

October 2009

Responding to sexual violence

A review of literature on good practice



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



CRIME AND JUSTICE RESEARCH CENTRE

Te Puni Rangahau Taihara, Ture



Commissioned by
the Ministry of Women's Affairs

Responding to sexual violence: A review of literature on good practice

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

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 October 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
Website: www.mwa.govt.nz

ISBN 978-0-478252-43-9

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

Contents

List of tables	iv
Acknowledgements	vi
Executive summary	vii
Part one: Overview of adult sexual violence and good practice	1
1 Introduction	1
1.1 Project overview	1
1.2 Approach to reviewing the literature	2
1.3 Structure of report	3
2 Overview of sexual violence.....	5
2.1 Terms and definitions.....	5
2.2 Nature of sexual violence.....	6
2.3 Legal framework for sexual violation offences	11
2.4 Victim/survivor needs	13
3 Overview and critique of good practice.....	23
3.1 What does good practice relate to?	23
3.2 What are the criteria used to judge good practice?	23
3.3 What are the outcomes against which good practice is evaluated?	27
3.4 Who has the power to define good practice?	29
3.5 Use of good practice in this review	30
Part two: Summary of the literature	31
4 Medical system.....	31
4.1 Introduction	31
4.2 Sources of medical care	32
4.3 Forensic medical examination	36
4.4 Follow-up medical care	42
4.5 Responding to the needs of diverse groups – medical system	43
5 Mental health system	49
5.1 Introduction	49
5.2 Crisis intervention.....	53
5.3 Post-crisis mental health care.....	55
5.4 Responding to the needs of diverse groups – mental health	58

6	Criminal justice system	63
6.1	Introduction	63
6.2	Police practices and initiatives	64
6.3	Prosecutors and the prosecution service.....	76
6.4	Specialist courts	80
6.5	Criminal justice system victim advocates	82
6.6	Statutory reform	84
6.7	Restorative justice debate.....	89
6.8	Responding to the needs of diverse groups – criminal justice system	93
7	Support services	97
7.1	Introduction	97
7.2	Specialist sexual violence services	97
7.3	Non-specialist sexual violence victim support systems	104
7.4	Community collaboration	108
7.5	Responding to the needs of diverse groups – support services.....	109
	Part three: Summary	115
8	Good practice services for adult survivors of sexual violence.....	115
8.1	New Zealand guidelines.....	115
8.2	Applicability to New Zealand context	117
8.3	Good practice programmes and services	118
8.4	Common good practice principles for delivery	118
	Appendix: Methodology – search criteria and sources of references	125
	References	127

List of tables

Table 1: Key issues for service delivery for victim/survivors from diverse groups	x
Table 2: Access issues for victim/survivors who have disabilities	19
Table 3: Key issues for service delivery for victim/survivors from diverse groups	21
Table 4: Needs and priorities of different parties.....	28
Table 5: Māori and counselling	59
Table 6: Inquisitorial and adversarial justice systems	88
Table 7: Arguments for and against the use of restorative justice	91
Table 8: RESTORE restorative justice programme.....	92
Table 9: Continuum of service delivery: support services.	110
Table 10: New Zealand guidelines	116
Table 11: Good practice programmes and services	119

Table 12: Common good practice principles of delivery.....	121
--	-----

List of boxes

Box 1: New Zealand legal definition of sexual violation.....	5
Box 2: Incidence and prevalence of sexual violence – measurement issues	8
Box 3: Promising practice criteria	27
Box 4: Good practice principles in the provision of medical services.....	32
Box 5: Health outcomes of violence against women	33
Box 6: Good practice recommendations for hospital emergency rooms.....	35
Box 7: Good practice recommendations for primary health care providers	36
Box 8: Good practice principles for performing a forensic medical examination.....	39
Box 9: Summary of Accident Compensation Corporation principles of good practice	52
Box 10: Good practice recommendations for mental health crisis intervention	54
Box 11: Effective long term mental health interventions.....	57
Box 12: Consumers' perspective's on good practice for mental health services	57
Box 13: Good practice principles for police	65
Box 14: Good practice guidelines for prosecutors (victim-based)	77
Box 15: Good practice guidelines for prosecutors	78
Box 16: Good practice guidelines for non-government organisation specialised sexual violence support services	100
Box 17: Australian Centre for the Study of Sexual Assault – Rape Crisis Online initiative ..	103
Box 18: Australian Centre for the Study of Sexual Assault – 'Another layer of trauma' workshop	103
Box 19: Australian Centre for the Study of Sexual Assault – co-ordination of community services	104

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.

We would also like to acknowledge and thank the Ministry of Women's Affairs staff for identifying and supplying the literature and providing valuable feedback on the various drafts of the report: Dr Denise Lievore, the Research Manager, Nicole Benkert, Research Co-ordinator and Lynda Byrne, Senior Policy Analyst.

Important advice and feedback on this work was also provided by the members of the project advisory group. This group was made up of representatives from the Ministry of Justice, 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. We would also like to acknowledge the advice and support provided by the members of the project steering group.

Finally we would like to acknowledge and thank Professor Rachel Jewkes for peer reviewing the final report and providing insightful and valuable comments.

Executive summary

Part one: Overview of adult sexual violence and good practice

1 Introduction

This report responds to a request by the Ministry of Women's Affairs to the Crime and Justice Research Centre to conduct a critical literature review outlining international and New Zealand perspectives on good practice for services that respond to adult survivors of sexual violence.

With regard to medical, criminal justice, mental health and support systems at different post-assault periods and in relation to diverse social and cultural groups, the specific objectives of this review were to:

- identify and critique good practice models within and across systems, internationally and in New Zealand
- describe factors that promote good practice within and across systems
- identify New Zealand guidelines for dealing with adult victim/survivors of sexual violence.

The literature reviewed was that supplied by the Ministry of Women's Affairs following a comprehensive search by ministry staff to identify a variety of relevant literature. The findings from the literature review will contribute to the Government's considerations for policy and practice responses for victim/survivors of adult sexual violence in New Zealand.

By definition, a literature review can cover only written material. The information in the review, including the summary tables, should be read as a *list of practices on which literature is available and that have been evaluated or otherwise deemed as good practice according to various criteria*, rather than a definitive or complete list of good practices.

2 Overview of sexual violence

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 of *sexual violence*, with particular attention given to literature relating to responses to victim/survivors of *sexual violation*. For the purposes of this review, the legal definition of sexual violation used is as outlined in section 128 of the Crimes Act 1961, which covers rape and unlawful sexual connection.¹

Sexual violence can occur in a range of contexts, but universally it is recognised as being *predominantly* a crime in which the victim is female and the perpetrator is male. The common perception of rape is that the perpetrators are strangers and/or recent acquaintances, and it is this notion of rape that is most commonly thought of as ‘real rape’. It is this form of sexual violence that much policy and practice tends to be built around. However, rather than strangers, the majority of rapes are committed by men who are known to victim/survivors as date rapes, acquaintance rapes or marital rapes. There is also often a lack of recognition that much sexual violence involves repeated assaults by the same (and sometimes different) perpetrators, with a significant overlap between victim/survivors who have experienced both rape and domestic violence.

Incidence and prevalence

Rates of sexual victimisation among the population are an important indicator of the level of service provision that is required. The most recent New Zealand Crime and Safety Survey (NZCASS), undertaken in 2006, found a 12-month *prevalence* rate of 3 percent for individuals aged 15 years or older who had experienced one or more occurrences of sexual victimisation in 2005. This equated to 6.4 *incidents* per 100 adults (9 per 100 women, 3 per 100 men) that year.

Some groups of the population are at higher risk of sexual victimisation than others. New Zealand research indicated those at higher risk included:

- women
- younger women (15–24 years)
- Māori women.

¹ ‘Rape’ in New Zealand is defined as being penetration of the vagina by a penis (section 128(2) of the Crimes Act 1961); whereas ‘unlawful sexual connection’ involves penetration of the anus, mouth or vagina by a penis, finger or an object (section 128(2) of the Crimes Act 1961).

Reporting and conviction rates

In New Zealand, estimates suggest just one in ten victim/survivors report sexual violence to the police. According to New Zealand Police data on recorded crime, this equates to just over five cases per 10,000 of population per year (equates to 2,364 cases in 2007/08). Moreover, among those who do report to the police there can be substantial attrition. This means only a small proportion of victim/survivors are choosing to access the criminal justice system.

Legal framework for sexual violation offences

There have been several significant reforms of the New Zealand legal system over the last two decades related to how crimes of sexual violence are dealt with in the criminal justice system. Despite these reforms there are still concerns that rape victims' experiences of the criminal justice system have not substantively improved and that a 'justice gap' remains. In response to some of these concerns, the Ministry of Justice recently issued a discussion paper to solicit the public's views about several proposed legislative amendments to the current law on sexual violence (Ministry of Justice, 2008).

Victim/survivor needs

The literature on effective service delivery for those who have experienced sexual violence presents findings as if victim/survivors were a homogenous group. It is likely that many of the findings will also relate to diverse populations of victim/survivors. However, good practice in service delivery requires an understanding of the unique needs of diverse populations of victim/survivors, particularly when these groups are often over-represented as users or potential users of sexual violence services. While the needs and issues of each group have been presented as distinct groups, there will of course be overlaps between groups (e.g. young, Pacific, transgendered sex workers), which would result in accumulated needs and in some cases increased risk.

Whilst acknowledging the importance of cultural competence in service delivery, guidelines note that it is important to consider each client as an individual and not make assumptions regarding the type of cultural approach that is appropriate or desirable for that person. It is also useful to consider the extent to which approaches considered culturally appropriate may also be good practice for all victim/survivors.

Table 1: Key issues for service delivery for victim/survivors from diverse groups

Group	Key issues
Māori	<p>Involvement of culturally appropriate supports and extended family</p> <p>Adherence to Māori models of health and well-being</p> <p>Māori personnel in existing services and the development of Māori services</p>
Pacific	<p>Involvement of extended family</p> <p>Provision of relevant information about formal services in Pacific languages and English</p> <p>Ensuring confidentiality</p> <p>Pacific personnel in existing services and the development of Pacific services.</p> <p>Understanding of the role of the church</p>
Young adult	<p>Confidentiality – especially in relation to parental disclosure</p>
Male	<p>Reassurance and counselling about masculinity and sexuality</p> <p>Dealing with issues around historical offences</p>
Gay, lesbian, bisexual, transgender, intersex	<p>Impact of homophobia of service providers</p> <p>Transgender counselling</p>
Victim/survivors with disabilities	<p>A range of access issues in relation to diverse disabilities</p> <p>Gaining informed consent of people with intellectual disabilities may be difficult</p> <p>The caretaker, family member or friend accompanying the victim/survivor may be the perpetrator</p> <p>Being recognised as credible by police and prosecution</p>
Rural	<p>Isolation – social and geographic</p> <p>Lack of service provision</p> <p>Familiarity, confidentiality and anonymity issues</p>
Sex-worker	<p>Multiplicity of social problems that can include drug abuse and social isolation</p> <p>Fear of public exposure and prejudice of mainstream services pose problems in accessing services</p>
Ethnic, migrant, refugee	<p>Diverse needs dependent on pre-migration experiences</p> <p>Language and communication difficulties, leading to issues around ascertaining informed consent and gaining evidential information</p> <p>Social isolation</p>

3 Overview and critique of good practice

In reviewing what is considered 'good practice', it is important to distinguish between two distinct applications.

- **The type of service delivery:** This is the particular type of adult sexual violence services that have been identified as good practice. This could be either a general category (e.g. forensic nursing) or a particular programme (e.g. Sexual Abuse Nurse Examiners programme).
- **The principles of delivery:** Good practice can also refer to principles of delivery (e.g. culturally appropriate or victim-centred). These principles can relate to a number of types of programmes and are critical factors in achieving successful outcomes.

The next issue is to understand the criteria used to identify a type of programme or principle of delivery as being 'good practice'. This is difficult when there is no agreed definition of what constitutes a 'good practice', 'best practice' or 'promising practice' in respect of sexual violence service provision. However, a review of other fields revealed a range of different types of criteria. This included good practice identified through:

- **proven effectiveness based on research evidence**
- **practice reflected in current trends** with promising initial reports
- **knowledge-based practice** that recognises the validity of experience of professional practitioners and the lived experience of service users.

The most practical and relevant set of criteria for sexual violence was that developed by the Australian Centre for the Study of Sexual Assault to identify 'good practice programmes'. The centre's criteria value 'evidence' and 'knowledge-based practice' but within a flexible framework as outlined below.

- **Compulsory criteria:**
 - have a clear focus: have a clearly defined conceptual framework, clear aims, and clear desired outcomes
 - take account of contemporary research and practice developments in the field of sexual assault
 - position diversity as key to the development, understanding and delivery of good practice models
 - demonstrate a sensitivity towards the barriers faced by victim/survivors in disclosing and reporting sexual assault, and other difficulties, if relevant
 - include processes of accountability and evaluation.
- **Optional criteria:**
 - are replicable (that is, able to be used by others)
 - have been evaluated as successful.

Unfortunately, whilst advocating this set of criteria as the most useful to the sexual violence sector, there was seldom sufficient information in the literature reviewed to evaluate initiatives against these criteria.

In reviewing the literature on good practice four final points should be considered.

- **Goals and priorities against which good practice has been measured:** There is much diversity in the needs and priorities of the various people and agencies involved (e.g. the victim/survivor, medical care provider, police, prosecutors and the court, mental health providers, community support groups). Whilst they may overlap, in some cases they may also be in conflict. For example, good practice according to support agencies may be that the victim/survivor's emotional needs be paramount at a time when the police require intensive questioning. Good practice for police is that which assists in the timely collection of uncontaminated forensic evidence, when a support agency might advocate that a victim/survivor's physical desire for a shower and a drink is the priority. An awareness of the different goals and priorities against which good practice is being measured is, therefore, an important consideration.
- **Input from victim/survivors in defining good practice:** Typically it is professional organisations and government departments that have the resources and power to make decisions and write policies regarding good practice, as opposed to the victim/survivors themselves who are most aware of their interests and needs. However, it is important that there is input from victim/survivors, otherwise organisations are in danger of devising systems that may be internally efficient but ineffective in terms of responsiveness to the needs of their client groups.
- **'Best' practice or 'good' practice.** Not only might what is best for victim/survivors be different from what is best for the police or other organisations, but what is best for particular victim/survivors may differ according to, for example, cultural background, gender or urban/rural context,. There is, accordingly, a growing tendency to move away from identifying 'best' practice to acknowledging a range of 'good' practices instead.
- **Applicability to New Zealand context.** There is limited research on the effectiveness of adult sexual violence services; what there is tends to come from overseas researchers, based on evaluations of programmes and initiatives in their jurisdiction. Hence, whether these findings are applicable to the New Zealand context, and in particular for Māori victim/survivors, must be considered.

Part two: Summary of the literature

The second part of this report presents a review of available literature on what is considered good practice across the four main service systems with which victim/survivors are likely to come in contact: medical, criminal justice, mental health and community support systems. Published New Zealand practice guidelines that prescribe how services should respond to adult victim/survivors of sexual violence are highlighted.

4 Medical system

Immediately following a rape, a victim/survivor needs to have any medical needs met, but for those who wish to bring the offender to account there may also be a need for forensic evidence to be collected. The co-occurrence of these needs results in the convergence of two different systems.

- Medical system – assessing and treating health concerns.
- Criminal justice system – collecting forensic evidence.

These two systems both involve medical intervention and are typically addressed together in what is referred to as the ‘**forensic medical examination**’. There is good coverage in the sexual violence literature on what is considered good practice in conducting a forensic medical examination, who should conduct it, where it should be conducted and the conditions under which it should be conducted.

Longer-term medical needs of victim/survivors may include ongoing treatment for sexual and reproductive health problems, pain syndromes, eating disorders and gastro-intestinal problems.

New Zealand guidelines located – medical system

The following New Zealand guidelines on how health care professionals should respond to adult victim/survivors of sexual violence were identified.

Sexual violence-specific guidelines

- *The Medical Management of Sexual Assault* (DSAC, 2006)

Generic guidelines with relevance to victim/survivors of sexual violence

- *Family Violence Intervention Guidelines: child and partner abuse* (Ministry of Health, 2002)
- *Screening, Risk Assessment and Intervention for Family Violence Including Child Abuse and Neglect* (Standards New Zealand, 2006)
- *Pacific Cultural Competencies: literature review* (Ministry of Health, 2008)

The generic guidelines provide the limited information available for appropriate ways of responding to victim/survivors from diverse groups including Māori and Pacific people.

Good practice programmes and services – medical system

International sources of literature identified the following as a good practice programme.

Forensic nursing – the use of specially trained forensic nurses providing 24-hour, first-response care to sexual assault patients in hospital or non-hospital settings.

Good practice principles of delivery – medical system

The review of the literature on good practice principles of delivery of medical care to victim/survivors is largely limited to international sources. The World Health Organization has published several general principles that should be considered as indicators of good practice in the provision of medical services to victim/survivors of sexual violence (WHO, 2003).

- The health and welfare of the patient (victim/survivor) is the foremost priority.
- Ideally, the health care and legal (forensic) services should be provided at the same time and place by the same person.
- Health workers should receive special training in providing services for victim/survivors of sexual violence and should also have a good understanding of local protocols, rules and laws applicable to the field of sexual violence.
- There should be a constructive and professional relationship with other individuals and groups treating and assisting the victim/survivor or investigating the crime.
- Health workers should be free of bias or prejudices and maintain high ethical standards in the provision of these services.
- Resource constraints may preclude the possibility of service provision in an ideal environment, but it is possible to improve the quality of existing facilities by ensuring they are accessible, secure, clean and private.

Hospital emergency rooms

No statistics are available on the proportion of victim/survivors treated in hospital emergency rooms in New Zealand, but at least some are referred there for forensic medical examinations or because of emergency medical needs. Good practice principles for emergency rooms based on United States research are:

- provide rape crisis advocates – let people know that they are available, so they do not have to ask

- provide comprehensive treatment, including pregnancy testing, screening for sexually transmitted infections including HIV/AIDS, and crisis counselling – if the hospital is unable to deliver, make referrals
- screen for sexual violence in the emergency room – both verbally and on intake forms
- have more specially trained clinicians
- provide better training for clinicians who handle sexual assaults – needed if the hospital is not a certified sexual assault forensic exam centre of excellence
- decrease waiting time in the emergency room.

Primary health care

In New Zealand, non-specialist primary health care for victim/survivors is typically delivered through community-based medical centres by the local general practitioner, Family Planning or Sexual Health Clinic. These medical centres can provide acute post-rape care and longer-term and/or follow-up care. These groups provide health care to the majority of victim/survivors who require medical care but do not wish to report their sexual assault to the police. Very limited literature was located about primary health care service providers working with victim/survivors of sexual violence. Information is limited to that included in the New Zealand knowledge-based practice guidelines listed above, of which the guidelines published by Doctors for Sexual Abuse Care (DSAC, 2006) are particularly useful.

The only other literature located on good practice recommendations for primary health care providers was based on Australian experiences. This included the following recommendations.

- Ensure that all discussions about sexual violence occur in a safe place where interruptions that could violate confidentiality cannot occur.
- Establish a relationship of trust by empowering the victim/survivors and supporting them to make their own decisions on treatment and recovery.
- Consider the traumatic potential of a range of procedures such as cervical smear and gynaecological examinations.
- Inform the victim/survivor that sexual assault is a crime and a violation of their human rights.
- Provide psychological support and appropriate referrals.
- Keep records in a form to provide victim/survivors' information to specialist sexual assault agencies, legal or other services within the community at the victim/survivors' request.

Forensic medical examination

There was good coverage in international and New Zealand literature on good practice principles for performing a forensic medical examination.

- Victim-centred approach
 - Informed choice and consent – victim/survivors should be provided with sufficient information to decide whether they want the examination, who will perform it and who will be present. It is important that they feel in control of the process
 - Ongoing communication – there should be ongoing communication between the medical practitioner and victim/survivors, explaining what each step involves and what its purpose is.
- Conducted when?
 - As soon as possible – to maximise the collection of forensic evidence and to avoid the victim/survivor experiencing unnecessary delays.
- Conducted by whom?
 - A specialist trained examiner – skilled not just in the collection of evidence, but also in understanding the impacts of sexual assault, and able to conduct the examination in a way that minimises the risk of secondary victimisation
 - A female examiner.
- Conducted how?
 - Respectfully – conducted in a professional but caring manner
 - Providing support – involvement of advocates/women's non-government organisations throughout, including proactive follow-up.
- Conducted where?
 - An appropriate environment – an environment that is safe, private, respectful and caring, and that is well equipped and has sterile conditions to ensure no contamination of evidence.

5 Mental health

Rape is considered to be one of the most severe types of trauma. Research indicates that in the aftermath of sexual assault some women may experience relatively short-term effects, while others will have chronic, long-lasting symptoms.

In New Zealand, crisis intervention by health professionals may be delivered by 'on-call' specialist sexual violence service crisis workers and counsellors and/or specialist sexual abuse doctors at the time of the forensic medical exam. Long-term interventions are delivered by counsellors or psychologists who are affiliated with specialist sexual violence services or working independently in the community. Many will be Accident Compensation Corporation (ACC) registered counsellors who can provide government-funded counselling to victims of sexual abuse, including sexual violation. Victim/survivors also receive treatment through non-specialist,

mainstream mental health services, particularly if they have pre-existing mental health concerns.

New Zealand guidelines located – mental health

New Zealand mental health practitioners have access to the recently published and comprehensive ACC guidelines on how criminal justice professionals should respond to adult victim/survivors of sexual violence.

Sexual violence–specific guidelines

- *Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand* (ACC, 2008).

Good practice programmes and services – mental health

The literature on the types of mental health programmes that are most effective for victim/survivors of sexual violence is sparse. The review highlighted a gap in knowledge about what types of counselling therapies or modalities are used in New Zealand and by whom.

Limited international sources identified the following.

Trauma-focused cognitive behavioural therapy approaches (e.g. prolonged exposure treatment, stress inoculation training and cognitive processing therapy) – for reducing short-term post-rape fear and anxiety symptoms.

This lack of research means interventions currently available may or may not be the most appropriate ones to respond to a victim/survivor's needs.

Good practice principles of delivery – mental health

Comprehensive guidelines for New Zealand mental health practitioners are provided in the ACC guidelines referred to above. The practice guidelines are organised into two parts. Part one: Principles and recommendations comprise 12 principles and recommendations designed for work with sexual violence victim/survivors within bicultural New Zealand. The recommendations are based on the best practice identified by the research. In Part two: Practice guide, the research findings are elaborated and greater detail is provided to support the 12 principles and recommendations.

Mental health crisis intervention

Counselling is beneficial through all stages of recovery, but crisis intervention during the initial stages immediately after rape is crucial to the health and well-being of victim/survivors. A combination of New Zealand and international sources identified the following good practice guidelines for mental health crisis intervention.

- Where possible, gather background information before arrival at the victim/survivor's location.

- Restore psychological safety by reassuring the victim/survivor that they are now safe.
- Assess the needs of the victim/survivor (information, medical care, counselling, support, legal assistance).
- Seek only the history required, avoid re-traumatising the victim/survivor by requiring them to verbalise and 're-live' the trauma unnecessarily.
- Correct misattributions.
- Provide information to the victim/survivor, including medical status, common reactions to assault and how to obtain further help.
- Distress can result in a limited capacity for the victim/survivor to make decisions. It may be necessary to transfer normal responsibilities and obligations to another individual. However, avoid inappropriately taking over decisions for the victim/survivor that risk replicating the dynamics of the assault.
- Restore and support effective coping.
- Show concern and empathy and encourage hope.
- Arrange for follow-up intervention as necessary.

Consumer perspectives on mental health care

New Zealand research with victim/survivors of sexual violence resulted in the following recommendations for support agencies and counsellors providing both crisis and long-term mental health care and support.

- All districts should have a well-publicised 24-hour crisis service available for rape/sexual assault victims, with personal service guaranteed (as opposed to reliance on answer-phones at night).
- Support agencies should ensure that all services are provided and conducted in an empowering and validating manner in order to avoid secondary victimisation.
- A limited number of appropriate counsellors should work as part of a multidisciplinary team with police and doctors to provide integrated service delivery.
- The availability of specialised rape/sexual assault counsellors within any generic support agency should be facilitated. These need to be carefully selected people, trained with a thorough knowledge and understanding of the needs and effects of rape, as well as an awareness of police and court processes.
- Counsellors should be flexible in adapting their style to the victim/survivor's needs, to ensure that the survivor retains a sense of their own power and autonomy within the therapeutic relationship.

6 Criminal justice system

The criminal justice system is the network of courts and legal processes that deals with the enforcement of criminal laws, including the laws that prohibit sexual violation. Key components and players are the complainant (the victim/survivor of the sexual violence), the accused (the perpetrator), the police, lawyers, judges and the court system itself. The collection of forensic evidence is also part of this system but is addressed in this review as part of the medical system.

Key concerns for the criminal justice sector in New Zealand and internationally are the low rates of reporting, prosecution and conviction of sexual violence offences and the potential secondary victimisation of victim/survivors who engage with this system.

New Zealand guidelines located – criminal justice system

The following New Zealand guidelines on how criminal justice professionals should respond to adult victim/survivors of sexual violence were identified.

Sexual violence–specific guidelines

- Adult Sexual Assault Investigation Policy (New Zealand Police, 1998)

Generic guidelines with relevance to victim/survivors of sexual violence

- *Prosecution Guidelines* (Crown Law Office, 1992)
- *Restorative Justice in New Zealand: best practice* (Ministry of Justice, 2004)

Good practice programmes/services – criminal justice system

International sources of literature identified the following as good practice.

Specialist courts, prosecutors and investigation units – specialisation is a way to develop and focus expertise as well as a way to send a message to the community that sexual offending is being taken seriously. It also aims to minimise the risk of secondary victimisation to victim/survivors.

Investigative interviewing techniques – to obtain complete, accurate and reliable information when interviewing victims, witnesses and suspects.

Good practice principles of delivery – criminal justice system

International sources identified the following six good practice principles of delivery for police when responding to victim/survivors of sexual violence.

- A dual focus on supporting the victim/survivors of violence and bringing the perpetrator to justice.
- Specialised ‘violence against women’ units staffed by specially trained personnel, who enable women to feel supported and work to prevent secondary victimisation.

- Safe and confidential environments for women to report violence.
- Consistent procedures in investigations of violence, and in protecting victim/survivors from secondary victimisation.
- Police co-ordination with other services in a co-operative, multi-agency response.
- Compulsory, ongoing and accredited training on issues surrounding violence against women.

New Zealand and overseas researchers have identified several factors related to the prosecution phase of sexual offending that were valued by victim/survivors. These factors are:

- victim/survivors are informed of case progress and have sufficient time to re-read statements
- waiting times and delays are minimised
- prosecutors meet and establish rapport with the complainant before the trial
- prosecutors are familiar with the facts of the case and provide courtroom advocacy that does 'justice' to the complainant's account.

These practices mirror many of the principles of good practice that have been developed for overseas lawyers working with clients who have experienced sexual violence.

7 Community support systems

A variety of support services are available in the community for victim/survivors of sexual violence. These include services that specialise in supporting victim/survivors of sexual violence, and non-specialist services that victim/survivors can also access for support. However, little is known about how well these support services meet the needs of victim/survivors.

New Zealand guidelines – support systems

No guidelines were located that specifically outlined good practice for support agencies working with victim/survivors of sexual violence.

Good practice programmes and services – support systems

Literature on the types of community support services that are most effective for victim/survivors of sexual violence was inconsistent with some areas covered better than others (e.g. there was extensive literature on sexual assault referral centres (SARCs) and very little on other specialist services). SARCs have attracted much attention and built up a strong body of evidence. Other types of intervention have received less attention and their effectiveness is unknown. Limited international sources identified the following.

Sexual assault referral centres bring together all the different legal and medical agencies in one place. There are no SARCs in New Zealand, but they have become popular in several countries overseas, including Australia, the United Kingdom, the United States, Canada and South Africa.

Community-based specialist sexual violence support services.

Those who have compared SARCs and specialist sexual violence support services have argued that each type has particular strengths and roles. Hence, it is vital that both services are available – one should not be implemented at the expense of the other. Support services need to be available to assist in the recovery of all victim/survivors of sexual violence, irrespective of whether they have reported the offence.

Good practice principles of delivery – support systems

Rape Crisis Network Europe has compiled key dimensions of good practice for community agencies supporting victim/survivors of sexual violence. The key dimensions are:

- ideological foundations – recognition that the organisational ethos guides service delivery
- a client-centred approach – action that focuses on the needs of the woman in crisis
- accessible services – offering a broad range of supports for victim/survivors
- promoting awareness and values – challenging myths about sexual violence
- improving societal responses to sexual violence – through education, awareness raising, advocacy and lobbying.

8 Summary and overview

In summary, in regards to the medical system there are comprehensive New Zealand guidelines related to the medical care of victim/survivors. There is good coverage in the literature on good practice for conducting a forensic medical examination. Forensic nursing is an initiative that has been implemented overseas and reviewed favourably. Its applicability to New Zealand would need to be assessed carefully, particularly the status of nurses in court as ‘ordinary witnesses’. There is a paucity of literature in relation to non-specialist primary health care.

The criminal justice system in New Zealand has undergone significant reform and the legal framework continues to be reviewed. There is a police policy for the investigation of adult sexual violence offences, which includes many of the good practice principles of delivery identified in this review. The extent to which the policy has been implemented and is adhered to is less clear. Specialisation is recognised as good practice particularly within the criminal justice systems, and the introduction

of specialist adult sexual assault teams within police is clearly positive. However, specialisation is still limited within the police and has not extended to the prosecution section of the criminal justice system.

There are comprehensive practice guidelines for the mental health care of victim/survivors in New Zealand that are easily accessible to all practitioners. There is very limited research internationally or in New Zealand about which types of mental health interventions are the most effective for victim/survivors.

New Zealand has a very pro-active network of specialist sexual violence support services with good links with other agencies, and a range of other non-specialist sexual violence victim support agencies. No practice guidelines were located in relation to support services in New Zealand, although it is not known whether individual agencies have their own 'in-house' documents.

This review has found that effective interventions with adult victim/survivors of sexual assault have received little research attention overseas, and in New Zealand this is limited to the efforts of just a few researchers. However, a plus of this New Zealand research is the priority given to the voice of the victim/survivor. Areas in most urgent need of research attention include:

- locating or developing guidelines for community support agencies working with victim/survivors of sexual violence
- developing guidelines for prosecutors working with victim/survivors of sexual violence
- developing guidelines and services to respond effectively and appropriately to Māori victim/survivors, particularly in relation to the criminal justice system
- developing guidelines and services to respond effectively and appropriately with other diverse groups of victim/survivors
- ensuring better monitoring and evaluation of the extent to which existing policies and guidelines have been implemented and adhered to
- obtaining ongoing feedback from victim/survivors on how effectively and appropriately services are responding to their needs.

The good practice highlighted in this review has relied heavily on overseas research. The unique characteristics of New Zealand mean it will be essential to carefully assess this practice for its applicability to New Zealand, particularly before any decisions regarding implementation are made. Consideration of diverse population groups and their needs is also essential, and collaboration with local groups and communities will ensure service delivery fits the local context.

Ensuring adult victim/survivors of sexual violence have access to the optimal services to assist in their recovery and well-being is crucial. This review has identified a variety of good practice programmes and principles of delivery for adult victim/survivors of sexual violence. Providing we critically assess who has identified these practices, on what outcomes and with what criteria, and ensure that the needs of victim/survivors remain paramount, then we are making a promising start.

Part one: Overview of adult sexual violence and good practice

1 Introduction

This report responds to a request by the Ministry of Women's Affairs to the Crime and Justice Research Centre to conduct a critical literature review, outlining international and New Zealand perspectives on best practice for services that respond to adult survivors of sexual violence.

1.1 Project overview

As part of its work to improve women's well-being, the Ministry of Women's Affairs is leading a research project on effective interventions for adult victim/survivors of sexual violence. The project has four interrelated work streams, comprising:

- 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 and Jordan, 2009)
- an environmental scan of agencies and key informants that respond to victim/survivors, focusing on systemic, organisational and other contextual factors that influence systems' and agencies' responses (Mossman et al., 2009b)
- a retrospective analysis of attrition of sexual violation incidents recorded by the New Zealand Police (Triggs et al., 2009)
- this literature review of good practice in service delivery for services that respond to adult victim/survivors of sexual violence (the literature review).

The findings from these work streams will contribute to the Government's considerations for policy and practice responses for victim/survivors of adult sexual violence. The Ministry of Women's Affairs is leading the research in partnership with the Ministry of Justice and New Zealand Police.

In May 2008, the Ministry of Women's Affairs contracted researchers from the Crime and Justice Research Centre, Victoria University of Wellington, to undertake all four work streams.

1.1.1 Objectives

With regard to medical, criminal justice, mental health and support systems at different post-assault periods and in relation to diverse social and cultural groups, the specific objectives of this work stream are to:

- identify and critique good practice models within and across systems, internationally and in New Zealand
- describe factors that promote good practice within and across systems
- identify New Zealand guidelines for dealing with adult victim/survivors of sexual violence.

The findings from the literature review will contribute to the Government's considerations for policy and practice responses for victim/survivors of adult sexual violence in New Zealand.

1.2 Approach to reviewing the literature

1.2.1 Sourcing the literature

The literature reviewed was supplied by the Ministry of Women's Affairs following a comprehensive search by ministry staff to identify a range of relevant literature.² The scope of the literature review, combined with the tight time-frame for completing the report, did not allow for an exhaustive analysis of all relevant literature produced over recent decades. Details of the search criteria and sources of references are in the Appendix.

The parameters for the review were as follows.

- The review focused on intervention services for adult victim/survivors of sexual violence.^{3,4}
- The review was primarily limited to international literature published in the past five to seven years to reflect substantial changes in responses to sexual violence in recent years.
- All relevant New Zealand literature was included. Very few victim/survivor sexual violence services have been evaluated. Therefore, New Zealand literature is also included that relates to victims in general, providing it had relevance for victim/survivors of sexual violence.

² The Crime and Justice Research Centre reviewed the literature supplied by the Ministry of Women's Affairs. Where a relevant primary source was referred to in the literature but was unavailable, we have cited the secondary source that was reviewed. In this case we have referred to both sources in the text, but included in the references list only the secondary source that was actually used.

³ The review does not cover best practice principles in relation to prevention of sexual violence – this is beyond the scope of this research, which focuses on the services and needs of victim/survivors.

⁴ An adult is defined as a person aged 16 years or older at the time of the assault. While it is recognised that some victim/survivors of adult sexual violence are also survivors of childhood sexual abuse, this is beyond the scope of this review.

It is important to note that the focus of this review is on the services and needs of victim/survivors of sexual violence. The services and needs of sexual violence offenders were not reviewed.

1.2.2 Scope of the literature review

The review primarily focuses on literature relating to sexual violence, with minimal inclusion of generic literature that could have some relevance to sexual violence, such as material on Māori mental health and education, or on different types of trauma-based therapy. Māori models tend not to be tested or evaluated within a Western framework.

1.2.3 What can and cannot be inferred from a review of literature

By definition, a literature review can cover only written material. There is a question about who determines the types of practices that are evaluated and/or written about in the professional literature. There may be other responses (e.g. therapeutic approaches) that are endorsed by practitioners and survivors, but have not been described or evaluated by knowledge-makers.

The information in the review, including the summary tables, should be read as a list of practices on which literature is available and that have been evaluated or otherwise deemed as good practice according to various criteria, rather than a definitive or complete list of good practices.

The reviewers were not asked to critically assess gaps in New Zealand services, to evaluate New Zealand services against good practice standards, or to determine what types of practices used in other countries might be suitable for implementation or adaptation in the New Zealand context. This report should not be seen as conclusive evidence of good practice or as endorsing any particular practices.

1.3 Structure of report

Part one of the report provides important background information, including an:

- overview of sexual violence (chapter 2)
- overview and critique of good practice (chapter 3).

Part two reviews the literature on good practice in relation to the four key systems that respond to victim/survivors of sexual violence. The systems are the:

- medical system (chapter 4)
- mental health system (chapter 5)
- criminal justice system (chapter 6)
- support services system (chapter 7)

Part three brings together the New Zealand guidelines identified for dealing with victim/survivors of sexual violence (chapter 8). It also summarises what are

considered good practices in responding to adult survivors of sexual violence, based on the literature that has been reviewed. There is consideration of the New Zealand context with a note that good practice identified overseas is only good practice in New Zealand if it works within this context.

2 Overview of sexual violence

This section provides an overview of sexual violence. It outlines terms and definitions relevant to this report and presents a general overview of the characteristics and prevalence of sexual violence.

