to prove 'beyond reasonable doubt' that they received consent.

*The onus is on the Crown not only prove that sexual violation occurred, but to prove beyond reasonable doubt that the victim did not consent, and that the accused did not believe on reasonable grounds the victim consented. The burden of proof is simply too high, and juries only need a little bit of doubt and won't convict. A suggestion is that the offender has to prove how he believed on reasonable grounds the victim consented. That means they are*

*required to give some explanation about how they believed the victim consented. (Police)*

### **Cases involving alcohol and other drugs**

Cases where alcohol or other drugs had been consumed by the complainant and/or accused were also seen to be particularly difficult to prove 'beyond reasonable doubt'.

*Juries clearly hold the victim responsible for her own state of intoxication and are loath to convict an offender who has sex with someone who is too intoxicated to provide consent (especially if the offender maintains that the victim was aware of what was happening and consenting to the acts). (Police)*

This appears to be contradictory to the law, as one Crown prosecutor pointed out. As the law stands, intoxication of the victim/complainant should not support the accused's defence.

*Whilst the consent provisions of the Crimes Act [1961] make it clear you cannot consent when under the influence, nonetheless it appears juries struggle. (Crown prosecutor)*

### **8.3.2 Cross-examination – attacks on victim/complainant credibility**

Because of the typical nature of the evidence (the victim/complainant's word against that of the accused), both police and Crown prosecutors raised the apparent ease with which the defence lawyer was able to plant reasonable doubt into the jurors' minds by attacking the victim/complainant's credibility. Of those who felt able to respond, 83 percent (n=34) of Crown prosecutors and 93 percent (n=126) of police felt that the cross-examination of victim/complainants by defence contributed to low rates of conviction in sexual violation cases.

The defence was able to attack a victim/complainant's credibility, either by referring to a complainant's past history or attacking minor inconsistencies in the victim/complainant's statement, making the complainant sound unreliable.

*The victim is required to be in the stand having her credibility and morals dragged through the mud by defence counsel questioning them in often an inappropriate and degrading manner. She is expected to justify her ability to recall the incident accurately and this often causes distress and confusion. Often the defence counsel will use any tack to call into question her credibility as a truthful witness; even if they have insufficient evidence to back this line of questioning up it is still sufficient to sometimes place doubt into the jury's mind as to the actual truth of what happened. (Police)*

*As you have one word against another, the credibility of a complainant is paramount. Any mix up of what happened in their accounts, while possibly stress related, how their memory recorded what happened, previous sexual history in the exceptions where it is admissible, alcohol, all make the task harder. (Police)*



*The fact that the complainant has to give evidence and be subjected to cross-examination that can affect a jury's perception. A single statement by a complainant confused about a question made by the defence counsel can be blown out of proportion and used by that counsel to implant doubt in the mind of the jury. (Police)*

As one detective noted, some behaviours consistent with the trauma faced by someone who had been sexually assaulted could even be used against them by the defence counsel, 'e.g. taking ... drugs, falling off the rails, trying to commit suicide'.

This type of cross-examination of complainants is why many survey respondents commented on the seemingly unfair nature of the situation.

*Cross-examination is almost always aggressive/robust/lengthy. Defence are effectively required to destroy complainants' credibility and do so through cross-examination. She ends up on trial. (Crown prosecutor)*

The re-traumatising consequences of victim/complainants' experiences of cross-examination have been well documented (Freckelton, 1998; Herman, 2005; Koss, 2000; Orth, 2002).

### 8.3.3 Rights of the accused

Three rights of the accused were seen to unfairly disadvantage the complainant. These rights were:

- the accused's right to remain silent
- that all prosecution evidence must be disclosed, but evidence to be presented by the defence need not
- that propensity evidence against the accused (e.g. similar convictions or previous similar behaviour) was inadmissible.

The right of the accused to remain silent was mentioned by a few as further exacerbating the injustice of the complainant being 'on trial' through cross-examination.

*I believe strongly that the complainant is more on trial than the accused. For the system to be fair, the accused must be compelled to testify. (Police)*

*Despite the best efforts of the courts it ends up being the victim who is on trial. The defence sits there not having to say or do anything while she gets hammered by the defence. I know that's our justice system but it is the biggest failing that I see. (Police)*

*Victims are often made to look bad in front of the jury by skilled questioning by experienced defence counsel while the offender can sit there smugly behind his lawyer and not have to justify anything or be cross examined. (Police)*

The result of the accused's right to remain silent was for the accused to be unfairly advantaged.

*Against this the accused has no obligation to give evidence and so the defence can generate all sorts of fanciful explanations to obtain reasonable doubt without having to back up any of their arguments. (Police)*

The other way the accused was seen to be advantaged was that the defence did not have to disclose all the evidence they were intending to present, in contrast to the prosecution who must disclose all evidence. Comments indicated this left room for the accused to 're-invent' an effective defence.

*Again, I have had sexual cases where defence under cross-examination have brought up matters not previously known to the prosecution OR have called defence witnesses with no warning; I still fail to understand why defence get a copy of everything the prosecution have and yet have no obligation to tell the prosecution of what their defence is, things they intend to raise. ... I believe the prosecution should be provided with a brief of evidence for any defence witnesses being called OR they are considering calling so as to balance up the case. (Police)*

*The accused can manufacture a defence, based on the disclosure we provide, right up until the trial starts. We constantly have defendants turning up at court and playing the consent' card even if they have repeatedly denied having sex with the victim at all. Defence lawyers have become skilled at presenting why this has happened and jurors are simply left with doubt and err on the side of caution. (Police)*

The final perceived disadvantage was that, in contrast to the complainant's past history typically being paraded before the jury, previous convictions of the accused, their past sexual history, and often other evidence showing similar behaviour were typically ruled as inadmissible.

### **8.3.4 Jurors' misunderstanding of the nature of sexual violation**

The failure of jurors to understand the evidence presented was also seen to work against a successful prosecution. Jurors' misunderstandings of the nature of sexual violation/rape were a commonly cited concern (41 percent of Crown prosecutors and 5 percent of police). For example, failing to understand that sexual violation can occur within in a marital relationship.

*The public's reluctance to accept that sexual assaults occur within relationships. That stranger attacks are the exception not the rule. (Crown prosecutor)*

Indeed, rather than the exception, stranger attacks appeared to be the more common perception that jurors had of sexual violation scenarios.

*Typical view it seems – is a woman running down street, clothes ripped, injured, screaming, being chased by a monster. (Crown prosecutor)*

The above picture of sexual violation can lead to expectations that do not fit all cases of sexual violation.

*Jury perception of what a rape victim looks like. Why didn't you scream? Where are your bruises? Why didn't you fight? Why did you drink so much? (Police)*

*Society's personal beliefs – this is hard for a jury because people can't free themselves from what they believe a rape is, how they believe a victim should act, who a victim should be. (Police)*

Lack of understanding was most evident where jurors could not understand that physical injuries may not be present or appreciate the different ways sexual violation victim/survivors might react.

*Jurors have a false belief that there should be injuries if there has been forceful penetration. (Crown prosecutor)*

*Jury needs to understand psychological concepts such as 'freeze response' in vulnerable adults and children. (Crown prosecutor)*

*Jurors are influenced by defence submissions about how a complainant should have reacted at the time or afterwards and yelled out/fought off etc. (Crown prosecutor)*

### **8.3.5 Jurors' reluctance to convict due to heavy penalties**

A few respondents perceived that the penalties associated with sexual violation could make it difficult for jurors to find the defendant guilty, especially in cases where it came down to one person's word against another's, and particularly where both the accused and victim/complainant were young (this was mentioned by three police and five Crown prosecutors).

*Other factors include the jury deciding a conviction will have a significant impact on the accused (i.e. in the case of a university student), the right of the accused to refuse to give an explanation at the time of the arrest and lawyer manipulation of the jury. (Police)*

An example from one detective suggested this was an intentional tactic used by some defence counsel.

*Reasonable doubt and confusion of juries by defence counsels. 'You may be really really suspicious of my client. You may think he did it but what if he was your son, if you say not guilty you are not saying it didn't happen you are just saying you can't be certain. If he was your son, your brother, your father you would want the jury to be completely certain before they sent him to jail for 10 years.' (Police)*

There was some evidence that these suspicions were true, with one detective commenting on a case where the jury agreed that sexual violation had occurred, but did not want the accused to go to jail, and asked the judge, 'if we convict, can we ask for leniency' (Police).