2.1 Terms and definitions

2.1.1 Sexual violence

‘Sexual violence’ is a broad term that covers a continuum of sexual offending behaviours.⁵ The Ministry of Women’s Affairs has a particular interest in what is considered good practice in responding to victim/survivors of ‘sexual violation’ (i.e. rape or unlawful sexual connection as outlined in section 128 of the Crimes Act 1961 – see Box 1).⁶

Box 1: New Zealand legal definition of sexual violation

‘Sexual violation’ is the act of a person who rapes another person or has unlawful sexual connection with another person (section 128(1) of the Crimes Act 1961).

‘Rape’ in New Zealand is defined as being penetration of the vagina by a penis (section 128(2) of the Crimes Act 1961); whereas **‘unlawful sexual connection’** involves penetration of the anus, mouth or vagina by a penis, finger or an object (section 128(2) of the Crimes Act 1961).

However, much of the literature reviewed, whilst encompassing sexual violation, tended to refer to sexual violence and to be related to the broader spectrum of sexual offending. This has meant that, while there has been particular attention to literature relating to sexual violation, the focus of the review has been on good practice in responding to victim/survivors of sexual violence.

⁵ Sexual assault is a similarly broad term used to describe any acts of unwanted sexual contact (Ballard and Alessi, 2002). We use this term interchangeably with sexual violence.

⁶ It should be noted that some international definitions of rape differ slightly from the legal definition set out in the New Zealand statute. The term ‘rape’ in this review should be understood as meaning the equivalent of the New Zealand term ‘sexual violation’. In the United Kingdom for example, the legal term ‘rape’ includes forms of penile penetration, which are largely covered in New Zealand within the term ‘unlawful sexual connection’ (i.e. penetration of a vagina, anus, or mouth by a penis (section 1 of the Sexual Offences Act 2003 (UK)), penetration of a vagina, anus, or mouth by a part of the body ‘or anything else’ (section 2(1) of the Sexual Offences Act 2003 (UK)) is ‘assault by penetration’).

2.1.2 Victim/survivor terminology

Considerable discussion and debate have surrounded the concepts of 'victimisation' and 'survival' (Gregory and Lees, 1999; Jordan, 2005b, 2008; Kelly, 1988; Lamb, 1999), with these terms often being viewed dichotomously. From the 1970s onwards, some feminists and rape crisis agencies strongly rejected the use of the word 'victim'. This was viewed as denoting passivity and accepting the objectification of women who had been raped. Instead the term 'survivor' was embraced since it more appropriately recognised and affirmed women's abilities to manage, survive and integrate their experience of sexual assault through the recovery process. However, for women who have lived through these experiences, the position is not always so clear.

The issue of victim/survivor terminology was raised in a recent New Zealand study of women who had been raped by a serial rapist (Jordan, 2005b; 2008). Based on comments from those interviewed, Jordan noted that using (2005b: 552), 'the terms "victim" and "survivor" in an oppositional manner may appeal to some strains of feminist political thinking yet do not resonate fully with women's lived experience'.

What the women's accounts demonstrated is that (Jordan, 2005b: 552), 'even at the very moment that they were being victimized, they were in survival mode. They were simultaneously victims and survivors'.

Throughout this review the term 'victim/survivor' has been used to reflect the fact that experiencing sexual violence is an act of victimisation and has to 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'.

2.2 Nature of sexual violence

Sexual violence can occur in a range of contexts, but universally it is recognised as being predominantly a crime in which the victim is female and the perpetrator is male (Gavey, 2005; Kelly, 2005; Lievore, 2004). The common perception of rape is that the perpetrators are strangers and/or recent acquaintances, and it is this notion of rape that is most commonly thought of as 'real rape'. It is this form of sexual violence that much policy and practice tends to be built around (Kelly, 2005). However, rather than strangers, the majority of rapes are committed by men who are known to victim/survivors (Heenan and Murray, 2006; Lievore, 2003; Jewkes, Sen and Garcia-Moreno, 2002) as date rapes, acquaintance rapes or marital rapes (Daane, 2006).

There is also a lack of recognition that much sexual violence involves repeated assaults by the same (and sometimes different) perpetrators (Lievore, 2005; Heenan and Murray, 2006), with an overlap between rape and domestic violence (Howard et al., 2003) and that the impacts of rape and domestic violence are cumulative (Fanslow and Robinson, 2004; Kelly, 2005).

There are certain personal, social and economic characteristics that are seen to increase the risk of victimisation. These include youthfulness; homelessness; poverty; social isolation; being a sole parent; refugee status; victim/survivors with physical, mental and intellectual disabilities; incarceration; marriage/cohabitation; and being a sex worker (Harcourt et al., 2001; Kelly, 2005; Jewkes, Sen and Garcia-Moreno, 2002; Mayhew and Reilly, 2007; Stermac and Paradis, 2001; and Nosek et al., 2004).

The lack of research into issues surrounding male rape (Chapleau, Oswald and Russell, 2008; King and Woollett, 1997; Jewkes, Sen and Garcia-Moreno, 2002) means that it is difficult to present any generalised commentary in respect of risk factors for men. However, most of the above risk factors involve 'victim vulnerability' in one form or another, and in that regard are likely to be applicable to both male and female victim/survivors.

These characteristics are reviewed in more detail below.

2.2.1 Incidence and prevalence of sexual violence

Rates of sexual victimisation among the population are an important indicator of the level of service provision that is required. The main method for estimating this is through national victimisation surveys where participants are asked to disclose personal experiences of all types of crime, including sexual violence, regardless of whether it has been reported to official sources.

When reviewing incidence and/or prevalence of sexual violence some key issues about measurement need consideration. Two measurement issues are outlined in Box 2.

The 2006 New Zealand Crime and Safety Survey (NZCASS) found a 12-month prevalence rate of 3 percent for individuals aged 15 years or older who had experienced one or more occurrences of sexual victimisation in 2005. This equated to 6.4 incidents per 100 adults (9 per 100 women, 3 per 100 men) that year. While the coverage of sexual victimisation was broader than sexual violation as defined for this review, it was reported that about a quarter of those incidents were related to 'forced' sexual intercourse or attempted forced sexual intercourse (Mayhew and Reilly, 2007).⁷ These rates were higher than had been found in the previous New Zealand National Survey of Crime Victims in 2001 where 12-month incidence rates for women were 4.5 per 100 and for men were 0.2 per 100 (Morris et al., 2003).

⁷ Sexual offences included sexual intercourse, attempted sexual intercourse, being touched in a way that was sexually distressing, and any other incident in which someone had been sexually violent, or threatened to be. This included incidents by spouses and intimate partners.

Box 2: Incidence and prevalence of sexual violence – measurement issues

Definition of sexual violence: Reviewing research on the prevalence of sexual violation is problematic. Some research refers specifically to rape. However, other research uses broader terms such as sexual violence, sexual assault, sexual abuse or sexual offending, with varying levels of clarity over the extent of sexual offending behaviour that is included. 'Sexual violation' is often included within a broader range of sexually abusive behaviours.

Incidence or prevalence: The situation is complicated further based on whether studies are referring to prevalence or incidence, the definitions of which can vary across disciplines. Rates can be reported across a lifetime or for a specified period such as the previous 12 months. Variations in victimisation figures across or within countries are likely to reflect differences in definitions and the types of rates used.

Prevalence: In victimisation surveys, prevalence rates measure *the number of people* victimised once or more, usually expressed as a percentage of the relevant population.

Incidence: Incidence rates measure the *total number of incidents* experienced by a given number of people, reflecting cases where an individual has been victimised more than once. Incidence rates are usually expressed per 100, 1,000 or 10,000 people.

Demographics and rates of victimisation

It is also important to understand any variations within those groups that are most at risk of sexual victimisation to ensure there are sufficient services for those most at risk.

Gender

As noted in the introduction to this section, the vast majority of offenders are male regardless of the gender of the victim, and the vast majority of victim/survivors are female.

The 2006 NZCASS found that women were twice as likely to be sexually victimised as men; 12-month prevalence rates were 4 percent for women and 2 percent for men (Mayhew and Reilly, 2007). The 2001 New Zealand National Survey of Crime Victims found the lifetime prevalence of sexual assault was 19 percent for women and 5 percent for men.⁸

Age

Younger women were found to be at higher risk of sexual violence in the 2006 NZCASS. The researchers found that 12 percent of women in the age group

⁸ This used a broad definition that included childhood sexual abuse.

15-24 years reported at least one sexual incident in 2005 compared with the average of 4 percent for women overall (Mayhew and Reilly, 2007).

Ethnicity

In New Zealand, Māori women have been identified as being at higher risk of sexual violence. The 2006 NZCASS found Māori women had a 12-month rate of sexual victimisation – double the average of all New Zealand women. Twelve-month incident rates were also higher for Māori women in the 2001 New Zealand National Survey of Crime Victims (7 percent for Māori women compared with 5 percent for New Zealand European women and 3 percent for Pacific women).

This higher rate of sexual victimisation for Māori women was less evident for lifetime rates of sexual victimisation according to the 2001 New Zealand National Survey of Crime Victims. When lifetime rates are considered, Pacific women had a lower rate than both New Zealand European and Māori women (6 percent compared with 20 percent and 23 percent respectively), although the authors cautioned that this low rate for Pacific women could be an artefact of the research methods used (Morris et al., 2003).⁹

Higher rates for sexual victimisation for indigenous peoples are not unique to New Zealand. In the United States, Tjaden and Thoennes (2000) found higher rates for indigenous American Indian and Alaskan Native women. Indigenous communities in Australia have also found rates 16–25 times higher for their women (Memmot et al., 2001). Tjaden and Thoennes (2000) also found a similarly low rate for ethnic minority groups (African American and Asian/Pacific Island).

In understanding these high rates of victimisation of Māori, the Ministry of Health (2002), in relation to family violence, points to the complexity of the issue. It notes that violence occurs within the historical context that reshaped the foundations of Māori society through the process of colonisation. It also occurs within a contemporary context of socio-economic disadvantage, which can be linked to a health status that is poorer than that of other ethnic groups within the New Zealand population (Ministry of Health, 2002: 13).

Relationship to offender

There is growing evidence that sexual violation is more often than not committed by someone known to the victim/survivor (Kelly, 2005). This may include current and ex-intimate partners, close family members, neighbours, acquaintances, professionals (e.g. medical and criminal justice officials) and others in positions of

⁹ The authors noted that a much smaller proportion of Pacific women disclosed sexual victimisation than did New Zealand European or Māori women. They suggested the low lifetime rate of sexual victimisation found for Pacific women was more likely to reflect a greater reluctance among Pacific people to define their experiences in this way and/or to disclose sexual violence, than any real difference. United States researchers made a similar conclusion in explaining lower rates of intimate partner sexual violence for Asian and Pacific women. They also concluded it was likely that the traditional values associated with these cultures had discouraged women from disclosing such victimisation (Tjaden and Thoennes, 2006).

authority or power (Kelly, 2005; Special Rapporteur, 1996; Jewkes, Sen and Garcia-Moreno, 2002).

The 2001 New Zealand National Survey of Crime Victims reported that three-quarters of those who had reported being sexually victimised had known the offender (Morris et al., 2003). The 2006 NZCASS found that over a third of sexual offences were committed by current partners.

2.2.2 Reporting to the police and conviction rates

Research evidence suggests that very few victim/survivors of sexual violence report what happened to the police. Moreover, among those who do report to the police, there can be substantial attrition (Kelly, 2002; Kong et al., 2003; Lievore, 2005; Mayhew and Reilly, 2007; Morris et al., 2003).

Reasons for not reporting identified in the literature (Epstein and Langenbahn, 1994; Gilmore and Pittman, 1993; Gregory and Lees, 1999; Kelly, 2002; Kelly, Lovett and Regan, 2005) include:¹⁰

- apprehension over the police response, fear of not being believed, etc.
- guilt, shame, embarrassment, self-blame
- fear of negative reaction from family, friends or partner
- apprehension concerning going to court, cross-examination etc.
- being actively dissuaded from doing so by family, friends etc.
- denying to themselves that what they experienced was rape.

Kelly, Lovett and Regan (2005: 7) have defined attrition as, 'the process by which rape cases drop out of the legal process, thus do not result in a criminal conviction'. Research that these authors conducted for the British Home Office revealed the four critical points where attrition occurs are:

- the decision to report
- the police investigation phase
- the prosecution filtering system
- acquittal at trial.

The authors found that the highest attrition of rape cases occurred at the earliest stages, with between half and two-thirds dropping out at the investigative stage (Kelly, Lovett and Regan, 2005).

¹⁰ Many of these reasons also act as barriers to victim/survivors in seeking help and/or care in general, see, for example, the research summarised by Lievore (2005).

Rates of reporting

The 2006 NZCASS found that only 9 percent of the sexual offences that respondents disclosed in the survey were reported to the police (Mayhew and Reilly, 2007). The best estimate of what this equates to in terms of population numbers and the scale of response required is provided by the New Zealand recorded crime statistics. These statistics suggest that in 2007/08 there were 2,364 recorded sexual attacks (including sexual violation), which translates to 5.6 cases per 10,000 of population (New Zealand Police, 2008). It should be noted that police data include crimes against victims of all ages, whereas the NZCASS was limited to those 15 years or older (Mayhew and Reilly, 2007).

Rates of convictions

A recent Ministry of Justice discussion document reported that, in New Zealand, the rate of convictions for offences that go to trial is lower for sexual offences compared with other crimes. Between 2004 and 2006 the rate of conviction for all sexual offences that went to trial was 46 percent compared with 55 percent of all violent crimes, and 70 percent for total crime (Ministry of Justice, 2008: 2).

2.3 Legal framework for sexual violation offences

It is useful to consider the New Zealand legal framework under which the sexual violation offences committed against victim/survivors are processed. There have been several significant reforms of the New Zealand legal system over the past two decades, resulting from concern over the way in which crimes of sexual violence are dealt with in the criminal justice system.

From the 1970s onwards, legal definitions of rape have been criticised for their failure to reflect women's experiences of sexual assault and violation both in New Zealand and internationally (Gavey, 2005; Kelly, 1988; Walklate, 1995; Young, 1998). Criticism of narrow legal definitions of rape led to many jurisdictions introducing legal reforms in this area (Kelly, 2005; Lord and Rassel, 2000; Regan and Kelly, 2003). In New Zealand pressure mounted from feminist groups to change the law, with such moves being supported by findings from the first major study in New Zealand of rape laws and procedures (Young, 1983a, 1983b).

The most significant changes occurred in 1985 when significant amendments were made to the Crimes Act 1961, Evidence Act 1908 and Summary Proceedings Act 1957, including the following.

- The broad category 'sexual violation' was introduced, incorporating rape as traditionally defined and adding offences described as 'unlawful sexual connection'. In practice this meant sexual violation offences were redefined to include forced anal and oral sex, using any object able to be used for that purpose.
- Sexual violation was made gender neutral, recognising both the possibility of male victim/survivors and female offenders.
- Spousal immunity was abolished – no longer could men use the fact that the victim/survivor was their wife as an automatic defence against rape charges.

This allowed, in principle at least, the possibility of men being convicted on charges of marital rape.

- A requirement was introduced specifying that the grounds for a belief in consent needed to be 'reasonable'.
- Changes were made to court and trial procedures in order to make giving evidence less traumatic for victim/survivors and limiting the publication of incident and personal details.
- The 'corroboration warning' was removed, which had required the judge to warn of the dangers of convicting based in the victim/survivor's uncorroborated evidence.

As subsequent commentators have noted, these legal changes have not always yielded in practice what they offered in principle (McDonald, 1994). For example, in relation to consent, in practice the victim/survivor has to demonstrate that their lack of consent was apparent, preferably by physical resistance. Mounting criticism has been voiced of the way this effectively places the burden of proof on the victim/survivor (Adler, 1987; Kennedy, 1992; Lees, 1997; Scutt, 1997; Smart, 1989; Temkin and Krahé, 2008).

Similarly, earlier amendments made through the Evidence Amendment Act 1977 saw a partial rape shield created with the inclusion of a particular rule that evidence may not be given, nor the complainant cross-examined, about the complainant's prior sexual history with any person other than the accused without the prior leave of the court (Young, 1983a, 1983b). The scope for such judicial discretion, it has been argued, leaves room for personal bias and the influence of rape myths to affect such decisions (McDonald, 1994).

More recently the New Zealand Evidence Act 2006 sought to extend the rape shield to provide a complete bar on any evidence being allowed regarding the complainant's 'reputation' in sexual matters (McDonald, 2009). While this has been welcomed in principle, concern has been voiced that this also may be compromised in practice (McDonald, 2009).

Legislation has also been introduced specifically aimed at mandating the provision of services to victims of crime. In New Zealand this is evident in the Victims of Offences Act 1987 and the Victims' Rights Act 2002 and, more recently, the Victims Charter 2008.

However, despite significant legislative and procedural changes, concern has been increasingly expressed that rape victim/survivors' experiences of the criminal justice system have not substantively improved and that a 'justice gap' remains (Gregory and Lees, 1999; Jordan, 2001, 2004; Kelly, Lovett and Regan, 2005; Lea, Lanvers and Shaw, 2003; Temkin, 1997; Temkin and Krahé, 2008). In response to some of these concerns, the Ministry of Justice has recently issued a discussion paper to solicit the public's views about proposed legislative amendments to the current law on sexual violence (Ministry of Justice, 2008).

2.4 Victim/survivor needs

High-quality service delivery is crucial in meeting the crisis and longer-term needs of victim/survivors to minimise the harm experienced and to promote future safety and well-being. Understanding the specific needs of victim/survivors is an important first step in ensuring the various services are set up to meet these needs.

2.4.1 Intervention stages and victim/survivors' needs

Rape and sexual violence are crimes where the adverse physical, mental, emotional and spiritual sequelae for the victim/survivor may be endured for many years after the initial assault: some consequences may become apparent immediately after the attack while others may surface after a delay. For this reason, rape victim/survivors may need different types of interventions at different times.

Key times when intervention may be required include the following.

- **Acute or crisis response:** To ensure physical safety and provide immediate medical care and emotional support. Also, after the offence is reported, to provide support during the obtaining of forensic evidence, and police interviewing (Burgess and Hazelwood, 2001; Olle, 2005).
- **Short-term needs:** To provide a co-ordinated response in relation to advocacy support, medical care, mental health needs and police involvement (where relevant) (Olle, 2005). This may include support during court preparation and managing trial processes and outcomes.
- **Long-term needs:** Counselling and support to manage any post-traumatic stress disorder (PTSD) effects. Some victim/survivors may not be ready to access counselling support until years after the sexual assault, or will become more aware of the effects over time.
- **Delayed effects:** These could result from the reporting or notification of historic sexual assaults (Olle, 2005), as well as from changing responses to, and awareness of, situations inducing fear, vulnerability etc. over time.

2.4.2 Needs of diverse population groups

Most research on effective service delivery for those who have experienced sexual violence treats the findings as if victim/survivors were a homogenous group. It is likely many of these findings will relate to women from diverse cultures and to men, boys and other populations of victim/survivors. However, it is important to review the distinctive and separate needs of these diverse groups to understand better when this might not be the case, and to consider when specialist services would be more appropriate.

Very little research was located on the specific needs and/or types of services for victim/survivors of sexual violence from diverse population groups. Where appropriate, material presented has been supplemented with that describing the more general needs of particular groups. In highlighting culturally appropriate ways

of working, it is useful to consider the extent to which such approaches may also be good practice for all victim/survivors.

Māori victim/survivors

This report gives special attention to the practices that are appropriate and effective for Māori victim/survivors of sexual violence. This attention is warranted for two reasons.

As noted in the section 2.2.1, Māori women are over-represented as victims of sexual violence – they have been found to experience sexual violence at up to twice the rate of other women in New Zealand. Hence, it is vitally important to better understand what comprises effective services for Māori victim/survivors.

On signing of the Treaty of Waitangi in 1840, a special relationship was established between Māori as tangata whenua (people of the land) and the Crown. A key aspect of the Treaty is that Māori are afforded the right to access services that have been constructed and implemented with the particular interests and needs of whānau (extended family), hapū (clan or sub-tribe) and iwi (tribe) in mind, and that measures taken strengthen the ability of whānau, hapū and iwi to control their own development and achieve their own aspirations (Ministry of Social Development, 2002). Hence, in reviewing good practice for services for Māori victim/survivors of sexual violence these rights must be taken into consideration.

With these two factors in mind, it is clear that a key component of good practice for any of the systems of service delivery that victim/survivors come in contact with (medical, criminal justice, mental health and/or community support systems) will be their cultural relevance and effectiveness for Māori victim/survivors.

In considering whether a service or system is culturally relevant, it is important to understand the differences in Māori world views of justice, health and well-being from that of the dominant European culture in New Zealand society. These differences and their implications for good practice in relation to medical, criminal justice, mental health and community support systems are reviewed in Part two of this report.

A key finding in itself is the lack of written material that specifically outlines good practice in working with Māori victim/survivors of sexual violence. The exceptions to this are the sexual abuse and mental injury practice guidelines (ACC, 2008) and the guidelines for sexual abuse doctors (DSAC, 2006). Both these guidelines have sections dedicated to good practice in relation to Māori. There are also some guidelines for Māori victims of family violence of whom a proportion will have experienced sexual violence (e.g. Ministry of Health, 2002; Standards New Zealand, 2006). Other than these, material presented is limited to more generic models of Māori health and well-being and Māori perspectives on justice (Durie, 2001, 2003; Jackson, 1987, 1988, 1989; Ministry of Justice, 2001).

Applicability of Western feminist world views on violence against women to Māori culture

A Western feminist world view often begins from the premise of individual women's equality, equity and human rights. Western feminists who offer an analysis of violence as men's abuse of power and control over women offer an important but

incomplete explanation of violence against Māori women, as they tend to obscure additional layers of cultural oppression and racism (Second Māori Taskforce on Whānau Violence, 2002). The collectivist nature of Māori society means that Māori values and practices focus on advancing the well-being and strengths of all group members, with a focus on communal success and responsibility (Paua Enterprises Ltd, 2006).

In the context of te ao Māori (a Māori world view), men and women are seen as essential parts in a collective whole: different, but complementary. The concepts of whakapapa (lineage or descent) and collective dynamic balance are also central to te ao Māori. The basic social unit of analysis is not at an individual level, but within the whakapapa groupings of whānau, hapū and iwi.

Colonisation, and its far-reaching impact on Māori, provides an important context for understanding and responding to violence against Māori women today. Western notions of individualism and gender relations, including views on male dominance within the home, had a drastic impact on women's role and status and on Māori social structures. This includes the breakdown of whānau, which was previously women's primary source of support, particularly in cases of domestic abuse, where violence was seen as an attack against the whakapapa (Balzer et al., 1997; Mikaere, 2006; Paua Enterprises Ltd, 2006).

When it comes to responding to violence against women, Māori women cannot be taken as separate from their whānau, hapū and iwi. Traditional Māori law was based on maintaining balance between whānau, hapū and iwi, including balance between women and men (Mikaere, 2006). Māori women have been active in responding to sexual violence since the 1950s. They have worked alongside as well as separate from men in responding to the needs of Māori as a whole. Some Māori researchers and activists acknowledge that some women receive negative messages from their whānau, and that it is not always safe for them to go to their families for help (Balzer et al., 1997). However, for many Māori the preferred response is to create non-violent communities by using cultural processes to improve collective well-being and promote the collective's obligations and responsibilities to the individual.¹¹

Whakapapa is a collective process. This means that the individual must always be viewed and treated in context of the collective ... Māori are not isolated individuals. The connectedness and relationships from whakapapa make it imperative that the individual is treated in context of the collective. Rehabilitation and healing cannot happen without the rehabilitation of everyone. The whole whānau needs to heal from the impacts of violence and abuse. (Second Māori Taskforce on Whānau Violence, 2002: 9)

Diverse realities

Understanding a traditional Māori view is clearly important. However, it must also be recognised that there is much diversity within Māori iwi and communities. Professor Mason Durie (Ngāti Kauwhata, Ngāti Raukawa, Rangitane) is an eminent

¹¹ It is important to emphasise that this represents one Māori world view – there will be others.

researcher and advocate in the areas of Māori health and mental health. He has written a key paper, *Ngā Matatini Māori: Diverse Māori Realities*, that argues policies and services for Māori should also consider the diverse social and cultural realities within which Māori live (Durie, 1995). Māori in New Zealand society today are not a homogenous group, they are as diverse and complex as other sections of the population, even though they may have certain characteristics and features in common (Durie, 1995). Māori sit on a continuum that ranges from those with more traditional lifestyle, beliefs and values to those with lifestyles, beliefs and values dominated by more contemporary Western influences. Hence, for all Māori to have access to appropriate services, a similar continuum of services must be available from which to choose.

Consideration of diverse realities is addressed in the recent Accident Compensation Corporation (ACC) guidelines, which state that when working with Māori clients it is important to consider each client as unique and not to assume that Māori models of therapy are appropriate or desirable for all Māori (ACC, 2008: 88).

Pacific victim/survivors

Pacific peoples in New Zealand consist of diverse ethnic groups with distinct similarities and differences (Koloto, 2003). The seven main Pacific groups are Samoan, Cook Islands, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan (Statistics New Zealand, 2007a, cited in Tiatia, 2008). Although there are some similarities between these groups each has its own cultural beliefs, values, traditions, language, social structure and history. Moreover, within each group there are sub-groups such as those born or raised in New Zealand, those born and raised overseas, and those who identify with multiple ethnicities (Ministry of Health, 2008). Clearly this last sub-group also applies to Māori.

Researchers have discussed the issue of the effects of migration on Pacific peoples. Asiasiga and Gray (1998) comment that perhaps one of the most significant is the break in kinship ties and the loss of collective support. One result of this that the church has become a substitute for village communities (Epati, 1995) and often plays a central role in the lives of Pacific people.

Lifetime rates of sexual victimisation of Pacific people have been found to be lower than those for both New Zealand European and Māori (Morris et al, 2003), although, as noted in section 2.2.1 this low rate was thought to be an artefact of the research methods used.

There has been a dearth of research about sexual violence in respect of Pacific people living in New Zealand. Research on New Zealand Pacific victims of violence, family violence (of which sexual offences were a subset) and property offences by Koloto (2003) found Pacific peoples underused formal support services, preferring informal support systems, primarily family and friends (59 percent), neighbours (3 percent) and pastor/church members (3 percent).

As with Māori, caution has been raised against assuming that any one therapeutic model or approach will meet the needs of all Pacific clients (ACC, 2008: 89). ACC notes that there are differences between what is appropriate or defines safe practice within customary culture for the diverse groups involved (ACC, 2008). Also, as with

Māori, Pacific cultures are based on the collective (extended family/aiga) rather than the individual and this must be acknowledged when meeting the needs of victim/survivors.

Young adult victim/survivors

Young adults form a significant group of known sexual assault victim/survivors. What little research has been done on this group, in New Zealand (Jackson, Cram, and Seymour, 2000) and in the United States (Black et al., 2008) suggests there is a low level of help-seeking behaviour following a sexual assault. Fears around the maintenance of confidentiality are a major barrier to accessing services. This has serious implications, given that adolescent girls and young women are at high risk of being victim/survivors of sexual assault (Tjaden and Thoennes, 1998). As well as the likelihood of experiencing emotional and mental health problems, untreated sexually transmitted infections and unwanted pregnancies, sexual assault is likely to have a significant adverse effect on this group of victim/survivors.

Male victim/survivors

Literature that specifically deals with male victim/survivors of sexual violence has begun to emerge over the past 20 years, although there is still a paucity of rigorous research studies in this area. A key issue, identified by a New Zealand counsellor, is that the extent of sexual violence against men is unknown, because so few report (Milne, 2005). Milne states, 'statistics can't show what people don't talk about' (p. 1).

Several issues related to male victim/survivors come through in the literature. It is important for service providers for this group to be aware of these.

- Men's reluctance to report sexual violence is often closely associated with their fears surrounding their sexuality (Crome, 2006), feelings of shame (King and Woollett, 1997), and fears that once abused they themselves will become abusers (Milne, 2001).
- There is often a significant delay before men report sexual violence.
- Men who do report rape are more likely to have suffered more physical injuries and have often been assaulted by multiple attackers (Chapleau, Oswald and Russell, 2008; Crome, 2006; Davies and Rogers, 2006).

Gay, lesbian, bisexual, transgender and intersex victim/survivors

There is very little literature specifically on sexual violence and the gay, lesbian, bisexual, intersex and transgender (transsexual, fa'afafine and whakawahine) communities; what literature there is tends to deal with same-sex domestic violence (Levanthal and Lundy, 1999; Farrell and Cerise, 2006). A recent New Zealand study investigated the issue of sexual coercion among gay men, bisexual men and takatāpui tāne (Fenaughty et al., 2006).¹² This is the only paper of its kind that focuses solely on men who have sex with men in New Zealand. However, rather

¹² In Fenaughty et al. (2006) the term 'takatāpui tāne' is used to refer to men who have sex with men but who do not identify as gay or bisexual.

than reviewing particular needs of this group, the paper focused more on the factors enabling sexual coercion to occur. It concluded that norms related to masculinity per se, rather than gay masculinity, were key to understanding sexual coercion among gay and bisexual men.

Reporting and help-seeking for incidents of sexual violence is low for these groups (Farrell and Cerise, 2006), with homophobia by police and community services identified as one of the major barriers (Levanthal and Lundy, 1999). Despite intersex people experiencing high rates of intimate partner and sexual abuse, the rate of reporting by or help-seeking for intersex people is the lowest of any of these groups (Pitts, Couch and Smith, 2006). Another particularly vulnerable group are transgendered individuals who work in the sex industry, so are at higher risk due to both their gender and their occupation. Difficulties in finding any type of employment have meant that a disproportionately higher number of transgendered individuals work in the sex industry (Jordan, 2005a).

Victim/survivors with disabilities

'Victim/survivors with disabilities' is a general term that in the early literature was used to describe survivors with a wide range of diverse characteristics and service needs (Sobsey and Doe, 1991; Sobsey, 1994, cited in Nosek et al., 2004). Types of disability vary to a great extent, and include sensory, physical, psychiatric and cognitive impairment (CROWD, 2008; Tyiska, 1998).

Those with intellectual or developmental disabilities appear to be at particularly high risk of sexual assault (Petersilia, 2001). For example, research conducted in Australia by the National Police Research Unit and Flinders University found that people with intellectual disabilities were ten times more likely to be sexually assaulted than people without intellectual disabilities (Brook, 1997).

Victim/survivors with disabilities often experience difficulties in accessing services for several reasons, as summarised in Table 2.

Table 2: Access issues for victim/survivors who have disabilities

Type of disability	Needs
Physical	Mobility/transport
Hearing	Communication (including hearing organisations not having text telephones) Interpreters and privacy (Obinna et al., 2005)
Cognitive	Communication (particularly if victims/survivor is 'non-verbal') (Tyiska, 1998) Safety within the organisation/institutional setting in which sexual violence most commonly occurs (Goodfellow and Camilleri, 2003; Davis, 2000) Recognition of problem of abuse by caregivers (Blyth, 2002; Davis, 2000; Nosek et al., 2004; Tyiska, 1998)
All forms of disability	Being taken seriously by law enforcement agencies (Hoog, 2004; Lievore, 2005) Being recognised as 'credible' by police and prosecution (Hoog, 2004; Lievore, 2005) Health problems or disabilities often mask offending (Blyth, 2002, Davis, 2000; Nosek et al., 2004; Tyiska, 1998)

Rural victim/survivors

Issues of rurality are particularly pertinent for New Zealand with its low population and relatively few urban centres. A simple universal definition of rurality does not exist (Lewis, 2003). However, commentators recommend that it is more useful to consider rurality as being on a continuum and that the distinguishing features are an area with a varied population density and varying levels of health and social resources (Averill, Padilla and Clements, 2007).

Such characteristics result in a unique set of circumstances surrounding meeting needs for victim/survivors of sexual violence within these communities.

- **Access to services** – physical and social distance from medical, police and support services (Lewis, 2003; Neame and Heenan, 2004; Parkinson, 2008a, 2008b).
- **Guarantee of confidentiality** – in small communities the lack of anonymity creates problems around maintaining confidentiality (Neame and Heenan, 2004; Parkinson, 2008a, 2008b).
- **Understanding offending as sexual assault** – linked to greater conservatism and adherence to traditional gender roles (Neame and Heenan, 2004; Parkinson, 2008a, 2008b).
- **Reporting to police** – small communities may have only part-time police cover, if any (Neame and Heenan, 2004); police may have a close relationship with the offender and/or victim/survivor and their families.

Sex-worker victim/survivors

A New Zealand report recently published by the Christchurch School of Medicine included survey information from a large study of sex-workers across all sectors of the industry. This study reported that in the last 12 months 3 percent of sex-workers had been raped by a client, with two-thirds electing not to report it to police (Abel, Fitzgerald and Brunton, 2008). This is supported by research in other countries that has found that sex-workers, in particular street sex-workers, experience high levels of physical and sexual violence (Kong et al., 2003; Harcourt et al., 2001).

Sex-workers are affected by rape in the same way as other victim/survivors (Quadara, 2008). Despite sex work in New Zealand being decriminalised in 2003, stigma associated with the sex industry still exists, and sex-workers face prejudice from mainstream service providers. Fear of public exposure is also a significant barrier to accessing services.

Ethnic, migrant and refugee victim/survivors

United Nations estimates suggest 80 percent of all refugee women have experienced rape and sexual abuse (Mehraby, 2001, cited in Savage, 2003). However, minimal research was found specifically on ethnic, migrant or refugee victim/survivors of sexual assault.

An Australian study by Lievore (2005) included interviews with immigrant service providers, with a particular focus on victim/survivors from non-English-speaking backgrounds. Points raised were that:

- these women are doubly disadvantaged by poor outreach from the mainstream sectors and by community silencing
- choices of many immigrant women were constrained and shaped by their alienation from a range of legal, health and victim services
- these women will face different issues depending on their pre-migration experiences
- the impact of sexual violence on women from collectivist communities could have a profound effect on the way that decisions are made and on the appropriateness of service models (which are usually geared towards women from the dominant individualistic culture).

Sexual violence workshops held in New Zealand with ethnic, migrant and refugee communities, revealed immigration status can be an important barrier to accessing services. Some men do not apply for residence for female partners, which creates uncertainty and insecurity for women. This was seen to be compounded when there was a considerable age gap between the pair, or when the male partner is a New Zealander. Workshop attendees also pointed to the often extreme social isolation of ethnic, migrant and refugee women, who are geographically isolated from family and other support networks, and with interaction with external agencies often through their husbands (Ministry of Women's Affairs, 2007).

In New Zealand, as elsewhere, refugees and new migrants do not come from a unified group, but come from many different countries. De Sousa (2007) argues that,

in New Zealand, there is much that newer migrant groups and mainstream services can learn from the experiences of Pacific people who are a diverse group representing over 20 cultures.

Table 3: Key issues for service delivery for victim/survivors from diverse groups

Group	Key issues
Māori	Involvement of culturally appropriate supports and extended family Adherence to Māori models of health and well-being Māori personnel in existing services and the development of Māori services
Pacific	Involvement of extended family Provision of relevant information in Pacific languages Ensuring confidentiality Pacific personnel in existing services and the development of Pacific services Understanding of the role of the Church.
Young adult	Confidentiality – especially in relation to parental disclosure
Male	Reassurance and counselling about masculinity and sexuality Dealing with issues around historical offences
Gay, lesbian, bisexual, transgender and intersex	Impact of homophobia of service providers Transgender counselling
Victim/survivors with disabilities	A range of access issues in relation to diverse disabilities Gaining informed consent of people with intellectual disabilities may be difficult The caretaker, family member or friend accompanying the victim/survivor may be the perpetrator Being recognised as credible by police and prosecution
Rural	Isolation – social and geographic Lack of service provision Familiarity, confidentiality and anonymity issues
Sex-worker	Multiplicity of social problems that can include drug abuse and social isolation Fear of public exposure and prejudice of mainstream services pose problems in accessing services
Ethnic, migrant, refugee	Diverse needs dependent on pre-migration experiences Language and communication difficulties, leading to issues around ascertaining informed consent and gaining evidential information. Social isolation

Summary

The literature on services for victim/survivors typically treats them as if they were a single homogenous group: with a close reading of the literature by and about diverse populations of victim/survivors it becomes clear that there are distinct needs that must be considered. It is also significant that these groups tend to be disproportionately represented as victim/survivors of sexual violence.

With reference to the literature, any service or criminal justice procedure that formulates a good practice model in relation to diverse populations of victim/survivors should have cognisance of the key points summarised in Table 3. Neither this list of victim/survivor groups nor the issues highlighted are exhaustive, but are offered as a possible starting point for the incorporation of the diverse needs of victim/survivors into the concept of 'good practice'. While the needs and issues of each group have been presented as distinct groups, there will be overlaps between groups (e.g. young, Pacific, transgender sex-workers), which would result in accumulated needs and, in some cases, increased risk.

3 Overview and critique of good practice

In a review of good practice for adult sexual violence services four key questions must be considered.

- What does good practice relate to – the type of programme or the way the programme is delivered?
- What are the criteria used to judge good practice?
- What are the outcomes against which good practice is evaluated?
- Who has the power to define good practice?

Each of these questions is considered below.

3.1 What does good practice relate to?

In reviewing the literature on adult sexual violence services, it is evident that good practice typically refers to one of two things.

- **The type of service delivery:** This is the particular type of adult sexual violence service that has been identified as good practice. This could relate to a general category (e.g. forensic nursing or specialised support services) or a particular programme (e.g. Sexual Abuse Nurse Examiners programme or Sexual Assault Referral Centres).
- **The principles of delivery:** Good practice can also refer to principles of delivery (e.g. culturally appropriate or victim-centred). Kelly (2005) refers to these as 'promising elements'. These principles can relate to a number of types of programmes and are critical factors in achieving successful outcomes.

To ensure that the needs of victim/survivors are met, it is important that the required 'components' of service delivery are available, but also that these individual components are delivered in an effective manner.

3.2 What are the criteria used to judge good practice?

There is no agreed definition of what constitutes 'good practice', 'best practice' or 'promising practice' in respect of sexual violence service provision. The terms are used throughout the literature on sexual violence and service provision for victim/survivors, sometimes interchangeably within the same text (e.g. Rape Crisis Network Europe, 2003).

The only area where there appears to be consensus is in *why* we need to identify good practice – which is to guide people to examples of what works to achieve desired outcomes (Cannon and Kilburn, 2003). However, as will be seen in section 3.1.2, there is less agreement on *which outcomes* are most important.

Although there is no universally accepted definition of ‘good practice’, several projects from diverse fields have formulated a process for evaluating their practices, which have varying degrees of applicability to sexual violence response services.

Proven effectiveness based on research evidence

‘Best’ or ‘good’ practice is commonly applied to those services or elements of programmes that have *proven* effectiveness in achieving desired outcomes. To be *proven*, typically refers to programmes that have met a strict set of criteria associated with a certain level of research evidence. Two common criteria are:

- the effectiveness of the programme is demonstrated through experimentally designed research producing statistically significant results¹³
- programme effects have been replicated by different researchers and/or transferred to different contexts using the same criterion as above.

Examples from different fields that require this level of research evidence and the associated best practice terms include:

- **empirically supported treatments** – to identify effective psychological interventions in the United States (Task Force of Division 12, 1993)
- **model programmes** – to identify effective family violence programmes (Cooper, Warthe and Hoffart, 2004)
- **proven practice** – in the field of family violence (Cannon and Kilburn, 2003)
- **best practice** – to identify effective family planning and reproductive health initiatives (Advance Africa, 2005).

However, some research studies that utilise different research methodologies or weaker designs (e.g. no randomly assigned comparison groups) may still provide useful evidence (Cannon and Kilburn, 2003). Hence, while ‘best practice’ is reserved for those studies achieving the highest level of research evidence, different terms are used to identify interventions or practices that are supported by varying levels of research evidence. For example ‘promising practices’ has been used to describe family violence programmes whose evaluations exhibit one or more design weaknesses (e.g. lack of control or comparison group) but still offer convincing results (Cannon and Kilburn, 2003); or for health initiatives that exhibit ‘inconclusive evidence of success or partial success’ (Advance Africa, 2005).

Unfortunately, very few adult sexual violence services or practices have been evaluated, let alone subject to experimental or even quasi-experimental design (Cooper, Warthe and Hoffart, 2004; Kelly, 2005). Indeed random allocation of victim/survivors to a ‘no treatment’ control would be considered inappropriate and unethical. This means relying solely on this type of research evidence may have limited value in identifying good practice in the field of adult sexual violence.

¹³ Experimental research design involves research participants being randomly assigned to either a treatment group or a control group that receives no treatment or services.

Wasco et al. (2004) reviewed some of the reasons for this lack of empirical evidence, based on difficulties they faced in their evaluation of sexual violence services in Illinois. These included:

- constraints around confidentiality and access to victim/survivors;
- difficulty getting 'informed consent' without using names of victim/survivors;
- inability to establish control groups of 'non-users'
- many users of services were too distressed to take part in the evaluation questionnaires or interviews
- the need to work at a 'hands-off distance' through the staff at the sexual violence support services.

Ferguson (2003) argues that this lack of research evidence is not necessarily problematic. He points out that attempts to apply an evidence-based, 'what works' approach have been criticised for valuing the views of experts over those of service users (Ferguson, 2003). There is, in fact, growing recognition that 'good' or 'best' practice is socially constructed and must, therefore, always be open to debate (Ferguson, 2003; Glasby and Beresford, 2006). Other criteria for good practice are considered below.

Practice that reflects current trends

In situations where research evidence is limited, other criteria and terms have been developed to identify potentially useful practice that may have more applicability to identifying good sexual violence services practice.

- **Worth watching** – this has been used in the family violence field to identify programmes that have not been comprehensively evaluated but where initial reports offer encouraging results (Cooper, Warthe and Hoffart, 2004).
- **State of the art** – refers to practices in family planning and reproductive health initiatives that reflect new trends and current thinking in the field (Advanced Africa, 2002, 2005).
- **Innovative practices** – are cutting-edge approaches in family planning/reproductive health initiatives that reflect new, possibly untested thinking. They can come in the form of pilot programmes or experimental projects. The promise of an innovation is based on speculation and lessons learned from other practices (Advance Africa, 2002; 2005).

Criteria from within the sexual violence sector

Within the sexual violence field, 'best/good practice' is often either not defined or used in a wholly subjective way (e.g. in a Rape Crisis Network Europe study, where the aim was to identify 'good practice' in the non-government organisation sector: the term was defined as being, 'action that proved successful or achieved positive outcomes for users of their services' (Rape Crisis Network Europe, 2003: 7).

There is often no explicit definition given, nor is there any explanation of the criteria used in the study, for determining what constitutes 'good' or 'best' practice' in any

particular context (Lovett, Regan and Kelly, 2004). This is so even where the term is a vital component of the study, discussion paper or journal article in question, for example in *Sexual Assault Referral Centres: developing good practice and maximising potentials* (Lovett, Regan and Kelly, 2004).

Within the sexual violence sector, 'evidence-based' practice is considered where available. However, either due to its limited availability, or perhaps to priority given to views of victim/survivors and practitioners, the 'knowledge-based' practice described by Glasby and Beresford (2006) is also commonly used to identify 'best/good' practice. 'Knowledge-based' practice recognises the validity of experience of practitioners and the lived experience of service users. Examples within the sector include the following.

- **Professional opinion:** Best or good practice is sometimes identified as a result of expert opinion. Within the field of sexual violence, this could be based on the clinical judgement of expert health professionals (e.g. *The Medical Management of Sexual Assault* (DSAC, 2006)). It could also be the opinion of a researcher recognised as an expert in the area following a review of available literature and their experience in the field (e.g. *Promising Practices Addressing Sexual Violence* (Kelly, 2005)).
- **Service users (victim/survivors):** Recommendations for good practice for support agencies, medical emergency room and counsellors and criminal justice systems based on the experience of the victim/survivors themselves (e.g. Campbell, 2005; Fry, 2007; Jordan, 1998).
- **Government review:** Amnesty International Australia published a comprehensive review of international 'good practice' to inform a national plan to eliminate violence against women (including sexual violence). The criterion it used was whether the practice or initiative had reached the policy implementation stage, from which it could be inferred that the initiative had passed the scrutiny of governmental review (Amnesty International Australia, 2008).

Perhaps the most practical set of criteria has been established by the Australian Centre for the Study of Sexual Assault, valuing 'evidence' and 'knowledge' based practice but within a flexible framework. It used the criteria presented in Box 3 to identify 'promising practices'.

Box 3: Promising practice criteria**Compulsory criteria**

- Have a clear focus: have a clearly defined conceptual framework, clear aims and clear desired outcomes.
- Take account of contemporary research and practice developments in the field of sexual assault.
- Position diversity as key to the development, understanding and delivery of good practice models.
- Demonstrate sensitivity towards the barriers faced by victim/survivors in disclosing and reporting sexual assault, and other difficulties, if relevant.
- Include processes of accountability and evaluation.

Optional criteria

- Be replicable (i.e. able to be used by others).
- Have been evaluated as successful.

(ACSSA, 2008)

3.3 What are the outcomes against which good practice is evaluated?

The question of defining 'good practice' in relation to services for victim/survivors of sexual violence necessitates consideration of the diverse needs and priorities held by the various people and agencies involved. These are the outcomes of relevance to the various parties against which best practice is measured. While these may overlap, in some cases they may be in conflict. This derives from each agency having its own role and professional agenda, and all parties having potentially different desired outcomes. Table 4 presents the key needs and priorities held by the different parties.

At times the needs of (or outcomes for) the victim/survivor may be at variance with the responsibilities and roles of the agencies involved, as evidenced in the following examples.

- Immediately following a recent attack, the processes around investigating the crime, making a statement and providing forensic evidence may not aid in meeting the victim/survivor's immediate needs for safety, comfort and security. Instead such procedures may add further distress, and bring with them the risk of secondary victimisation (Orth, 2002).
- At the very time a rape victim/survivor is seeking to be believed and validated, the police will be intent on obtaining proof and verification that the victim/survivor is telling the truth (Jordan, 2001, 2008). This may mean the police's questioning style and attempts to obtain factual information will be experienced as interrogatory and disbelieving, placing an onus on police to ensure a validating approach is adopted.

- Similarly, the victim/survivor will be interacting with institutions and systems oriented towards professional control and procedural efficiency at a time when the victim/survivor is struggling in the aftermath of rape to regain a sense of autonomy and personal agency (Jordan, 2001, 2008). This can result in their feeling controlled and subordinated to organisational processes, placing an onus on all agencies involved to treat them with respect, keep them informed and maximise their choices.

Table 4: Needs and priorities of different parties

Group	Key needs and priorities
Victim/survivor	<p>Immediate needs are for safety, validation, medical treatment, washing and changing, contacting family/friends, dealing with trauma, and reassurance about subsequent health issues</p> <p>Long-term needs may include psychosocial support, managing post-traumatic stress disorder impacts (that can affect sleep, eating, mental health, work, relationships and lifestyle), preparation for court, support in court and debriefing following court</p>
Medical care providers	<p>Immediate role is to assess and treat medical needs, and collect forensic evidence where required</p> <p>Longer-term involvement with overseeing the well-being and recovery of the victim/survivor, may be required to provide expert testimony in a prosecution</p>
Police	<p>Immediate role is to collect admissible and reliable evidence from crime scene and witnesses, including the victim/survivor</p> <p>Longer-term role involves conducting a proper investigation; arresting and charging the offender(s); providing protection for the victim/survivor</p>
Prosecutors and the court	<p>Overall aim is to ensure that the rule of law is maintained and the interests of justice are upheld. This is achieved by ensuring, for example, that reliable and admissible evidence is put before the court; that appropriate charges are filed in relevant cases; that any convictions are safely and rightly obtained; that appropriate sentences are handed down; and that witnesses (including the victim/survivor) are properly convened, prepared and supported</p>
Mental health providers	<p>Immediate aim is to alleviate short-term distress</p> <p>Longer-term role involves providing timely and effective treatments to prevent long-term adverse mental health impacts</p>
Support services	<p>Immediate aim is to provide crisis support for the victim/survivor, supporting their emotional well-being and acting as an advocate during police and medical processes</p> <p>Longer-term role may include serving as an advocate for the victim/survivor throughout police investigation and court processes: provision of ongoing counselling; preparation and support for court, and debriefing afterwards; providing support for partners and other family members</p>

It is also possible that there may be clashes between the priorities of the different organisations involved, at various stages in the process. For example, the support agencies may be advocating for the victim/survivor's emotional needs to be paramount at a time when the police require intensive questioning, or for the victim/survivor's physical desire for a shower and a drink to be enabled, when this could disrupt or contaminate the evidential examination.

An essential component of any consideration of evaluating services for victim/survivors of sexual violence is an appreciation of the multiplicity of outcomes for the various people involved in the process. However, *the paramount consideration has to be the welfare and well-being of the victim/survivor*. Without that consideration as a guiding principle, the issue of 'good practice' is little more than a discussion about the desirable practices identified by different groups in order to achieve their own particular imperatives.

3.4 Who has the power to define good practice?

Considering that the concerns and priorities of the various groups involved in service provision for adult victim/survivors of sexual violence are not always the same and sometimes are in conflict, it raises the question of who determines good practice, and in whose interests?

Typically, **professional organisations and government departments** have the resources and power to make decisions and write policies regarding good practice, as opposed to victim/survivors, who are most aware of their own interests and needs. Without input from victim/survivors, organisations are in danger of devising systems that may be internally efficient but ineffective in terms of responsiveness to the needs of their client groups. Therefore, in reviewing good practice it is important to consider whether what is published is what the victim/survivor would consider best practice in terms of their needs.

Defining best practice within professional organisations can also be problematic. In the mental health field for example, it is accepted that different individuals will respond to different types of treatment and that a range of counselling models can be effective (Wampold, 2001). Hence, the identification of a particular model as 'best' practice might imply that it is better than other models, when this is likely to be contextually dependent.

'Best' or 'good' practice: Not only might what is best for victim/survivors be different from what is best for the police or other organisations, but what is best for particular victim/survivors may differ according to cultural background, gender and urban/rural context, for example. Furthermore, attributing something to be the *best* forecloses room for challenge and improvement; and what is judged best practice at one point in time may not be so judged in the years to follow (Calder, 2000). There is, accordingly, a growing tendency to move away from identifying 'best' practice to acknowledging a range of 'good' practices instead (see, for example, Amnesty International Australia, 2008; Kelly, 2005; Regan and Kelly, 2003).

A final and important consideration is the country or culture on which good practice is based. As noted earlier, there is limited research on the effectiveness of adult

sexual violence services. What there is tends to come from **overseas researchers**, based on evaluations of programmes and initiatives in their jurisdiction. Hence, whether these findings are applicable to the New Zealand context, and in particular for Māori victim/survivors, must be considered.

3.5 Use of good practice in this review

Having considered the above four issues, we decided to:

- refer to 'good' practice rather than 'best' practice
- distinguish between good 'principles of delivery' and good 'types of service delivery'
- use a range of good practice criteria (i.e. all available literature in the field of sexual violence services), including evidence-based, knowledge-based and practice reflecting current trends
- where good practice is identified, note what this has been based on (victim/survivor's perspective or research evidence) and, where possible, relate it to the New Zealand context.

Part two: Summary of the literature

The second part of this report reviews available literature on what is considered good practice across the four main service systems, with which victim/survivors are likely to come in contact. The systems are the:

- medical system (assessment and treatment of injuries and collection of forensic evidence) (chapter 4).
- mental health system (crisis and longer term interventions) (chapter 5).
- criminal justice system (police, lawyers, judges, the court system) (chapter 6)
- community support system (specialist sexual violence support agencies and other more generic victim support services) (chapter 7).

Victim/survivor experiences of these systems can range from supportive, highly validating and therapeutic through to inflicting secondary victimisation. Understanding good practice within and across these systems is essential to minimising harm and maximising potential benefits for victim/survivors.

4 Medical system

4.1 Introduction

Immediately following rape there can be two differing sets of needs for a victim/survivor. They need to have any medical needs met, but also, for those who wish to bring the offender to account, there is a need for forensic evidence to be collected. The co-occurrence of these needs results in the convergence of two different systems.

- **Medical system** – assessing and treating health concerns.
- **Criminal justice system** – collecting forensic evidence.¹⁴

These two systems both involve medical intervention and are typically addressed together in what is referred to as the ‘forensic medical examination’. There is useful coverage in the sexual violence literature on what is considered good practice in conducting a forensic medical examination. This has included who should conduct it, where it should be conducted and the conditions under which it should be conducted. A key and influential piece of work on this is the review by Kelly and Regan (2003) *Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations*.

¹⁴ Collection of forensic evidence is relevant only to victim/survivors who wish to lay a complaint against their perpetrator.

These immediate responses post-rape are often referred to as 'acute post-rape care'. Responses following this can be divided into addressing short-term and longer-term needs. However, very little research was found on what was considered good practices following acute post-care, hence, for the purposes of this review the two stages have been combined into 'follow-up care'.

The World Health Organization guidelines for the medico-legal care for victim/survivors of sexual violence identified principles that should be considered as indicators of good practice in the provision of medical services to victim/survivors of sexual violence (WHO, 2003) (see Box 4). These principles apply to all modes of delivery, and appear to be applicable to acute and follow-up care.

Box 4: Good practice principles in the provision of medical services

- The health and welfare of the patient (victim/survivor) is the foremost priority.
- Ideally, the health care and legal (forensic) services should be provided at the same time and place by the same person.
- Health workers should receive special training in providing services for victim/survivors of sexual violence and should have a good understanding of local protocols, rules and laws applicable to the field of sexual violence.
- There should be a constructive and professional relationship with other individuals and groups treating and assisting the victim/survivor or investigating the crime.
- Health workers should be free of bias or prejudices and maintain high ethical standards in the provision of these services.
- Resource constraints may preclude the possibility of service provision in an ideal facility, but it is possible to improve the quality of existing facilities by ensuring they are accessible, secure, clean and private.

(WHO, 2003)

This section of the literature review covers:

- sources of medical care, i.e. hospital emergency rooms; primary health care
- forensic medical examination and acute post-rape care, i.e. Doctors for Sexual Abuse Care (DSAC), forensic nursing, forensic rape kits
- follow-up medical care.

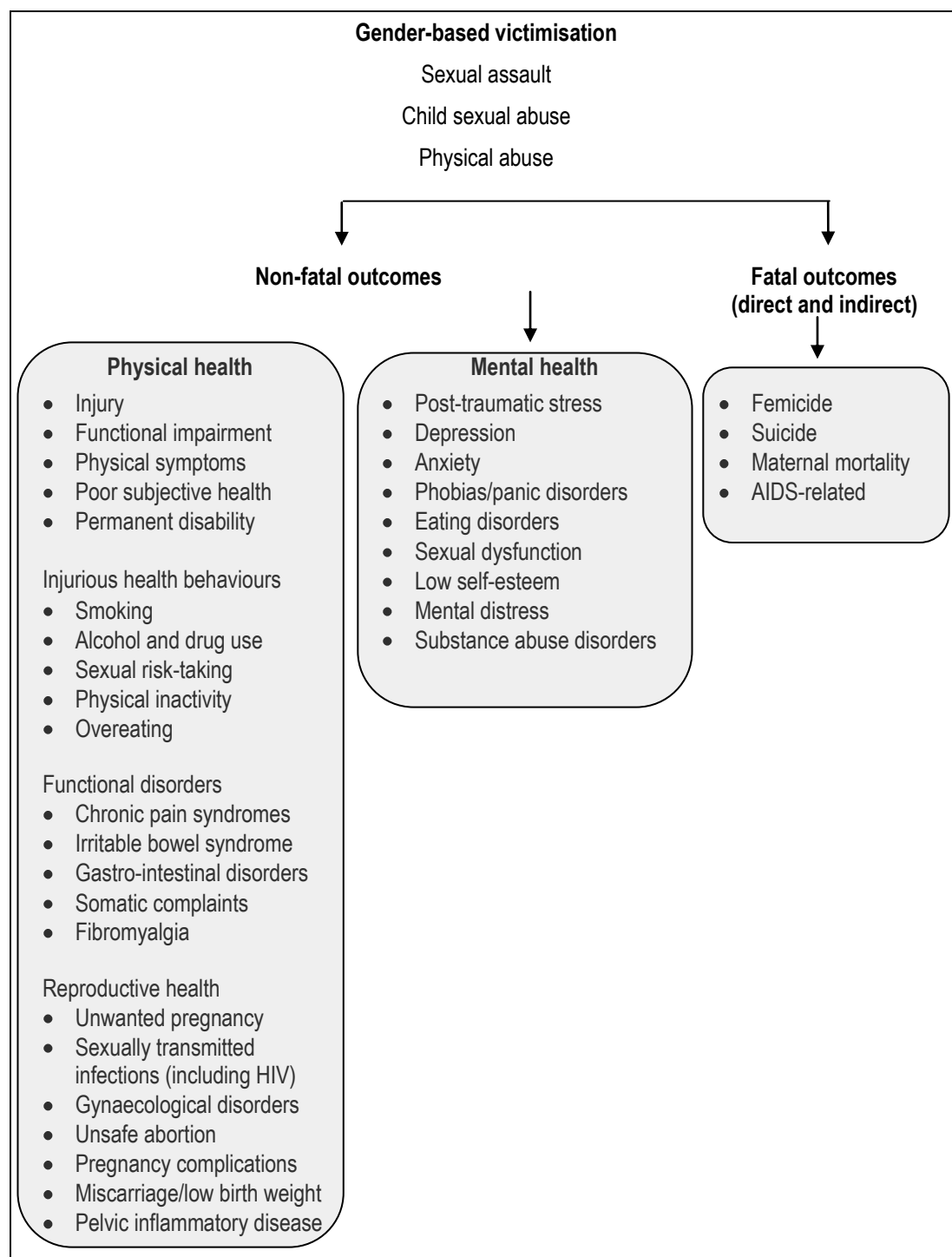
This section does not cover the delivery of mental health needs, which is dealt with under the mental health system (chapter 5).

4.2 Sources of medical care

The health consequences of sexual violence are numerous and varied, and include physical and psychological effects, both short and long term. This is demonstrated in

Box 5, which summarises the health outcomes of violence against women, including health outcomes of sexual violence.

Box 5: Health outcomes of violence against women



Source: Adapted from M. C. Ellsberg and L. Heise (2005) *Researching Violence against Women: a practical guide for researchers and activists*. Washington DC, United States: World Health Organization, p. 23.

In the United States, a third of female (32 percent) and 16 percent of male victim/survivors of rape were physically injured; of those women who were injured just over a third (36 percent) said they had received medical treatment (Gonzales, Schofield and Schmitt, 2006).¹⁵

In New Zealand, those victim/survivors who access medical care will do this through either a hospital emergency department or a primary health care service.

4.2.1 Hospital emergency rooms

There are no statistics available on what proportion of victim/survivors are treated in hospital emergency rooms in New Zealand, but at least some are referred there for forensic medical examinations or because of emergency acute post-rape medical needs.

International literature on sexual violence identifies that there are specific problems with this context that limit the victim/survivors having their needs met (Kelly and Regan, 2003; Logan, Cole and Capillo, 2007). Irrespective of whether the attending physicians have been trained or are experienced in treating victim/survivors of sexual violence, emergency rooms present difficulties, including:

- delays as patients with physical injuries are prioritised; studies indicate around 70 percent of sexual violence victim/survivors show no obvious serious physical injury (Cantu, Coppola and Lindner, 2003, Deming, Mittleman and Wetli, 1983, Marchbanks, Lui and Mercy, 1990)
- lack of privacy
- lack of facilities for changing, showering and making phone calls
- lack of counselling and support services
- a reluctance of attending doctors to be involved in the court process following their examination of the victim/survivor (Logan, Cole and Capillo, 2007).

Box 6 lists the recommendations for good practice for victim/survivors of sexual assault following a study of hospital emergency rooms in New York (Fry, 2007). These recommendations were based on comments provided by victim/survivors.

¹⁵ The majority of victim/survivors do not seek help, so the proportion of all victim/survivors who receive medical treatment would be much smaller.

Box 6: Good practice recommendations for hospital emergency rooms

- Provide rape crisis advocates – let people know that they are available, so they do not have to ask.
- Provide comprehensive treatment including pregnancy testing, screening for sexually transmitted infections including HIV/AIDS, and crisis counselling – if the hospital is unable to deliver, make referrals.
- Screening for sexual violence should occur in the emergency room – both verbally and on the intake forms.
- Have more specially trained clinicians.
- Provide better training for clinicians who handle sexual assaults.
- Decrease the waiting time in the emergency room.

(Fry, 2007)

Note: There is debate as to whether tests for sexually transmitted infections should happen at the initial examination or be delayed until a follow-up consultation with appropriate counselling (Ackerman et al., 2006).

4.2.2 Primary health care

Primary health care is typically delivered through community-based medical centres by a local general practitioner, Family Planning or Sexual Health Clinics. These medical centres can provide acute post-rape care, and longer-term and/or follow-up care. These groups provide health care to the majority of victim/survivors who require medical care but do not wish to report their sexual assault to the police. They can also be the venue for forensic medical examinations for those victim/survivors who do report to the police (Beckett, 2007). Forensic medical examinations are covered in section 4.3.

Very limited literature was located about primary health care service providers working with victim/survivors of sexual violence. The *Family Violence Intervention Guidelines: child and partner abuse* (Ministry of Health, 2002), whilst not specific to victim/survivors of sexual violence, are relevant due to the overlap between rape and domestic violence. They were developed as a practical tool to assist health providers to work safely and effectively with victims of violence and abuse. The guidelines recognise the valuable role health care providers can play in the early intervention and prevention of family violence, as victims of abuse seek health care more often than individuals who have not experienced abuse. They cover the appropriate conditions for conducting an interview (e.g. for partner abuse – questioning about violence should be conducted in private) and outline a range of good practice guidelines for health care consultations.

Astbury (2006), based on experiences in Australia, reviewed appropriate treatment for victim/survivors of sexual violence in the primary care setting. Considering that the majority of victim/survivors who seek help access primary health care services rather than specialist sexual assault services, Astbury suggested the lack of research in this area was a concern.

In her review, Astbury does not distinguish between acute post-rape care and follow-up care. She points out that, as primary health care providers have been trained to develop expertise in the diagnosis and treatment of ill health, when they provide treatment plans and give advice, they expect clients to adhere to those plans and advice, with patient compliance being a primary goal. Astbury raises concerns that this approach could be counterproductive with victim/survivors as it mimics the controlling behaviour of the perpetrator. She also asserts that the range of physical examinations that general practitioners routinely engage in (particularly gynaecological examinations) have the potential to cause secondary victimisation (Astbury, 2006).

Box 7 lists some of Astbury's (2006) recommendations for generalist primary health care providers who are working with victim/survivors of sexual violence or sexual assault. Her recommendations are based on the limited research that was available.

Box 7: Good practice recommendations for primary health care providers

- Ensure that all discussions about sexual violence occur in a safe place where interruptions that could violate confidentiality cannot occur.
- Establish a relationship of trust by empowering the victim/survivors and supporting them to make their own decisions on treatment and recovery.
- Consider the traumatic potential of a range of procedures such as cervical smears and gynaecological examinations.
- Inform the victim/survivor that sexual assault is a crime and a violation of their human rights.
- Provide psychological support and appropriate referrals.
- Keep records to enable the provision of victim/survivors' information to specialist sexual assault agencies, legal or other services within the community at the victim/survivors' request.

(Astbury, 2006)

4.3 Forensic medical examination

In New Zealand it is estimated that one in ten victim/survivors of sexual violence report to the police (Mayhew and Reilly, 2007), and many of those who do are likely to require a forensic medical examination. As noted above, these victim/survivors can be referred to either a hospital or a primary health care facility, as per regional police protocols (Beckett, 2007). At either location, the forensic medical examinations will be performed by a specialist sexual assault doctor (most often a Doctors for Sexual Abuse Care-trained doctor).

4.3.1 Doctors for Sexual Abuse Care

Until the late 1980s, in New Zealand it was usual for forensic and medical examinations of sexual violence victim/survivors to be undertaken by a police surgeon, sometimes in a police cell (Jordan, 2001). Concerned doctors formed a

professional organisation, Doctors for Sexual Abuse Care (DSAC), with the specific aim of ensuring the maintenance of internationally recognised standards of best practice in the medical and forensic management of sexual assault (DSAC, 2006). These doctors provide medical care for child and adult victim/survivors of sexual assault in New Zealand.

DSAC provides a range of victim/survivor services, including the provision of education and training programmes; liaison with allied organisations, such as the police and Crown prosecutors; accreditation (in conjunction with the police) for doctors trained in forensic examinations; as well as publishing and regularly updating a comprehensive medical manual, *The Medical Management of Sexual Assault*, which is in its sixth edition (DSAC, 2006).

In addition to performing forensic medical examinations, DSAC-affiliated or -trained doctors also provide specialist sexual abuse medical care for child and adult victim/survivors as required (regardless of whether the sexual violence has been reported to the police).

DSAC-trained doctors are on call-out throughout most of the country to perform forensic medical examinations. The preferred practice is for a victim/survivor to be referred to a support agency by the police and for a medical examination to be undertaken at a clinic by a female DSAC-trained doctor (Jordan, 2001).

In New Zealand there is some confusion over the role of DSAC-trained doctors. DSAC has identified four functions of a forensic practitioner (doctor or nurse) with regard to adult sexual assault patients. The functions are to:

- perform an examination and recording findings
- interpret findings, including being an 'expert witness' in court, explaining what the findings were and how they might be interpreted
- provide a therapeutic function, including treating injuries, deciding on need for inpatient treatment, prescribing emergency contraception and sexually transmitted infection prophylaxis, Accident Compensation Corporation (ACC) paperwork for cover of treatment, assessment of safety and mental state
- follow up on factors affecting safety, physical symptoms and mental state to monitor outcome and promote recovery.¹⁶

No evaluations of DSAC or its training procedures have been carried out, and no literature was found on similar schemes overseas. However, it is clear that the use of specialist, trained sexual assault medical examiners is considered good practice by researchers in New Zealand and elsewhere (Beckett, 2007; Jordan, 1998; Kelly and Regan, 2003; Ledray, 2001; Plichta, Clements and Houseman, 2007).

¹⁶ Personal communication – information retrieved from a letter by Carol Shand, Acting president of DSAC to Ministry of Health dated 16/8/07, and released to the researchers by DSAC 14/8/08.

4.3.2 Good practice guidelines for performing a forensic medical examination

In the United Kingdom, early medical responses were predominantly forensic (Blair, 1985), meaning rapid processing of victim/survivors without consideration for their psychological health (Campbell and Raja, 1999). This is in contrast to more recent understanding that if the forensic examination is combined with sensitive medical care, this will provide an opportunity to begin the victim/survivor's recovery (Beckett, 2007).

In New Zealand, the DSAC manual includes detailed guidelines for conducting a forensic medical examination. This includes appropriate medical procedures but also how to provide effective support (DSAC, 2006). These guidelines are based on research and informed by professional clinical opinion. Jan Jordan has also published recommendations based on her interviews with victim/survivors (Jordan, 1998, 2004, 2008). In the United Kingdom, Kelly and Regan (2003) have published comprehensive guidelines based on an international review of literature. Common points from all these sources are summarised in Box 8.

Recognition of the physical and psychosocial consequences of sexual violence has been followed by a growing realisation that the levels of support required during this examination period could not be delivered by legal and medical systems alone (Astbury, 2006; Campbell and Raja, 1999; Campbell and Ahrens, 1998; Ledray, 2001; O'Shea, 2006). Strong arguments have accordingly been made not only for specialist responses but for these to be delivered in collaborative systems that incorporate high levels of psychosocial support (Beckett, 2007).

Box 8: Good practice principles for performing a forensic medical examination

Victim-centred approach

- Informed choice and consent – victim/survivors should be provided with sufficient information to decide whether they want the examination, who will perform it and who will be present. It is important that they feel in control of the process.
- Ongoing communication – there should be ongoing communication between the medical practitioner and victim/survivors, explaining what each step involves and its purpose is.

When?

- As soon as possible – to maximise the collection of forensic evidence, and to avoid the victim/survivor experiencing unnecessary delays.

Who by?

- Specialist trained examiner – skilled not just in the collection of evidence, but also in understanding the impacts of sexual assault, and able to conduct the examination in a way that minimises the risk of secondary victimisation.
- Female examiner.

How?

- Respectfully – conducted in a professional but caring manner.
- Provide support – involvement of advocates/women's non-government organisations throughout, including proactive follow-up.

Where?

- Appropriate environment – an environment that is safe, private, respectful and caring; and is well-equipped, and has sterile conditions to ensure no contamination of evidence.¹⁷

(DSAC, 2006; Jordan, 1998, 2004, 2008; Kelly and Regan, 2003)

4.3.3 Forensic nursing

There are no forensic nursing programmes in New Zealand, but they have been introduced successfully in Europe, the United States and Canada as a means of addressing problems encountered with the recruitment and retention of female doctors and providing the best possible service to victims. Specially trained forensic nurses provide a 24-hour-a-day, first-response care to sexual assault patients in hospital or non-hospital settings.

¹⁷ Kelly and Regan (2003) suggest a dedicated space that combines clinical needs for cleanliness in the examination room, with a separate calming and relaxing location to undertake interview and support work.

Kelly (2005) identifies forensic nursing as a promising practice, although she cautions for the need for forensic nurses to receive sufficient court training. This reflects the considerable literature on the operation of forensic nursing schemes in the United States, which conclude that the Sexual Abuse Nurse Examiners projects are beneficial (for example, Ahrens et al., 2000; Campbell and Diegael, 2004; Crandall and Helitzer 2003; Kelly, 2005; Lang and Brockway, 2001; Littel, 2001; Regan, Lovett and Kelly, 2004). Benefits of forensic nursing cited by these authors include:

- increased availability (particularly during the daytime)
- less expense
- prompt and compassionate care to victims
- less psychological trauma and secondary victimisation avoided
- enhanced collection of evidence.

The best known model of forensic nursing is the Sexual Abuse Nurse Examiners programme in the United States (Beckett, 2007; Patterson, Campbell and Townsend, 2006). The goals of the Sexual Abuse Nurse Examiners forensic nursing programme are to:

- provide prompt and compassionate care that addresses victim/survivors' emotional and medical needs
- improve the quality of forensic evidence collection (Patterson, Campbell and Townsend, 2006).

Crandall and Helitzer's (2003) study in which comparative data from pre- and post-Sexual Abuse Nurse Examiners cases were used found that victim/survivors who had been examined by qualified Sexual Abuse Nurse Examiners nurses received:

- more medical services for sexual assault, including sexually transmitted infection treatment, pregnancy testing and treatment
- a greater number and more-comprehensive type of referrals to victim services.

They also found that more victim/survivors:

- reported to the police (72 percent compared with 60 percent)
- had sexual assault victim/survivors' kits collected (88 percent compared with 30 percent).

However, Patterson, Campbell and Townsend (2006) warn that not all Sexual Abuse Nurse Examiners programmes have the same emphasis and those that prioritised the collection of forensic evidence and prosecution of cases provided fewer services to victim/survivors.

In New Zealand there are no forensic nursing programmes enabling nurses to conduct forensic medical examinations. However, DSAC supports the concept of specialist nurses providing assessments for sexual assault or abuse, provided that

they are appropriately trained and supported in a multidisciplinary fashion (i.e. a minimum training requirement of nurse practitioner and previous wide clinical experience in an appropriate area). They also point out that any forensic medical practitioner, including forensic nurses, should:

- have a wide experience of relevant normal ano-genital examinations (e.g. working in a sexual health or family planning clinic, or general practice doing examinations and seeing normal genitalia). This experience assists in the identification of abnormal circumstances and increases credibility at court.
- not work in isolation and should participate in peer review.¹⁸

While their therapeutic benefits are apparent, it is important to note, from a criminal justice perspective, that the scope of any forensic nursing programme in New Zealand will be limited by whether or not courts accept such nurses as 'ordinary' witnesses (testifying on their personal opinion), as opposed to doctors who are accepted as 'expert' witnesses. For their full benefit to be realised legal provisions would be needed that allowed them to be accepted as 'expert witnesses'.¹⁹

In the United States, forensic nurses conduct the majority of forensic medical examinations and provide services to the police and participate in the court proceedings; whereas, in the United Kingdom, the forensic nurse's practice is limited because they are accepted by the courts as an ordinary witness only (O'Shea, 2006).

4.3.4 Forensic rape kits

Rape kits were developed to standardise the collection and recording of relevant physical forensic evidence for use in a criminal investigation (DSAC, 2006; Du Mont, Parnis and Mason, 2004; Parnis and Du Mont, 2003). Rape kits are known by a variety of different names including the forensic medical examination kit (DSAC, 2006) and sexual assault evidence kit (Parnis and Du Mont, 2003).

The kits are designed to collect the required evidence to help establish proof of:

- offender identity
- time-frame of the offence
- evidence or otherwise of the use of force
- corroboration of the victim/survivor's account (Kelly and Regan, 2003; Du Mont, Parnis and Mason, 2004).

Studies that have looked at the impact on victim/survivors reported that the vast majority of victim/survivors found the use of the rape kit somewhat or very intrusive

¹⁸ Personal communication - letter by Carol Shand, Acting president of DSAC to Ministry of Health dated 16/8/07, and released to the researchers by DSAC 14/8/08.

¹⁹ It is unclear whether a nurse practitioner in New Zealand can give evidence as an expert witness in court, as in many parts of the United States.

and distressing, although these negative impacts can be ameliorated when there is a good relationship between health professional and victim/survivor, with each step carefully explained (Jordan, 2008).²⁰

Although their primary purpose is to collect evidence, interestingly, such processes may also have a therapeutic role. Undergoing a forensic examination has been found to corroborate women's narratives of being sexually victimised, and to have a positive effect on emotional and psychological well-being (Du Mont, Parnis and Mason, 2004; Parnis and Du Mont, 2003).