### **8.3.6 Factors that contribute to low rates of conviction in cases involving particular groups of victim/survivors**

Police and Crown prosecutors were asked to comment on any factors that they believe contribute to low conviction rates where the victim/complainant is Māori, Pacific, or young (16–25 years) or has an intellectual disability. They were also

asked to comment similarly on any other specific groups of victims. The response rates for these questions were particularly low, for example, only 33 (16 percent) police and 10 (21 percent) Crown prosecutors commented on the low conviction rates for Māori. The number of responses for the other groups was similar. Many factors identified were the same as those identified as reasons that prevented or discouraged these groups from initially reporting (see section 7.1), fewer focused on attrition once in the criminal justice system.

### **Māori**

Ten police respondents thought that family pressure is the biggest factor discouraging Māori victim/survivors from going through the criminal justice system.

*Family pressure! There is so much pressure from immediate and extended family not to 'nark'. I admire the Māori complainants who go through with the complaints and do not succumb to outside pressures. (Police)*

One detective attributed some of this whānau pressure to the high level of sexual abuse in Māori families, which was seen as influencing them to withdraw support, or pressure the victim/survivor to withdraw. There may also be pressure from the offender to withdraw. Victims can feel isolated from whānau and may not wish to upset them or may feel they have done something wrong. The whānau may choose to 'deal with it in-house'. Whānau interference may result in victim/survivors' refusal to testify against whānau offenders.

The second factor, identified by both police and Crown prosecutors, relates to credibility – the *'inability to present well as [a] compelling witness'* to juries (n=12).

*Most jury members in our area are middle class Europeans, although there is usually at least one or two Māori on most juries. Many of our victims are low socio-economic Māori women who because of their background, and upbringing, use language and manner of speaking and talk about a lifestyle which does not endear them to the jury. (Police)*

*They are more likely to come from a home that the defence can present as 'dysfunctional'. Sometimes the complainant is not as educated/articulate as others, terminology of court can confuse and undermine their confidence, making them fear being thought stupid or inferior. (Crown prosecutor)*

Complainants may not appear comfortable in the court environment and come across as *'too lax'* and *'easily swayed by defence'*. Crown prosecutors suggested Māori did not perform well in court because of their shyness and can find it difficult to *'respond [and] handle demanding cross-examination'*.

A third factor, identified by six police and Crown prosecutors was institutional racism.

*Māori tend to be treated with less sympathy by courts and juries. This is based on racism. (Police)*

The lack of Māori tikanga at court was also identified as an issue by two police respondents.

*Any prosecution has to be meaningful to both victim and offender, a Pākehā system may not be as meaningful to either in a situation where a Māori woman was raped by an uncle or kaumātua; surely a hearing on a marae is better. (Police)*

All of the above factors raise questions about how well the Western approach to trials works for victim/survivors who are Māori.

### **Pacific peoples**

The main factor contributing to low conviction rates for cases involving Pacific victim/survivors, as identified by 18 police and Crown prosecutors, was pressure from families and churches.

*In my experience a great deal of family/church pressure can be exerted on Polynesian complainants. Often there has been a 'formal apology' between families and it is swept under the carpet and the complainant made to feel bad continuing process. Also 'normalised' and 'minimised'. (Crown prosecutor)*

Other factors included racism (n=8) and credibility issues (n=5). Five respondents also pointed to language difficulties (n=5).

*Language difficulties can make victims appear unsure while giving evidence and they may also be caught by verbal traps in questions from defence counsel. Also Pacific Islanders' body language when speaking to someone in authority may lead a jury to incorrectly conclude they are being evasive. (Police)*

### **Young people**

Credibility was the factor most frequently identified (n=13) as contributing to low conviction rates where the victim/complainant was young (i.e. aged 16–25). Police and Crown prosecutors stated that often young people did not present well in court, and were more easily confused and swayed under cross-examination.

*The victims are unable to explain properly what they saw or when asked by defence, 'Why would the offender do something like that?'. Or 'Are you really sure about that?'. They can't answer with any certainty, which creates doubt. (Police)*

Another factor, linked to issues of credibility, is that juries tend not to like young people (identified by 13 respondents).

*Juries just don't like teenagers, they seem to view them as vindictive or foolish: 'she must have known what would happen when she got into a car full of drunk boys'. (Police)*

Consumption of alcohol and other drugs was identified by nine respondents as a factor in the low conviction rates where the victim/complainant is young. They believe juries are unsympathetic to young people who have been drinking.

*Prejudice ... young persons who binge drink or take drugs are 'fair game', 'got what they asked for', 'what do you expect – take responsibility for your actions'. (Crown prosecutor)*

Service providers raised the issue of victim/complainants who have their cases heard in Youth Court because the offender is aged under 17. Youth Court is set up for the rehabilitation of young offenders, and with the focus on the young offender, the victim loses the protection she would have had in the adult court. The laws that protect her in the adult court do not apply.

### ***Victim/survivors with intellectual disabilities***

Credibility was identified as a major factor in the low conviction rate for victim/complainants with intellectual disabilities. Major barriers include the difficulties with cross-examination and eliciting information, issues of consent, and getting the jury to understand why the victim/complainant acted in a particular way.

*It is almost impossible to get a conviction – cross-examination is a real issue. Always the ability of defence counsel to make it look as though complainant would say anything, make things up, is unreliable etc. Getting out ingredients of the offence often difficult also. (Crown prosecutor)*

Jury prejudice was also a factor in the low conviction rate identified by 11 respondents. This is compounded by the distrust of expert witnesses by both the jury and judges, which was identified by an additional six respondents.

*Judges and juries struggle with expert evidence (which avoids the ultimate issue) and idea of convicting someone for doing something so serious on the word of someone who is not like them. Fear – scared of getting it wrong. (Crown prosecutor)*

### ***Other groups***

Other groups of victim/survivors with low conviction rates identified by respondents were sex-workers, ethnic minorities, and gay, lesbian, transgender, bisexual, intersex people.

Jury prejudice and/or lack of knowledge was a factor identified for sex-workers (n=7), ethnic minority groups (n=3), and men (n=8).

*The ignorant public view that certain types of people may attract this type of trouble. (Police)*

For sex-workers, proving non-consent was seen to be particularly problematic with the added issue of sex being part of a financial transaction (n=15).

*The likelihood of getting a conviction for sexual violation of a person who engages in trading sex for money is practically nil due to the obvious inherent difficulties surrounding buying a person's consent for a particular act, and especially with regard to the continuation of sex after consent is withdrawn. (Police)*

## **8.4 Survey respondents' suggestions for change**

Survey respondents were given the opportunity to suggest possible changes to the criminal justice system to assist in the successful prosecution of sexual violation

offences. Suggestions were also made on how to improve the experiences of victim/survivors, which, as many pointed out, could result in higher numbers of victim/survivors choosing to report to police and engage with the criminal justice system.

Note: In considering the material presented in this section, it is important to understand it has been based on what is in the best interests of victim/survivors, which was the focus of this research. However, the justice system is founded on the rights of the accused who is presumed innocent unless proven to be guilty beyond reasonable doubt. What is in the best interests of the accused would be best described by defence lawyers, who were not part of this research. Therefore, any recommendations on possible changes to the criminal justice system would need to carefully consider the potential impacts on the right of the accused to a fair trial.

The section begins with specific changes within the criminal justice system respondents would like to see and ends with a broader look at what might be done to support victim/survivors and make accessing justice less traumatising.

### 8.4.1 Suggestions for changes to the criminal justice system

As highlighted earlier in this section, some survey respondents had concerns about the criminal justice system. For example, sizeable proportions (41–80 percent) of the various groups of survey respondents either would not recommend or were unsure whether they would recommend that a close friend or family member who had been sexually violated go through the criminal justice system. Of those who responded, three-quarters of police (n=95; 71 percent) and just over half of Crown prosecutors (n=17; 55 percent) said legislative provisions should be changed for adult sexual violation offences. Service providers and DSAC RLDS were asked a similar question and had an even stronger response (n=118; 92 percent and n=7; 100 percent, respectively) said they felt aspects of the criminal justice system's processing of sexual violation complaints needed improving.

Those who felt that changes were not necessary did not always offer explanations. Although two Crown prosecutors referred to changes that had already been made, they did not rule out the need for further changes at a later point.

*At present there have been changes and as more research such as this is done, I am sure the need for more legislative changes or refinements will become self-evident. (Crown prosecutor)*

*I believe the amendments made over the last 10–15 years have addressed many concerns. The only change would be to an inquisitorial system possibly. (Crown prosecutor)*

The remainder of this section brings together suggestions on what might be done to increase the number of successful prosecutions and make the system less traumatising for victim/survivors.