Issues of good practice relate mainly to procedures for using a rape kit and in what circumstances they should or should not be used. Good procedural practices around using a rape kit for a forensic medical examination have been presented in section 4.3.2. Guidelines on *when* they should be used are based around their potential evidential value in any particular case. Kelly and Regan (2003) strongly recommend that their use must be adapted to the facts of the case. For example, unless the victim/survivor is a child under the age of 16, proving sexual connection took place and in some circumstances, the identification of the accused, is not in and of itself proof that the crime has been committed (Kelly and Regan, 2003).²¹ However, it may not always be possible to predict at this point what the likely defence will be.

Parnis and Du Mont (2003) highlight that some medical evidence gathered through the rape kit may have little effect on legal outcomes, and sometimes can work against the woman who has been sexually assaulted (e.g. back door evidence at trial, where evidence of an unrelated sexually transmitted infection may be used as evidence of the victim/survivor's sexual promiscuity). Experienced forensic examiners will recognise situations when it is not necessary to ask a victim/survivor to undergo such an intrusive procedure, especially where the victim/survivor is highly distressed to begin with.

If a victim/survivor does not report the assault to the police, a decision must still be made whether to offer to collect evidence and to store the information in case the victim/survivor changes their mind in the future. This should be an informed choice made by the victim/survivor. However, it is likely other factors will also have an impact, such as the cost of the rape kits and the time it takes to conduct the examination (DSAC, 2006).

4.4 Follow-up medical care

The importance of follow-up medical care for victim/survivors of sexual violence is widely recognised (Cantu, Coppola and Lindher, 2003; DSAC, 2006; Ferguson, 2006; Olle, 2005). After the acute post-rape care, there may be a range of short-term and longer-term medical needs of victim/survivors, including ongoing

²⁰ It is likely that the impacts of the kit would be difficult to separate from other aspects of the examination.

²¹ This is applicable to jurisdictions (including New Zealand) where the age of consent for sexual intercourse is 16 years.

assessment and treatment for sexual and reproductive health problems, pain syndromes, eating disorders, gastro-intestinal problems, and assessment and treatment of mental health needs (Astbury, 2006; Krakow et al., 2002; Leserman et al., 1998). However, there appears to be little research on good practice principles in relation to these; what research there is tends to be related to follow-up mental health care, which is dealt with in chapter 5.

In New Zealand, the DSAC manual recommends that following a forensic medical examination, doctors should make a phone call or visit at one week, and follow-up visits at three weeks and three months post-assault.

One issue is how to increase the likelihood of victim/survivors seeking follow-up medical care. A study in the United States found only 22 percent of sexual assault victim/survivors who had seen a forensic nurse sought follow-up medical care. These authors identified several characteristics of victim/survivors that predicted follow-up care (e.g. age, nature of injuries, prescription of medication, nature of the assault, relationship with offender), but could not identify any such evidence in relation to procedural factors (Ackerman et al., 2006).

In New Zealand, women who were asked to report to sexual health clinics for follow-up tests found this practice difficult to manage because of their public nature and the social stigma attached to 'VD' (venereal disease) clinics (Jordan, 2008).

4.5 Responding to the needs of diverse groups – medical system

The health care system that operates in New Zealand predominantly reflects a westernised approach to health. Commentators have questioned the ability of this system to meet the needs of all sectors of society. It has been argued that the New Zealand health care system, based on European/westernised culture, values individualism and self-advocacy. As such it provides care in a manner that advantages certain groups, including higher socio-economic groups, non-Māori, non-Pacific people, and people without disabilities (Jensen and Smith, 2006).

Whilst acknowledging the diverse realities within any group (Durie, 1995), some of the key differences in the needs of particular groups and their implications for good practice for these groups are reviewed below.

4.5.1 Māori victim/survivors

Traditional Māori approaches to health and well-being are more holistic than Western approaches (Durie, 2001, 2006; Ministry of Health, 2002). But all are underpinned by the desire to improve Māori health outcomes through the promotion of whānau ora – moving towards strengthening Māori whānau (i.e. a collective approach).²² Several Māori models and frameworks illustrate Māori holistic

²² He Korowai Oranga: Māori Health Strategy also cites whānau ora as its overall aim and describes this as supporting Māori families to achieve maximum health and well-being (Minister of Health and Associate Minister of Health, 2002).

approaches to health and well-being, but perhaps the most well-known is Te Whare Tapa Whā (Durie, 2001), which has subsequently become embedded in Māori health policy (Pitama et. al., 2007).²³ In contrast to Western approaches to health, which tend to focus on physical aspects of being unwell, Te Whare Tapa Whā consists of four dimensions of health and well-being:

- te taha hinengaro (psychological or mental health)
- te taha wairua (spiritual health)
- te taha tinana (physical health)
- te taha whānau (health of the extended family).

It is generally agreed that for services to be effective for Māori (including those who are victim/survivors of sexual violence), they should respect and address, in an integrated manner, all of these four dimensions (Durie, 2001). For a fuller understanding of Māori understanding and approaches to health, see *Mauri Ora: the dynamics of Māori health* (Durie, 2001).

Three guidelines were located that provide guidance on the appropriate way to meet the needs of Māori victim/survivors of sexual violence. One was the *Medical Management of Sexual Assault* manual, which included some general guidance on providing medical care to Māori victim/survivors (DSAC, 2006), and the other two were guidelines for working with Māori victims of family violence:

- *Family Violence Intervention Guidelines: child and partner abuse* (Ministry of Health, 2002)
- *Screening, Risk Assessment and Intervention for Family Violence Including Child Abuse and Neglect* (Standards New Zealand, 2006).

The Standards New Zealand guidelines are based largely on the Ministry of Health guidelines. Neither is specific to victim/survivors of sexual violence. However, they are relevant as a significant proportion of women who have been abused by their partner will have experienced sexual violence (Fanslow and Robinson, 2004).

Guidance on the delivery of culturally safe and competent interventions that respond to Māori victims of family violence was the same for both sets of guidelines, and included:

- **victim safety and protection must be paramount**
- the **provision of a Māori-friendly environment** – for example, Māori images in environment, Māori staff, staff conveying a genuine attitude that is gentle, welcoming, caring, non-judgmental and respectful – first contact is vital

²³ There are also models for assessing health service effectiveness from a Māori cultural perspective. For example, Hua Oranga (Kingi and Durie, 2004), which is based on Te Whare Tapa Whā, and He Taura Tieke, which is based on key elements indicated by research as being consistent with Māori views – technical and clinical competence, structural and systemic responsiveness and consumer satisfaction (Ministry of Health, 1995, cited in Ministry of Health, 2002).

- **culturally safe and competent interactions** – for example, familiarisation with Māori models of health, engagement with local hapū and kaumātua to provide cultural guidance
- **a collaborative community approach to family violence** – for example, development of knowledge of referral agencies appropriate for Māori (Ministry of Health, 2002: 13–17).

The Ministry of Health guidelines also stress the importance of the first point of contact with Māori women, which can influence their level of trust in the health care provider. Culturally safe and competent interactions are seen as essential and some suggestions are outlined.

Medical Management of Sexual Assault (DSAC, 2006) provides guidelines for doctors working with victim/survivors of sexual violence. The importance of cultural competence, including working appropriately with Māori, is outlined in section A2 of the manual, Principles of effective support. The manual states that Māori are at greater risk of heightened trauma from the Pākehā (European) medical, police and criminal justice processes. In response, the manual recommends ‘a commitment of health professionals to the principles of Te Tiriti o Waitangi and biculturalism and to work towards better meeting the unique needs of Māori’ (p. 5, section A2).

The manual notes the importance of recognising that Māori health models include a more holistic world view than European health models, and provides specific guidance in relation to providing crisis medical care to Māori victim/survivors. This includes:

- understanding the special significance of parts of the body to Māori (e.g. wharetangata (uterus) is the birthplace of whakapapa; the head is extremely tapu (sacred), so taking head hairs can have extra significance; the body itself is tapu (sacred) and food is noa (neutral), so making sure food is away from examination couches and bottoms are away from food places such as tables)
- being aware that body language and ways of expressing oneself can be different (e.g. the appropriateness of eye contact, expressing hostility);
- anticipating that family (whānau) involvement might be the norm and meeting with whānau before any examination; and the individual or whānau may wish to have an opportunity for karakia (incantation/prayer) and/or mihi (greeting speech)
- providing a culturally appropriate person or people to support the patient and doctor during medical examination and to support whānau during and after medical examination; ensuring that the support person is consulted and involved with the process from the beginning or at the time of referral; and that it is welcoming and appropriate to be able to offer kai and inu (food and drink) (DSAC, 2006: 6, section A2).

4.5.2 Pacific victim/survivors

Traditional Pacific approaches to health and well-being are, as with those of Māori, more holistic than Western approaches. As with Māori, the perspective is collective and family based. Effective services thus need to take account of Pacific family and community structures, values, beliefs and practices specifically in relation to health and ill health (Tiatia, 2008). In meeting the health needs of Pacific clients it is also important to acknowledge the importance of Christianity, spirituality and the pivotal role of the church in Pacific families and communities (ACC, 2006).

Two publications were located that provided limited guidance on the appropriate way to meet the needs of Pacific victim/survivors of sexual violence. These are the same as those cited above for Māori.

Guidance on the delivery of culturally safe and competent interventions that respond to Pacific victims of family violence for the most part replicate those for Māori as described above. Additional points included awareness of the effects of migration on Pacific peoples; and recognising that, for solutions to be meaningful to Pacific peoples, other sectors might need to be involved (Ministry of Health, 2002: 13–17).

It is acknowledged that services provided by Pacific people for Pacific people cannot meet the needs of the entire community (Tiatia, 2008). Therefore, it is important that mainstream and other (e.g. Māori) providers are supported and encouraged to offer their services in a manner acceptable to and appropriate for Pacific people (Tukuitonga, 1999, cited in Tiatia, 2008).

4.5.3 Young adult victim/survivors

Research indicated that one of the main reasons that young adults and adolescents seek help less often from service providers is because they fear being blamed and are concerned that information will not be held in confidence (Black et al., 2008; Jackson, Cram and Seymour, 2000). Hence, it is clear that, in relation to these groups of service users, it is essential that privacy and confidentiality are integrated into any medical, counselling or legal service provision. In New Zealand this issue has been recognised, and youth (12–18 years) are entitled to health care without the consent of their parents (Ministry of Health, 1998).

4.5.4 Male victim/survivors

Medical Management of Sexual Assault (DSAC, 2006) gives principles of effective support for male victim/survivors of sexual violence. These include:

- helping male victim/survivors to understand that male sexual assault is not uncommon and that the assault was not their fault
- emphasising confidentiality, because some male victim/survivors may fear public disclosure of the assault and the stigma associated with male sexual victimisation
- respecting and honouring requests for an advocate of a particular gender

- encouraging advocacy programmes and mental health services to build their capacity to serve male sexual assault victim/survivors and to increase their accessibility to this population (ACC, 2008: 10).

Kelly (2002) also suggests that it might be more appropriate that examinations are carried out by women.

4.5.5 Victim/survivors with disabilities

The medical practitioner treating an adult with a disability who has been sexually assaulted has the same responsibility as with other victim/survivors to provide crisis care, follow-up care, and forensic medical examinations if required (Blyth, 2002).

Medical Management of Sexual Assault (DSAC, 2006) provides some guidelines for doctors working with people with disabilities. These include understanding the nature of sexual violence for this group (e.g. caretakers, family members or friends may be responsible for the sexual assault); that communication can be difficult but must be done in a clear and respectful manner, and that information may need to be sourced from others; and that the ability to consent to an examination may be compromised.

Blyth (2002) outlines the processes for establishing informed consent for individuals with intellectual disabilities in Australia. In New Zealand, The Code of Health and Disability Services Consumers' Rights details steps for medical practitioners to take if they judge that the victim/survivor is not competent to make an informed choice (DSAC, 2006).

4.5.6 Sex-worker victim/survivors

New Zealand research with sex-workers documented the distrust sex-workers had in health care workers (Abel, Fitzgerald and Brunton, 2008). Much of this distrust arose from sex-workers' fears of the judgemental and discriminatory attitudes of health care professionals, and that health care providers would be not accepting of their profession. Social workers were particularly distrusted, but there was also a perceived threat posed by visiting doctors, psychologists and other health professionals. It was argued that the most effective way to provide health care services that are acceptable to sex-workers is to involve them in the design and running of those services. Outreach services are also important and are provided through the New Zealand Prostitutes Collective, either in its offices or through outreach work on the streets.

Since the Prostitution Reform Act 2003, guidelines for informing best practice in relation to occupational health and safety have been adopted in New Zealand. This includes guidelines on how to reduce the risk of violence and sets out brothel managers' responsibilities in relation to managing hazards in the workplace, including violence (Department of Labour, 2004).

4.5.7 Ethnic, migrant and refugee victim/survivors

For non–English-speaking individuals, communication issues can make informed consent and collection of evidential information difficult. The name of the interpreter and the language used is a requirement of the Consent to Medical Examination Form, listed in the *Medical Management of Sexual Assault* (DSAC, 2006).

The Ministry of Health has produced a handbook on refugee health care, providing guidelines for health professionals who care for refugee people, including how to conduct culturally sensitive consultations and the effective use of interpreters (Ministry of Health, 2001).

5 Mental health system

5.1 Introduction

Rape is considered to be one of the most severe types of trauma (Breslau et al., 1991 cited in Koss et al., 2003), and its psychological impact has been extensively researched (e.g. Foa and Rothbaum, 1998; Koss et al., 1994, Crowell and Burgess, 1996, and Golding 1999, all three cited in Koss et al., 2003).

Research indicates that, in the aftermath of sexual assault, some women may experience relatively short-term impacts on their mental health, while others will have chronic, long-lasting symptoms (Ahrens and Campbell, 2000; Goodman, Koss and Russo, 1993; Olle, 2005). Factors that seem influential include victim/survivors having already experienced forms of sexual or violent victimisation, their state of mind at the time of the attack, their relationship with the offender, and the extent to which they subsequently receive support and positive intervention. The most frequently experienced effects include fear, anxiety, depression, and loss of trust and self-esteem (Ahrens, 2006; Astbury, 2006; Howard et al., 2003; Petrak, 2002; Wasco, 2003). Post-traumatic stress disorder (PTSD) is also recognised as a common psychological response, with 90 percent of victim/survivors found to meet the criteria for PTSD within two weeks of a sexual assault (Rothbaum et al., 1992, cited in Koss et al., 2003).

Despite this, the literature identifies that not all victim/survivors seek mental health treatment following sexual assault. Campbell (2001) reported that rates of mental health services utilisation vary across studies, but it appeared 25–40 percent of victim/survivors seek treatment.

The delivery of mental health interventions is typically divided into three stages.

- **Crisis intervention** – this occurs immediately or soon after the sexual assault.
- **Short-term** – post-crisis responses addressing short-term needs.
- **Long term intervention** – in the months and/or years after the sexual assault.

In New Zealand, crisis intervention by health professionals may be delivered by ‘on-call’ specialist sexual violence service crisis workers and counsellors and/or specialist sexual abuse doctors at the time of the forensic medical examination. These professionals may also deliver follow-up short-term interventions or may refer the victim/survivor to another specialist counsellor.

Longer-term interventions are delivered by counsellors or psychologists who are either affiliated with specialist sexual violence services or working independently in the community. Many of these counsellors will be Accident Compensation

Corporation (ACC)²⁴ registered counsellors who can provide government-funded counselling to victims of sexual abuse, including sexual violation.

Eligibility for government-subsidised treatment through ACC-registered counsellors is determined by acceptance of a claim by the ACC Sensitive Claims Unit of mental injury resulting from sexual abuse/violence. The Sensitive Claims Unit operates under a third-party funding system, where independent practitioners are funded on a per-client basis to provide counselling services to sexual abuse victim/survivors. In order to be a service provider of sexual abuse counselling, practitioners must be specifically accredited by ACC. Accreditation requires practitioners to be registered (if appropriate to their discipline) as current members of a relevant professional body, for example, the New Zealand Association of Counsellors or New Zealand Psychology Society), to have received training specifically related to sexual abuse treatment, and to receive regular supervision (Jenner, Woolley and Mortimer, 2006).

Victim/survivors also receive treatment through non-specialist, mainstream mental health services. It could be that victim/survivors who had pre-existing mental health problems, preferred non-specialist services, or sought help with problematic mental health concerns that had not initially have been identified as being the result of sexual violence (e.g. depression, suicidality, substance abuse, anxiety).

This section presents available literature on good practice for mental health crisis intervention and post-crisis intervention. However, before this there is a brief discussion on the appropriateness of psychiatric diagnosis and the welfare of those delivering mental health. New Zealand good practice guidelines are also identified.

5.1.1 Labelling debate

A formal diagnosis such as of PTSD can be useful in scientifically documenting the impacts of the trauma of rape, and as way for a person to qualify for funding criteria for treatment (Koss et al., 2003). However, feminist researchers and counsellors have criticised the use of the psychiatric diagnosis such as PTSD as the main way of understanding and responding to the psychological distress of victim/survivors of sexual violence. This is because, like all psychiatric diagnoses, PTSD individualises and pathologises a victim/survivor of sexual violence as a person with a psychiatric disorder. They argue that by focusing on the victim/survivor as a person with a mental illness needing treatment, attention is deflected from the social causation of rape, and onto a de-contextualised and medicalised set of symptoms rather than the overall health and well-being of the victim/survivors (Astbury, 2006; Koss et al., 2003).

In the New Zealand context, the recently published *Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand* (ACC, 2008), argues that sexual

²⁴ ACC is the government agency responsible for receiving, processing and providing financial subsidies for services for individuals who have experienced sexual abuse, including sexual violation. New Zealand is the only country that provides nationwide government-funded treatment (through ACC services) of mental injury resulting from an episode or episodes of sexual abuse (Evans and Taylor, 2004).

abuse is a complex life experience, not a diagnosis or disorder, and although there is a higher rate of PTSD after sexual assault than for any other type of trauma, a diagnosis of PTSD is not inevitable for all victim/survivors.

5.1.2 Welfare of mental health providers

Several studies have documented that mental health providers working with sexual violence victim/survivors may experience secondary traumatic stress symptoms that mirror those of their clients (Astin, 1997; Brady et al., 1999; Ebeth, 1989; Hartman, 1996; Monroe et al., 1995; Pickett et al., 1994; Schauben and Frazier, 1995; Wasco 1999, all cited in Campbell, 2001). Self-awareness and self-care strategies are particularly important for therapists engaged in this kind of work.

5.1.3 New Zealand good practice guidelines

Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand (ACC, 2008) describes good practice guidelines for professionals from all disciplines providing therapeutic services to people who have experienced sexual abuse, which includes sexual violation. The guidelines have been created from principles developed by the Canadian Task Force on Empirically Supported Treatments, together with evidence from a series of research studies undertaken in New Zealand that are directly relevant to professional practice in New Zealand. The guidelines were designed to be 'appropriate to the unique needs of males as well as females, while also taking into account cultural considerations of various ethnic groups' (ACC, 2008: 8).

The guidelines were specifically designed for therapists, counsellors and practitioners providing therapy, counselling and treatment (referred to collectively as 'therapists' in the document). However, given the dearth of New Zealand good practice guidelines for working with victim/survivors of sexual violence, it is likely that they will be used in wider contexts. The guidelines acknowledge this by suggesting that they are aimed at 'any mode of professional involvement in which the focus is on improved mental health and the enhancement of personal, social, and emotional life' (ACC, 2008: 49).

The practice guidelines are organised into two parts: Part one comprises the principles and recommendations designed for work with sexual violence victim/survivors within bicultural New Zealand. The recommendations are based on the good practice identified by the research (see Box 9). Part two is the practice guide, which elaborates on research findings and provides greater detail to support the principles and recommendations.

Box 9: Summary of Accident Compensation Corporation principles of good practice

Principle 1: Safety – The safety of the client and relevant others is paramount throughout the therapy process. Aspects of safety include risk to self, risk from others, and risk to others (including abuse or neglect of children). Cultural safety is also important, including ethnicity, religion, gender, age, sexual orientation, gender identity, and (dis)ability (p. 21).

Principle 2: Client focus – A client focus emphasises the importance of tailoring therapy to the client on the basis of a detailed assessment. The most appropriate therapy depends on several factors, including the victim/survivor's age, culture, type of sexual violence, and the frequency and severity of the abuse. Complex need can be identified early in the process through assessment so that the relevant services are accessed for the client (p. 23).

Principle 3: Therapeutic relationship – The guidelines state that the therapeutic relationship is one of the foundations on which successful therapy rests, and the quality of the therapeutic environment will influence the outcome of therapy. The therapeutic relationship should be evaluated in a cultural context as cultural preferences may be pivotal in developing a positive therapeutic relationship (p. 25).

Principle 4: Culture, identity and diversity – Considerations of culture, identity and diversity emerge as a strong principle for inclusion in the guidelines as culture impacts on therapy. A lack of knowledge and respect for differing cultural world views, systems of belief, social customs and ways of being can undermine the therapeutic relationship. The guidelines state that where possible and favoured by the victim/survivor, a therapist and client match is preferable whether this is ethnic, religious, gender or otherwise. Practitioners also need to have a good understanding of the impact of their own culture as well as that of the victim/survivor (p. 27).

Principle 5: Effects – Sexual violence always affects the victim/survivors in some way, and there is a vast array of emotional, behavioural, social, cognitive, physical, and environmental effects of sexual violence, which differ with each individual. There is a close interplay between coping strategies and effect. Effects may be expressed in a cultural context and may refer to tapu, tikanga, whakapapa, and identity issues. Sexual abuse is a complex life experience, not a diagnosis or disorder, and those who have experienced sexual violence can display a variety of effects at any point in time (p. 31).

Principle 6: Assessment – Assessment is an essential process for understanding the victim/survivor and formulation of a therapy approach. Assessment should use a variety of approaches and sources and is an ongoing process. Important areas to assess include safety, risk, and physical and mental health, as well as relationships, family/whānau, identity and self-esteem (p. 33).

Principle 7: Goals – Collaborative goal-setting is an essential component of effective therapy, as client-focussed approaches are important for good outcomes. It is important to emphasise realistic goals that can be attained (p. 37).

Box 9: continued

Principle 8: Rationale and process – Explaining the process and rationale of therapy to the victim/survivors is essential, including preparing them for therapy and providing information about what to expect, reflecting the principle of informed consent. The pacing and timing of therapy should meet the needs of the victim/survivors and are particularly important aspects for Māori and Pacific peoples (p. 39).

Principle 9: Monitor and feedback – Monitoring is undertaken collaboratively with the victim/survivors and needs to be regular so that it can guide the direction of the therapy. Therapy must always be judged in terms of the extent to which it is benefiting the victim/survivors, and the extent to which goals have been achieved. Feedback to victim/survivors is useful because it enables them to evaluate progress (p. 41).

Principle 10: Opportunities and challenges – Therapists who work with people who are victim/survivors of sexual violence have the responsibility to provide the most effective professional service possible, as well as ensuring that the victim/survivors are protected from further harm. Therapy with victim/survivors who have been sexually abused requires specialised training and supervised experience. Practitioners must have processes in place to deal with practitioner stress, fatigue and burnout (p. 43).

Principle 11: Context – Understanding the social, familial and physical environments of each victim/survivor is pivotal in ensuring effective therapy. Effects can be triggered or can re-emerge with a changed environment. This may include living situations, social or intimate relationships, or a subsequent triggering event (p. 46).

Principle 12: Therapy completion – Ending therapy requires collaboration between the therapist and victim/survivor and can be planned for early in therapy. Finishing therapy is not the end of the victim/survivor's journey, and also involves helping clients to anticipate and plan for setbacks in their progress. The therapeutic relationship can have emotional significance, and there needs to be open discussion and collaboration with the victim/survivor (p. 47).

(ACC, 2008)

5.2 Crisis intervention

Counselling is beneficial through all stages of recovery, but crisis intervention during the initial stages immediately after rape is crucial to health and well-being of victim/survivors (Daane, 2006). Hence, it is important that assessment and intervention in relation to a rape victim/survivor's psychological state happens as early as possible. For a rape victim/survivor who undergoes a forensic medical examination and assessment, there is an opportunity to also assess his or her psychological status. The victim/survivor can then be referred on for appropriate services.

The immediate crisis reactions to sexual violation are shock, fear and feelings of hopelessness, resulting in high levels of acute distress (Astbury, 2006; DSAC, 2006). This distress is described as corresponding to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) Acute Stress Disorder (DSAC, 2006). It is suggested that these levels of distress are high in the first week, tend to peak at three weeks and stay for the next month. The manual goes on to say that in the first month, 90 percent of people who have been sexually assaulted show symptoms of PTSD, although this cannot be diagnosed until symptoms have persisted for more than a month (DSAC, 2006).

The goal of crisis intervention is to assist in returning the victim/survivor to pre-crisis (pre-rape) levels of functioning (Daane, 2006; DSAC, 2006). Limited literature was located on good practice guidelines for crisis mental health interventions. A World Health Organization review on health responses to rape victim/survivors concluded that research evidence on the appropriateness of interventions to reduce early distress and prevent later psychopathology was inconsistent (Wang and Rowley, 2007).

Some authors have offered recommendations that appear to be based on a combination of clinical judgement and review of very limited literature (Daane, 2006; DSAC, 2006; Osterman, Bariaz and Johnson, 2001). These recommendations appear in Box 10.

Box 10: Good practice recommendations for mental health crisis intervention

- Where possible gather background information before arrival at the victim/survivor's location.
- Restore psychological safety by reassuring victim/survivor that he or she is now safe.
- Assess the needs of the victim/survivor (information, medical care, counselling, support, legal assistance).
- Seek only the history required, avoid re-traumatising victim/survivor by requiring him or her to verbalise and 're-live' the trauma unnecessarily.
- Correct misattributions.
- Provide information to victim/survivor, including medical status, common reactions to assault and how to obtain further help.
- Distress can result in a limited capacity for the victim/survivor to make decisions; it may be necessary to transfer normal responsibilities and obligations to another individual. However, the practitioner should avoid inappropriately taking over decisions for the victim/survivor that risk replicating the dynamics of the assault.
- Restore and support effective coping.
- Show concern and empathy and encourage hope.
- Arrange for follow-up intervention as necessary.

(Daane, 2006; DSAC, 2006; Osterman, Bariaz and Johnson, 2001)

5.3 Post-crisis mental health care

The majority of trauma victim/survivors recover spontaneously. However, 25–30 percent of women who have been raped continue to experience negative effects for several years, including major depression, generalised anxiety, panic attacks, phobias and suicidal ideation (Astbury, 2006). Development of persistent PTSD is common (DSAC, 2006; Koss et al., 2003; Wang and Rowley, 2007). In a review of the research conducted on PTSD, Foa and Rothbaum (1998) noted that while not all trauma sufferers will necessarily experience PTSD, victim/survivors of sexual assault tend to have longer-lasting reactions than victims of non-sexual assaults, and also that those who initially experience more severe symptoms are also more likely to have persistent symptoms.

Problems such as depression and anxiety are often co-morbid with PTSD. While some problems might improve with the treatment of PTSD this does not always happen. The co-morbid disorder may even impede effective treatment of the PTSD and may require specific treatment (National Collaborating Centre for Mental Health, 2005).

A systematic review of empirical evidence for the treatment of PTSD as a result of different traumatic events commissioned by the National Institute of Clinical Excellence (National Collaborating Centre for Mental Health, 2005). The findings of the review are generic to the treatment of PTSD regardless of the particular trauma that caused the symptoms, and so findings are applicable to those suffering from PTSD as a result of sexual violence. The reviewers noted that PTSD sufferers may be first accessed through primary health care (e.g. a general practitioner) or secondary health care such as hospital emergency departments, and presented the following recommendations.

- When PTSD sufferers present to primary care, general practitioners should take responsibility for the initial assessment and co-ordination of care.
- Assessment should be done by competent people and be comprehensive, including, physical, psychological and social needs and a risk assessment.
- When patient care is split between primary and secondary health professionals, there should be clear agreement about responsibility for monitoring patients.
- Families and carers have a key role in supporting sufferers, but may also need support themselves. Healthcare professionals should be aware of the impact of PTSD on the whole family.
- Where the healthcare professionals and the PTSD sufferer are from different ethnic or cultural backgrounds, the professionals should familiarise themselves with the sufferer's cultural background.
- Language and cultural differences should not be a barrier to the provision of effective trauma-focused interventions. This could be achieved through the use of interpreters and bicultural therapists.

Once mental health needs have been identified longer-term treatment will be referred to mental health providers. As noted earlier in New Zealand these providers

can be generic mental health providers or those specialising in the treatment of sexual violence (e.g. ACC-registered counsellors).

5.3.1 Effectiveness of different types of mental health interventions

This review revealed a gap in knowledge about what types of counselling therapies or modalities are used in New Zealand and by whom; and it was beyond the scope of the review to consider clinicians' or counsellors' views on what types of therapy might work and how or why they work.

A review of overseas literature also located very few articles that commented on the effectiveness of different types of mental health interventions (Astbury, 2006; Campbell, 2001; Wang and Rowley, 2007). Evidence on what is effective was limited and incomplete (Astbury, 2006; Campbell, 2001). This lack of research means that interventions available may or may not be the most appropriate ones to respond to a victim/survivor's needs (Astbury, 2006).

The most comprehensive information located was from a recent World Health Organization review on therapeutic approaches to victim/survivors' mental health needs (Wang and Rowley, 2007). In reviewing evidence on the major therapeutic approaches used to treat survivors of sexual violence findings on the comparative superiority of approaches were also inconsistent. A summary of findings from the Wang and Rowley (2007) review appears below.

- Different types of cognitive behavioural therapies aimed at managing the memory of the trauma were found to reduce sequelae such as anxiety, depression and PTSD, at different post-rape stages. These included prolonged exposure treatment and stress inoculation training. Cognitive processing therapy has also been found to be effective in treating PTSD. There is evidence that brief interventions improve functioning and decrease the severity of re-experiencing and arousal symptoms associated with PTSD.²⁵
- Relational therapy, which integrates a victim/survivor's immediate social network into the treatment, has also been found to decrease symptoms of depression compared with those undergoing individual treatment, although decreases in PTSD symptoms were similar and there were no significant differences in family functioning between the two groups.
- Not all forms of therapy have been evaluated. For example, feminist approaches often integrate elements of cognitive behavioural therapy with group therapy to reduce short-term fear and anxiety as well as longer-term issues of self-blame, shame and guilt. Feminist therapies seek to help the survivor to see a victim/survivor's experience as part of a larger social problem and thus to reframe the causes of the sexual violence and reduce long-term feelings of personal guilt, shame and self-blame. There are some indications

²⁵ For more details on the characteristics of these interventions, see Wang and Rowley (2007: 41–43) or National Collaborating Centre for Mental Health (2005: 52–56).

that feminist therapeutic approaches are effective, but there does not seem to have been any research documenting integrated therapies.

The latter point highlights one of the inherent limitations of literature reviews and what can and cannot be inferred.

Box 11 presents the key findings on which Astbury (2006), Campbell (2001) and Wang and Rowley (2007) concurred.

Box 11: Effective long term mental health interventions

- Trauma-focused cognitive behavioural approaches to therapy (e.g. prolonged exposure treatment, stress inoculation training, and cognitive processing therapy) can be effective, particularly in reducing short-term post-rape fear and anxiety symptoms.
- Feminist therapies are less well researched, but may be helpful in addressing longer-term self-blame.

Astbury (2006); Campbell (2001); Wang and Rowley (2007)

5.3.2 Victim/survivors' perspectives on good practice

Following in-depth interviews with 48 sexual violence victim/survivors, Jordan (1998) made the following recommendations for New Zealand support agencies and counsellors providing both crisis and long-term support mental health care and support (see Box 12).

Box 12: Consumers' perspective's on good practice for mental health services

- All districts should have a well-publicised 24-hour crisis service available for rape/sexual assault victims, with personal service guaranteed (as opposed to reliance on answer-phones at night).
- Support agencies should ensure that all services are provided and conducted in an empowering and validating manner in order to avoid secondary victimisation.
- A limited number of appropriate counsellors should work as part of a multidisciplinary team with police and doctors to provide integrated service delivery.
- The availability of specialised rape/sexual assault counsellors within any generic support agency should be facilitated. These need to be carefully selected people, trained to have a thorough knowledge and understanding of the needs and effects of rape, as well as an awareness of police and court processes.
- Counsellors should be flexible in adapting their style to the woman's needs, to ensure that the survivor retains a sense of their own power and autonomy within the therapeutic relationship.

(Jordan, 1998: 93)

5.4 Responding to the needs of diverse groups – mental health

Responding to the specific needs of special population groups, including Māori and Pacific peoples, Asian peoples and other ethnic communities, refugee and migrant communities, and people with disabilities, was one of ten leading challenges to improving the quality of New Zealand mental health and addiction services (Minister of Health, 2005). Hence, one of the strengths of *Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand* (ACC, 2008) is that it addresses cultural diversity and issues of cultural safety specific to the New Zealand context.

When working with victim/survivors from another culture, the ACC guidelines suggest that a therapist should consider whether they are the most appropriate person to work with this client. Because of the shortage of counsellors and therapists from all ethnic groups in New Zealand, it is likely that a client may be from another culture to the Pākehā therapist. When this happens, the therapist should not make assumptions about what is best for the victim/survivors, and may need to obtain their consent to consult with others about cultural issues, and to receive cultural supervision (ACC, 2008).

5.4.1 Māori victim/survivors

Achieving improvement in Māori mental health outcomes was singled out as a specific challenge for New Zealand (Minister of Health, 2005). Key to this is understanding the approaches to mental health services that are effective for Māori. These same approaches are likely to underpin good practice in providing counselling to Māori victim/survivors of sexual violence. Pitama and her colleagues (2007) note that within psychological practice Te Whare Tapa Whā forms the foundation of a number of practice frameworks. One of these is the Meihana Model, a clinical assessment framework that encompasses the four original dimensions (see chapter 4) and adds two additional elements – taiao (the physical environment) and iwi katoa (societal impact on the client/whānau).

Durie (2003) has written that conventional Western approaches to counselling do not always meet the needs of Māori. Māori understandings of well-being and mental health are underpinned by a relational perspective, which emphasises the wider set of relationships between the individual and the environment that affect mental health. This is at odds with the more tightly focused orientation of many Western psychological interventions, which tend to centre on acquiring particular skills or overcoming emotional or behavioural problems. They may exclude consideration of the wider environment, and may not adequately recognise culture as a means of change. Māori approaches seek balance across the spiritual, mental, physical and social domains.

The primary aims [of Māori-centred methods] are to develop a secure cultural identity, establish balanced relationships with whānau and society, and achieve a sense of reciprocity with the wider social and physical environments. (Durie, 2003: 50).

Many of the above points are included in the ACC practitioner guidelines in the section on cultural awareness when working with Māori clients. Within a holistic

framework, using a Māori approach that acknowledges the wairua (spiritual aspect) is considered paramount in the healing process for Māori victim/survivors of sexual violence (ACC, 2008). Other points highlighted included that cultural issues such as tribal preferences and styles need to be considered because shared understandings and beliefs are important. The process of whanaungatanga (making family and ancestral connections) and references to shared experiences are seen as important elements in establishing a therapeutic relationship as well as reinforcing the focus on whānau (ACC, 2008: 88–89). Whilst acknowledging a traditional way of working with Māori, the section also notes that it is important to consider each client as unique and to not assume that Māori models of therapy are appropriate or desirable for all Māori (ACC, 2008: 88).

In considering the type of approaches available to Māori, Durie (2003) has identified three approaches to incorporating Māori cultural beliefs and values into counselling and healing (see Table 5). They centre on the use of traditional healing services, creating bicultural models by adding Māori values and practices to mainstream treatment programmes, and developing Māori-centred techniques.

Table 5: Māori and counselling

	Broad approaches		
	Traditional healing	Bicultural models of treatment	Māori-centred approaches
Approach	Customary practices	Modification of conventional Western methods, partnership	Māori concepts and values form basis for interventions
Examples	Rongoa, mirimiri, karakia	Bicultural therapy	Mauri therapy, Paiheretia
Type of therapist	Tohunga	Psychologists, Māori community experts	Mauri therapists, relational therapists

Source: M. Durie (2003) *Ngā Kāhui Pou Launching Māori Futures*. Wellington: Huia Publishers, p. 47.

Durie (2003) notes that different forms of therapy need not be in conflict and that a single approach is unlikely to meet multiple and complex needs. Ideally, Māori who live in two worlds (i.e. both Māori and Pākehā) would have access to the benefits of both.

5.4.2 Pacific victim/survivors

As mentioned in chapter 2, Pacific people in New Zealand come from a number of diverse cultural backgrounds, with differing systems of social organisation and perspectives on mental health. There is also a growing number of New Zealand-born Pacific people, whose views of traditional cultural values are influenced by contemporary ideas.

The New Zealand ACC guidelines address appropriate ways of working with Pacific people, but note that there is no 'one size fits all' and there are differences between

what is appropriate for the different Pacific communities. However, whilst acknowledging the cultural and intergenerational diversity, there is sufficient common ground to enable identification of a Pacific world view on mental health, which is applicable also to mental health service provision for Pacific victim/survivors of sexual violence. The Northern Regional Pacific Mental Health and Addictions Plan 2003/05 is useful in understanding this world view (Counties Manukau District Health Board, 2003).

Pacific models of mental health are underpinned by a holistic view of health. For Pacific people, recovery is achieved through harmony between the physical, spiritual, emotional and family domains (see chapter 4). The centrality of the extended family in Pacific cultures means that families are critical to recovery. Educating non-English-speaking Pacific families about mental health, and assisting them by providing information in their own language, could therefore be seen as a key role of effective service provision (Counties Manukau District Health Board, 2003).

There is some overlap, at a conceptual level at least, in good practice principles for mental health services for Pacific people and Māori. As for Māori, conventional approaches tend to be neither appropriate nor effective for Pacific people; Pacific mental health staff need to be clinically and culturally competent; and the mainstream workforce needs to be more responsive to the needs of Pacific people and to understand the cultural values that influence their mental health (Counties Manukau District Health Board, 2003).

Recovery is also assisted through partnerships between mental health service providers, clients and a wider network, ranging from employers and landlords to social and government agencies (ACC, 2008; Counties Manukau District Health Board, 2003). This entails recognising consumers' strengths and ability to resolve their own problems, engaging communities and developing community resources, and working with other health and social services in an integrated, multidisciplinary system of care (Counties Manukau District Health Board, 2003).

The Mental Health Commission (2001, cited in Tiatia, 2008) noted that some Pacific people choose to access traditional healers for their mental health needs, and anecdotal evidence indicates that the percentage is large. The implication of the use of traditional healers and how this fits with mainstream mental health services has not been explored, but there are examples of where partnerships between Pacific mental health services and Pacific traditional healers work well (e.g. Faleola Services (Counties Manukau District Health Board) and Isalei Pacific Mental Health service (Waitemata District Health Board) support and monitor Pacific service users who wish to access traditional healers) (Ministry of Health, 2008: 18).

In relation to the specific counselling needs for Pacific sexual violence victim/survivors, the New Zealand ACC guidelines suggest that mental health practitioners be aware that this group of clients may find it very difficult to talk about sexual matters. It is also noted that, for this group, important goals for healing may include forgiveness (of the perpetrator), strengthening cultural identity, and strengthening family connections (ACC, 2008: 89–125).

5.4.3 Victim/survivors with disabilities

People with disabilities are at higher risk of all types of abuse, and it is important that the therapist understands the implications of the disability. People with intellectual difficulties are at high risk of being sexually abused on an ongoing basis, and their mental health problems often go undiagnosed. In addition, victim/survivors with intellectual difficulties are less likely to be believed when reporting sexual abuse. The New Zealand guidelines (ACC, 2008) provide checklists for therapists to consider when working with clients with intellectual difficulties.

In *Myalla: responding to people with intellectual disabilities who have been sexually assaulted*, Julie Blyth (2002) has produced a practical resource, based on current research, aimed at improving the quality of services to victim/survivors with intellectual disabilities.

5.4.4 Male victim/survivors

The New Zealand guidelines (ACC, 2008) recognise that men are less likely to disclose sexual abuse, less likely to seek assistance, and more likely to feel confused about their sexual orientation, and experience increased sense of shame about being abused, than women victim/survivors.

Issues for counsellors to be aware of include:

- male victim/survivors need reassurance about issues concerning their sexuality in a way that female victim/survivors may not necessarily need (Crome, 2006)
- given the length of time for many men between the rape and the reporting, it is highly likely that this group of victim/survivors will be experiencing chronic mental health issues (Crome, 2006).

5.4.5 Ethnic, migrant and refugee victim/survivors

Studies from various parts of the world have found proportionately higher rates of psychiatric hospitalisation among recent migrants, but it is not possible to determine the prevalence of mental illness in immigrant groups in New Zealand from official mental health data (Abbott, 1997).

In her paper *Sailing in a new direction: multicultural mental health in New Zealand* (2007), DeSousa found that although new migrants and refugees make up an increasingly significant section of the population (one in five New Zealanders were not born in New Zealand), they underutilise mental health services. She recommends workforce development is needed to reduce prejudice and discrimination and make the services more culturally acceptable.

More specifically related to sexual violence, Savage (2003) noted that the disgrace and shame associated with rape, particularly in more traditional cultures, results in low levels of disclosure and the silencing of the voices of the abused. She points out that in some communities there is no alternative language for the symptomology and concept of PTSD than they are 'mad' (Savage, 2003: 3). Specialist counsellors

working with refugee women have found that establishing a therapeutic relationship of trust can aid disclosure in the long term (Savage, 2003).

5.4.6 Sex-worker victim/survivors

A recent review and consultation process in Australia noted that sexual assault counselling services are not equipped to deal with sex-workers as victim/survivors because of the multiple difficulties sex-workers face (Quadara, 2008). These included:

- stigma and prejudice within counselling services
- sex-workers having to 're-educate' counsellors before they could begin working on the impacts of sexual assault (Quadara, 2008).

Some sexual assault services have addressed issues of barriers to accessing services, by providing an information sheet explicitly for sex-workers, or outreach counselling for street-based sex-workers. It has been suggested that counselling services may benefit from attending training by sex-work organisations and obtaining sex-workers' advice to inform service provision and crisis care (Quadara, 2008).

6 Criminal justice system

6.1 Introduction

If a victim/survivor reports the offence, they enter a criminal justice system that can be experienced in diverse ways, ranging from highly validating and supportive to inflicting secondary victimisation (Herman, 2005; Jordan, 2004). Key needs for victim/survivors who enter this system are to be believed, have sufficient support and be provided with good ongoing information (Jordan, 2008; Lievore, 2005).

The criminal justice system is the network of courts and legal processes that deals with the enforcement of criminal laws, including the laws that prohibit sexual violation. Key components and players are the complainant (the victim/survivor of the sexual violence), the accused (the alleged perpetrator), the police, lawyers, judges and the court system itself. The collection of forensic evidence is also part of this system but has been addressed in chapter 4.

There are two key issues with the criminal justice system in relation to sexual violence.

- The low rates of reporting, prosecution and conviction of sexual violence offences. In New Zealand and globally these rates are lower than for other crimes (Amnesty International Australia, 2008; Ministry of Justice, 2008).
- The impact of criminal justice system processes on those victim/survivors who engage in this system. The literature has consistently identified this area as being one of potential secondary victimisation, where victim/survivors are at risk of experiencing 'a second rape' (Koss, 2000; Lees, 1996; Lievore, 2005; Moul, 2000; Scutt, 1998; Thomas, 1994). Despite significant legislative and procedural changes around the world, concern has been increasingly expressed that rape victim/survivors' experiences of the criminal justice system have not substantively improved (Gregory and Lees 1999; Jordan, 2001, 2004; Kelly, Lovett and Regan, 2005; Lea, Lanvers and Shaw, 2003; Temkin, 1997; Temkin and Krahé, 2008).

These two issues are obviously interrelated. The New Zealand Law Commission was recently reported as saying that evidence from focus groups showed that one reason why many women did not lay complaints was because the ordeal of a sexual offence trial was regarded as so unpleasant that they did not want to go through it (Watkins, 2008).

A number of initiatives have been undertaken to address these two issues. The remainder of this section will examine the literature in relation to:

- police practices and initiatives
- specialist prosecutors
- specialist courts

- victim advisors
- statutory reform
- restorative justice.

6.2 Police practices and initiatives

Police occupy a pivotal role in the criminal justice system as the first agency that the reporting victim/survivor encounters. The quality of that contact with the police officer often determines the future of the prosecution process (Campbell and Raja, 1999; Epstein and Langenbahn, 1994; Felson and Pare, 2005; Goodstein and Lutze, 1992; Gilmore and Pittman, 1993; Jordan, 1998, 2004; Lord and Rassel, 2000). On this basis alone, it is clearly in the overall interests of law enforcement for the police to act in ways that are consistent with promoting the victim/survivor's emotional well-being (Burgess, 1999). Historically, however, police departments internationally have been criticised for often displaying myth-informed, judgemental and disbelieving attitudes that resulted in rape complainants feeling interrogated (Chambers and Millar, 1983; Gregory and Lees, 1999; Jordan, 2004). Increasing acknowledgement has been given to the ways in which the trauma suffered by a rape victim/survivor can be compounded by involvement with police officers and procedures. The police response to rape victim/survivors has been the subject of considerable pressure to improve police performance overall (Brown and Heidensohn, 2000; Epstein and Langenbahn, 1994; Gregory and Lees, 1999; Temkin, 1997).

In relation to their role as law enforcers, police, when an alleged sexual assault/rape is reported, have to:

- ensure the safety of the victim/survivor
- investigate whether a sexual offence has been committed
- identify those responsible for the offending
- decide whether there is sufficient evidence to make an arrest
- decide on the type, severity and number of the charges to be laid.

6.2.1 Good practice principles

Amnesty International Australia (2008) identified six police practices that support women through reporting and investigation procedures and protect them from further victimisation. These are applicable to all forms of violence against women, including sexual violence, and appear in Box 13.

We use these Amnesty International Australia (2008) good practices as a framework for exploring literature on good police practices and, where relevant, comment on how these relate to New Zealand police guidelines. There is also a brief section on the use of female police officers, which has also been discussed as good practice in some literature.

Box 13: Good practice principles for police

- A dual focus on supporting the victim/survivors of violence and bringing the perpetrator to justice.
- Specialised ‘violence against women’ units staffed by specially trained personnel, which enable women to feel supported and work to prevent secondary victimisation.
- Safe and confidential environments for women to report violence.
- Consistent procedures in investigations of violence, and in protecting victim/survivors from secondary victimisation.
- Police co-ordination with other services in a co-operative, multi-agency response.
- Compulsory, ongoing and accredited training on issues surrounding violence against women.

(Amnesty International Australia, 2008: 50).

6.2.2 New Zealand Police good practice guidelines.

Police policy and principles for the investigation of adult sexual assault (including rape) are primarily outlined in the Adult Sexual Assault Investigation (ASAI) Policy published by the New Zealand Police in 1998.²⁶ This policy was developed with assistance from medical practitioner groups, counselling agencies, and community groups. Twelve aspects of an investigation are covered, including roles and responsibilities of various parties, specific staffing and training requirements, and investigation procedures. Overarching principles are also outlined. The principles and practices set out in this policy were aimed at ensuring the effective prosecution of sexual assault offences, but they also clearly identified a role for police in ensuring victim/survivor safety and well-being. For example, under section 1 ‘Policy principles’, the first point states (New Zealand Police, 1998: 11):

- 1.1 *The police acknowledge the destructive consequences of adult sexual assault, and that the safety of the victim is paramount.*

Later, section 1.11 states (New Zealand Police, 1998: 11–12):

- 1.11 *The police response to the needs of the victim is aimed at:*
- i. ensuring early intervention and maximum protection;*
 - ii. aiding the victim’s long term recovery from the trauma; and*
 - iii. ensuring the victim’s co-operation with the investigation through to completion.*

²⁶ This policy is under review (Personal communication, New Zealand Police, 5 September, 2008).

The ASAI Policy is specific to the investigation of adult sexual assault offences. However, some police practices are common to other types of offending and are also covered in more general guidelines. For this reason, the policy was designed to be used in conjunction with these other more generic guidelines that govern police practice. At the time of publication the additional guidelines cited included the *Manual of Best Practice*, Victims of Crime Policy, Family Violence Policy, and, in the case of an intellectually disabled victim/survivor, the Policy and Guidelines for the Investigation of Child Sexual Abuse and Serious Physical Abuse (New Zealand Police, 1998).

The ASAI Policy and relevant sections of the *Manual of Best Practice* were reviewed by Dame Margaret Bazley in 2007 as part of the Commission of Inquiry into Police Conduct (Bazley, 2007). Bazley commented that in general she was impressed with the policies and the apparent shift towards practices that recognise the impact of recent trauma, encourage a good working relationship with professional support agencies, and restore to the victim/survivors a sense of empowerment. However, there were areas that raised some concerns. These concerns resulted in two recommendations:

- a review of the ASAI Policy to ensure that the training and resources necessary for its effective implementation are available
- the incorporation of the ASAI Policy within the 'sexual offences' section of the *Manual of Best Practice* to reduce inconsistencies between the two (Bazley, 2007: 91–92).

It is important to note that reviews of policy are different to evaluations of how well a policy has been implemented. In her report, Bazley (2007) cited some concerns in this regard with reports of some experienced detectives being unaware of the existence of the ASAI Policy as recently as March 2005.

We found one other piece of research on pre-trial sexual violence interventions that included an assessment of issues around the implementation of the ASAI Policy. This was a doctoral research study carried out by Linda Beckett that included visits to all 12 police districts to interview relevant police, medical and agency personnel (Beckett, 2007). A total of 113 interviews (44 of which were with police personnel with relevant expertise in relation to sexual assault investigation) were carried out. The qualitative interview data were analysed and triangulated using additional interviews, source documents, site visits and participant observation. Beckett's research identified some difficulties with the implementation of the policy; significant among these has been the time-lapse in establishing the positions and procedures to ensure the policy moves from paper status to practical reality. These findings are discussed in more detail below.

6.2.3 Dual focus on support and conviction

A primary role for police is the investigation and conviction of offending and/or offenders. However, it is widely recognised that co-ordinating the provision of support for victim/survivors is also good practice for police (Amnesty International Australia, 2008; Beckett, 2007; Epstein and Langenbahn, 1994, Metropolitan Police Service, 2005). In the United States, the provision of 'in-house victim/witness

advocates' has been a strategy recommended as good practice (Epstein and Langenbahn, 1994). In other countries, including New Zealand, the police have formal relationships with external specialist support agencies such as Rape Crisis groups and Victim Support (Beckett, 2007).

This dual focus on support and conviction, however, can be challenging for police. Historically, a gulf has existed between the needs of rape victim/survivors and the responsibilities of the police. This arises in part from the police being focused on outcome, which for them ideally means offender identification, prosecution and conviction, while the paramount needs of victim/survivors may revolve more around process, particularly in the initial stages but also throughout their engagement with the criminal justice system. A traumatised person often needs support and belief at the same time that the police are required to be obtaining evidence and conducting interviews (Jordan, 2001). They may adopt an interrogative style that can be experienced as hostile and disbelieving by victim/survivors, and may even result in some genuine complainants deciding to withdraw the allegation (Jordan, 2001, 2004). Addressing these competing needs has been recognised as a potential source of tension for police:

A common source of concern is the perceived failure of the police to strike a consistent and compassionate balance between the victim/survivors' needs and the demands of investigative and administrative priorities. (Law Reform Commission of Victoria, 1991, cited in Gilmore and Pittman, 1993: 12)

In New Zealand, recognition of the importance of the dual focus on both conviction and support for victim/survivors is evident in the ASAI Policy. As illustrated in section 2 'The police commitment', the main functions of police in a sexual assault are listed as (New Zealand Police, 1998: 12):

- 2.1.1 to ensure the safety of the victim;
- 2.1.2 to investigate and, when evidence is available, consider the prosecution;
- 2.1.3 to coordinate the support for the victim, and keep the victim informed of the progress of the investigation as far as possible; and
- 2.1.4 to identify those responsible for offending and ensure they are held accountable.

While police are responsible for co-ordinating the provision of the support, the policy suggests that it is the support person (e.g. specialist sexual violence support worker) who is responsible for ensuring the victim/survivor receives crisis support, counselling and the initiation of therapy (section 2.5.2).

Support for the victim/survivor was recognised as important in the New Zealand Commission of Inquiry into Police Conduct. Bazley (2007) recommended that sexual violence complainants and their support people should be provided with ongoing information regarding case progress and delays and given assistance to understand the reasons for any decision not to prosecute.

Based on research with victim/survivors, Jordan (2004) was of the view that supporting a complainant's well-being is important even in cases that the police suspect, or even know, to be a false allegation, since at least some of the latter may

mask underlying issues requiring referral for counselling or other appropriate intervention.

6.2.4 Specialist units

Specialised sex crime units are also recognised as good practice (Amnesty International Australia, 2008; Brown and Heidensohn, 2000; Epstein and Langenbahn, 1994; Lord and Rassel, 2000; Metropolitan Police Service, 2005). They are seen as a way to develop and focus expertise, as well as a way to send a message to the community that sexual offending is being taken seriously.

Specialisation was supported in the New Zealand ASAI policy, including the setting up of specialised Adult Sexual Assault Teams and the development of specialist co-ordinator positions at the district level. There have been some concerns raised over the delays in implementing this part of the policy (Bazley, 2007; Beckett, 2007). However, in 2006 Auckland police formed a specialised Adult Sexual Assault Team (New Zealand Police, 2006). Initially, the team included a detective sergeant, four Criminal Investigation Branch (CIB) staff, and one General Duties Branch attachment. Two of the staff were women.²⁷ The team comes under the Auckland CIB General Squad where the Child Abuse Team is also aligned, and operates along similar lines to Child Abuse Team. The Adult Sexual Assault Team is expected to enhance relationships with agencies such as Auckland Sexual Abuse HELP and Doctors for Sexual Abuse Care (New Zealand Police, 2006).

Specialised units have been introduced within the United Kingdom context. In London, under Project Sapphire, dedicated Sexual Offences Investigation Teams were established by the Metropolitan Police. These teams included specialist officers and a dedicated detective inspector who was only responsible for investigating rape and other serious sexual offences. The Sexual Offences Investigation Teams were well resourced, with experienced staff, especially at the supervisory level. They also had senior team management to ensure compliance with standards for rape investigations. In a qualitative review of police practice in London, Sexual Offences Investigation Teams and dedicated investigators were two of a range of factors that were found to impact positively on both the proportion of crimes solved and the level of care afforded to victims (Metropolitan Police Service, 2005).

In the United States, Epstein and Langenbahn (1994) emphasised that recruitment to specialised sex offence units should involve employing staff who not only have the necessary technical skills with respect to investigation and interviewing but who also have the necessary personal skills for dealing empathically with victim/survivors and who are positively motivated to work specifically in a sex crimes unit.

²⁷ The Adult Sexual Assault Team comprises nine members, four of whom are women. Specialist teams have recently begun operating in Waitakere and Manukau, with discussion in place about the possibility of these being introduced in Wellington and Christchurch (Detective Sergeant Andy King, public forum, Auckland, 29 August 2008).

6.2.5 Safe, confidential and respectful environments

Adherence to professional policy and procedural guidelines is important, but rape victim/survivors are also sensitive to the attitudes conveyed, whether verbal or non-verbal (Temkin and Krahé, 2008). The loss of safety and control experienced creates a need for reassurance and validation. This is enhanced by the fact that many of those victimised have internalised societal rape myths that blame women in particular for 'getting themselves raped'. Key themes emerging from Jordan's interview studies with rape complainants include:

- the need to be believed by the police
- to be treated with respect
- to be able to exercise some choice or control over processes and personnel
- to be provided with ongoing information and support (Jordan, 1998, 2001, 2004, 2008).

The need for an appropriate environment is recognised in the New Zealand ASAI Policy, which states that interviews with victims must be conducted in an area that is appropriate, comfortable, secure, private and safe and should not be a suspect interview room (section 5.3.3.). It is not clear whether all police stations in New Zealand are equally able to comply with this part of the policy. Bazley (2007) noted that dedicated facilities especially designed for the interviewing and examination of the victims of sexual assault tended to be limited to larger police stations.

Studies of victim/survivors in New Zealand have revealed cases where safe, confidential and private interviewing environments have not always been provided. Examples of failure to provide such an environment included multiple interruptions when a statement was being taken, statements being taken in the same rooms used for interviewing offenders, and women reporting feeling on show as the 'latest victim' when having to walk repeatedly through the station (Jordan, 2004, 2008).

Epstein and Langenbahn (1994) suggest two procedures, based on recommendations for United States law enforcement that can assist with victim/survivors' need for privacy and confidentiality.

- Reporting: offering different options for reporting, including third-party reporting by rape crisis centres without identifying the victim, and information-only reports without prosecution (blind reporting).²⁸
- Ensuring privacy: victim/survivors have the right to confidentiality; police can conceal the information from the public and the media, and by doing so can alleviate victim/survivors' fears in this respect.

²⁸ Both these options are aimed at enabling victim/survivors to let police know of an assault, providing them with intelligence information, rather than making a complaint that would be fully investigated.

These two procedures have subsequently been supported as good practice in a review of sexual assault investigation practices in police and sheriff departments in nine United States counties (Lord and Rassel, 2000).

Police attitude towards victim/survivors

A profound scepticism towards women rape complainants has been evident in criminal justice systems internationally. Concern has been expressed regarding the high proportions of sexual assault complaints that are believed by police to be false (Gregory and Lees, 1999; Jordan, 2004; Kelly, 2002; Lievore, 2005; Temkin, 1997). As well as doubting the veracity of rape allegations, researchers have observed a tendency for many officers to have their thinking dominated by prevalent rape myths and stereotypes (Burgess, 1999; Hinck and Thomas, 1999; Kelly, 1988; Lees, 1997; Regan and Kelly, 2003).

A dominant construct has been that of the 'real' or 'ideal' rape victim. Typically, this stereotype depicts genuine rape victim/survivors as morally chaste women who are raped by a stranger, and whose resistance results in them being physically injured (Du Mont, Miller and Myhr, 2003). Achieving legitimate victim status and a sympathetic police response has been harder to achieve for women whose morality is viewed questionably (such as sex-workers, hitch-hikers, and women frequenting bars or nightclubs) or who are viewed as having questionable credibility (e.g. those with intellectual impairment and/or psychiatric histories), as well as those who belong to ethnic and sexual minorities (Du Mont, Miller and Myhr, 2003; Jordan, 2004).

Razack (1994, cited in Du Mont, Miller and Myhr, 2003: 470) has argued that 'race never absents itself from the rape script,' with Black and Aboriginal women considered 'less inherently worthy than White women'. This can result in minimisation of sexual assaults committed against ethnic minorities, contrasted with maximisation of media attention to sexual assaults perpetrated by ethnic minorities (Ardovini-Brooker and Caringella-Macdonald, 2002). Translated to the New Zealand context, this could result in an added scepticism surrounding complaints of rape/sexual assault made by members of ethnic minorities.

When rape complainants encounter such scepticism, it impacts negatively on their well-being, as well as increasing the likelihood of their withdrawing the complaint or their co-operation with police (Jordan, 2004).

Cultural awareness

Part of providing a 'respectful' environment is ensuring that victim/survivors are treated in a culturally appropriate environment. In New Zealand Māori are over-represented as victims of sexual violation, so it is particularly important that police respond to Māori in a culturally appropriate manner. In the New Zealand ASAI Policy there are several references to police practices being culturally appropriate (e.g. sections 1.5, 2.2.1, 2.2.2, 2.3.1, 2.5.2, 3.1.6 and 5.2.1). Police staff must be able to respond appropriately to Māori victims and those who support them, including whānau, hapū, iwi and Māori agencies.

More recently, the New Zealand Police contributed to the funding of the publication of standards for the screening, risk assessment and intervention for family violence

including child abuse and neglect (*Screening, Risk Assessment and Intervention for Family Violence Including Child Abuse and Neglect*, Standards New Zealand, 2006). Development of these standards aimed to establish the minimum requirements that should be met by individuals and agencies/services, including the police, involved in working with families living with family violence, child abuse or neglect. Within these standards are guidelines for cultural awareness and working appropriately with Māori whānau violence, Pacific peoples and family/fanau violence, and immigrant and ethnic communities. The standards were adapted from the Ministry of Health guidelines on family violence interventions (see section 4.5 of this review).

6.2.6 Consistent and effective investigation practices

Over the years, studies conducted with victim/survivors in New Zealand have revealed widespread inconsistency in the quality of response rape complainants received (Jordan, 1998, 2001, 2004). Partly in response to this research, there have been some significant changes in respect to policies regarding sexual offence investigations, including the development of the ASAI Policy (New Zealand Police, 1998).

The ASAI Policy has a specific section on the investigation procedures that should be adhered to (section 5, Procedures – investigation management). This includes the roles of specific staff, how victim/survivor safety should be ensured, specific procedures for interviews and the investigation in general, and how the medical examination should be carried out.

There is evidence from the United Kingdom that appropriate policies can help to improve investigation practices. London police instigated Project Sapphire to improve victim/survivor care and rape investigations. At the inception of the project, best practice policies and procedures were identified and published. A qualitative review of the three ‘highest’ and the three ‘lowest’ performing boroughs found that greater successes in rape investigations were being achieved in those boroughs where there was adherence to the policies and evidence of strong performances in the identified areas of ‘best practice’ (Metropolitan Police Service, 2005).

Project Sapphire identified the following best practices for the investigation process:

- continuity in investigations, rather than a series of separate stages
- a victim-focused ethos at the core of each investigation
- prosecution teams (specialist officers, inspectors working with the prosecutors)
- post-event analysis and sharing of intelligence to reassure the victim/survivors and to reduce the risk re-offending
- a clear commitment to making offenders accountable and achieving a positive outcome for victim/survivors (Metropolitan Police Service, 2005).

As noted earlier, it is adherence to good policy, not the policy itself, which results in positive outcomes for victim/survivors. Overseas researchers have noted that the effectiveness of such policies has not always been successful, and this can often be because they appear to be imposed on a top-down basis (Brogden and Shearing,

1993; Chan, 2003). Thus, one barrier to the New Zealand ASAI Policy achieving significant changes in police practice derives from a lack of support for the policy at all levels, with cynicism and resistance noted by many rank-and-file officers to directives imposed at national level (Bazley, 2007; Jordan, 2006).

Investigative interviewing

Another New Zealand initiative reflecting good practice is the Investigative Interviewing Project that is being introduced by the New Zealand Police. The aim of investigative interviewing is to obtain complete, accurate and reliable information when interviewing victims, witnesses and suspects. This will have the potential to improve rape complainants' experiences of police interviewing.

An investigative interviewing strategy was developed following a review of international police interviewing techniques (Schollum, 2005). The aim of the review was to benchmark the New Zealand position and to provide a progressive pathway forward for further development and enhancement of police interviewing based on international best practice.

The Investigative Interviewing Strategy covers:

- national ownership and overarching strategy
- policy and guidance
- ethical principles
- internationally affirmed interview model (based on the international best practice British PEACE interviewing model (PEACE = Planning and Preparation, Engage and Explain, Account, Closure, Evaluation))
- national standards
- comprehensive national training framework, structure and programme
- quality assurance regime
- technology
- interview facilities.

The Investigative Interviewing Unit was established in 2007 to implement and oversee the Investigative Interviewing Strategy and to provide national ownership for all investigative interviewing-related matters. A key focus of the unit is to implement the comprehensive programme of investigative interview training of which there are four levels. This is under way, with the aim of 6,000 frontline staff receiving level 1 training by 2010 and a further 84 receiving the specialist Level 3 interviewer training for adult sexual abuse interviews by the end of the 2008/09 financial year.

At a general level, the training is practice-based and includes learning about the psychology of memory and other processes essential to ethical interviewing; how to use the free recall, conversation management and enhanced cognitive interview models; and techniques for different types of interviewees. All levels of interviewing are complainant- or witness-centred, so that the most complete accurate and reliable amount of information is obtained. The training is based on empirical

research in psychology and investigative interviewing and international good practice. Each level of training then builds on the particular area of expertise required. (Specialist training as good practice is reviewed in more detail in section 6.2.8 of this chapter.)

The Investigative Interviewing Project is being piloted and will need to be evaluated, and the practices appraised in the context of overall support service provision (Personal communication, New Zealand Police, June 2008). There was initially some resistance to the practice of delayed interviewing, with victims and witnesses of serious crime (including adult sexual assault), as it represented a departure from the traditional police emphasis on interviewing victims/witnesses as soon as possible after the event (Jordan, 2001). However, more recently it has been acknowledged that there are advantages to delayed interviewing and that recall may in fact be positively assisted by such a move (Jordan, 2004). This is in part because many sexual offences occur when the victim/survivor is drunk or drugged and/or physically exhausted, and because the immediate impact of shock or trauma can interrupt clear recall.

6.2.7 Police interagency collaboration

In the London-based Project Sapphire (Metropolitan Police Service, 2005), partnership was identified as being a key to successful police investigations and positive outcomes for victim/survivors, with sexual offences investigation teams building and maintaining good links with prosecutors, Sexual Abuse Referral Centres, and forensic services.

In the New Zealand ASAI Policy there are several references to interagency collaboration, including the importance of taking an interagency approach to investigations (section 1.6), ensuring police are trained to work effectively with other agencies (section 2.2.2), while section 2.5 lays out the responsibilities of the various agencies that are likely to be involved.

Based on research carried out in New Zealand it has been argued that the key to improving responses to sexual violence lies in the collaborative partnerships necessary to ensure the provision of holistic, specialist multi-agency services (Beckett, 2007). While moves towards greater victim-centredness and improved collaborative service delivery were strongly advocated, their effectiveness was seen to be dependent on two factors: prioritisation and adequate resourcing.

6.2.8 Police training

Specialist police training on issues surrounding violence against women also features as an important aspect of good practice (Amnesty International Australia, 2008; Epstein and Langenbahn, 1994; Lord and Rassel, 2000; Metropolitan Police Service, 2005).

Based on United States law enforcement agencies, Epstein and Langenbahn (1994: 21–22) identified three arenas for police training:

- **academy training** for new recruits, which would include the rudiments of the law, needs of the victim/survivor and details for the initial interview
- **in-house training for investigators**, which would include victim/survivor interview techniques, co-ordinating with community support agencies and understanding victim/survivors' emotional needs
- specialised training for investigators.

The New Zealand Police ASAI Policy has a section dedicated to the training requirements of police sexual violation investigators, which includes the development of a specialist training programme (New Zealand Police, 1998). The New Zealand Police delivers a variety of courses that contribute to the way police respond to reports of adult sexual violation. These include:

- the Adult Sexual Assault five-day course
- the Adult Sexual Assault Initial Complaint course
- investigative interviewing courses
- support services and external training.

The Adult Sexual Assault five-day course is seen as the biggest driver of raising awareness, changing attitudes toward sexual violence complaints and complainants, and dealing with these in the most effective manner. This training package was developed in 2002, piloted in 2003 and confirmed in 2004 (Personal communication, New Zealand Police, 12 December 2008).

These courses are presented by non-police specialist practitioners and police staff. Course content includes case studies as well as:

- history, myths and perspectives
- forensics and DNA
- dealing with victims
- drug-assisted sexual assault
- rape trauma and post-traumatic stress disorder (PTSD)
- interviewing (victims and suspects)
- medicals
- criminal profiling
- cultural aspects
- prosecution and court aspects
- offender perspective.

Over the past four years, police have been working to build the capacity of the comprehensive training programme to cater for more police staff attendees. To date approximately 50 percent of the CIB have attended the Adult Sexual Assault five-day course and an additional 3,151 police staff have undergone other training that contributes to the police adult sexual assault response. Police are committed to delivering this training to ensure there is a critical mass of appropriately trained staff in the police approach to adult sexual violation. Police envisage that the building of critical mass will take three to four years if all training courses are delivered at their maximum capacity (Personal communication, New Zealand Police, 12 December 2008).

Since that study there has been no further evaluation or research published specifically addressing the adequacy of the New Zealand police training. However, Bazley's (2007) Commission of Inquiry into Police Conduct, raised concerns over whether there were sufficient resources devoted to the implementation of the ASAI Policy, in particular the delivery of the specialist training of investigators.

6.2.9 Female police officers

Greater deployment of female police officers to sexual assault cases has sometimes been advocated as a good practice measure for police departments to follow (Goodstein and Lutze, 1992; Pike, 1992). In parts of Britain, for instance, dedicated units have been established that are staffed by specially trained officers, most of whom are women, but usually managed by a male detective (Brown and Heidensohn, 2000; Lees, 1997).

However, researchers caution that problems can arise when supervisors assume that female detectives will require less training and less experience than their male counterparts in order to manage sexual assault cases competently (Easteal, 1993; Pollock, 1995).

Contrary to popular assumptions, overseas research has found that rape complainants do not automatically prefer to speak with female officers and, when they do, do not always find them more understanding than their male counterparts (Goodstein and Lutze, 1992; Gregory and Lees, 1999; Heidensohn, 1992; Radford, 1987; Toner, 1982). In a New Zealand study, the negative experiences some women had with hostile and disbelieving policewomen raised doubts regarding assumptions of 'natural' sympathy and aptitude (Jordan, 2002, 2004). Conversely, there were also women complainants who rated highly the sensitivity with which some male officers treated them.

However, the gender of the officer is critical when the victim/survivor has strong preferences and requests an officer of a particular gender (Jordan, 2002). Given the difficulty many victim/survivors face in articulating their needs, the responsibility lies with the police to offer them a choice, wherever possible, between equally qualified officers of either gender.

6.2.10 Specialised women's police stations

Other reforms that have been described in overseas literature include initiatives such as specialised women's police stations, which have been adopted, for example, in such Latin American countries as Argentina, Brazil, Colombia, Costa Rica, Ecuador, Nicaragua, Peru and Uruguay (Kelly, 2005; Waller, 2003; Morrison, Ellsberg and Bott, 2007). However, evaluations of specialist female stations have unearthed a number of problems (Jubb and Izumino, 2003, and World Bank, 2006, both cited in Morrison Ellsberg and Bott, 2007). These include:

- special stations are often severely under-funded
- officers receive inadequate training
- stations lack equipment, transportation and other key resources
- even when they work well, these officers' efforts are often undermined by other parts of the criminal justice system that are unable or unwilling to enforce the law
- the existence of women's police stations encourages regular police stations to abdicate their responsibilities for crimes against women.

6.3 Prosecutors and the prosecution service

The role of prosecutors varies across jurisdictions. In New Zealand, all prosecutions under the general criminal law are brought by the police (Crown Law Office, 1992).²⁹ Crown prosecutors are involved with sexual violation offences only after indictable charges have been laid by the police and a judge has committed the offence to trial. There appears to be no requirement that prosecutors be specially trained in matters related to sexual assault before they act in these cases.³⁰

Regardless of the specifics, it is recognised that the successful prosecution of sexual offences is more difficult than for other crimes; less than half the sexual offences that go to trial in New Zealand result in a conviction (Ministry of Justice, 2008). Several factors associated with sexual violation offences can act as barriers to their successful prosecution (see Office for Criminal Justice Reform, 2006; Regan and Kelly, 2003).

- **Evidential difficulties and burden of proof** – in the majority of sexual violation cases the perpetrator is known to the victim/survivor and the case rests on one person's word against another. Proving beyond reasonable doubt that sexual violation occurred is difficult, particularly when there are no injuries or forensic evidence available, as is often the case.

²⁹ In other countries such as the United Kingdom Crown prosecutors are involved with the investigation and decision-making around whether to prosecute.

³⁰ In New Zealand, while there appear to be no specialist crown prosecutors, the New Zealand Police is developing specialist police investigating squads (Adult Sexual Assault Teams). These are reviewed in section 6.2.4.

- **Victim/survivors' withdrawal from the legal process** – due to fear of going through the criminal justice process (recounting traumatic events and having to endure cross-examination, which can include information on their past sexual behaviour).
- **Public and juries attitude** – continued culture of scepticism, in which women's accusations are received, and belief in rape myths have implications in relation to a jury's willingness to convict the accused.
- **Defendant's previous behaviour** – relevant evidence about a defendant's previous behaviour and convictions is kept from juries.

These difficulties point to the need for specially trained and experienced prosecutors who will be alert to these potential pitfalls and will have developed skills and expertise in prosecuting sexual violation cases.

6.3.1 Good practice guidelines for prosecutors

In New Zealand, there are no prosecution guidelines specific to sexual violence offences; the only procedural guidelines are the prosecution guidelines issued by the Crown Law Office (1992). These are generic guidelines that refer to the roles of both police and Crown prosecutors. The guidelines include details of who may institute a prosecution, factors that should be taken into account when deciding whether to prosecute, and procedures to be followed following indictments.

No research was found on how well the practices outlined in the New Zealand prosecution guidelines responded to the specific needs of victim/survivors of sexual violence. However, researchers have identified several factors related to the prosecution phase of sexual offending that were valued by victim/survivors (Jordan, 2008; Kelly, Lovett and Regan, 2005; Lievore, 2005; Orth, 2002). These are presented in Box 14.

Box 14: Good practice guidelines for prosecutors (victim-based)

- Victim/survivors are informed of case progress and have sufficient time to re-read statements.
- Waiting times and delays are minimised.
- Prosecutors meet and establish rapport with the complainant prior to the trial's commencement.
- Prosecutors are familiar with the facts of the case and provide courtroom advocacy that does 'justice' to the complainant's account.