Themes that emerged across groups of respondents (criminal justice and non-criminal justice groups) were surprisingly similar and are reviewed together below. Many of the suggestions made by police and prosecutors were in response to the factors they had identified as contributing to the low rate of conviction. Suggestions were wide ranging and often quite technical. While it was beyond the scope of this report to present the full detail provided, the main themes are covered.

### **Presentation of evidence by the complainant**

Several suggestions for improvement centred on how victim/complainants are required to give evidence, in particular, the cross-examination of their evidence by the defence.

**Greater judicial control:** Some informants felt that the judge should exert more control over the nature and content of the defence cross-examination of complainants and asking of leading questions.<sup>51</sup> There was a suggestion that judges were reluctant to do this for fear of appeals if the accused was convicted and that also affected their summing up of a case.

*The reason judges do not, is a fear or concern of a successful appeal against conviction on the grounds of unfair trial because some line of cross-examination that was prevented. Perhaps cross-examination could be limited to certain specific topics rather than free-ranging ability currently available. (Crown prosecutor)*

*The matter of consent, the latitude defence is given and the ways judges are required to sum up so as to avoid appeals if a suspect is convicted. (Police)*

However, limiting the degree of cross-examination of complainants was not a view shared by all, and one Crown prosecutor made the distinction between challenges to the victim/complainant's credibility and attacks on the victim/complainant's character.

*Credibility should be challenged. Remember complainants can lie! If identity of accused is an issue the defence MUST be able to challenge credibility. If consent is an issue – same. Attacks on character are rare. (Crown prosecutor)*

**Better court preparation for victim/complainants:** Two Crown prosecutors felt there was inadequate court preparation for victim/complainants. It was felt better preparation would make it easier for the victim/complainant and make the evidence presented more compelling.

**Evidence-in-chief by video record:** A suggested solution to the defence attacking a victim/complainant's credibility by focusing on minor inconsistencies involved video-recording the victim/complainant's initial statement and allowing this to be presented as the 'evidence-in-chief'. Seventy-one percent (n=25) of Crown prosecutors and 89 percent (n=175) of police thought that this would be a good idea.

---

<sup>51</sup> One Crown prosecutor suggested this could be achieved by amending section 35 of the Evidence Act 2006.



*I consider that allowing video-taped statements from complainants to be played as evidence-in-chief is likely to have a beneficial effect. Given the time lapses between complaint and trial, clearly a complainant's memory of matters is clearer at the time of making their initial statement. Another way in which this would be of assistance is the ability that defence counsel currently has to cross-examine on a previous inconsistent statement. Obviously, given time lapses between initial statement and giving evidence in trial, complainants are not 'word perfect'. They are frequently cross-examined and criticised for any differences between initial statement and evidence in court, even if these seem to be minor or inconsequential differences. Those inconsistencies often take on an unmerited significance with defence counsel inviting the jury to infer that the evidence is either unreliable, or lacking in credit. (Crown prosecutor)*

As illustrated in the quotation above, the advantages of video-recording are in the provision of a more accurate reflection of events to juries. Naturally, over time, victim/complainants tend to forget things and the use of video-taping would reduce or eliminate inconsistencies in victim/complainants' statements caused by such memory loss that tend to be picked up and exaggerated by defence counsel.

Concerns were raised, however, about the impact if the quality of the video was poor, that using video could 'depersonalise' the victim/complainant to the jury, and that some victim/complainants might present better evidence orally under the direction of the prosecution. Two prosecutors mentioned that police PEACE<sup>52</sup> interview techniques (used in videos) are about information gathering and do not build a 'picture' in the way that a prosecutor can.

A concern of service providers and at least one detective was the potential for video footage to be used as gratification for perpetrators, which could happen because defence counsel has access to all prosecution evidence.

*Evidence-in-chief recorded on video is not a good idea. As with all the rights baddies have they would get access to their video, for which they can do anything with. A rape complaint is a very personal ordeal and I don't believe the privacy of the complainant can be protected when it is disclosed; It would also give the offender (and lawyer) an opportunity to learn character traits and information about the victim and exploit those. (Police)*

**Alternative provisions for giving evidence:** Most Crown prosecutors (84 percent, n=37) viewed the use of screens for victim/complainants in the courtroom and the use of closed-circuit television as a good idea, if they helped the victim feel more relaxed and improved their ability to give clear, coherent evidence. Ensuring victim/complainants can give evidence in a safe way and are free from intimidation were also commented on by court victim advisers (n=5) as important.

*If a complainant feels intimidated or frightened, the evidence does not come out well. Protecting the complainant is crucial to the trial outcome. (Crown prosecutor)*

---

<sup>52</sup> PEACE is short for Planning & Preparation, Engage & Explain, Account, Closure, Evaluation.

*Good to have options. Not sure on impact at trial. Can 'de-personalise' the complainant in the eyes of the jury, which is not always a good thing (particularly with video). Giving evidence in court must, however, be a nightmare so everything possible to put the complainant at ease is a good thing. (Crown prosecutor)*

Weighing up the welfare of the victim/complainant and getting the desired court outcome can be difficult. Currently, screens can be used if requested in advance and the judge approves. However, giving evidence using closed-circuit television is permitted only in the cases of child complainants.

### **Presentation of evidence by the accused/defence**

Several suggestions related to the presentation of defence evidence.

**Abolish the accused's right to silence:** Several police and Crown prosecutors felt an accused's right to silence was an unfair advantage because defence arguments were difficult to challenge. Police and Crown prosecutors gave examples of how this can result in apparent injustices, including not being able to challenge a defence raised that contradicts earlier offender comments.

*I have had cases where the accused denies intercourse altogether and once DNA is located in the victim's vagina the defence is changed to one of consent! (Police)*

*For example, ... an intruder rapist who stated at interview that he didn't know the victim and that he had never been in her address. ... When I informed him he had been identified through a DNA match he still denied ever meeting the victim. ... He will totally fabricate a story as he now understands he can't deny contact with the victim due to the strong DNA evidence. This victim ... has to go through a trial and the defendant is allowed to change his story to suit his defence. He was given ample opportunity to explain the presence of his DNA when interviewed, but couldn't. (Police)*

Suggestions were made to modify the accused's right to silence.

*It would help if defendants were not allowed to change their stories or be required to give their explanation at the time of arrest – like they do in the UK [United Kingdom]. (Police)*

*Accused right to silence modified so that cannot later raise a defence, which has not been advanced at [initial] interview (after legal advice). (Crown prosecutor)*

Other suggestions were that if the accused did elect to remain silent, inferences from this could be made to the jury, apparently similar to the current situation in England.

*if a suspect elects their right to silence, certain inferences may be drawn as per UK [United Kingdom] rights. (Crown prosecutor)*

*Accused persons should be advised to give an explanation and that failure to do so may impede their defence later. This is done in England. (Police)*

**Disclosure of defence evidence:** Another popular suggestion was that defence counsel should be required to disclose to the prosecution all defence evidence to be presented.<sup>53</sup>

*Most importantly, I believe the prosecution should be provided with a brief of evidence for any defence witnesses being called OR they are considering calling so as to balance up the case. (Police)*

*The fact that the accused can come up with an explanation to the facts at the time of trial after having all the intervening time to concoct their story – in this regards I believe the British requirement for accused to come up with their explanation when spoken to by police, not make something up 18 months later would be of assistance. (Police)*

A couple of DSAC RLDs also had strong views on the disclosure of defence evidence.

*If the defence calls in own expert medical witness, their report should be available for perusal by the prosecution expert medical witness well before the date of the court appearance. (DSAC RLD)*

**Onus on accused to prove consent had been given:** In cases that centre on proving whether or not sex was consensual, the prosecution needs to prove the accused did not believe, on reasonable grounds, that the complainant had given consent. There was support from a few police (n=5) and Crown prosecutors (n=7) to reverse the onus of proof, so that the defence must show what steps were taken by the accused to determine that consent had been given.

*At least part of the onus of proving consent should be placed upon the suspect. He should have to prove to the court how he knew the woman was consenting. (Police)*

Service providers echoed this view.

*The question of consent – the question of consent needs to be more positively reframed and the offender asked what they did to seek consent i.e. what actions they took. (SSVA)*

**Allow propensity evidence to be admissible:** Another fairly strong theme to emerge was to allow propensity evidence relating to the accused's previous actions to be admissible. Ninety-four percent (n=185) of police were supportive of allowing similar convictions of the accused to be admissible as evidence.<sup>54</sup>

*Return to rules of res gestae [things done], allow recent complaint and adopt rules similar to UK [United Kingdom]. (Crown prosecutor)*

---

<sup>53</sup> Under the Criminal Disclosure Act 2008, which came into effect on 29 June 2009, if an accused is going to call alibi evidence or expert evidence, then they must notify the prosecution at least 14 days before the trial that they intend to do so. Any brief of evidence or report must be provided to the prosecutor within at least the 14 days.