(Jordan, 2008; Kelly, Lovett and Regan, 2005; Lievore, 2005; Orth, 2002)

In Jordan's (2008) New Zealand research, victim/survivors expressed particular frustration when trial dates were frequently changed. This left them feeling they had no control of the process, and that their lives were on hold. An example of good practice related to a large-scale case involving multiple victim/survivors of a single

perpetrator (Jordan, 2008). Because of their numbers and the high-risk nature of the offender, the women were able to put pressure on the police and prosecutors to be more responsive to their needs, resulting in their being:

- given a dedicated policewoman to provide information and emotional support
- provided with regular letters and updates in regards to court dates and timelines
- given the opportunity to meet prosecutors well before the trial began
- given information regarding court layout, people able to be present etc., and where possible, the women were taken in to view the courtroom before the trial commenced
- able to provide evidence in a customised court layout with the aim of enabling the women to feel safe with the rapist present in court (e.g. the witness box was not in direct line with the defendant, and there were additional security measures)
- given permission to do things to help them feel more comfortable/strong (e.g. one woman was given permission to sprinkle what she termed the 'glitter of courage' in the witness box, and also put it in the box where the accused stood to assist her in overcoming her fear).

Many of these practices and those identified by other researchers (Kelly, Lovett and Regan, 2005; Lievore, 2005; Orth, 2002) mirror some of the 'best practice' guidelines for lawyers working with clients who have experienced sexual violence published by Legal Aid Queensland (2007) (see Box 15). It is unclear how these guidelines were arrived at, but there appears to be an emphasis on taking a victim-centred approach.

Box 15: Good practice guidelines for prosecutors

- Taking appropriate precautions to ensure the client's emotional and physical safety.
- Giving clients appropriate information on legal options and to actively involve them to assess their own legal needs and to make decisions.
- Working collaboratively with other support services and develop and maintain knowledge of resources and services that can assist clients who have experienced sexual violence.
- When interviewing clients be respectful, avoid being judgmental, inappropriate, insensitive or inattentive.
- When preparing for court hearings, ensure that cultural, sexuality and disability issues are addressed.
- Developing and maintaining knowledge of the social context of violence including issues of power, control and gender.

(Legal Aid Queensland, 2007)

6.3.2 Specialist prosecutors

Commentators have identified specialisation of prosecutors as good practice (Amnesty International Australia, 2008; Cossins, 2007; Kelly, 2005). The key feature of specialist prosecutors is the receipt of specialised training to take into account the unique features of sex offences and the development of expertise in prosecuting sexual offence cases. As noted earlier, New Zealand prosecutors do not specialise.

Promising elements of specialist prosecutors

Several potential benefits of specialist sexual offence prosecutors have been identified (Kelly, 2005; Schonteich, 2001). These include:

- the development of expertise in prosecuting sexual offence cases
- the development of expertise and skills to take on more difficult cases, with successful prosecutions having the potential to challenge rape myths
- more continuity of personnel, with the same prosecutor preparing and managing a case from start to finish
- a more consistent approach to the prosecution
- the reduction of the secondary victimisation of complainants, with prosecutors having sufficient skills to conduct an empathetic yet enquiring consultation with a rape victim/survivor.

As a result of these potential advantages, several countries have moved down this path, with specialist prosecutors operating in the mainstream, as part of a specialist prosecuting unit, or within specialised courts.

- Victoria, Australia – The Specialist Sex Offences Unit in the Office of Public Prosecutions was set up in April 2007. Crown prosecutors, solicitors and advocates are located in the same unit and work as a team (Ministry of Justice, 2008). This is a dedicated unit aiming to achieve a more consistent approach to the handling of sexual offence cases as well as making the process less traumatic for victim/survivors (ACSSA, 2007).
- South Africa – The Sexual Offences and Community Affairs Unit was set up in September 1999. This is one of several specific investigating directorates set up in South Africa to deal with a range of serious crimes (e.g. organised crime, corruption, and serious economic offending). These units conduct prosecution-driven investigations, with oversight from a senior prosecutor. In addition, they aim to determine policy and set minimum standards for service provision by the criminal justice system to women. They also offer training courses for other prosecutors and have assisted in the setting up of specialist courts and the country's first one-stop-centre (Schonteich, 2001).
- United Kingdom – Specialist rape prosecutors have been introduced across England and Wales. There were 520 in 2006 (Office for Criminal Justice Reform, 2006). A commitment to introduce specialist training for police, prosecutors, and barristers acting in rape cases has also been announced (Baird, 2007).

No evaluations of these initiatives were located, although the high conviction rates that are achieved in South Africa by specialist courts with specialist prosecutors (as reviewed in section 6.4) could be seen as partial evidence of their success.

6.4 Specialist courts

In New Zealand, there are several specialist courts, including Family Violence Courts and a Youth Drug Court in Christchurch, but no specialist court for sexual violence offences.

Elsewhere, specialised offence courts and specialised court procedures have been advocated as a way both to increase rates of conviction and to reduce secondary victimisation of victim/survivors (Amnesty International Australia, 2008; Cossins, 2007; Walker and Louw, 2003).

The primary rationale for specialist courts is that a degree of specialisation is deemed necessary in order to effectively address cases that are legally and factually complex (Walker and Louw, 2003). This principle has been applied to a range of different types of offences, resulting in drug courts; child sexual assault, domestic or family violence courts; mental health courts; and community courts. Intended outcomes of specialist courts include benefits for victim/survivors, the community and the offender (Lexicon Ltd, 2005).

Promising elements of specialist courts

Several potential benefits of specialised sexual offences courts have been identified (see Kelly, 2005; Ministry of Justice, 2008; Rasool, 2000) and include:

- the ability to draw special attention to a class of offence
- the ability of lawyers and judges to be appropriately trained and develop subject expertise, which can lead to greater efficiency and a higher quality of service (e.g. greater consistency in court processes for specific offences, efficient case processing, increased rates of conviction)
- the provision of continuity of court personnel
- the potential to customise procedural and evidential rules
- the potential to customise facilities to specific complainant needs (e.g. separate waiting rooms, closed-circuit television equipment)
- greater co-ordination of social and support services.

Specialised sexual violence offence courts appear to be unique to South Africa. The first one was set up in Wynberg in 1993 to deal with sexual offences against both women and children; 62 are now in operation (Ministry of Justice, 2008).

These courts have been the subject of a number of studies, including the evaluation of two courts (Wynberg and Bloemfontein), revealing positive and negative outcomes (Moult, 2000; Walker and Louw, 2005a, 2005b, 2007).

The aim – to increase the rate of conviction of sexual offences – appears to have been achieved in these courts: conviction rates of 50–70 percent for the court at

Wynberg (Moult, 2000) and 52 percent for the court at Bloemfontein (Walker and Louw, 2005a) are well in excess of the national average of 10 percent.

Researchers surmised that the courts were viewed in a positive light by the legal personnel involved (Walker and Louw, 2007); the families of the victim/survivors (Walker and Louw, 2005b) and the victim/survivors themselves (Walker and Louw, 2005a). Victim/survivors were satisfied with their dealings with the police service and interactions with state physicians and medical staff. And the families were generally positive in regard to the specialist court helping to reduce secondary victimisation. Procedural improvements, such as courts being equipped with video-link equipment and separate waiting rooms, have also been noted (Sadan et al., 2001, cited in Kelly 2005).

However, despite these achievements, the research has pointed to some flaws and areas for improvement in the specialist sexual offence courts.

- **Not addressing the needs of victim/survivors** – concern of secondary victimisation and insufficient provision of support and counselling pre- and post-trial (Moult, 2000; Rasool, 2000; Walker and Louw, 2003, 2005a, 2005b, 2007).
- **Capacity issues** – shortage of trained staff. Cases subjected to delays and postponements, with 76 percent of victim/survivors having to wait in excess of six months for a court hearing (Moult, 2000; Vetten, 2001).
- **Issues of justice** – questions over the impartiality of the court set-up, as well as credibility of decisions within the broader legal context due to the narrow caseload of judges limiting their general experience (Walker and Louw, 2003, 2007). No procedural guidelines for officials means women do not receive consistent and reliable service (Rasool, 2000).
- **Insufficient infrastructure** – insufficient space at some courts means that court rooms or waiting rooms cannot always be set aside (Rasool, 2000; Vetten, 2001).

On one level, these specialised courts could be seen as good practice, particularly with respect to those outcomes most desired by government, police and prosecution agencies (i.e. improved rates of conviction). There is also consensus that the primary objective of these courts, the welfare of the victim/survivor, and the move towards a victim-centred justice system, is a move in the right direction. Where opinion is divided is how well the current system is actually meeting this primary objective and whether high conviction rates are being achieved at the expense of the welfare and needs of the victim/survivor (Moult, 2000).

Good practice guidelines for specialist courts

The research on these specialised sexual violence courts has not yet reached the point of arriving at good practice principles, although the areas for improvement listed above would be important considerations in any future development of such courts.

Reviews of other types of specialist courts have progressed further, and lessons learnt would have applicability to specialist sexual violence courts. A review by Lexicon Ltd (2005) of specialist courts (drug, mental health, and domestic violence

and community courts) across three jurisdictions identified three features associated with successful outcomes:

- **a flexible judicial attitude** with a willingness to participate in the ongoing monitoring of offenders' behaviour and to communicate to others the benefits of the work they do
- **an adequate pool of committed and trained professionals** (e.g. lawyers, administrators, probation officers and others supervising court programmes)
- **budget-holders with vision** who are willing to invest resources in an enterprise that is likely to deliver tangible benefits only in the longer term.

6.5 Criminal justice system victim advocates

In New Zealand, criminal justice system advocacy is provided to victim/survivors by 'victim advisers'. The court victim adviser service was introduced as a pilot in four courts in 1993 and extended to a further ten courts in 1996, and in 2001 was further extended and renamed 'Court Services for Victims'. Victim advisers are specialist court staff employed to support victim/survivors through the court process, including the provision of case information; facilitation of their safety and protection of victims in court; and liaison with police, prosecutors, the judiciary and community organisations. They also inform the court of the victims' views and ensure that victims of crime are informed of their rights under victims' legislation.

There can be confusion over the role of victim advisers compared with others who provide support and advocacy to victim/survivors during the court process. Victim/survivors may also receive support and advocacy from community-based specialist sexual violence support services (e.g. Rape Crisis workers) or Victim Support (a nationwide non-specialist support group for victims). When the general meaning of the word 'advocate' is considered (i.e. someone who represents or speaks on behalf of another), it would be appropriate for all of these groups to be described as 'victim advocates'. However, there is a difference in the services they provide to victim/survivors.

The support services provided by community agencies are considerably broader than those provided by victim advisers. Contact with community agencies can commence from the time of the assault and be ongoing throughout police and court processes. Support, advocacy and counselling can also be provided regardless of whether the victim/survivor enters into the criminal justice system. The role of victim advisers is more limited, applying primarily to the victim/survivors' interaction with the court; and only the victim advisers have a statutory role that is set out by the courts.

In New Zealand, there has been very little evaluation of the services provided by victim advisers (Church et al., 1995; Crooks and Jefferies, 2003). Crooks and Jefferies (2003) looked at court services for victim/survivors provided by victim advisers, in relation to meeting the needs of Māori and Pacific victims of crime. The report was not specific to victim/survivors of sexual violence, but the findings are likely to have relevance to Māori and Pacific victim/survivors who go through the legal process.

The main recommendation of Crooks and Jefferies (2003) was that court services should be improved to meet the needs of Māori and Pacific victims. The report concluded that this could be achieved by implementing robust recruitment and training procedures; formulating a strategic commitment to these communities; promoting the service nationwide (e.g. translating current publicity material); introducing interpreters; and ensuring that court environments and services respect the privacy, security and culture of these groups.

A pertinent point, however, was made about court services: many of the advisers found it difficult to pinpoint how successful their level of service was to any of their clients. Not receiving complaints was seen as being 'success enough'.

It is noteworthy that a recent report published by the Ministry of Women's Affairs (2008) proposed the introduction of 'independent victim advocates' to courts to complement the services already provided to victims of family violence by victim advisers and family court co-ordinators. The report supported the development of the role of independent victim advocates and indicated they were likely to be introduced in all Family Violence Courts from July 2008. It was suggested that consideration should be given to whether independent victim advocates would also be appropriate for victim/survivors of sexual violence.

Legal representation for victim/survivors

These discussions are premised on the idea that in an adversarial criminal justice system the victim/survivor is only a witness to a crime, and the main protagonists are the prosecutors and the defendant. It is noteworthy that in France, which has an inquisitorial system, the victim of the crime has legal representation in court and their interests are protected to a greater extent by a lawyer (Waller, 2003).

The question of advocacy in that context is not about protecting victim/survivors' 'interests' but a much more assertive and radical stance of protecting victim/survivors' legal rights.

In common law jurisdictions, such as the United Kingdom, the United States and New Zealand, victim/survivors do not have legal standing in court – they are not parties to proceedings (Murphy, 2001). This means they have no representation when submissions are made for judicial decision in matters that not only affect the trial but may also affect them – for example, in issues regarding whether or not a victim/survivor can continue to have a formal support person in the court, the possibility of alternative modes of evidence and so on. There is also no right of appeal from victim/survivors in situations where they consider an injustice to have occurred.

One United States initiative that is actively campaigning to provide legal advocacy services to victim/survivors is called the Victim Advocacy and Research Group. It supports 'lawyers for victims at both the trial and appellate levels of the criminal justice system ... to ensure respect for fundamental constitutional principles. And to identify and eradicate gender bias in the criminal common law' (Murphy, 2001: 123). This type of victim advocacy goes much further than that which is commonly discussed in the literature.

6.6 Statutory reform

While many countries, including New Zealand, have introduced statutory reforms, there has been little research to date to assess the relative merits of these. What have been identified are ‘promising practices’ that may not have been proven to be effective, but that reflect both human rights concerns as well as current knowledge and understanding regarding sexual violence (Kelly, 2005). Some of those identified include measures already introduced in New Zealand, such as criminalising rape in marriage and setting the age of consent for those involved in the sex industry at 18 years (see section 2.3).

A recent review in the United Kingdom of rape law and trial procedures identified key areas for reform relating to evidential law and issues of consent in particular (Temkin and Krahé, 2008). Greater recognition is also being given in law to mandating victim/survivors’ rights.

6.6.1 Proposed legislative amendments in New Zealand

In New Zealand, mounting concern has been raised regarding the ways in which crimes of sexual violence are dealt with in the criminal justice system. While there is some agreement about the need for change, the best way to proceed has not yet been determined and various options exist. Recently, the Ministry of Justice (2008) issued a discussion paper to solicit the public’s views about proposed legislative amendments to the current law on sexual violence, including:

- adding a definition of consent to current legislation
- extending the provisions protecting victim/survivors from questions concerning their sexual history
- defining the actions required in relation to the defence of ‘reasonable belief in consent’.

In addition, the public has been asked to present their views about more systemic changes to the criminal justice system’s procedures in respect of sexual violence. Topics for discussion include: consideration of an inquisitorial system of justice; the development of specialist sexual offence courts and specialist prosecution units; as well as a discussion about the feasibility of multi-agency models of handling rape complaints, for example, Sexual Assault Referral Centres (Ministry of Justice, 2008).

Many of the key areas presented in the discussion document are reviewed in the remainder of this statutory reform section.

6.6.2 Legal definitions of rape

As noted earlier, significant changes to the definition of rape were enacted in New Zealand in 1985 (see section 2.3). These changes are consistent with reforms advocated internationally. For instance, making rape a gender-neutral offence, removing the rape in marriage exemption, and extending the definition of rape to include other forms of penetration all reflect common changes in many European countries (Regan and Kelly, 2003). Some countries such as Canada and states in

the United States have moved towards defining levels of rape/sexual assault (Kong et al., 2003; Regan and Kelly, 2003), a change not currently followed by European countries with the exception of Finland (for further discussion, see Regan and Kelly, 2003).

6.6.3 Legal definitions of consent

In New Zealand, the Crimes Act 1961 does not define what constitutes consent, but provides a negative definition of consent by listing circumstances that should not be taken as signifying consent (section 128A of the Crimes Act 1961). These circumstances include the victim/survivor being asleep; unconscious; or intellectually or mentally impaired. Judges have directed juries to determine that consent needs to be 'freely and voluntarily given' (Ministry of Justice, 2008). These conditions of consent include some of those identified as good practice by Amnesty International Australia (2008).

In New Zealand and the United Kingdom, the prosecution needs to prove that the accused did not believe, on reasonable grounds, that the complainant was consenting, while Canada and some states and territories in Australia are among those jurisdictions that have moved in recent years towards defining what constitutes consent. The latter require the court to consider the steps taken by the accused to determine that consent was given (Ministry of Justice, 2008). This latter move has been incorporated to some extent in the United Kingdom's Sexual Offences Act 2003, which explicitly states that when determining 'reasonableness', all the surrounding circumstances need to be considered, including any steps taken by the accused to ascertain consent has been given. Such moves internationally have prompted the inclusion of this issue in the Ministry of Justice (2008) discussion document relating to New Zealand's current consideration of improvements to sexual violence legislation.

6.6.4 Extending the rape shield

The Ministry of Justice, in its public discussion document (Ministry of Justice, 2008), has a preliminary proposal to amend the rape shield so that evidence about previous sexual experience between the complainant and any person, including the accused, is inadmissible without prior agreement of the judge. This reflects the view that the prior sexual relationship between the complainant and accused is never relevant, since consent to sexual activity on one occasion does not imply that a person automatically agrees to sexual activity on another occasion. Such an extension is viewed problematically in some quarters as preventing an accused from being able to comment or answer questions regarding previous occasions could impact unfairly on the decision to run an effective defence (Buckingham, 2008). It is also possible that the complainant may wish to contrast previous occasions with the specific occasion in dispute (Buckingham, 2008).

6.6.5 Procedural reforms

In a review of procedural reforms across European countries, Regan and Kelly (2003) reported that there was no common 'good practice' across Europe that

enabled complainants to give their best evidence in court, whilst protecting their dignity and integrity and limiting the extent of secondary victimisation. Procedural reforms that some countries have incorporated include:

- introducing screens in courts to enable victims/witnesses to give evidence without having to see their attacker
- removing the right of the accused to be able to cross-examine the victim/witness
- ensuring the right of the victim/witness to have a support person present when they give evidence
- allowing video and other forms of technical equipment to enable the victim/witness to be cross-examined when outside the courtroom
- removing unnecessary people, including the offender, when the victim/witness gives their evidence
- ensuring name and address suppression for the victim/witness
- ensuring the right to legal assistance before, and representation during court cases
- allowing a non-government organisation to be party to the case (Regan and Kelly, 2003: 17).

The first three points listed above are provided for in the New Zealand criminal justice system. There are also calls from some quarters to allow video-recorded victim/survivor statements as evidence in trials, reflecting recent reforms in the United Kingdom (Baird, 2007).

While procedural reforms are important, their effectiveness is likely to be limited because, as even legal commentators have observed, one of the main barriers to achieving justice for rape victims lies in the attitudinal views and biases that are still entrenched in both criminal justice system practitioners and the public at large (Kelly, 2005; Temkin and Krahé, 2008). A further challenge is achieving a balance between the needs of a victim/survivor with the evidential needs of a justice system that has been designed to determine the criminal liability of the accused (Flatman and Bagaric, 2001; Wang and Rowley, 2007).

6.6.6 Victims' rights

Kelly (2005) suggests the right to anonymity for victim/survivors is critical. She notes that in the United Kingdom, even at the initial investigations stage, a woman's name, picture and workplace can appear in salacious media coverage. In New Zealand, this is less of a risk because of suppression orders and limits on media coverage.

Increasing pressure has been placed on the criminal justice system to make victim/survivors more central within its processes, evident in New Zealand first in the Victims of Offences Act 1987, later replaced by the Victims' Rights Act 2002. This legislation imposes clear obligations on specified agencies to provide information and offer assistance to the victims of criminal offences, including victim/survivors of

sexual violence. It also prohibits the disclosure in court of the victim/survivor's address except in particular circumstances, and increases the scope for victim/survivors to have their views represented in relation to such matters as how the offence impacted on them, their views regarding the accused's release on bail and so forth. More recently (September 2008) the Government introduced the Victims Charter, which sets out the standard of service that a victim/survivor can expect from government agencies if a crime is committed against them or their family/whānau. For more details, see Ministry of Justice (no date).

The introduction of the Victims Charter was accompanied by the launch of a website specifically oriented towards providing information for crime victims, as well as an 0800 number available seven days a week from 9 am to 11 pm to provide information for people affected by crime about the justice system and support services available.

The introduction of these resources for victim/survivors reflects internationally accepted indicators of 'good practice' aimed at increasing the levels of support and information available and mandating compassionate and respectful treatment of victim/survivors throughout their interactions with the criminal justice system.

6.6.7 Adversarial or inquisitorial approach?

Countries around the world tend to have one of two systems of justice: an 'adversarial' or 'inquisitorial' system. An adversarial justice system of law is generally adopted in common law countries, including New Zealand and the United Kingdom, while the inquisitorial justice system is found in Europe among civil law systems (i.e. those deriving from Roman law or the Napoleonic Code). Key characteristics of these two systems are in Table 6.

The possibility that all, or some, of the aspects of an inquisitorial system could be incorporated into sexual violence legislation in New Zealand is one of the issues opened up for public discussion by the Ministry of Justice (2008).

The brutal impacts of the traditional, adversarial justice system on rape victim/survivors have been increasingly acknowledged by overseas and New Zealand researchers, with rape trial experiences likened to a 'second rape' (Koss, 2000; Lees, 1996; McDonald, 1997; Scutt, 1998; Thomas, 1994). Research data obtained from nearly 1,000 criminal trials in the United States showed that the majority of rape victim/survivors believed that rapists had more rights than they did, that the criminal justice system was unfair, and that they were not given adequate information about their case, nor input and control into its handling (Frazier and Haney, 1996).

Table 6: Inquisitorial and adversarial justice systems

Inquisitorial justice system	Adversarial justice system
Principle	
Aims to get to the truth through extensive investigation and examination of all evidence	Assumes that truth is most likely to result from open competition between the prosecution and defence
Key features	
<p>Investigating magistrate: responsible for supervising and actively gathering evidence; questioning witnesses; deciding whether charges should be brought.</p> <p>Judge presiding over trial will be a different person to the investigating magistrate. Judges have increased judicial discretion and exercise a larger and more active role.</p> <p>Rules around admissibility of evidence are significantly more lenient.</p> <p>Who holds the burden of proof and level of proof required varies in different countries.</p>	<p>Lawyers for each party present arguments and question and cross-examine witnesses.</p> <p>Offers stronger protection for defendants in their interpretation of right to silence.</p> <p>Presumption of innocence. Burden of proof on prosecution to prove accused's guilt beyond reasonable doubt.</p>

Source: Adapted from Ministry of Justice (2008) *Improvements to Sexual Violence Legislation in New Zealand: public discussion document*. Wellington: Ministry of Justice, pp. 27–28.

A recent book reviewing data relating to sexual assault trials concluded:

Despite all the efforts and undoubted improvements over the past thirty years, the rape trial as it is configured in the common law world is frequently not up to the task of delivering justice for rape victims. (Temkin and Krahé, 2008: 209)

Concerns such as these, coupled with increasing rates of attrition with sexual violence cases, have prompted greater debate over the issue of whether or not legal reform measures are able to improve the current system, or whether an alternative approach needs to be developed (Bronitt, 1998; Henning and Bronitt, 1998; Taslitz, 1999; Thomas, 1994; van de Zandt, 1998). The inquisitorial approach, common in many European countries, is offered as a possibly more suitable approach for sexual offences.

There is no clear evidence that an inquisitorial system is superior in the case of sexual violence offences, although, in a review of attrition in reported sexual violence across several European countries, Regan and Kelly (2003) reported, with the exception of Sweden, that countries with adversarial legal systems tended to have the highest attrition rates. It has also been suggested that the less restrictive approach to evidence of the inquisitorial system may be more suited to sexual offences, and in particular historical offences (Ministry of Justice, 2008).

6.7 Restorative justice debate

Among common law jurisdictions, New Zealand has been at the forefront of developments in the delivery of restorative justice processes and, in 2008, the Ministry of Justice opened up for discussion whether restorative justice processes should be available in cases of sexual violence (Ministry of Justice, 2008).

While it is considered as an appropriate practice for most offending, the use of restorative justice with adult cases of sexual violence is a contentious issue. Hence, while restorative justice for sexual violence cannot yet be identified as 'good practice', it is 'worth watching', particularly for use with Māori victim/survivors of sexual violence. For this reason, this section provides some context to the use of restorative justice in New Zealand together with some of the issues being debated.

6.7.1 Restorative justice in New Zealand

In New Zealand there is legislative provision for the use of restorative justice at various points in the criminal justice system, including pre-sentence, following a guilty plea, post-sentence, and as part of the Police Adult Diversion Scheme (Ministry of Justice, 2008: p. 28).

New Zealand introduced the first community panel restorative justice adult diversion programmes in 1996 with the support of the Ministry of Justice's Crime Prevention Unit (Paulin, Kingi and Huirama, 2005). Further expansion occurred in 2001 with the introduction of 'court-referred' restorative justice conferences at four courts.

The schemes dealt with adult offenders and relatively serious offences (Morris et al., 2005). Meanwhile, the number of community-based programmes based on the initial community panel model for adult offenders has continued to grow (Kingi, Paulin and Porima, 2008). Some of these programmes deliver restorative justice processes in family, domestic and sexual violence cases.

The Ministry of Justice recognised the need for some operational guidance and, following an extensive consultation process with restorative justice practitioners, published a set of principles of good practice identifying how and when restorative justice processes should be used in criminal cases (Ministry of Justice, 2004). In relation to sexual violence these guidelines state, 'the use of restorative justice processes in cases of family violence and sexual violence must be very carefully considered' (p. 19).

More recently, the Ministry of Justice (2008) has indicated that while restorative justice processes may not be appropriate in all sexual violence cases, they could provide a useful approach to sexual offending with the development of specific service standards drawing on specialist knowledge in the service sector.

6.7.2 Models of restorative justice

In traditional criminal justice systems, professionals representing the state make the decisions on how to respond to an offender's behaviour. Restorative justice processes, in contrast, aim to involve victims, offenders and their 'communities of care' in the decisions (Braithwaite, 1989; Hudson, 2003).

Restorative justice processes operate differently within and across different countries,³¹ although a common prerequisite for restorative justice processes to operate is that the offender must admit their guilt. Allison Morris (2002) has argued that there is no single 'right way' to deliver restorative justice. She states that the essence of restorative justice is not the adoption of one form rather than another; it is the adoption of any form that reflects restorative values and aims to achieve restorative processes, outcomes and objectives (Morris, 2002). New Zealand has followed along similar lines identifying core values and suggesting that to be 'restorative', processes and outcomes need to reflect these values (Ministry of Justice, 2004).

6.7.3 Restorative justice processes with sexual violence offending

There is a much contested debate around the use of restorative justice processes in 'gendered violence' (partner, family and sexual violence) (Cossins, 2008; Daly, 2002, 2008; Strang and Braithwaite, 2002; Stubbs, 2007). Some advocates envisage these processes as having the potential to increase women's choices, provide women with a voice, and draw on the support of family/whānau and friends in a way that may increase their safety (Morris and Gelsthorpe, 2000). Daly (2006) has also recently argued, based on an Australian study of victim/survivors of young sexual offenders, that restorative justice processes may be less victimising than the court process for victims. Opponents draw attention to the unequal power relationships between victim/survivors and perpetrators, and raise concerns that restorative justice processes may compromise women's safety and expose them to further victimisation (Busch, 2002; Lewis et al., 2001; Stubbs, 2002).

The main arguments for and against the use of restorative justice processes with sexual violence case are set out in Table 7.

³¹ For example, victim–offender mediation (Czech Republic), Community and Family Group conferencing (New Zealand), Peace-making Committees (South Africa), Circle Sentencing (Canada), and Youth Offenders Panels (UK), (United Nations, 2006: 17–28).

Table 7: Arguments for and against the use of restorative justice

Arguments for restorative justice	Arguments against restorative justice
<p>Only a minority of sexual assault cases are dealt with by the criminal justice system – a different process may encourage victim/survivors to report.</p> <p>Low prosecution rates and low conviction rates (especially for young offenders) in criminal justice system.</p> <p>Can address a need for non-punitive retribution.</p> <p>Ensures other people are protected from the offender.</p>	<p>Sexual violence is a serious crime—using restorative justice processes may undermine that message.</p> <p>Sexual offending needs to be strongly condemned – restorative justice process may be seen as implicitly condoning or treating the offending as minor.</p> <p>Because of its ‘closed’ nature, the restorative justice process might result in sexual offending becoming less visible.</p> <p>Government may redirect funding into restorative justice programmes and away from services to victims.</p>
Relating to offenders	
<p>Assists the offender to receive appropriate treatment.</p> <p>Understanding the harm they have caused may create greater empathy in offenders.</p>	<p>Offenders will not be deterred by the restorative justice process.</p> <p>Offenders may use the process to blame the victim.</p>
Relating to victim/survivors	
<p>Provides victim/survivors with more information about the process.</p> <p>Ensures victim/survivors are treated respectfully and fairly.</p> <p>Acknowledges the wrong victim/survivors have suffered.</p> <p>Affords an opportunity for victim/survivors to tell their story.</p> <p>Ensures that the people of significance to the victim/survivor know about the wrong.</p>	<p>Victim/survivors may be re-victimised by the process.</p> <p>Offenders are often family members and pressure may be exerted on victim/survivors to participate in restorative justice.</p>

Source: Adapted from M. Neave (2004) ‘Restorative justice: when is it appropriate?’ Paper presented at Victorian Law Reform Commission, La Trobe University Law School, 6 October.

Mary Koss (2000, 2006a), while supportive of the use of some types of restorative justice in relation to sexual offending, has criticised the use of victim–offender mediation type of restorative justice in such circumstances (Koss, 2006a). She writes that ‘mediation is thoroughly discredited for gender-based violence’ (p. 222).

Instead, Koss supports the concept of restorative justice using a community panel model. Koss gives the example of the RESTORE programme in Arizona. The criteria for the acceptance of cases are set out in Table 8.

Table 8: RESTORE restorative justice programme

Accepts cases	Excludes cases
Where there has been a guilty plea for a misdemeanour sex offence. ¹	Where those involved are aged under 18 years.
Where the victim/survivor and the offender have agreed to take part.	Where cases involve a repeat offender.
Where the matter has been court ordered.	Where the sexual assaults are part of ongoing intimate partner violence.
	Where severe levels of violence are involved.

Note

- 1 In the United States a misdemeanour is a 'lesser' criminal offence, punishable by a year or less in prison and would be similar to a 'summary offence' in New Zealand.

A typical referral would be an acquaintance rape, where both parties had been drinking (Koss et al., 2004; Koss, 2006b). The programme has not been subject to an independent evaluation.

Based on Koss's work in the United States, Project Restore was launched in Auckland, New Zealand in August 2005 (DSAC, 2005; Ministry of Justice, 2008). The project provides a restorative justice option for victim/survivors of sexual offending and is run by an executive committee drawn from groups such as Auckland Sexual Abuse HELP, SAFE Network, Rape Prevention Education, and Restorative Justice Auckland Trust. The focus of the project is sexual assaults in which the victim/survivor and attacker are known to each other. It is intended to meet the victim/survivor's need for the attacker to acknowledge wrongdoing. Cases are referred through community groups or the court (after a guilty plea). Best practice guidelines are being developed and an evaluation is being undertaken (Ministry of Justice, 2008).

Firm research evidence on the effectiveness of restorative justice processes in 'gendered' violence cases is scant, and such pointers as exist are somewhat contested (Stubbs, 2004). In New Zealand, Kingi, Paulin and Porima (2008) studied five restorative justice programmes that use a mix of victim–offender conferencing and community panel models; and in South Africa, a victim–offender conferencing restorative justice programme was evaluated (Dissell, 2005). In both these countries, the cases dealt with by restorative justice mainly involved assaults and other violence (South Africa) or family violence specifically (New Zealand). Both programmes dealt with just a small number of sexual offending cases (one percent in both) and there was insufficient evidence for the researchers to come to any specific conclusions about the quality of the service provided for victim/survivors of sexual violence.

Judith Herman (2005) conducted research in the United States with 22 victim/survivors of sexual and domestic violence. She argued that survivors' views of justice do not fit well into either retributive or restorative models. The important points highlighted were that victim/survivors wanted vindication, validation and community denunciation of what had happened to them, so that the burden of disgrace would be transferred from them to the offender. A common objective of public exposure cited by the victim/survivors was to ensure safety for

themselves and other potential victims. Herman argues that adapting restorative justice models with feminist leadership, extensive community organising, and close and active collaboration with state authorities could create a reliable context for supporting victim/survivors and would send a clear message that these crimes are taken seriously.

The use of restorative justice processes with sexual violence cases is clearly still up for discussion. The current debate is still around whether or not it should be used, rather than what are the good practice guidelines. Those who advocate its use generally agree it is not appropriate in all sexual violence cases, but suggest that with careful selection, planning and the use of facilitators skilled in restorative justice processes, it can provide a forum for addressing victim/survivors' needs (Daly, 2006; Morris and Gelsthorpe, 2000; Zehr, 2007).

6.8 Responding to the needs of diverse groups – criminal justice system

6.8.1 Māori victim/survivors

There has been much discussion on how appropriate the existing New Zealand criminal justice system is for Māori people, with strong advocacy for a separate Māori system of justice (Jackson, 1987, 1988, 1989, 1995). These debates centre on fundamental differences between the approach of the current criminal justice system and the traditional Māori world view of justice; and the implications of these differences for the promises and rights given to Māori on signing the Treaty of Waitangi (i.e. the right and ability of Māori to have control over decisions that affect Māori).

Most of what has been written has focused on the failure of the current New Zealand system in relation specifically to Māori offenders. However, its relevance extends also to Māori victims, as within traditional Māori society the offender and the victim, together with their whānau, are inextricably linked (Cram, Pihama and Karehana, 1999; Jackson, 1988, 1989; Ministry of Justice, 2001). The key failures that affect the role and treatment of Māori victim/survivors are considered below. For a full understanding of Māori perspectives on justice, see Moana Jackson's work *The Māori and the Criminal Justice System: a new perspective: He Whaipaanga Hou* (1987, 1988, 1989) and the Ministry of Justice's (2001) *He Hinatore ki to Ao Māori – A Glimpse into the Māori World: Māori perspectives on justice*.

This review found very little material on the appropriate way of responding to Māori who have been victim/survivors of sexual violation. The New Zealand Police ASAI Policy was the only criminal justice guideline specifically related to sexual violence located as part of this review (see section 6.2). There are multiple references in this policy to the importance of police working in a culturally appropriate manner when investigating reports of sexual violence (see section 6.2.5). However, details on how this might be achieved were limited.

The only other document located that discussed appropriate ways of responding to Māori victims was the non-specific sexual violence report by Cram, Pihama and

Karehana (1999) *Meeting the Needs of Māori Victims of Crime*. Conclusions made in this report were based on interviews with Māori key informants (n=10) and Māori victims of crime (n=70). The report outlined appropriate support services for Māori, which are reviewed in section 7.5.1. The main content of the report focused on Māori approaches and experiences of justice, and through this the term 'victim' itself was found to be problematic from a Māori perspective.

'Victim' was seen to imply an individual experience, whereas in Māori society whakapapa links mean that a transgression (or crime) will affect the whānau of both the 'victim' and the 'perpetrator' and their wider communities (Cram, Pihama and Karehana, 1999). This mirrors one of the key failures of the current criminal justice system raised by Jackson (1987, 1988, 1989), that of the current system being centred on an individual offender and victim. In contrast, in a traditional Māori system, an offender was never regarded as solely to blame for their crimes. Rather the offender's whānau was deemed equally liable for the offender's actions, which were held to have aggrieved not just another individual but another whānau (Jackson, 1988, 1989).

Cram, Pihama and Karehana (1999) also criticised the term 'victim' for implying a powerlessness that was viewed as likely to hinder resolution of the individual and their wider networks. This is important, as rather than seeking revenge, restoration and the need to get on with life and to restore balance are key aims of Māori justice (Cram, Pihama and Karehana, 1999). This highlights another key difference in the existing system and that of a Māori approach to justice. A Māori justice system would focus on restitution and compensation rather than on retribution, and would be shaped by traditions of mediation, rather than simply punishing offenders often by imprisonment, which is the focus of the existing system (Cram, Pihama and Karehana, 1999; Jackson, 1989). Within the latter system, the primary role of 'victim' is as a witness to crime, with healing and resolution a lower priority (Cram, Pihama and Karehana, 1999).

Whilst acknowledging the diverse realities within any group (Durie, 1995), in considering the points above, it appears that in responding to the needs of Māori victim/survivors inclusion of the victim's and offender's whānau and their wider communities would be good practice. A focus on how to achieve restoration and healing rather than how to convict the offender may also be more appropriate. McElrea (1995), in fact, draws attention to the ability of restorative justice frameworks to allow culturally sensitive responses to crime within the current criminal justice system.