<sup>54</sup> Propensity evidence is not inadmissible as a matter of course, rather it is at the discretion of the judge, who often rules it inadmissible.

*Allow evidence of previous sexual offending by the accused. At the moment we are limited with only similar fact evidence. The similar fact has to be too close to the actions of the accused in this particular instance. (Police)*

*Give prosecutors the power to show previous offending or complaints that there may be against the accused as we all know they look nothing like they did at the time of the offence when the jury first gets to see them. (Police)*

*Similar convictions should be admissible as it is a known fact that often people that commit these types of crime have a propensity as a recidivist offender. It could be like the driving matters and Breach of Protection Orders in which people are charged as 2nd, 3rd or subsequent offenders meaning higher penalties etc. (Police)*

However, some comments suggested more thought needed to be given to this issue; for example, that similar convictions should not be admissible but the law regarding similar fact evidence should be expanded.

*A person's similar convictions may already be admissible under 'propensity' legislation in the Evidence Act. A person's history should not be used against them as a matter of course. The jury is judging the person on the facts of the case before them at the time, not on something that occurred 10 years prior. To do so would be most unfair and this applies in all cases not just sexual offending. A jury should make a decision on the case before it, not on the person's history. If the Crown proves the case then so be it, but to muddy the waters with other convictions is most unfair. (Police)*

### **Education of juries and the public**

As noted in section 8.3.1, criminal justice system survey respondents felt jurors' misunderstandings of the nature of sexual violence contributed to the low conviction rate.

*Frequently a defence case is based on the myths of sexual offending, for example questions such as, if this really happened, why did you not seek assistance at the time? These questions rely on a jury's acceptance of those myths or assumptions made about sexual offending. (Police)*

In response, it was suggested that jurors needed to be educated by being given information before evidence is presented, the use of expert witnesses, or, more generally, through a public education campaign. Suggestions on what education should cover included the nature of sexual violation and dispelling rape myths. There should also be education about consent law, and education for victim/complainants about the importance of reporting early so forensic evidence can be gathered.

*Give jurors an introduction to what constitutes a rape/sexual violation before evidence is called and by an independent group or standard DVD presentation. Try to better educate them and overcome their stereotypes before trial. (Police)*

*Allow professional psychologists to give evidence to the jury to explain some of the myths surrounding sex crimes and disclosures ... i.e. when people disclose, why they sometimes don't, why they succumb to their attacker on occasion ...*

*why there is no medical evidence on many cases ... the difference between offending against adults and kids ... etc. (Police)*

*Educate the public that sexual violations are not always violent, and that they can occur within families; educate the public that in situations where the victim is incapacitated by alcohol/drugs the onus remains on the offender to 'keep it in his pants' and not to take advantage of the victim's inability to physically resist. (Police)*

Improved education was a view service providers supported (n=7).

*I feel very strongly that in order to give a fair trial, jury and judges should be well educated about sexual assault. They should be consulted by or include experts in the field such as DSAC, doctors, psychologists, representatives from specialists such as Rape Crisis. (Mental health counsellor)*

### **Changes to criminal justice system**

Several suggestions were made for more fundamental changes to the criminal justice system. These are reviewed below.

**Judge-only trials:** Two-thirds of Crown prosecutors (n=23) and 90 percent (n=170) of police thought that sexual violation cases, rather than being decided by a jury, should be judge-only trials. Those supportive of the idea felt it was more appropriate because judges had more experience and expertise in these matters. Some qualified their support, preferring a panel of judges.

*Obviously trial judges see a full range of alleged offences including sexual violence. This is not true for the vast majority of jurors. Trial Judges are more aware of the 'myths' of sexual offending and are less likely to be swayed by them, trial Judges are also more likely to approach matters in a 'forensic' way rather than emotional. (Crown prosecutor)*

*Take out the juries and have the matter heard before three judges!!! Juries (with no disrespect to them) have no idea about legislation and all a defence lawyer needs to do is to confuse them and then make themselves sound good in front of the jury. While our poor victims are stuck and most victims state that the trial and defence lawyer questioning is worse than the actual assault! (Police)*

Those with reservations about judge-only trials commented that judges might have their own prejudices.

*Male middle-class judges will be no better than juries – same prejudices. (Crown prosecutor)*

*All individuals bring their own preconceptions and stereotypes. Placing any decision in the hands of one person is undesirable. (Crown prosecutor)*

**Inquisitorial system of justice:** A judge or panel of judges holding the decision-making power is also a characteristic of the inquisitorial system of justice common in many European countries. However, within the inquisitorial system, rather than defence and prosecution competing against each other, the judge (or investigating

magistrate) is responsible for the supervision and gathering of relevant evidence, as well as the questioning of witnesses.

There has been discussion about whether an inquisitorial system would be more appropriate in cases of sexual violation, in contrast to the current New Zealand adversarial system. When asked about this, around a third of Crown prosecutors (15 out of 46) felt adopting an inquisitorial system in the case of sexual violation offences would be a good idea. A greater proportion were unsure (20 out of 46), and 11 out of 46 thought such a system would be inappropriate. More police thought this would be a good idea (57 percent, n=118), with the remainder equally divided between being unsure and unsupportive. There was also support for this approach from service providers (n=11) and one DSAC RLD.

Those who were supportive of an inquisitorial system thought it would be better for the complainant (less harrowing) and that it would allow the accused to be questioned, so a more complete picture of the incident could be considered. Those who were unsupportive felt it was inappropriate to treat sexual violation complainants different from other complainants.

**A verdict of 'not proven':** As highlighted earlier, the typical nature of evidence in sexual violation cases can make it particularly difficult for juries to decide beyond reasonable doubt whether an accused is guilty. In Scotland, three verdicts are possible: not guilty, guilty, and not proven (McFadzean and Scott, 2005). The idea of an additional verdict option of 'not proven' in New Zealand was canvassed with survey participants, and got very mixed responses, which are reviewed below.

Around half the Crown prosecutors thought the option of a not proven verdict was inappropriate (n=22), with the remainder equally divided between being unsure or thinking it was a good idea. In contrast, over half the police thought it would be a good idea (n=121).

Those who were supportive thought it might be better for the complainant and ease their mind, and might make things clearer to the public.

*If only for the peace of mind of a complainant. It's very difficult to explain the tripartite direction and its consequences to a victim. (Crown prosecutor)*

*I strongly support an additional verdict of 'not proven'. I believe it would go a long way towards promoting public acceptance following an unsuccessful prosecution and be of great assistance to the complainant. (Police)*

*I have considered on a number of occasions that a jury's verdict of 'not guilty' was in the category of 'not proven'. Often acquittals are equated with a finding of innocence incorrectly in the media. The verdict of 'not proven' perhaps would clarify the difference to the media and public at large. (Crown prosecutor)*

This latter quotation points to one of the major flaws with this idea, which some Crown prosecutors commented on strongly: a finding of 'not guilty' legally means the case has not been proven, so introducing a 'not proven' finding would lead to a 'not guilty' finding implying innocence.

*'Not guilty' means 'not proven', it has never meant a finding of innocence. The confusion is caused by the presumption of innocence which is a legal fiction*

*designed to secure a fair trial. So a verdict of 'not proven' to me would be meaningless and in a sense suggest that anyone who was found 'not guilty' is factually innocent, whereas all it means is that the accused was not proven guilty beyond reasonable doubt. Of course it may well be that an accused that is found 'not guilty' is factually innocent but not necessarily. (Crown prosecutor)*

Not only was it felt that such an additional verdict was unnecessary, there was concern it could decrease the already low rate of convictions, because juries could see it as an easy option.

*A 'soft option' which would see more juries failing to arrive at concluded verdicts. (Crown prosecutor).*

*The Scottish use of a 'not proven' verdict is likely to be used where the jury believes that the offending has occurred but is confused by legal arguments. It is likely to be used by defence counsels to move the theoretical boundaries of 'reasonable doubt' and in turn lead to even less convictions!!! (Police)*

**Expediting trials:** Reducing the time it takes for sexual violation cases to get to trial was an improvement both criminal justice system and non-criminal justice system groups called for. The negative effects of long waiting periods were commented on by service providers.

*The long length of time it takes from formal complaint to court case is very detrimental to the survivor. They maintain a high level of anxiety for months, sometimes longer than a year. Cases should be heard in court within three to four months of complaint at least. (Mental health counsellor)*

*Less time to process [sexual violence] complaint, 'it takes so long, it's like them getting abused over again'. Their confidence is easily smashed. It is another kind of system abusing them. Waiting if there are other cases. (Māori community agency)*

There were suggestions that sexual violation trials should be 'fast-tracked', with, for example, all cases making it to trial within six months. A Crown prosecutor suggested that if trials took longer than 6–12 months, then there should be limits on what evidence is challenged. Police and Crown prosecutors commented on the way that the defence has the ability to delay a case coming to trial, and that the longer a complainant has to wait, the less reliable their memory of events can become.

The potential positive outcomes of reduced delays were clearly evident to some informants.

*Due to the shambles we call the court process, the victim impact is far too great, a short fast-tracked process would be greatly beneficial to the victim. This alone would, in my opinion, encourage the victim to follow the prosecution through to its conclusion. (Police)*

*This [would result] in being able to get sexual assault cases before the court in a timely manner. Having to wait 18–24 months for trial puts off complainants. (Police)*

Long delays also had adverse effects on DSAC RLDs.

*The time and stress involved in going to court for the doctors is one of the major stresses of this work and also a major detractor in recruitment. There needs to be an urgent addressing of the amount of doctors' time wasted by the court process. Could give you numerous examples where doctors are held up in court for several hours when eventual time on the stand is minimal and all the while they remain unable to attend to any other work. (DSAC RLD)*

**Restorative justice:** A few respondents felt a restorative justice approach might be more appropriate for some victim/survivors, particularly where the accused was known to them or they were in an ongoing relationship with the accused.

*By and large the instrument is too blunt. Victims more often want justice in the form of an acknowledgement that what happened was wrong and not OK and the only option for this to occur is to try and persuade a jury to convict the accused and place that person in prison for a significant period of time. Restorative Justice systems are generally what is required in many of the cases we see (DSAC RLD)*

*Restorative Justice ... if this is a choice that the victim wants, and their whānau, this should be recognised as an intervention outside of the [current] systems, that has worked for Māori for generations. (SSVA)*

**Specialist courts:** There were a few calls for specialised or dedicated courts for sexual violation, like the family violence and youth courts, with a judiciary that has specialist training.

#### **8.4.1 Support for victim/complainants during criminal justice system process**

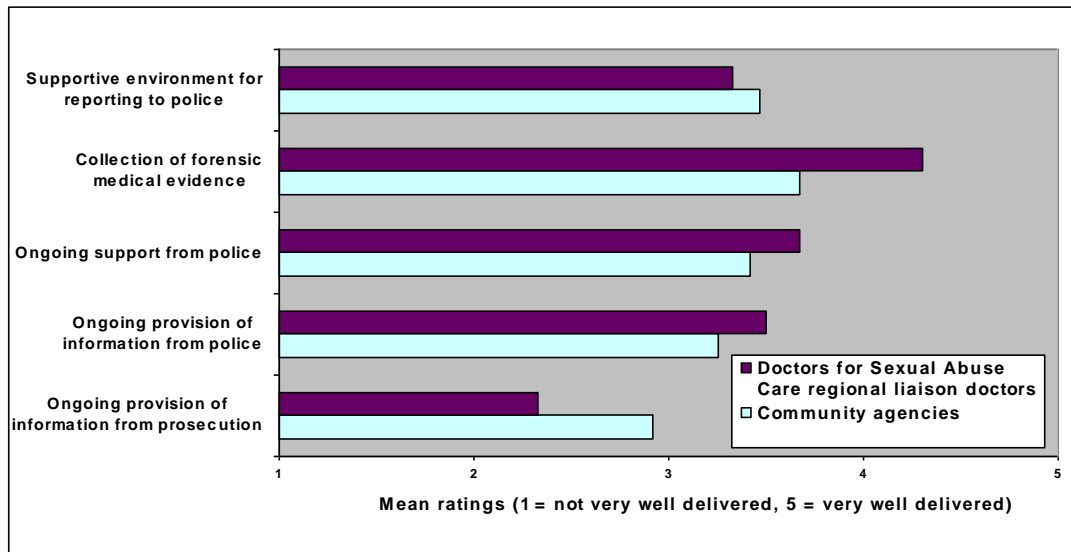
Throughout this chapter the trauma experienced by victim/survivors at various stages of the criminal justice system has been made clear. Provision of information and support to a victim/complainant as they progress through this process is essential.

*Overall there have been improvements in this area but much work still needs to be done. This is the area that is most concerning and distressing for victims, information and being fully informed is key and often falls down due to agencies not sure whose role it is. (Victim Support)*

Community service providers and DSAC RLDs were invited to rate, from their perspective, the support available to victim/survivors from different criminal justice groups as their case progressed. Mean ratings from both groups are presented in Figure 9.



**Figure 9: Mean ratings of how well aspects of the criminal justice system are delivered to victim/survivors**



Community service providers and the DSAC RLDs gave similar ratings. With the exception of ‘ongoing provision of information from the prosecution’, all aspects of the criminal justice system were given average or better ratings.<sup>55</sup>

*We work very closely with [area] CIB [Criminal Investigation Branch] to provide the most positive assistance to victims of sexual assaults. Feedback from police to Victim Support is positive and there is excellent collaboration amongst the various people involved (police, general practitioner doing forensic, Victim Support workers). (Victim Support)*

*Clients of mine who have been involved in the police procedure have universally met with little/no support, re-traumatised by poor communication, heavy handed, intrusive behaviour and no understanding of the impact of their behaviour on the victim/survivor. (Mental health counsellor)*

However, some respondents from both groups felt an overall rating was difficult because responses could vary depending on the individual involved.

*Variable level of response from police – individuals provide excellent service but some don’t. Some police give us feedback re: case progression but others don’t. Very little communication with prosecution regarding cases unless driven by doctor. (DSAC RLD).*

*Mixed reports. Some positive, some negative. Depends too much on individual detectives. Not consistent response. Going to police often intimidating – hostile environment, especially for children and young people. I have known young*

<sup>55</sup> The number of responses from service providers on the different criminal justice system aspects ranged from 83 to 29 out of a possible 179. Responses from DSAC RLDs ranged from 6 to 10 out of 10.

*clients to be more traumatised after evidential interviews. (Mental health counsellor)*

More support and information would be welcomed from Crown prosecutors. The potential value of this was highlighted by a DSAC RLD and a court victim adviser.

*Earlier and more in depth involvement of the Crown prosecutors so that the complainant has more support information and involvement, the case has more prep time before court, the expert witnesses such as doctors are consulted more appropriately and with adequate notice. Too often cases are being prepared at the last minute. The complainant is often left feeling like a peripheral player in their own case. ... Having seen how marginalised complainants are in the legal process I could not myself go through it unless it was a stranger or significant public safety issue. (DSAC RLD)*

*All victims of sexual abuse should have more contact with the Crown prosecutors, as most prosecutors meet with the victim only once, and this is usually for an hour, 1 week before the trial. Often victims tell us that they have information and knowledge of the crime that the Crown is unaware of, and establishing a relationship between prosecutor and victim allows for a better prosecution, and most likely, a better chance of conviction. As it is, prosecutors may not know the best questions to ask, as they have the minimum of information. ... Victims have expressed frustration and lack of trust in the prosecution process, and feel disempowered by this distance between victim and prosecutor. (Court victim adviser)*

In terms of more support from police, points raised included easier access to police to have questions answered and regular updates on case progress, so victim/survivors had time to prepare themselves for each stage.

Other suggestions for how a victim/survivor's experience of the criminal justice system might be improved included the following.

**Improved environment and facilities:** Improvements in the environments victim/survivors come into contact with were also suggested, in particular when victim/survivors first report.

*Specialist staff on call to deal with victims in an environment where victims feel at ease, instead of watch house or reception counters where they may be lining up with offenders reporting on bail or other complainants reporting not so sensitive matters. Police stations are intimidating to some people, especially when they need to express personal experiences of sexual nature to police staff and have never been inside a Police Station before. (Police)*

There were some suggestions that this could be a one-stop shop separate from the police station where all parties were housed under one roof.

*'One-stop shop' for Adult Sexual Assault Investigation i.e. Police, DSAC, Safe Care, ACC all in the same facility, away from Central Station. (Police)*

*I believe a one-stop shop for all sex victims in Hawkes Bay would be fantastic. A place where victims could come to and be interviewed away from a police*

*station and have medical and support staff on hand to complete the medical examination and the like. I think this would be fantastic for the victim and staff and there would be closed consultation between all groups and possibly promote the early reporting for victims. Police stations are ugly and the interview rooms often cold and defaced via tagging – NOT a place for a victim!! (Police)*

Suggestions for improving court facilities included increasing the number of private rooms for victim/complainants, and ensuring there were facilities where the victim/complainant did not have 'to run the gauntlet' past the accused's friends and family. Other suggestions included more regular breaks for the victim/complainant during proceedings.