This is clearly a complex topic, and full coverage is beyond the scope of this report. However, an important point to note is the limited amount of published material on the appropriate way for criminal justice systems to deal with Māori.

6.8.2 Pacific victim/survivors

Epati (1995) notes that, in Samoan culture, traditional systems of cultural and social justice are based on the notion that communal interest overrides that of the individual. He states that in the main this is true for most of the Pacific cultures, with any differences among individual Pacific cultures, being only a matter of degree.

This Pacific view aligns with traditional Māori systems of justice, both of which conflict with the concepts underpinning Western law and legal systems.

There is little published material in relation to Pacific peoples and their involvement in the criminal justice system. Research is scarce and tends to focus on the generic needs of victims of crime (see Koloto, 2003). As mentioned previously, Koloto's study focused on the needs of New Zealand Pacific victims of crime, including some victims of family violence where sexual offending occurred. In relation to the criminal justice system, the interviewees wanted:

- **more information on formal support services:** in particular someone to explain legal terminology and their rights as a victim of crime (Koloto, 2003, p. 51)
- **more Pacific support organisations:** information in Pacific languages and translation of legal terminology; not only asking for more Pacific services by and for Pacific people, but also more Pacific personnel in existing services such as Victim Support (Koloto, 2003, p. 52).

In line with McElrea's (1995) assertion that restorative justice frameworks allow culturally sensitive responses to crime, Epati (1995) sees the utilisation of restorative justice as a step in the right direction in responding in a culturally appropriate manner to the needs of Pacific peoples. However, he goes on to say that when and how this could occur within the formal judicial process needs further contemplation. Koloto (2003) also agrees with the potential of the use of restorative justice to address the needs of Pacific victims, but found that participants in her study were not aware of this as an option.

6.8.3 Sex-worker victim/survivors

Historically it has been difficult for sex-workers who were raped to feel confident about reporting such attacks to the police (Hester and Westmarland, 2004). In countries where prostitution is criminalised, sex-workers often resist or avoid interactions with law enforcement agencies, and may also be wary of encountering stigmatising or victim-blaming attitudes (Penfold et al., 2004). Early indicators in New Zealand following the Prostitution Reform Act 2003 suggest that in a decriminalised environment there is still considerable reluctance on the part of sex-workers to report violent incidents to the police (Abel, Fitzgerald and Brunton, 2008; Prostitution Law Review Committee, 2008). The preferred option is still to confide in fellow workers, or sometimes management in the case of brothel workers, or consult with the New Zealand Prostitutes Collective (Abel, Fitzgerald and Brunton, 2008; Prostitution Law Review Committee, 2008).

Writing within the Australian context, Quadara (2008: 23) noted that, 'misperceptions about sex work and sex workers impact on systemic responses to victim/survivors of sexual assault who are also sex workers'. Her overview identified a failure on the part of some agencies to conceptualise sexual assault as a form of harm for sex-workers, and advocated that it would be good practice for legislative and industry protocols to prioritise sex-workers' personal physical safety and sexual autonomy, not just their sexual health and occupational health.

6.8.4 Victim/survivors with disabilities

Researchers have identified a lack of responsiveness by law enforcement agencies to victim/survivors with disabilities (Hoog, 2004; Lievore, 2005). Issues faced by this group are around judgments to their credibility in either being believed by police in the first instance or prosecution decisions about their status as witness.

In the United States, Lang and Brockway (2001) suggested good practice for criminal justice personnel working with victim/survivors with disabilities is to ensure, if an interpreter is required, that this person be independent. This is because the abusers of people with disabilities are often caregivers or family members, and thus the perpetrator may be the person who is accompanying the victim/survivor to an interview. If this person interprets for the client, there is unlikely to be a full, open disclosure of the facts.

Also, in the United States, the California legislature amended its penal codes in 1998 to provide alternative methods of presenting the testimony of people with cognitive disabilities who are the witnesses/victims of violent and/or sexual crime. These alternatives include the use of video-taped testimony and closed-circuit television, as well as provisions aimed at assisting and reassuring the victim/witness (e.g. allowing breaks from the stand and the presence of support people, and accommodating specific requirements to aid communication) (Petersilia, 2001).

In Australia, although the same laws around sexual assault apply to adults irrespective of whether they have a disability, some additional laws apply specifically to sexual assault against people with intellectual disabilities (Blyth, 2002: 60).

We were unable to locate any references to criminal justice approaches taken in New Zealand that specifically responded to the needs of victim/survivors of sexual violence who have intellectual or other disabilities.

7 Support services

7.1 Introduction

This section reviews the literature on how the support needs of victim/survivors can best be met. This includes those services that specialise in supporting victim/survivors of sexual violence, and non-specialist services where victim/survivors can also turn to for support. While there is a growing body of research assessing the impacts of engagement with the criminal justice system, fewer studies have been conducted into how well support services meet the needs of victim/survivors (Campbell, 2006; Lievore, 2005; Lovett, Regan and Kelly, 2004).

In New Zealand these support services are predominantly delivered in the community by non-government organisations (NGOs). However, overseas support services can also be provided through government-funded initiatives (e.g. sexual assault referral centres (SARCs)) based in either a hospital or the community.

7.2 Specialist sexual violence services

In this section we review specialist models of service delivery for victim/survivors of sexual assault: NGO-specialised sexual violence support services, state-funded SARCs.

7.2.1 Specialised sexual violence support services (non-government organisations)

Background to specialised sexual violence support services

In New Zealand, specialised sexual violence support services (SSVSs) are delivered by a variety of NGOs, including rape crisis centres, HELP Foundation Sexual Abuse Centres, and other independent rape and/or sexual assault centres.

The first SSVSs were the rape crisis centres that emerged in many countries, including New Zealand, in the 1970s and early 1980s as part of the radical feminist movement's desire to eliminate rape and violence against women (Beckett, 2007). In contrast to traditional social service agencies, many of these centres were run as feminist collectives where power and decision-making were shared among all members of the organisations. Although each centre was independent, they operated along similar lines, offering 24-hour crisis lines to provide information, referrals and crisis counselling. These centres also trained volunteers as legal and medical advocates to accompany and support victim/survivors through the police, medical and justice systems (Campbell and Martin, 2001).

In documenting the anti-rape movement, Campbell and Martin (2001) describe a process evident in many countries, including New Zealand, of a shift away from feminist activism towards professionalisation as SSVSs sought and won government funding. Whereas the political activism of the SSVSs has tempered over time, the

direct services these agencies provide to victim/survivors remained essentially the same: a 24-hour hotline; counselling (individual, group support groups), and legal and medical advocacy. An Australian evaluation by Lievore (2005) found the specialist help provided by counsellors from SSVS organisations was rated more highly by victim/survivors than that provided by other formal helping agencies (e.g. medical and mental health services and not-for-profit community organisations that offer counselling, and crisis helplines).

Recently in New Zealand, a national collective of NGOs working in this sector has been formed, named Te Ohaakii a Hine – National Network Ending Sexual Violence Together.

Evaluations

No evaluations of New Zealand services were located, although, in a comparison of models of service delivery across countries, positive characteristics of the New Zealand SSVSs were commented on by Kelly (2005). SSVS-type agencies in New Zealand and North America were judged to have particularly strong links with other agencies, with SSVS advocates expected to be linked in with victim/survivors at the earliest point.

Campbell and Martin (2001) claim that few studies have explicitly examined if and how SSVSs benefit victim/survivors. Researchers and anti-rape activists have assumed that SSVSs help survivors 'precisely because the job of rape victim advocates is to intervene and prevent victim-blaming harm to survivors' (Campbell and Martin, 2001: 234). While some research does show that SSVS advocates appeared to be successful in helping victim/survivors obtain needed resources from community systems (e.g. Campbell, 1998, Campbell and Bybee, 1997, both cited in Campbell and Martin, 2001), few studies included victim/survivors who **did not** receive help from SSVSs.

In an attempt to answer whether survivors who received help from SSVS advocacy were better off than those who did not, in the United States Campbell and Raja (1999) interviewed 102 rape survivors recruited through a variety of neighbourhood contexts (e.g. public transportation, bookstores, beauty and nail salons). They found only one in five victim/survivors had worked with an SSVS advocate; but that working with an SSVS advocate was associated with reduced victim/survivor distress, particularly for victim/survivors of non-stranger sexual violence (acquaintance rape, date rape and marital rape).

In a further study, Rebecca Campbell (2006) interviewed 81 sexual violence victim/survivors, 36 of whom were treated at a hospital where rape victim advocates from a local SSVS worked, and 45 from a hospital where rape victim advocates did not work. The hospitals were similar in all other aspects:

The study found that victim/survivors who worked with an advocate during their emergency:

- were significantly more likely to have police reports taken
- were less likely to be treated negatively by police officers
- reported less distress after their contact with the legal system

- received more medical services, including emergency contraception and sexually transmitted disease prophylaxis
- reported significantly fewer negative interpersonal interactions with medical system personnel
- reported less distress from their medical contact experiences.³²

In her study in New York City, Fry (2007) found that of all the sectors (hospital, rape crisis/victim assistance, law enforcement and criminal justice systems), victim/survivors were most satisfied with the care they received at rape crisis programmes. Fry concludes that this is likely because, in New York city, rape crisis programmes are mandated to deliver victim-centred care and to promote healing and recovery, where other victim service sectors may operate under different mandates such as providing medical care, enforcing the law and ensuring community safety.

Campbell and Martin (2001) drew attention to a negative finding in relation to SSVSs. They found that access to rape crisis centres in Chicago varied as a function of race, with ethnic minority groups being less likely to contact an SSVS. While there are no similar studies in the New Zealand context, the access of Māori, Pacific peoples and other ethnic minorities to SSVSs is an area that needs to be researched.

Only two sets of guidelines for SSVSs were located. A comprehensive set of national standards of practice developed for Australian services against sexual violence (Dean, Hardiman and Draper, 1998) and those compiled by the Rape Crisis Network Europe (2003) for NGOs supporting women who have experienced sexual violence. The Rape Crisis Network Europe guidelines were based on information from 14 member organisations that completed a survey. Rape Crisis Network Europe defined good practice as *action that proved successful or achieved positive outcomes for users of their services*. The study does not provide details on how the rape crisis groups measured their success, but drew up a list of what it identified as the key dimensions of good practice. Guidelines appear in Box 16.

³² Unfortunately, without a more sophisticated randomised control trial, it is not possible to know whether benefits associated with getting care services with advocates was because the better services elect to use advocates.

Box 16: Good practice guidelines for non-government organisation specialised sexual violence support services

- Ideological foundations – recognition that the organisational ethos guides service delivery.
- Client-centred approach – action that focuses on the needs of the woman in crisis.
- Accessible services – offering a broad range of supports for victim/survivors.
- Promoting awareness and values – challenging myths about sexual violence.
- Improving societal responses to sexual violence – through education, awareness raising, advocacy and lobbying.

(Rape Crisis Network Europe, 2003)

7.2.2 Sexual assault referral centres

There are no SARCs in New Zealand, but they have become popular in several countries overseas, including Australia, the United Kingdom, the United States and South Africa.

SARCs are centres that bring together all of the different legal and medical agencies in one place and provide a variety of medical, legal, counselling and support services to victim/survivors. Several countries have developed SARCs in an attempt to improve the care of sexual violence victim/survivors so that they are less traumatised by the need to access all the various services and have forensic evidence and police statements gathered efficiently at the same time. They are typically state funded, either through victim services or health care budgets, or in the United Kingdom through police budgets (Kelly, 2005).

These centres are also known as sexual assault centres, sexual assault treatment units, and in South Africa as Thuthuzela Care Centres. Although SARCs are based in hospitals in most countries, some in the United Kingdom and those in Australia are community based. Common characteristics of SARCs include:

- integrated and co-ordinated services, so victim/survivors do not have to deal with different agencies in different locations
- comprehensive care to anyone who has experienced recent sexual assault (sometimes limited to the previous two weeks)
- development of expertise in responding to sexual assault
- availability to women, men and in some instances children
- access is usually through the hospital emergency room, where necessary medical care is provided
- forensic examinations are provided

- immediate support and follow-up
- shower facilities for the victim/survivors.

Evaluations

An evaluation of SARCs in the United Kingdom by Lovett, Regan and Kelly (2004), reported that victim/survivors valued highly the services provided by SARCs.

Aspects they particularly appreciated included:

- the automatic provision of female examiners and support staff
- proactive follow-up
- advocacy and case tracking
- ease of access to advice and information by telephone.

SARCs were seen to combine the needs of victim/survivors and those of the criminal justice system. Service provision in areas without SARCs was more likely to be driven by the criminal justice system's needs. Areas where there were SARCs provided a greater range of support and referral networks were more formalised.

Further aspects of good practice within SARCs identified by Kelly (2005) included:

- services are provided regardless of whether a report will be made to the police
- victim/survivors are offered the option of having samples taken and having these stored for a period, so that the decision about reporting can be taken at a later date.

Several criticisms of SARCs are as follows.

- SARCs do not work with victim/survivors of historical sexual violence.
- SARCs work with a very small percentage of sexual violence victim/survivors. In the United Kingdom, on average only 10 percent of victim/survivors reported their experiences to the police.
- There are questions over the out-of-hours access to SARCs (Lovett, Regan and Kelly, 2004; Kelly, 2005).
- SARCs predominantly use a medico-legal model of delivery of services, although in Canada, SARCs offer a more holistic service because they are strongly influenced by feminist perspectives (Kelly, 2005). Fry (2007) found that victim/survivors were more satisfied with care received at SARCs that operated from a victim-centred approach.
- SARCs are relatively expensive to run in the United Kingdom. Rape crisis centres receive only 20 percent of the funding received annually by SARCs (Rape Crisis (England and Wales) and Women's Research Centre, 2008). In the United Kingdom SARCs have effectively reduced the funding available to rape crisis groups, which has resulted in rape crisis centres in the United Kingdom closing or reducing services (Rape Crisis (England and Wales) and Women's Research Centre, 2008).

How can sexual assault referral centres and sexual violence support services work together?

A document published in the United Kingdom by End Violence against Women, Rape Crisis (England & Wales), the Child & Woman Abuse Studies Unit and Fawcett (2008) entitled *Not 'Either/Or' but 'Both/And': why we need rape crisis centres and sexual assault referral centres* weighs up the merits of SARCs against rape crisis centres. It was strongly argued that each type of service had particular strengths and roles. Hence, it was vital that both types of service were available, and one should not be implemented at the expense of the other. The authors concluded:

Those who report sexual assault deserve high-quality responses – forensic medical examinations, follow-up and support and advocacy – which only a well-funded SARC can provide. Those who choose not to report, or who have unresolved issues from historic assaults, also need access to high-quality responses – long-term practical and psychological support and advocacy – which a RCC [rape crisis centre] can deliver expertly. If we are ever to meet the needs of survivors better we need RCCs and SARCs. (End Violence against Women, 2008: 7)

In New Zealand it could be argued that some of the NGO SSVS centres are incorporating aspects of the SARCs into their own models of service delivery, combining the positive aspects of both. For example, the Hutt Rape Counselling Network in Wellington works with police and Doctors for Sexual Abuse Care doctors, and has a custom-made room on-site in which forensic medical examinations can be carried out.

7.2.3 Examples of good practice sexual assault referral centre initiatives

The Australian Centre for the Study of Sexual Assault has been proactive in identifying promising practice and has developed a database containing a national collection of programmes and/or approaches that aim to improve understanding of, and response to, sexual assault (child and adult). Such initiatives are worth watching as they demonstrate promising practice in an environment that is similar to New Zealand. Three initiatives are described in Boxes 17–19.³³

³³ See Box 3 for the promising practice criteria of the Australian Centre for the Study of Sexual Assault.

Box 17: Australian Centre for the Study of Sexual Assault – Rape Crisis Online initiative

Rape Crisis Online

One community service that meets five of the seven Australian Centre for the Study of Sexual Assault criteria of good practice is Rape Crisis Online, which is a therapeutic-response programme for victim/survivors of sexual assault. It offers an alternative way for callers to access New South Wales Rape Crisis Centre counsellors by providing a real time, online, person-to-person crisis intervention service accessed via the centre's website. Online access is for one or two contacts only, after which the callers are encouraged to make telephone contact with the service. Online contact gives the person the opportunity to check the centre out, before committing to the more personal voice-to-voice contact.

One way the Rape Crisis Online service reflects good practice is by taking into account contemporary research that indicates that 65 percent of people aged under 25 years use the Internet as their first source of information-gathering in relation to health.

(ACSSA, 2005)

Box 18: Australian Centre for the Study of Sexual Assault – 'Another layer of trauma' workshop

'Another layer of trauma' workshop

Another community service that is worth watching is the Western Australian full-day workshop 'Another layer of trauma', which meets the seven criteria of good practice established by the Australian Centre for the Study of Sexual Assault. The workshop focuses on the traumatic impact of sexual abuse on Aboriginal communities. It analyses and discusses this in the context of the multiple layers of trauma, both historical and current, that Aboriginal people have experienced. This validates the experience of Aboriginal people, and recognises the historical issues of dispossession and assimilation that they have suffered.

Although Māori experiences of colonisation, dispossession and assimilation were different to those of Aboriginal people, within a Māori context sexual abuse may also be experienced as 'another layer of trauma'.

(ACSSA, 2005)

Box 19: Australian Centre for the Study of Sexual Assault – co-ordination of community services

Co-ordination of community services

The Victorian CASA Forum Inc is the peak body for the state's 15 Centres Against Sexual Assault, and the Victorian Sexual Assault Crisis Line. It started in 1987 and is ongoing. The forum promotes a close working relationship between the agencies working with victim/survivors of sexual violence. The forum reflects 'good practice' through various initiatives such as the:

- introduction in 2004 of a single free-call number across the state which provides access to the closest regional CASA during business hours
- establishment of the Sexual Assault Crisis Line to provide victim/survivors a single point for after-hours access to crisis care, police and others charged with the responsibility of responding to sexual assault
- development of the *Victorian Standards of Practice for Centres Against Sexual Assault* which have been recognised as setting a benchmark for the provision of counselling and advocacy for victim/survivors of sexual assault in Victoria (ACSSA, 2005).

7.3 Non-specialist sexual violence victim support systems

Non-specialist sexual violence victim support services are those that provide support services for a range of individuals of whom victim/survivors of sexual violence are just one group.

7.3.1 Women's refuges and shelters

Women's Refuge provides 24-hour support, advocacy and accommodation for women and their children who are experiencing family violence. There is a National Collective of Independent Women's Refuges, which is the umbrella organisation for around 50 refuges across New Zealand. There are also refuges, not affiliated with National Collective of Independent Women's Refuges, funded by government, church and community groups (Lievore and Mayhew, 2007).

No evaluations or good practice guidelines were found in relation to women's refuges or shelters and service provision for victim/survivors of sexual violence. However, these services, developed for victim/survivors of domestic violence, appear to play an important role in providing services for victim/survivors of sexual violence, providing counselling, advocacy and temporary accommodation in cases of marital rape and date rape (Howard et al., 2003).

A study by Howard et al. (2003) explored the intersection between rape and domestic violence. They reviewed several studies that showed battered women were at risk of rape, with 32 percent to 39 percent of battered women reporting at least one, if not many incidents of rape by their partners (Bowker, 1983, Campbell 1989, Campbell and Soeken, 1999, Freize 1983, Mahoney 1999, Randall and

Haskings 1995, Sheilds and Hannneke 1983, Walker 1984, all cited in Howard et al., 2003).

The results of a large-scale New Zealand study on violence against women also demonstrated that sexual violence is an often hidden aspect of family violence, with 42 percent of women who had experienced moderate or severe physical violence also having experienced sexual violence (Fanslow and Robinson, 2004).

Tutty, Weaver and Rothery's (1999) nationwide Canadian study of women staying in shelters or refuges for victim/survivors of domestic violence found that 20 percent of the women reported sexual violence by their current partners (64 percent) and ex-partners (21 percent).

In the United States, Campbell and Ahrens (1998) found that many rape victim/survivors did not feel safe in their homes following a sexual assault *regardless* of whether the assault was committed by someone known to them or a stranger. In response to these needs, some SSVSs negotiated for domestic violence refuges to provide safe housing, counselling and advocacy for victim/survivors of sexual violence regardless of whether they were in a battering relationship. These arrangements provided additional services to rape victim/survivors. However, because of a huge demand for these services, the refuges were overwhelmed and unable to meet the needs of all the women requesting help (Campbell and Ahrens 1998).

7.3.2 One-stop shops

One-stop shops provide integrated services that can respond to both adults and children and/or across sexual and domestic violence or any form of violence against women. They are distinguished from SARCs by this broader focus, with SARCs limited to recent sexual assaults. However, like SARCs, the integrated model of one-stop shops aim to assist service users through the provision of a range of related services under one roof and increase effectiveness of services through inter-agency collaboration.

In New Zealand, Beckett (2007) identified the Kimiora sexual assault centre in New Plymouth as having elements of good practice. This sexual assault centre appeared to be based on this one-stop shop model. She described it as a specialist facility, containing a reception area; an interview room with recording facilities; three offices; a lounge; a kitchen; a medical/forensic examination room; and showering facilities. It houses police on their year-long sexual crimes rotation and delivers specialist services through DSAC-trained doctors and specialist support/advocates. Plus factors included the positive and relaxed atmosphere, provision of privacy and safety.³⁴

A press release in May 2007 suggested a similar initiative was to be set up under one roof in South Auckland, which was described as a 'one-stop shop' bringing

³⁴ It appears this centre is run by the New Plymouth Police Child Sexual Assault Team. It is located in a house separate from the Police station and works in an integrated way with DSAC and local SSVS organisations.

together specialists from Child, Youth and Family Services, the Counties Manukau District Health Board and some community agencies (Mangnell, 2008). It was reported to be a multi-agency service for victims of child abuse, adult sexual assault and family violence, housing medical staff and facilities, family safety teams with members from the police, Child, Youth and Family Services and Women's Refuge, as well as police evidential, child abuse and adult sexual assault teams.

No evaluations of these New Zealand one-stop shop initiatives were located. If evaluations are undertaken, there will need to be special attention to whether the needs of adult versus child sexual violence victim/survivors are appropriately prioritised.

One-stop shops are a model of provision developed primarily in the Third World to maximise scarce resources. The most well-known and promoted good practice example of a one-stop shop is the overseas model developed in Malaysia, which is being replicated in much of Asia (Kelly, 2005). An evaluation of this model found implementation outside of the major metropolitan areas often lacked vital components and were frequently 'done on the cheap'. Also missing was the partnership with women's NGOs to provide support and counselling (Siti Hawa, 2000, cited in Kelly, 2005).

Whilst many practitioners support the idea of one-stop shops in principle, recognising the connections between forms of violence, there are also concerns that:

- child victim/survivors could be prioritised for services before adult victim/survivors
- domestic violence victim/survivors could be prioritised for services before sexual violence victim/survivors (Kelly, 2005).

7.3.3 Multi-service centres

Multi-service centres are another form of integrated service delivery, where SSVSs have merged with other related community agencies or services as a way to maximise scarce funding (e.g. domestic violence, drug and alcohol services), or where SSVSs extend their services to victims of other crime (O'Sullivan and Carlton, 2001). They are distinguished from SARCs and one-stop shops as their services extend to victims/individuals who have not experienced any type of sexual victimisation. We are not aware of this type of service centre in New Zealand.

There have been mixed research findings in relation to this model of service delivery. A study conducted by O'Sullivan and Carlton (2001) examined three models of sexual assault programmes in North Carolina, one of which was a 'multi-service' model. These included:

- independent specialist sexual assault services
- combined sexual assault/domestic violence programmes
- sexual assault programmes embedded in family or drug and alcohol organisations.

The researchers were struck by two findings. First, of the three types of service models, the independent centres were the only ones that advanced inclusive definitions of sexual assault, incorporated cultural concerns in assessing their services and outreach, used volunteers as community educators, and targeted community education to young people and males. Second, embedded centres, particularly ones with domestic violence programmes, seemed to under-serve sexual assault victim/survivors in their communities. They found that domestic violence victim/survivors typically had serious, complicated and immediate needs that could place a burden on resources that could have been used to promote sexual assault services.

Another study (Campbell and Ahrens, 1998), however, argued that although there were occasionally 'turf wars' between SSVSs and other agencies (e.g. drug and alcohol services), the integrated programmes enhanced service provision and brought rape crisis services to people who would not otherwise have accessed them.

Zweig and Burt (2007) further note there is a high co-occurrence of domestic violence and sexual assault with other issues such as substance abuse or mental health issues, yet few programmes provide services that formally address these multiple issues. Multi-agency centres might be one way to address this gap.

7.3.4 Other non-specialist services

Victim Support

In New Zealand, support is available to all victims of crime, including victim/survivors of sexual violence, by the nationwide NGO called Victim Support. Victim Support offices are located in police stations around New Zealand. Victim Support workers are volunteers and can play a leading role in supporting victim/survivors of sexual violence in areas where there are no SSVS centres. An early New Zealand evaluation of Victim Support schemes provided some general guidelines on ways the service could be improved, including the establishment of a national co-ordinating body (Neale and Gray, 1990). There was also a recommendation that this national co-ordinating body could negotiate with other service agencies in supporting victims of specific crimes. It is unknown whether this recommendation has been carried out, but this could have the potential to impact on the quality of their service to victim/survivors of sexual violence. A recent thesis suggested the lack of specialised knowledge and training for dealing with rape can reduce the effectiveness of the assistance provided by Victim Support (Beckett, 2007).

Hotlines

Several organisations in New Zealand operate hotlines that offer accessibility and may be a point of contact for victim/survivors of sexual violence, including Lifeline, Youthline, Samaritans, Mensline, OUTline NZ (gay, lesbian, bisexual, transgender and intersex). However, no literature was located that evaluated these services in relation to victim/survivors of sexual violence.

7.4 Community collaboration

Community collaboration is often viewed as a positive aspect of effective service delivery. The establishment of SARCs, one-stop shops and multi-service centres are examples of community collaboration to provide an integrated service to victim/survivors of sexual violence. Research in New Zealand on pre-court interventions for victim/survivors concluded that the most effective forms of service delivery to victim/survivors result from specialist, multi-agency collaboration, reflecting high levels of co-operation and co-ordinated working relationships (Beckett, 2007).

The literature described some other models that have developed to meet specific needs in communities. For example, in the United States Campbell and Ahrens (1998) described a partnership rape crisis centres formed with local churches, as some survivors of sexual violence never report the rape to the police or seek medical treatment (see also section 2.2.2), preferring to turn to their churches for support. Rape Crisis was concerned that clergy may not have adequate information for working with rape survivors. As a result they created a church outreach worker position, employed by the Rape Crisis centre, but working in different churches across the community to provide on-site assistance to women.

An Australian collaboration between domestic violence, sexual violence and mental health organisations, called the Partnership project, identified systemic issues that worked against successful collaboration.

- Collaboration takes time and resources. Small organisations such as sexual assault services have limited resources, while most clinical mental health professionals have very high caseloads.
- When organisations are under pressure they tend to be crisis-driven, reactive and rigid.
- Few positions are specifically funded to create links between organisations.
- Rigid funding arrangements contribute to services operating in silos.
- Fragmentation of services and 'over-specialisation' results in narrow targeting of services or long waiting lists (Victorian Government, 2006).

In contrast, Campbell and Ahrens (1998) identify three key practices for successful community co-ordination in the delivery of support to victim/survivors of sexual violence:

- changing the competitive model to a collaborative model with excellent communication between agencies;
- making the focus of collaboration and communication the improvement of service delivery to the victim/survivors of sexual violence;
- understanding the larger social context of rape itself, and promoting effective community responses to rape.

7.5 Responding to the needs of diverse groups – support services

Support services provide services or assist victim/survivors in terms of their medical, criminal justice and mental health needs. Hence, many of the points already raised in the previous three sections in relation to the specific needs and ways to respond to diverse groups also apply to this section. To avoid repetition only new issues have been covered below.

The material covered in the ethnic, migrant and refugee section below also has relevance to Māori and Pacific peoples, as it includes Australian research on sexual violence in relation to ethnic minorities and indigenous peoples.

7.5.1 Māori victim/survivors

Māori women have been working in the field of sexual violence for many years. The Māori women's welfare league was set up in the early 1950s and Te Kākano o te Whānau, a national rape and sexual abuse movement, was established in the mid-1980s to provide services for Māori women who are victims of incest, rape, sexual abuse and related violence (Balzer et al., 1997).

This could explain why in many respects community support services are further ahead than medical or criminal justice systems in responding to the need of Māori victim/survivors. There are several kaupapa Māori agencies (guided by Māori philosophies and principles) that offer specialist support to victim/survivors of sexual violence, including Te Puna Oranga in Christchurch, Awhina Wahine in Wellington and Tu Wahine in Auckland.

No guidelines were located that dealt specifically with good practice in provision of community support services for Māori who had been victim/survivors of sexual violence. However, as noted in the introduction above, many of the points included in other guidelines reviewed under other systems would have relevance.

For example:

- *Family Violence Intervention Guidelines: child and partner abuse* (Ministry of Health, 2002)
- *Screening, Risk Assessment and Intervention for Family Violence Including Child Abuse and Neglect* (Standards New Zealand, 2006)
- *Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand* (ACC, 2008).

Cram, Pihama and Karehana (1999) researched the needs of support systems for Māori victims of crime in general (i.e. not specifically victim/survivors of sexual violence). The central place of whānau in supporting the victim/survivor was highlighted, and also the importance of providing support for the whānau, ensuring both the needs of the individual and the whānau were met. Support groups rated highly by Māori were:

- easily contactable

- willing to give as much support as needed
- followed up clients and offered ongoing support
- were Māori-friendly.

A model illustrating a continuum of support services for Māori was presented (see Table 9).

Table 9: Continuum of service delivery: support services.

Mainstream	Taha Māori	Kaupapa Māori
<i>Involving Māori</i> These services have a responsibility to deliver services to Māori – but have no explicit approach.	<i>Focus on Māori</i> Māori issues are treated to one side of mainstream service provision. A Māori-friendly service with internal Māori staff.	<i>Kaupapa Māori</i> A ‘for Māori by Māori’ approach that is under Māori control.

Source: Adapted from F. Cram, L. Pihama and M. Karehana (1999) *Meeting the Needs of Māori Victims of Crime*. Report prepared for Te Puni Kōkiri. Auckland: University of Auckland, p. 75.

Participants interviewed by Cram, Pihama and Karehana (1999) clearly favoured kaupapa Māori services, but attempts by other ‘mainstream’ services to provide a more Māori-friendly approach were also acknowledged. A continuum of service provision from which Māori can then choose services most appropriate for them is similar to that advocated by Durie (2003).

7.5.2 Pacific victim/survivors

No information was located on community support services that respond specifically to need of Pacific victim/survivors of sexual violence. However, as has already been noted, Pacific victims of crime (including family violence of a sexual nature) tended not to access formal support services, preferring informal support systems, such as family, friends, and church ministers and members (Koloto, 2003).

Koloto (2003) points out that a Pacific victim of crime (including sexual violence) is a member of an extended family/aiga/kainga and the victim’s help-seeking behaviours reflect cultural and social practices and knowledge and awareness of available support services. The impacts of crime are not limited to the individual. Therefore, as with Māori, it is important for Pacific victim/survivors of sexual violence to be able to choose from a range of services that which most suits their need.

Koloto’s research with Pacific victims of crime found, in terms of formal support, interviewees said they wanted:

- more information on support services
- provision of and access to formal Pacific services by and for Pacific peoples (although some raised concerns about confidentiality within their communities)
- more Pacific staff in services who could speak their language.

As with Māori, no guidelines were located that dealt specifically with good practice in provision of community support services for Pacific victim/survivors of sexual violence. However, the guidelines described in the previous section can be deemed as having relevance not only for Māori but for Pacific peoples also (Ministry of Health, 2002; Standards New Zealand, 2006; ACC, 2008).

ACC (2008) guidelines advise that there is no one model that meets the needs of all Pacific peoples and as with Māori it should not be assumed that Pacific people would prefer to work with people of the same ethnicity. However, it should be recognised that the church, Christianity and spirituality are elements of both the family and the community, and that those who work with Pacific peoples must be prepared to visit clients in their own homes where appropriate.

7.5.3 Sex-worker victim/survivors

Abel, Fitzgerald and Brunton (2008) describes how in New Zealand sex-workers' rights and grassroots organisations such as the New Zealand Prostitutes Collective have become increasingly important in recent years, offering drop-in as well as community-based outreach options for the delivery of health services, including sexual health clinics, advocacy and support services. Many combine with other agencies to work together to provide a more integrated, holistic service for sex-workers to keep them safe.

7.5.4 Victim/survivors with disabilities

In 1998 a United States symposium was co-ordinated by the National Organisation for Victim Assistance to address the issues of victims of crime with disabilities (Tyiska, 1998). Developing good relationships between victim support groups and disability advocates was seen crucial in order for people with disabilities to access justice, and quality, comprehensive services.

A partnership between the victim assistance and disability advocacy fields needs to be built that fosters mutual respect and sharing of ideas, knowledge, capabilities, successes, and collaborative efforts in order to develop strategies to address the problems. (Tyiska, 1998: p. 14)

7.5.5 Ethnic, migrant and refugee victim/survivors

Overseas statistics indicate that usage of specialist sexual violence services by indigenous women and those from ethnic minority communities is unlikely to match the real extent of sexual violence experienced within those communities (Weeks, 2001). Recent workshops conducted in New Zealand with diverse population groups suggest the situation is no different here.³⁵ This raises questions around the access and equity practices of services that respond to sexual violence survivors.

³⁵ See Ministry of Women's Affairs (no date).

Accessible services are underpinned by recognition of diversity and identification and disbanding of barriers, including:

- victim/survivors' lack of knowledge about the issue
- lack of information about services
- physical barriers to access
- inappropriate services
- inappropriate values or philosophy of management
- unsympathetic community attitudes (Office of the Status of Women, 1993, cited in Weeks, 2001).

In the context of cultural diversity, these barriers may also include ignorance of cultural values and practices, language and racism.

Mainstream services and workers seeking to provide access and equity to survivors from diverse population groups may be faced with a number of dilemmas. Acquiring in-depth knowledge of and sensitivity to other cultures can take years, and it is difficult for workers in small services to become experts in a range of cultural backgrounds. Added to this, it is clear that sexual violence within diverse communities is also the concern of those communities, and not simply mainstream services. Ethno-specific sexual violence services may be desirable, but small ethnic communities are unlikely to be able to support the development of the specialist knowledge and skills required to respond to sexual violence survivors.

An Australian survey of 54 services, completed in 2000, found that eight major strategies, listed below, were used to provide accessible and equitable services (Weeks, 2001). Strategies to incorporate cultural diversity into daily operations were slightly more likely to be ongoing initiatives, rather than time-limited projects. Some involved securing extra funding or staff. While few initiatives had been formally evaluated, all had been verbally evaluated and reported on outcomes as part of service planning.

- Outreach and community development projects established community needs, the absence of service users in communities, and built relationships with specific communities. These projects ranged from working with women in prison, to flexible delivery for Aboriginal women in provincial and remote areas, and establishing links with and developing resources for ethnic communities.
- Media, communication and educational strategies often used radio programmes and publications in community languages to share knowledge. Some engaged in a two-way process to establish what sexual violence meant for that community and used the information to develop educational resources, such as videos.
- Some services reorganised staffing to designate an access and equity worker, who works in collaboration with other community organisations to develop access and equity for minority groups.

- Services with community or collective management structures have designated positions on the management group for representatives from particular cultural and other groups. Others call on cultural consultants to advise and oversee particular projects.
- Several services employed Aboriginal women, not necessarily in specially designated positions. At least one service reported a steady increase in Aboriginal women using the service.
- Some services employed ethnic minority workers or bilingual workers for specific cultural projects. However, unless there are dedicated positions for women from diverse communities, jobs often cease when the project ends.
- Collaborative projects enable sexual violence services to combine their specialist knowledge with the cultural knowledge and experience of generalist organisations representing specific cultural groups.
- The Queensland Government funded specialist organisations for Aboriginal and immigrant women, which have sexual violence workers within them.

Weeks (2001) concluded that the most effective way of providing access and equity is to:

- move beyond short-term projects
- incorporate diversification throughout all tiers of service operation, as well as in policies, protocols and practices
- use a combination of strategies, because initiatives such as cultural consultants, outreach and community development are mutually reinforcing
- develop separate strategies to respond to indigenous women and women from different ethnic communities, as the issues will vary across communities.

Part three: Summary

8 Good practice services for adult survivors of sexual violence

This section brings together the findings from the four different systems (medical, criminal justice, mental health and support services). It presents:

- New Zealand guidelines that were identified for dealing with adult victim/survivors of sexual violence
- programmes and services identified as good practice
- common good practice principles of service delivery.

Much of the good practice identified through this review has been based on overseas literature. It is important that this practice is carefully assessed for its applicability to New Zealand, particularly before any decisions are made on implementation. This section, therefore, briefly reviews some of the key characteristics and issues that impact on service provision in New Zealand.