**Increase availability of ongoing support by those with specialist knowledge:**

Providing adequate funding to ensure support could be made available from those with specialist knowledge about victim/survivors' needs was highlighted by one court victim adviser.

*I would like to see agencies such as HELP funded to provide professional court support. A few years ago they did secure limited funding to do this role – it was invaluable to victims. Some victims do not want their close friends or family as support people. (Court victim adviser)*

**Specialist trained police and Adult Sexual Assault Teams:** Specialised Adult Sexual Assault Teams operate in only two areas in Auckland (Auckland City and Henderson). The availability of similar speciality teams in all areas was a suggestion some police (n=17) made. It was felt that this would increase the consistency of how victim/survivors were treated, and reduce the number of people dealing with each case.

*Having a specific unit of well trained detectives that deal with all sexual violation complaints from start to finish – whether or not they are historic. The victim still has too many people to speak with before the file is passed to an appropriately trained person. At the point the victim comes forward they should be passed to a trained police officer who knows how to deal with victims of these crimes. (Police)*

*If Christchurch has a Sexual Assault Team I believe there would be more consistency with how victims are dealt with initially and through the process to court. There would be more interagency liaison and I believe more support to the victim through officers meeting and liaising with safe care workers and other agencies. Also possibly more liaison with DSAC doctors with the investigators. (Police)*

## 8.5 Summary

### 8.5.1 Overall views on criminal justice system

The majority of respondents were supportive of victim/survivors reporting sexual violation to the police. However, only a few said they would recommend a friend or family member goes through the entire criminal justice system because of the likely trauma, with only a low probability of a guilty verdict being reached. Many commented that they saw no difference in how diverse groups of victim/survivors were treated by the criminal justice system or that they were all mistreated equally.

### 8.5.2 Attrition points

Attrition is defined as where a sexual violence case does not proceed from one phase of the criminal justice system to the next. However, the greatest loss of sexual violation cases occurs before criminal justice system processing as a result of non-reporting.

Possible reasons for the attrition of sexual violation cases that do enter the criminal justice system, included victim/complainant withdrawal, insufficient evidence to proceed, the suspect cannot be located, charges have been amended, the process has become too harmful for a victim/complainant, or the accused is acquitted.

### 8.5.3 Factors contributing to a low rate of conviction

Several factors associated with sexual violation cases were identified that made meeting the criminal standard of proof particularly difficult. These included:

- the nature of evidence, in particular a lack of corroborating evidence and difficulties in proving non-consent
- cross-examination tactics – the ability of the defence to discredit the victim/complainant as a reliable witness
- rights of the accused – the inability of the prosecution to challenge the accused when the accused uses their right to remain silent
- jury members' lack of understanding about the nature of sexual violation.

### 8.5.4 Survey respondents' suggestions for change

Survey respondents made suggestions in four areas to improve the criminal justice system for victim/complainants.

- **Change how a complainant gives evidence**, for example, by:
  - having greater judicial control over the nature and content of the cross-examination of victim/complainants
  - using alternative provisions to make it safer and easier for victim/complainants to give evidence, including considering whether giving evidence-in-chief via a video recording might be appropriate.

- **Change the availability and presentation of evidence by the accused/defence** by:
  - abolishing the accused's right to silence
  - increasing the admissibility of propensity evidence (similar convictions and previous similar behaviour)
  - requiring the full disclosure of defence evidence
  - placing more onus on the accused to prove consent had been given.
- **Educate juries and the public about sexual violation** by:
  - giving jurors more information before evidence is presented
  - using expert witnesses
  - having a public education campaign.
- **Consider alternative systems of criminal justice**, such as:
  - judge-only trials (either a single judge or panel of judges)
  - an inquisitorial system of justice
  - different options for verdicts
  - expediting trials
  - restorative justice
  - specialist courts.

Other suggestions on how the experience of victim/complainants might be improved included more specialisation by police and other criminal justice professionals; the ongoing provision of information for victim/survivors, and an improved environment and facilities for victim/survivors when reporting to police and during court hearings.

## Part six: Key findings

### 9 Key findings

This environmental scan surveyed two groups of individuals and agencies that respond to adult victim/survivors of sexual violence.

- **Community service providers:** specialist sexual violence agencies (SSVAs) (n=27), women's refuges (n=11), Victim Support offices (n=42), mental health counselling services (n=66), medical service providers (n=15), and other community agencies (n=18). These service providers respond to the needs of victim/survivors who do not access criminal justice services, as well as those who report their assault to police. The level of specialisation, the types of services offered, and the nature and extent of their interactions with victim/survivors varied considerably across survey respondents.
- **Criminal justice groups:** police (n=206), Doctors for Sexual Abuse (DSAC) regional liaison doctors (RLDs; regional co-ordinators of sexual assault doctors who perform forensic medical examinations) (n=10), court victim advisers (n=17) and Crown prosecutors (n=46).

The aim of surveying these individuals and agencies was to identify their views on:

- the factors influencing victim/survivors' access to the criminal justice system and non-criminal justice services
- victim services' capacity to meet victim/survivors' needs, including identifying gaps in services
- the views of victim services on 'what works' to promote recovery and resilience
- the impact of location on victim/survivors' ability to disclose sexual violence, particularly in respect of the level of services available locally, and have their needs met
- the views of police and prosecutors on the attrition of recorded sexual violation offences and the impact of systemic, organisational and other contextual factors on investigating and prosecuting sexual violation offences.

This chapter summarises the key findings in relation to these research objectives in four sections:

- victim/survivors' access to services, including their ability to disclose and impact of location (section 9.1)
- capacity of victim services: gaps, ways to improve (section 9.2)
- what works to promote recovery and resilience (section 9.3)
- criminal justice system: access and attrition (section 9.4).

## **9.1 Victim/survivors' access to services**

### **9.1.1 Awareness of services**

The environmental scan of community service providers highlighted the wide range of agencies that offer services to victim/survivors of sexual violence. Although service providers might exist, those needing their services can access them only if they are aware of the services.

Survey responses revealed that self-referral by the victim/survivor was the most common form of referral for all service providers except for Victim Support, where 85 percent came from police referrals. This reliance on self-referral points to the crucial importance of visibility and awareness of agencies and their services. It is concerning that service providers identified a distinct lack of information for victim/survivors about the services available. One way to improve access to service providers is to ensure they have sufficient resources to promote and advertise their services effectively.

SSVAs, in particular, identified improving access as an important factor in improving service delivery. They also felt addressing public misunderstandings about sexual violation/rape was important. This was seen as a way to reduce the stigma associated with rape that acted as a barrier to victim/survivors accessing services recognised as specialising in sexual violence.

### **9.1.2 Barriers to accessing services**

Survey respondents identified factors that, in their view, limited victim/survivors' ability to access the services they needed. These included victim/survivors' feelings of shame and self-blame, with many believing their actions had contributed to the sexual violation, and being influenced by common rape myths. Addressing public misunderstandings about sexual violation was seen as an important way to improve understanding and counter rape myths. Further, as survey respondents pointed out, it is only those who recognised, and could name, their experience as 'rape' that were likely to seek assistance.

The cost of services was another frequently mentioned barrier, particularly in relation to accessing emotional support services. Many Accident Compensation Corporation (ACC) counsellors commented that they had to charge a surcharge because services were not fully covered by ACC funding. The costs of transport and childcare to enable victim/survivors to access services were also seen as prohibitive for some, particularly those in rural areas. Fully funding treatment services and providing the supports necessary to enable victim/survivors to get to services would ensure victim/survivors could access appropriate responses.

A significant barrier to accessing mental health counselling was the ineligibility for ACC funding for those now living in New Zealand but whose sexual violence occurred outside of New Zealand (e.g. Pacific peoples and other ethnic minority, migrant and refugee groups).

### **9.1.3 Impact of location on access to services**

A regional breakdown of perceived gaps in services suggested some regions around New Zealand are better resourced than others. For example, Canterbury was seen to be well resourced, but Bay of Plenty was seen to have insufficient services. The challenge is to increase the coverage of services to ensure victim/survivors in all regions can access services to meet their needs.

The particular types of services that were seen to be lacking in some areas included SSVAs and services for special groups (e.g. Māori and men). Access to 24-hour medical treatment and female doctors was also seen as insufficient in some areas. The greatest concern among survey respondents was the inadequacy of services to meet victim/survivors' needs for emotional support.

Survey respondents also suggested that victim/survivors in rural locations might have difficulty in accessing services, either because of a lack of services or because it was more difficult to ensure confidentiality. There was a risk of family members finding out when victim/survivors did not want them to know, or service providers being related or known to the victim/survivor or perpetrator. It is also important to recognise that rural areas require additional staff to compensate for the travel time required to cover wide geographical areas in order to see clients.

### **9.1.4 Access to services for diverse groups of victim/survivors**

Half the community service providers (52 percent) identified gaps in services in their own communities for victim/survivors who were migrants or refugees, and around one-third identified gaps in services for Pacific peoples, sex-workers, men and people with disabilities. For Māori victim/survivors the most pressing need was for more qualified/experienced Māori counsellors.

## **9.2 Capacity of victim/survivor services**

The perception gained from survey respondents was that, in general, coverage of community service providers offering a range of sexual violence services was reasonably good across New Zealand. Indeed, the majority of respondents thought there were sufficient services to enable victim/survivors to disclose to a formal agency if they wished to do so. What was less evident from the survey findings was the capacity of these services to deliver effective services. Survey respondents were asked what services they delivered, but they were not asked if they were sufficiently resourced (funding and staffing) to deliver the services offered.

### **9.2.1 Capacity limited by insufficient funding**

Looking at survey responses a little closer it appeared that while services may exist, the level of service provided can be compromised because of insufficient funding. This could put those delivering the services under extreme pressure, as they attempted to stretch their resources to provide the support they knew victim/survivors needed. Increased funding was identified as a top priority by those most likely to deliver crisis intervention to victim/survivors of sexual violence (SSVAs



and women's refuges) and by those most likely to be responding to the effects of sexual violence (mental health counselling services). Many of the other ways that agencies could see to improve the quality of services were also funding-related (e.g. more staff, more qualified and experienced staff, improved training, and improved facilities and equipment).

There were several references to the delays and waiting lists victim/survivors must face, particularly in relation to accessing counselling services. This again suggests that although services may exist, they may not be sufficiently resourced to meet the demand, or there may be insufficient qualified and experienced staff to deliver these services.

Further research should focus on whether service providers are adequately funded to deliver services they offer effectively.

### **9.2.2 Capacity to meet the needs of diverse groups**

Another concern that arose from respondents was the ability of service providers to deliver effective services to all groups of victim/survivors. Only a few services specialised in delivering services to specific groups, which means most minority groups of victim/survivors must rely on mainstream services. This is a concern, with many service providers having reservations about their ability to meet the needs of some groups of victim/survivors (e.g. ethnic minority groups, migrants, refugees, Pacific peoples, men, and people with disabilities). This suggests existing service providers need access to better training in order to work effectively with these groups and more efforts need to be made to develop diversity in the workforce, recruiting staff from diverse groups and then giving them specialist training in sexual violence.

It should be noted that not all victim/survivors preferred to deal with someone similar to themselves, but it is important they have a choice, which is rare today.

## **9.3 'What works' to promote recovery and resilience**

Respondents identified five groups of factors that work to promote recovery and resilience.

### **9.3.1 Specialist services**

The effect of any incident of sexual violence can be highly traumatic, making it imperative that those working with victim/survivors understand the factors that influence a victim/survivors' ability to recover and move on with their lives. As highlighted in this report, victim/survivors have high and complex needs. Individuals and agencies that are insufficiently qualified risk harming or further traumatising victim/survivors.

SSVAs are the only agencies that focus solely on victim/survivors, so they work with the greatest volume of victim/survivors. This means SSVAs are most likely to have developed the greatest expertise in understanding the needs of this client group.

Therefore, they are in the best position to provide crisis intervention, counselling, and follow-up work, all interventions identified as effective in promoting the recovery and well-being of victim/survivors.

The implication here is that victim/survivors from all areas of New Zealand must have access to SSVAs; currently, some regions have no SSVAs.

### **9.3.2 Effective counselling**

Many respondents saw counselling as one of the more effective ways to assist in the recovery and well-being of victim/survivors. This means the delays in gaining approval to access ACC-funded assistance, the lack of specialised counsellors, and the waiting lists of those who are available are concerns. Māori victim/survivors are over-represented as victim/survivors of sexual violence, which means the lack of specialised Māori counsellors is particularly important to address.

### **9.3.3 Good inter-agency collaboration**

Good inter-agency collaboration was identified throughout the report as an important aspect in the delivery of effective services. This is essential to enable referrals to the most appropriate support and allow multi-agency responses to ensure best outcomes. Yet many respondents (70 percent) suggested they did not have formal agreements with other agencies to ensure effective referrals occurred. It is important to consider the barriers to good collaboration among agencies and what enables positive collaboration models to develop and be sustained.

### **9.3.4 What works for diverse groups**

The importance of providing for the needs for specific groups of victim/survivors has been reiterated throughout this report. For example, the most valuable approach to promoting recovery and resiliency for Māori was seen to be the supply of specialist support services that provide a whānau-based holistic approach to treatment. Recognising that what works for diverse groups may be different is an important starting point, what is needed now is a better understanding of how the needs of diverse groups might vary.

### **9.3.5 Consistency of care**

There is much agreement among what works to promote the recovery and resiliency of victim/survivors of sexual violence. This includes services that are immediately accessible and affordable, offer a choice of services, are widely advertised, and are staffed by individuals who are appropriately skilled, approachable, knowledgeable and non-judgemental. The challenge is how to achieve consistency of such services ensuring effective services with competent staff are accessible to all.

## **9.4 Criminal justice system – access and attrition**

An environmental scan of criminal justice system processes revealed a complex system, involving protracted processes that victim/survivors had to negotiate. At several points in the system, seeking justice was seen to be re-traumatising for victim/survivors, and many respondents raised concerns about the system's ability to deliver justice for all victim/survivors.

The majority of respondents were supportive of victim/survivors reporting sexual violation to the police, but a smaller proportion said they would advise a friend or family member to go through the criminal justice system (only 20 percent of DSAC RLDS, 38 percent of service providers, 39 percent of Crown prosecutors, and 59 percent of police). Of particular note were the number of respondents who said their advice would depend on the individual circumstances of the case (e.g. if there was no corroborating evidence and the case relied on disproving consent, the vulnerability of victim/survivor, and whether the victim/survivor had been under the influence of alcohol or other drugs at the time of the assault). Such replies suggested a clear recognition among respondents that some types of victim/survivors are less likely to receive justice.

### **9.4.1 Access to criminal justice system**

Only one in ten victim/survivors chooses to report their assault to police. Community service providers identified the barriers to victim/survivors reporting as:

- shame and self-blame
- the fear of not being believed
- disbelief in the criminal justice system
- the fear of the consequence (retribution or reprisal by the perpetrator or public exposure)
- family or community pressure not to report.

It is important that police and other criminal justice professionals take into consideration these barriers when they respond to victim/survivors. However, the greatest difference will be made with interventions aimed at changing societal misunderstandings about the true nature of sexual violation.

Some survey respondents had concerns whether all groups of victim/complainants had equal access to justice. A few suggestions were made about factors that might limit justice to certain groups of victim/survivors (e.g. Māori, Pacific, young victim/survivors, or victim/survivors with an intellectual disability). Factors included credibility issues, and jury members' prejudices against certain groups. Family and community pressures on victim/survivors not to report or follow through with complaints was also noted in relation to Māori, Pacific peoples, other ethnic groups, migrants, and refugees.

## 9.4.2 Attrition of sexual violence cases

Clearly evident from this report was a continuing concern among survey respondents about the high rate of attrition of sexual violence cases that still exists in New Zealand (i.e. the high rate of reported cases that do not proceed from one phase of the criminal justice process to the next). Survey respondents identified factors that affected the reporting and successful prosecution of sexual violation offences. However, many of these factors appeared to confirm previously identified issues rather than offer new insights.

Police survey respondents perceived victim/complainant withdrawal to be the most common factor contributing to attrition at all points during the police processing of a complaint, except 'during investigation' when a police decision to discontinue because of insufficient evidence was more common. Victim/complainant withdrawal, while less common, could also occur during court proceedings. Some of the reasons police gave to explain why a victim/complainant might withdraw their complaint were:

- fear of the legal process (including fear of cross-examination by the defence, fear of facing the accused, and lengthy delays because of a protracted court process)
- being in a relationship with the accused (partners or acquaintances), and not wanting them to be convicted or go to jail, fearing retribution, or reconciling with the accused
- coming under pressure from a third party to make the initial complaint, and then subsequently withdrawing
- being under the influence of alcohol and other drugs – the victim/complainant decided after sobering up not to continue or was concerned that their level of intoxication might have contributed to the situation
- reporting only to inform police – some victim/complainants just want the police to know what has happened (or want safety or medical assistance) but do not want to make a complaint.

The other main reason for an initial report of sexual violence not to proceed was if the evidential threshold was judged not to have been met (e.g. evidence of a false complaint, insufficient evidence, or lack of corroborating evidence). Other less common reasons included charges being dropped or amended after plea bargaining, the case being dropped because of concern about the welfare of the victim/complainant, and defendant absconding or dying.

The final point of possible attrition is where, based on the evidence presented, the jury fails to find the accused guilty 'beyond reasonable doubt' and there is an acquittal. Police and Crown prosecutors pointed to several factors associated with sexual violation cases that made meeting the criminal standard of proof particularly difficult. These included:

- the nature of evidence, in particular the lack of corroborating evidence
- cross-examination tactics – the ability of the defence to discredit the victim/complainant as a reliable witness
- the rights of the accused – the inability of the prosecution to challenge an accused using their right to remain silent
- jury members' lack of understanding about the nature of sexual violation (and issues of consent).

Survey respondents made a range of suggestions for changes that might address these factors and increase the rate of conviction for sexual violence offences.

It is clear some of the factors contributing to attrition identified above are difficult, if not impossible, to address (e.g. the defendant absconding or dying) and others it would be inappropriate to do so (e.g. clear evidence of a false complaint).

Addressing other factors would require changes to criminal procedures (e.g. speeding up the trial process or altering what evidence is admissible and how it can be presented and cross-examined) or fundamental changes to the criminal justice system (e.g. judge-only trials, consideration of an inquisitorial system of justice, and specialist courts).

Others factors (e.g. victim/complainant withdrawal) might be reduced by increasing victim/complainant access to specialised support services and/or continuing and expanding specialist training of police and other criminal justice professionals to ensure they respond consistently and appropriately to victim/survivors. Improvements to the environment and facilities for victim/survivors when reporting to police and during court hearings might also improve the experience for victim/survivors.

While many of the above changes might reduce attrition, their effectiveness is likely to be limited because of entrenched attitudes and misunderstandings about the nature of sexual violation held by members of the criminal justice system (e.g. juries) and the public. Comments throughout this report have made it clear that the dominant stereotype of sexual violation/rape as an act committed by strangers is still pervasive. This greatly affects the ability of those whose sexual violation experience does not fit this stereotype to be able to access justice. Addressing this and countering other rape myths relies on more education of juries and wider society.

### **9.5 Concluding comment**

The strength of this report has been the bringing together of information about the agencies, services and systems that victim/survivors may come in contact with. The roles and responsibilities of the various groups have been described, and many of the processes a victim/survivor must negotiate have been provided. Consequently, our understanding of the capacity of these groups to respond effectively to victim/survivors and the factors that affect their ability to do so has been enhanced.

Findings have revealed a range of community service providers, with varying levels of specialisation that offer a variety of services and support to victim/survivors

throughout New Zealand. However, just because services exist, it does not mean victim/survivors can access them or that the services have the capacity to meet the all the needs of victim/survivors. Questions were raised about the adequacy of existing services to meet, in particular, the needs of victim/survivors in more remote rural areas and from diverse groups.

To improve service delivery it was clear that service providers required increased funding in order to employ a sufficient number of experienced and qualified staff, and ensure services were delivered in appropriate facilities. There was also a pressing need to increase qualified and experienced staff to work with Māori victim/survivors. Societal misunderstanding of the nature of sexual violence was also seen as a significant barrier to all victim/survivors being able to identify their experiences as sexual violation and to access appropriate support and justice.

Many of the concerns and criticisms identified in relation to the treatment of victim/survivors within the criminal justice system were not new. Improvements in some areas were recognised (e.g. legislative reforms, increased specialisation and training within police), but there was a strong sense that more needed to be done before victim/survivors could be guaranteed a fair and just system.

Key challenges are:

- deciding what needs to be done to ensure there is consistently good practice among all those who respond to victim/survivors
- gaining a better understanding of what is effective and fair practice for diverse groups of victim/survivors.

In relation to the criminal justice system, a further challenge to making changes will be to achieve the right balance between the needs of victim/survivors and the evidential needs of a justice system that has been designed to determine the accused's criminal liability.

The objectives and intended scope of this report were very broad. In attempting to present such a complete picture of all the agencies, services and systems that victim/survivors might come in contact with, there has been a trade-off in the inability to fully explore all the complexities of the information provided by survey respondents. Therefore, rather than providing all the definitive answers, this report provides a starting point for identifying issues that require more attention.



# Glossary of Māori terms

This glossary explains te reo Māori used in the report (Ryan, 1995).

hapū	sub-tribe
hauora	healthy – in this context referring to a local māori health service
hui	meeting
iwi	people, tribe
kaumātua	elder
kaupapa	theme, topic
kaupapa Māori	underpinned by Māori philosophies and practices
mahi	work
mana	integrity, prestige
Māori	indigenous people of New Zealand
marae	Māori meeting place
Pākehā	non-Māori, European
rangatahi	youth
koro	elderly man
kuia	elderly woman
tuakana–teina	in the context of this report, meaning roughly ‘inter-generational’; relates to status dynamics within Māori society where a younger person needs to show respect for their elders
te reo Māori	Māori language
tikanga	custom, rule, principles
utu	revenge or retaliation
whakamā	embarrassment or loss of mana, shy
whakapapa	genealogy, family tree
whānau	extended family
whanaungatanga	relationship, kinship





## References

- Campbell, R. (2006) 'Rape survivors experiences with the legal and medical systems: do rape victim advocates make a difference?'. *Violence against Women*, 12(1): 30–45.
- Campbell, R., and Raja, S. (1999) 'Secondary victimisation of rape victims: Insights from mental health professionals who treat survivors of violence', *Violence and Victims*, 14(3): 261–275.
- Freckelton, I. (1998) 'Sexual offence prosecutions: a barrister's perspective', in P. Eastaer (Ed.), *Balancing the Scales: law reform and Australian culture*. Leichhardt, Sydney: Federation Press.
- Herman, J. (2005) 'Justice from the victim's perspective', *Violence against Women*, 11(5): 571–602.
- Jordan, J. (2004) *The Word of a Woman? Police, rape and belief*. Houndmills, Basingstoke: Palgrave Macmillan.
- Kelly, L., Lovett, J., and Regan, L. (2005) *A Gap or a Chasm? Attrition in reported rape cases*. Home Office Research Study No. 293. London: Home Office.
- Kingi V., and Jordan, J., (with Moeke-Maxwell, T., and Fairbairn-Dunlop, P.) (2009) *Responding to sexual violence: Pathways to recovery*. Wellington: Ministry of Women's Affairs.
- Koss, M. (2000) 'Blame, shame and community', *American Psychologist*, 55(11): 1332–1343.
- Lievore, D. (2005) *No Longer Silent: a study of women's help-seeking decisions and service responses to sexual assault*. Report prepared by the Australian Institute of Criminology for the Australian Government's Office for Women. Canberra: Commonwealth of Australia.
- Lievore, D., and Mayhew, P. (2007) *The Scale and Nature of Family Violence in New Zealand*. Wellington: Ministry of Social Development.
- Lovett, J., Regan, L., and Kelly, L. (2004) *Sexual Assault Referral Centres: developing good practice and maximising potentials*. Home Office Research Study No. 285. London: Home Office.
- McDonald, E. (1997) "'Real rape" in New Zealand: women complainants' experience of the court process', *Yearbook of New Zealand Jurisprudence*, 1(1): 59–80.
- McFadzean, D., and Scott, K. (2005) 'Scottish criminal justice and the police', in D. Donnelly and K. Scott (Eds), *Policing Scotland*. Willan Publishing. Pp. 202–224.
- McIntosh, I. (2009) 'Important changes to criminal law.'  
<http://www.adls.org.nz/filedownload?id=fcf8e91a-3fd6-439c-9188-e9167e6939f6>.
- Mossman, E., Jordan, J., MacGibbon, L., Kingi, K., and Moore, L., (2009a) *Responding to sexual violence: A review of literature on good practice*. Wellington: Ministry of Women's Affairs.

Ministry of Women's Affairs  
PO Box 10 049, Wellington 6143  
tel: (04) 915 7112 fax: (04) 916 1604  
email: [mwa@mwa.govt.nz](mailto:mwa@mwa.govt.nz)

[www.mwa.govt.nz](http://www.mwa.govt.nz)