8.1 New Zealand guidelines

Table 10 presents the New Zealand guidelines that were identified for dealing with adult victim/survivors of sexual violence. Some were developed with victim/survivors of sexual violence in mind, others are non-specific to sexual violence but have key relevance to this group.

Guidelines specific to victim/survivors of sexual violence were comprehensive, particularly the medical and mental health guidelines. However, as raised in several chapters, it is not just the content but also the implementation of the guidelines that is critical. Active monitoring of services would need to occur in order to assess this.

No guidelines were located for support services, although this may well be a reflection of their predominantly non-government organisation status.

Non-government organisations may have their own 'in-house' practice guideline documents that were unavailable for this review. However, national standards for these types of services were located for Australia and Europe.

Table 10: New Zealand guidelines

Guideline	Reference	System – service and sector
Specific to victim/survivors of sexual violence		
The Medical Management of Sexual Assault	DSAC (2006)	Medical – forensic examination, crisis and long term medical care – adults and children
Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand	ACC (2008)	Mental health – counselling – adults and children
Adult Sexual Assault Investigation Policy	New Zealand Police (1998)	Criminal justice – police – adults
Generic guidelines with relevance to victim/survivors of sexual violence		
Family Violence Intervention Guidelines: child and partner abuse	Ministry of Health (2002)	Medical – primary health care – adults and children
Screening, Risk Assessment and Intervention for Family Violence Including Child Abuse and Neglect	Standards New Zealand (2006)	Medical – primary health care – adults and children
Pacific Cultural Competencies: literature review	Ministry of Health (2008)	Medical – primary health care/Pacific peoples
Prosecution Guidelines	Crown Law Office (1992)	Criminal justice – prosecution
Restorative Justice in New Zealand: best practice	Ministry of Justice (2004)	Criminal justice – restorative justice

8.2 Applicability to New Zealand context

New Zealand is a country with a small population from diverse cultural backgrounds. The majority of New Zealanders are of European descent, with Māori representing less than 15 percent of the population. The country has relatively few large urban centres, with most of the landscape being made up of relatively isolated rural areas. It has a centralised system of government and an adversarial justice system.

Any programmes or services identified as good practice overseas are only good practice in New Zealand if they work within this context. For example, forensic nursing has been established as good practice in many countries. While forensic nurses' therapeutic benefits are transferable to New Zealand, their wider role may be limited through their inability to act as 'expert' witnesses in court cases in the New Zealand legal system. The sparsely populated rural areas also make the resourcing of specialist services to all areas difficult (e.g. Doctors for Sexual Abuse Care (DSAC) trained doctors, specialist police teams and specialist sexual offences courts).

The small size of New Zealand and its centralised system of government has helped the nation-wide implementation of new policies and service strategies such as policing strategies and health services. For example, the country has developed some innovative practices such as the national co-ordination of specialist sexual assault doctors through DSAC, state funding for rehabilitative mental health counselling for sexual abuse (Accident Compensation Corporation) and the national networking of the non-government organisation (NGO) specialised sexual violence support services (SSVSs) to develop strong and co-ordinated services and provide a voice at the national level (e.g. Te Ohaakii a Hine – National Network Ending Sexual Violence Together). The strong links New Zealand NGO SSVSs had developed with other agencies was commented on by Kelly (2005), which may mean models of service delivery advocated in other larger countries (e.g. sexual assault referral centres) may not be so applicable or necessary in New Zealand.

The lack of national networking historically has resulted in some communities developing their own models of service delivery in partnership with agencies such as the police and DSAC-affiliated doctors. This could be seen as a positive aspect enabling models to be developed that fit the local context, facilitating grassroots' involvement. This may better meet the needs of the diverse population groups across New Zealand rather than the imposition of a single, nationally developed model of service delivery.

There are also some disadvantages to being a small country, and a major barrier in New Zealand to developing strong co-ordinated services to meet the needs of victim/survivors of sexual violence has been the lack of funding within the NGO sector (Ministry of Social Development, 2008). Although not relating specifically to services for victim/survivors of sexual violence, the Ministry of Social Development has acknowledged the inadequacy of funding for NGO services to families, children and young people. The ministry recognised that without sustainable funding there would be a decline in the level, intensity and/or quality of essential NGO services. The Government would itself need to step in to deliver these essential services.

Through its Pathways to Partnership programme established in 2007, the Ministry of Social Development has begun to address issues of funding for the NGO sector (Ministry of Social Development, 2008: 3). The consistent and guaranteed resourcing of the NGOs is essential for their ongoing involvement in an integrated model of multi-agency service delivery.

Another challenge specific to New Zealand is the provision of appropriate and effective services for Māori, in particular that they have access to kaupapa Māori services (services ‘for Māori by Māori’, see Table 11). This review found that the only area where this type of service was currently available for Māori victim/survivors of sexual violence was at the community NGO level through the kaupapa SSVSs (and these were limited to the main centres). Barriers to achieving better service provision for Māori include a lack of resources for Māori to be able to develop these services and the Māori workforce needed to provide these services.

The Māori Potential Approach, the public policy framework developed by Te Puni Kōkiri (2008), provides insights into how this situation might be improved. The framework aims to better position Māori to build and leverage off their collective resources, knowledge, skills and leadership capability. The framework identifies three fundamental key enablers to Māori achieving full physical, psychological, emotional and spiritual well-being: mātauranga – building knowledge and skills; whakamana – strengthening leadership and decision-making; rawa – development and use of resources. While this policy framework applies to all government services, the principles and framework are also relevant to achieving effective provision of sexual violence services for Māori in New Zealand.

Clearly the unique characteristics of New Zealand mean that good practice based on overseas experience will need to be carefully assessed for its applicability to New Zealand.

8.3 Good practice programmes and services

The types of services and programmes that have been identified in this review as good practice are summarised in Table 12. Those highlighted are those for which there was either research evidence available or where they had been identified as such by experts in the field. As indicated in the table, some of those have already been incorporated in New Zealand.

8.4 Common good practice principles for delivery

In general, there was more literature and agreement over principles of delivery than particular types of service delivery. Many of those that emerged were common to a number of systems and services. The heavy reliance on international literature means their applicability to the New Zealand context will also need to be carefully considered. However, many of the principles identified appear more easily transferable to the New Zealand context, for example, for services to be culturally appropriate. Table 12 presents the overarching good practice principles for delivery that came through from the multiple types of services reviewed.

Table 11: Good practice programmes and services

Programme/service	Identified by	Evidence (e.g. knowledge-based (victim/professional), research evidence)	Country research evidence based on	Status
Medical				
Forensic nursing (Sexual Abuse Nurse Examiners programme)	Kelly (2005)	Review of research evidence	International	Used overseas not in New Zealand
Mental health				
Cognitive Behavioural Therapies (e.g. prolonged exposure treatment, stress inoculation training and cognitive processing therapy) for reducing short-term post- rape fear and anxiety symptoms	Astbury (2006) Campbell (2001) Wang and Rowley (2007)	Reviews of research evidence	International	Used overseas and in New Zealand
Criminal justice				
Specialist courts	Amnesty International Australia (2008) Kelly (2005) Cossins (2007)	Review of research evidence	International	Used overseas not in New Zealand
Specialist prosecutors	Amnesty International Australia (2008) Cossins (2007) Walker and Louw (2003)	Reviews of research evidence	International	Used overseas in South Africa not in New Zealand

Programme/service	Identified by	Evidence (e.g. knowledge-based (victim/professional), research evidence)	Country research evidence based on	Status
Specialist police investigation units	Amnesty International Australia (2008) Brown and Heidensohn (2000) Metropolitan Police Service (2005) Epstein and Langenbahn (1994) Lord and Rassel (2000)	Reviews of research evidence and individual research findings	International	Used overseas and recently introduced in New Zealand
Investigative interviewing techniques	Schollum (2005)	Reviews of research evidence	International	Used overseas and in New Zealand
Support services				
Community-based, specialist sexual violence support services	Campbell and Raja (1999)	Findings of a research study	United States	Used overseas and in New Zealand
Sexual assault referral centres, but in combination with, not instead of, community based non-government organisation specialist sexual violence support services	Kelly (2005) Lovett, Regan and Kelly (2004)	Reviews of research evidence	International	Used overseas but not in New Zealand

Table 12: Common good practice principles of delivery

Programme/service	System applicable to – identified by	Type of evidence	Country
Victim/survivor needs paramount Safety of victim/survivor. There should be informed choice and consent regarding all procedures and uptake of services to ensure victim/survivors do not feel disempowered (e.g. availability and choice regarding gender and ethnicity of service providers). For those engaged with the criminal justice system, there must be ongoing communication and provision of information regarding case development and progression. Victim/survivors should be treated with respect, empathy and in ways that validate their experience.	Medical – WHO (2003), DSAC (2006), Jordan (2008), Kelly and Regan (2008)	Victim/survivor perspective Review of research evidence Knowledge -based	International and New Zealand
	Criminal justice system – Legal Aid Queensland (2007); Jordan (multiple); New Zealand Police (1998).	Knowledge -based	New Zealand
	Mental health – ACC (2008)	Victim/survivor perspective Knowledge-based	International and New Zealand
	Support services – Rape Crisis Network Europe (2003)	Knowledge-based	International
Specialisation and training Service delivery should be by appropriately trained, skilled, experienced and informed individuals and professionals. For victim/survivors' needs to be met, the unique impacts and complexities associated with sexual violence must be understood and incorporated.	Medical – WHO (2003); Fry (2007), DSAC (2006), Jordan (2008), Kelly and Regan (2008)	Victim/survivor perspective Review of research findings Knowledge-based	International and New Zealand
	Mental health –Jordan (1998)	Victim/survivor perspective	New Zealand
	Criminal justice system – Amnesty International Australia (2008); Metropolitan Police Service (2005); Legal Aid Queensland (2007); Kelly (2005); Jordan (multiple); New Zealand Police (1998)	Victim/survivor perspective Review of research findings Knowledge-based Research finding	International and New Zealand

Programme/service	System applicable to – identified by	Type of evidence	Country
Culturally appropriate Māori victim/survivors must have access to appropriate and effective services, either run by Māori, or from non-Māori service providers who are trained in culturally appropriate protocols. These must be developed in partnership with Māori. Services must also be adapted to meet the needs of victim/survivors from diverse ethnic groups (e.g. Pacific women, new migrants and refugees). Specialist understanding is required to inform service delivery relevant to the needs of diverse groups of victim/survivors.	Medical – DSAC (2006), Ministry of Health (2002)	Knowledge-based	New Zealand
	Mental health – ACC (2008)	Knowledge-based	New Zealand
	Criminal justice system – Jordan (multiple), New Zealand Police (1998)	Victim/survivor perspective Knowledge-based	New Zealand
	Support services – ACSSA (2008)	Knowledge-based	International
Multi-agency response Integrated service provision across multi-agencies with high levels of co-operation and co-ordinated working relationships (i.e. medical, criminal justice, mental health and specialist community support agencies).	Medical – WHO (2003)	Review of research evidence	International
	Criminal justice system – Jordan (multiple); New Zealand Police (1998); Metropolitan Police Service (2005)	Victim/survivor perspective Knowledge-based Research finding	International and New Zealand

Programme/service	System applicable to – identified by	Type of evidence	Country
Appropriate environment Services should be physically accessible, financially affordable, and provided in a welcoming, non-judgmental and non-intimidating manner.	Medical – WHO (2003), Astbury (2006), DSAC (2006), Jordan (2008), Kelly and Regan (2008)	Victim/survivor perspective Review of research findings Knowledge-based	International and New Zealand
	Mental health – Jordan (1998)	Victim/survivor perspective	New Zealand
	Criminal justice system – Amnesty International Australia (2008); Legal Aid Queensland (2007); Jordan (multiple)	Victim/survivor perspective Review of research findings Knowledge-based	International and New Zealand
	Support services – Rape Crisis Network Europe (2003)	Knowledge-based	International
Accountable There must be a commitment to ongoing evaluation of service delivery with assessment based on research evidence, practice standards and client feedback.	Mental health – ACC (2008)	Knowledge-based	New Zealand
	Support services – ACSSA (2008)	Knowledge-based	International
Ensure support is available Service providers must facilitate for victim/survivors to have access to a support person at the earliest opportunity.	Medical – Fry (2007), DSAC (2006), Jordan (2008), Kelly and Regan (2003)	Victim/survivor perspective, Review of research findings Knowledge-based	International and New Zealand
	Criminal justice system – Amnesty International Australia (2008); New Zealand Police (1998)	Review of research findings Knowledge-based	International and New Zealand

In summary, in regards to the medical system there are comprehensive New Zealand guidelines related to the medical care of victim/survivors. The review of literature found extensive research on good practice for conducting a forensic medical examination. Forensic nursing was an initiative reviewed favourably that had been implemented successfully overseas. Its applicability to New Zealand would need to be assessed carefully, particularly in relation to the status of nurses in court as 'ordinary witnesses'. There appears to be a paucity of literature in relation to non-specialist primary health care.

The criminal justice system in New Zealand has undergone significant reform and the legal framework continues to be reviewed. There is a police policy for the investigation of adult sexual violence offences that includes many of the good practice principles of delivery featured in Table 12. The extent to which this policy has been implemented and adhered to is less clear. Specialisation, particularly within the criminal justice system, has been recognised as good practice and the introduction of specialist adult sexual assault teams within police is clearly a positive move. However, specialisation in New Zealand is still limited within police and has not extended to the prosecution section of the criminal justice system.

There are comprehensive practice guidelines for the mental health care of victim/survivors in New Zealand that are easily accessible via the internet to all practitioners. There is very limited research internationally or in New Zealand about which types of mental health interventions are the most effective for victim/survivors.

New Zealand has a very proactive network of SSVSs with good links with other agencies. There are also a range of other non-specialist sexual violence victim support agencies. Unlike Europe and Australia there appears to be no national practice guidelines for sexual violence support services in New Zealand. It is not known if individual agencies have their own 'in-house' documents.

Ensuring adult victim/survivors of sexual violence have access to the optimal services to assist in their recovery and well-being is crucial, and Kelly (2005: 2) points out there is still a long way to go:

Despite three decades of research, advocacy and campaigning, even the most basic issues matter, such as ensuring that women reporting sexual violence are treated with respect and dignity, cannot be guaranteed even in high resource contexts.

However, this review has identified a variety of good practice programmes and principles of delivery for adult victim/survivors of sexual violence. Providing we critically assess who has identified these practices, on what outcomes and what criteria, and ensure that the needs of victim/survivors remain paramount, then we are making a promising start.

Appendix: Methodology – search criteria and sources of references

Search criteria

The search was conducted by the Ministry of Women's Affairs' Information Services and by the business information specialist at Wellington City Libraries. It focused on material published in English, primarily since 2000, from New Zealand, Australia, Canada, the United Kingdom, the United States and South Africa.

Key words

- Victim(s), victim support, survivors.
- Sexual violence, sexual assault, rape, attack, sex*offending.
- Best practice, guidelines, models.
- Medical, emotional, mental health, community, criminal justice, police, prosecut*, court.
- New Zealand, Australia, Canada, United Kingdom, United States, South Africa.

Databases and other reference sources

- Ministry of Women's Affairs in-house library.
- Te Puna – National Library of New Zealand Database.
- Internet.
- Google scholar <http://scholar.google.co.nz>.
- New Zealand Family Violence Clearing House.
- National Resource Center on Domestic Violence <http://new.vawnet.org/>.
- Contemporary Women's issues.
- Masterfile Premier.
- The Australia/New Zealand Reference Centre.
- Gale's General OneFile.
- Innz (Index to New Zealand periodicals).
- Australian Centre for the Study of Sexual Assault.
- References traced from articles and books.

The Ministry of Women's Affairs' research manager scanned the final list and decided which literature should be included or excluded. Given the volume of

international practice guidelines for different types of agencies and systems, the final list contained a selection of guidelines for the different systems, rather than all available references. This was considered sufficient for the purpose of extracting high-level best practice principles. The list also contained some references published before 2000, where these were regarded as key references or where there was little other information available (e.g. in relation to specific population groups). Also included were diverse newspaper articles from New Zealand and journal articles from *Journal of Interpersonal Violence* and *Violence against Women*.

References

- Abel, G., Fitzgerald, L., and Brunton, C. (2008) *The Impact of the Prostitution Reform Act on the Health and Safety Practices of Sex Workers*. Christchurch: Department of Public Health and General Practice.
- Abbott, M. (1997) 'Refugees and immigrants', in P. Ellis and C. Collings (Eds), *Mental Health in New Zealand from a Public Health Perspective*. Wellington: Ministry of Health.
- ACC (2008) *Sexual Abuse and Mental Injury: practice guidelines for Aotearoa New Zealand*. Wellington: Accident Compensation Corporation.
- Ackerman, D., Sugar, N., Fine, D., and Eckert, L. (2006) 'Sexual assault victims: Factors associated with follow-up care'. *American Journal of Obstetrics and Gynaecology*, 194(6): 1653–1659.
- ACCSA (Australian Centre for the Study of Sexual Assault) (2005) Special 'Good Practice' Edition. *AWARE: ACSSA Issues*, 7(June): 1–20. Melbourne: Australian Institute of Family Studies. Retrieved from <http://www.aifs.gov.au/acssa/pubs/newsletter/n7.html>
- ACSSA (Australian Centre for the Study of Sexual Assault) (2007) 'Agency profile: Specialist Sex Offences Unit, Office of Public Prosecutions, Victoria: Interview with Michele Williams, SC, August 2007. *ACSSA Newsletter*, 17: 19–21. Melbourne: Australian Institute of Family Studies. Retrieved from http://www.aifs.gov.au/acssa/pubs/newsletter/n17pdf/n17_7.pdf
- ACSSA (Australian Centre for the Study of Sexual Assault) (2008) *Promising Practice Programs & Responses for Sexual Assault*. Melbourne: Australian Institute of Family Studies. Retrieved from <http://www.aifs.gov.au/acssa/ppdb/promising practice.html>
- Adler, Z. (1987) *Rape on Trial*. London: Routledge and Kegan Paul.
- Advance Africa (2002) *The Best Practices Compendium: conclusions and lessons learned from the advisory group meetings*. Arlington, VA: Advance Africa.
- Advance Africa (2005) *Best Practices Final Report*. Arlington, VA: Advance Africa.
- Ahrens, C. E. (2006) 'Being silenced: the impact of negative social reactions on the disclosure of rape'. *American Journal of Community Psychology*, 38(3–4): 263–274.
- Ahrens, C. E., and Campbell, R. (2000) 'Assisting rape victims as they recover from rape: The impact on friends'. *Journal of Interpersonal Violence*, 15: 959–986.
- Ahrens, C. E., Campbell, R., Wasco, S., Aponte, G., Grubstein, L., and Davidson II, W. S. (2000) 'Sexual Assault Nurse Examiner (SANE) programs: alternative systems for service delivery for sexual assault victims'. *Journal of Interpersonal Violence*, 15: 921–943.
- Amnesty International Australia (2008) *Setting the Standard: international good practice to inform an Australian national plan of action to eliminate violence against women*. Broadway, NSW: Amnesty International Australia.

- Ardovini-Brooker, J., and Caringella-Macdonald, S. (2002) 'Media attributions of blame and sympathy in ten rape cases'. *Criminal Justice Studies*, 15(1): 3–18.
- Asiasiga, L., and Gray, A. (1998) *Intervening to Prevent Family Violence in Pacific Communities*. Wellington: Ministry of Justice.
- Astbury, J. (2006) *Services for Victim/Survivors of Sexual Assault: identifying needs, interventions and provision of services in Australia*. ACSSA Issues No. 6. Melbourne: Australian Centre for the Study of Sexual Assault. Retrieved from <http://www.aifs.gov.au/acssa/pubs/issue/i6.html>
- Averill, J., Padilla, A. O., and Clements, P. T. (2007) 'Frightened in isolation: unique considerations for research of sexual assault and interpersonal violence in rural areas'. *Journal of Forensic Nursing*, 3(1): 42–46.
- Baird, V. (2007) *Convicting Rapists and Protecting Victims: government announces new measures*. Press release, 28 November 2007, London.
- Ballard, M. B., and Alessi, H. D. (2002) 'Counseling sexual abuse and rape victims', in L. D. Burlew and D. Capuzzi (Eds), *Sexuality Counseling* (pp. 307–328). Hauppauge, New York: Nova.
- Balzer, R., Haimona, D., Henare, M., and Matchitt, V. (1997) *Māori Family Violence in Aotearoa*. Wellington: Te Puni Kōkiri.
- Bazley, M. (2007) *Report of the Commission of Inquiry into Police Conduct*. Wellington: Commission of Inquiry into Police Conduct.
- Beckett, L. (2007) 'Care in collaboration: preventing secondary victimisation through a holistic approach to pre-court sexual violence interventions'. Doctoral thesis, Victoria University of Wellington, Wellington.
- Black, B. M., Tolman, R. M., Callahan, M., Saunders, D. G., and Weisz, A. N. (2008) 'When will adolescents tell someone about dating violence victimization?'. *Violence against Women*, 14: 741–758.
- Blair, I. (1985) *Investigating Rape: a new approach for police*. London: Croom Helm/Police Foundation.
- Blyth, J. (2002) *Myalla: responding to people with intellectual disabilities who have been sexually assaulted*. Sydney: Northern Sydney Sexual Assault Service.
- Braithwaite, J. (1989) *Crime, Shame and Reintegration*. Cambridge: Cambridge University Press.
- Brogden, M., and Shearing, C. (1993) *Policing for a New South Africa*. London: Routledge.
- Bronitt, S. (1998) 'The rules of recent complaint: Rape myths and the legal construction of the 'reasonable' rape victim'', in P. Eastaugh (Ed.), *Balancing the scales: rape, law reform and Australian culture*. Leichhardt, Sydney: Federation Press.
- Brook, J. (1997) 'Sexual abuse and people with intellectual disabilities. *Social Work Review*, 9(3): 16–17.
- Brown, J., and Heidensohn, F. (2000) *Gender and Policing: comparative perspectives*. Basingstoke: MacMillan.

- Buckingham, D. (2008) *Submission on Ministry of Justice Public Discussion Document: improvements to sexual violence legislation in New Zealand*. Wellington: New Zealand Law Society. Retrieved from http://www.lawsociety.org.nz/__data/assets/pdf_file/0011/4889/Sexual_Violence_Legislation_in_NZ-3009.pdf
- Burgess, A. W. (1999) 'Public beliefs and attitudes towards rape', in A. W. Burgess and R. R. Hazelwood (Eds), *Practical Aspects of Rape Investigation: a multidisciplinary approach* (2nd ed.) Boca Raton: CRC Press.
- Burgess, A. W., and Hazelwood, R. R. (2001) 'Victim care services and the Comprehensive Sexual Assault Assessment Tool (CSAAT)', in R. Hazelwood and A. W. Burgess (Eds), *Practical Aspects of Rape Investigation: a multidisciplinary approach* (3rd ed.) (pp. 47–67). Boca Raton, London, New York, Washington DC: CRC Press.
- Busch, R. (2002) 'Family violence and restorative justice initiatives: Who pays if we get it wrong?', in H. Strang and J. Braithwaite (Eds), *Restorative Justice and Family Violence*. Cambridge: Cambridge University Press.
- Calder, J. (2000) 'Beauty lies in the eye of the beholder'. *International Review of Research in Open and Distance Learning*, 1(1): 1–10.
- Campbell, R. (2001) *Mental Health Services for Rape Survivors: current issues in therapeutic practice*. Minnesota: Minnesota Center against Violence and Abuse.
- Campbell, R. (2005) 'What really happened? A validation study of rape survivors' help-seeking experiences with the legal and medical systems'. *Violence and Victims*, 20(1): 55–68.
- 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 Ahrens, C. E. (1998) 'Innovative community services for rape victims: an application of multiple case study methodology.' *American Journal of Community Psychology*, 26(4): 537–571.
- Campbell, R., and Diegael, R. (2004) 'The effectiveness of Sexual Assault Nurse Examiner (SANE) programs'. *VAWnet: National Online Resource Center on Violence against Women*. Retrieved November 2008 from http://new.vawnet.org/category/Main_Doc.php?docid=417
- Campbell, R., and Martin, P. (2001) 'Services for sexual assault survivors: the role of rape crisis centres', in C. Renzetti, J. Edelson' and R. Bergen (Eds), *Sourcebook on Violence against Women*. Thousand Oaks, California: Sage Publications.
- Campbell, R., and Raja, S. (1999) 'Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence'. *Violence and Victims*, 14(3): 261–275.
- Cannon, J. S., and Kilburn, M. R. (2003) 'Meeting decision-makers' needs for evidence-based information on child and family policy'. *Journal of Policy Analysis and Management*, 22(4): 665.
- Cantu, M., Coppola, M., and Lindner, A. (2003) 'Evaluation and management of the sexually assaulted woman'. *Emergency Medicine Clinics of North America*, 21: 737–750.

- Chambers, G., and Millar, A. (1983) *Investigating Sexual Assault*. Edinburgh: Scottish Office Central Research Unit.
- Chan, J. B. (2003) *Fair Cop: learning the art of policing*. Toronto: University of Toronto Press.
- Chapleau, K. M., Oswald, D. L., and Russell, B. L. (2008) 'Male rape myths: the role of gender, violence, and sexism'. *Journal of Interpersonal Violence*, 23: 600–615.
- Church, A., Lang, K., Leigh, J., Young, P., Gray, A., and Edgar, N. (1995) *Victims Court Assistance: an evaluation of the pilot scheme*. Wellington: Policy and Research Division, Department of Justice.
- Cooper, M., Warthe, D. G., and Hoffart, I. (2004) *Family and Sexual Violence Sector Review. Companion document 2: review of best practice in family and sexual violence programming*. Calgary, Canada: United Way of Calgary; City of Calgary; Calgary Child and Family Services.
- Cossins, A. (2007) *A Best Practice Model for the Prosecution of Complaints of Sexual Assault by the NSW Criminal Justice System*. Sydney: New South Wales Rape Crisis Centre.
- Cossins, A. (2008) 'Restorative justice and child sex offences: the theory and the practice'. *British Journal of Criminology*, 48(3): 359–378.
- Counties Manukau District Health Board (on behalf of four northern district health boards) (2003) *The Northern Regional Pacific Mental Health and Addictions Plan 2003/05*. Manukau: Counties Manukau District Health Board.
- Cram, F., Pihama, L., and Karehana, M. (1999) *Meeting the Needs of Māori Victims of Crime*. Report prepared for Te Puni Kōkiri. Auckland: University of Auckland.
- Crandall, C. S., and Helitzer, D. (2003) *Impact Evaluation of a Sexual Assault Nurse Examiner (SANE) Program*. Albuquerque, NM: University of New Mexico School of Medicine.
- Crome, S. (2006) *Male Survivors of Sexual Assault and Rape*. ACSSA Wrap No. 2. Melbourne: Australian Institute of Family Studies.
- Crooks, H., and Jefferies, R. (2003) *How Well is the Service Meeting the Needs of Māori and Pacific Victims?* Wellington: Department for Courts.
- CROWD (Center for Research on Women with Disabilities) (2008) *Violence Against Women with Disabilities*. Retrieved 15 July 2008 from <http://www.bcm.edu/crowd/?PMID=1325>
- Crown Law Office (1992) *Prosecution Guidelines*. Wellington: Crown Law Office.
- Daane, D. M. (2006) 'Rape: victims and survivors', in J. H. Hendricks and B. D. Byers (Eds), *Crisis Intervention in Criminal Justice/Social Service* (4th ed.) (pp. 233–263). Springfield, United States: Charles C Thomas.
- Daly, K. (2002) 'Sexual assault and restorative justice', in H. Strang and J. Braithwaite (Eds.), *Restorative justice and family violence* (pp. 62–88) Cambridge: Cambridge University Press.
- Daly, K. (2006) 'Restorative justice and sexual assault: an archival study of court and conference cases.' *British Journal of Criminology*, 46(2): 344–356.

- Daly, K. (2008) 'Setting the record straight and a call for radical change: a reply to Annie Cossins on "Restorative justice and child sex offences"'. *British Journal of Criminology*, 48(4): 557–566.
- Davies, M., and Rogers, P. (2006) 'Perceptions of male victims in depicted sexual assaults: a review of the literature'. *Aggression and Violent Behavior*, 11(4): 367–377.
- Davis, C. (2000) 'Responding to sexual abuse: organisational issues for consideration'. Paper presented at the Advocating for the Future: Sharing the Road Conference, September, Brisbane.
- Dean, C., Hardiman, A., and Draper, G. (1998) *National Standards of Practice Manual for Services against Sexual Violence*. Victoria: National Association of Services against Sexual Violence.
- Deming, J., Mittleman, R., and Wetli, C. (1983) 'Forensic science aspects of fatal sexual assaults on women'. *Journal of Forensic Science*, 28: 572–576.
- Department of Labour (2004) *A Guide to Occupational Health and Safety in the New Zealand Sex Industry*. Wellington: Department of Labour.
- DeSousa, R. (2007) 'Sailing in a new direction: multicultural mental health in New Zealand'. *Mental Health Foundation of New Zealand Newsletter*, 11(Spring)
- Dissel, A. (2005) 'Piloting victim-offender conferencing in South Africa', in T. Maepa (Ed.), *Beyond Retribution: prospects for restorative justice in South Africa*. Institute for Security Studies.
- DSAC (Doctors for Sexual Abuse Care) (2005) *National Newsletter*, 64(September)
- DSAC (2006) *The Medical Management of Sexual Assault* (6th ed.). Auckland: Doctors for Sexual Abuse Care.
- Du Mont, M., Miller, K. L., and Myhr, T. L. (2003) 'The role of "real rape" and "real victim": stereotypes in the police reporting practices of sexually assaulted women'. *Violence against Women*, 9(4): 466–486.
- Du Mont, J., Parnis, D., and Mason, R. (2004) 'Documenting the health impacts of sexual violence: an evaluation of two forensic protocols'. Paper presented at the Global forum for Health Research, Mexico City, November.
- Durie, M. (1995) *Ngā Matatini Māori: Diverse Māori Realities*. Palmerston North: Massey University.
- Durie, M. (2001) *Mauri Ora: the dynamics of Māori health*. Melbourne: Oxford University Press.
- Durie, M. (2003) *Ngā Kāhui Pou Launching Māori Futures*. Wellington: Huia Publishers.
- Duire, M. (2006) 'Measuring Māori well-being'. New Zealand Treasury guest lecture series. Paper presented at the New Zealand Treasury, Wellington, 1 August 2006.
- Easteal, P. (1993) *Without Consent: confronting adult sexual violence*. Proceedings of a conference. Canberra: Australian Institute of Criminology.

- End Violence against Women (2008) *Not 'Either/Or' but 'Both/And': why we need rape crisis centres and sexual assault referral centres*. Retrieved 15 July 2008 from http://www.endviolenceagainstwomen.org.uk/data/files/rape_crisis_and_sarcs.pdf
- Epati, A. S. (1995) 'Samoan notions of cultural and social justice: conflicts with Western law systems', in F. W. M. McElrea (Ed.), *Re-thinking Criminal Justice*. Volume I: Justice in the Community (pp. 49–56). Wellington: Legal Research Foundation.
- Epstein, J., and Langenbahn, S. (1994) *The Criminal Justice and Community Response to Rape*. Contract No. OJP-89-C-009 ed. Washington, DC: United States Department of Justice: National Institute of Justice.
- Evans, I., and Taylor, J. (2004) *Childhood Sexual Abuse and Mental Injury in Adults: a critical analysis for Aotearoa/New Zealand*. Palmerston North: Psychology Centre, Massey University.
- Fanslow, J. L., and Robinson, E. M. (2004) 'Violence against women in New Zealand: prevalence and health consequences'. *New Zealand Medical Journal*, 117(1206): 1173–1184.
- Farrell, J., and Cerise, S. (2006) *Fair's Fair: a snapshot of violence and abuse in Sydney LGBT relationships*. Sydney: AIDS Council of NSW and Same Sex Domestic Violence Interagency and Working Group.
- Felson, R., and Pare, P. (2005) 'The reporting of domestic violence and sexual assault by nonstrangers to the police'. *Journal of Marriage and Family*, 67(3): 597–610.
- Fenaughty, J., Braun, V., Gavey, N., Aspin, C., Reynolds, P., and Schmidt, J. (2006) *Sexual Coercion among Gay Men, Bisexual Men and Takapui Tane in Aotearoa/New Zealand*. Auckland: Department of Psychology, University of Auckland.
- Ferguson, C. (2006) 'Providing quality care to the sexual assault survivor: education and training for medical professionals'. *Journal of Midwifery and Women's Health*, 51(6): 486–492.
- Ferguson, H. (2003) 'Outline of a critical best practice perspective on social work and social care'. *British Journal of Social Work*, 33: 1005–1024.
- Flatman, G., and Bagaric, M. (2001) 'The victim and the prosecutor: the relevance of victims in prosecution decision making'. *Deakin Law Review*, Volume 2. Retrieved 20 May 2009 from <http://www.austlii.edu.au/au/journals/DeakinLRev/2001/2.html>
- Foa, E. B., and Rothbaum, B. O. (1998) *Treating the Victim of Rape: cognitive behaviour theory for PTSD*. New York: Guilford Press.
- Frazier, P. A., and Haney, B. (1996) 'Sexual assault cases in the legal system: police, prosecutor, and victim perspectives'. *Law and Human Behavior*, 20: 607–628.
- Fry, D. (2007) *A Room of Our Own: sexual survivors evaluate services*. New York: New York City Alliance against Sexual Assault.
- Gavey, N. (2005) *Just Sex? The cultural scaffolding of rape*. Hove, East Sussex: Routledge.

- Gilmore, K., and Pittman, L. (1993) *To Report or Not To Report: a study of victim/survivors of sexual assault and their experience of making an initial report to the police*. Melbourne: Melbourne Centre against Sexual Assault (CASA House) and Royal Women's Hospital.
- Glasby, J., and Beresford, P. (2006) 'Commentary and issues: Who knows best? Evidence-based practice and the service user contribution'. *Critical Social Policy*, 25: 268–284.
- Gonzales, A., Schofield, R., and Schmitt, G. (2006) *Extent, Nature, and Consequences of Rape Victimization: findings from the National Violence against Women Survey*. Washington: National Institute of Justice.
- Goodfellow, J., and Camilleri, M. (2003) *Beyond Belief, Beyond Justice: the difficulties for victim/survivors when reporting sexual assault and seeking justice*. Melbourne: Disability Discrimination Legal Service.
- Goodman, L. A., Koss, M., and Russo, N. F. (1993) 'Violence against women: physical and mental health effects. Part 1: Research findings'. *Applied and Preventive Psychology*, 2: 79–89.
- Goodstein, L., and Lutze, F. (1992) 'Rape and criminal justice system responses', in I. Moyer (Ed.), *The Changing Roles of Women in the Criminal Justice System: offenders, victims, and professionals* (2nd ed.) Illinois: Waveland Press.
- Gregory, J., and Lees, S. (1999) *Policing Sexual Assault*. London: Routledge.
- Harcourt, C., van Beek, I., Heslop, J., McMahon, M., and Donovan, B. (2001) 'The health and welfare needs of female and transgender street sex workers in New South Wales'. *Australian and New Zealand Journal of Public Health*, 25(1): 84–89.
- Heenan, M., and Murray, S. (2006) *Study of Reported Rapes in Victoria 2000–2003: summary research report*. Melbourne: Office of Women's Policy, Department for Victorian Communities.
- Heidensohn, F. (1992) *Women in Control? The role of women in law enforcement*. Oxford: Clarendon Press.
- Henning, T., and Bronitt, S. (1998) 'Rape victims on trial: regulating the use and abuse of sexual history evidence', in P. Eastaugh (Ed.), *Balancing the Scales: rape, law reform and Australian culture*. Leichhardt, Sydney: Federation Press.
- Herman, J. L. (2005) 'Justice from the victim's perspective'. *Violence against Women*, 11(5): 571–602.
- Hester, M., and Westmarland, N. (2004) *Tackling Street Prostitution: towards a holistic approach*. Research study 279. London: Home Office.
- Hinck, S. S., and Thomas, R. W. (1999) 'Rape myth acceptance in college students: how far have we come?' *Sex Roles*, 40(9/10): 815–832.
- Hoog, C. (2004) *Model Protocol on Safety Planning for Domestic Violence Victims with Disabilities*. Washington, DC: Washington State Coalition against Domestic Violence.
- Howard, A., Riger, S., Campbell, R., and Wasco, S. (2003) 'Counseling services for battered women: a comparison of outcomes for physical and sexual assault survivors'. *Journal of Interpersonal Violence*, 18(7): 717–734.

- Hudson, B. (2003) 'Victims and offenders', in A. von Hirsch, J. Roberts, and A. Bottoms (Eds), *Restorative Justice and Criminal Justice: competing or reconcilable paradigms?* Oxford: Hart Publishing.
- Jackson, M. (1987) *The Māori and the Criminal Justice System: a new perspective: He Whauipaanga Hou*. Study Series 18. Wellington: Department of Justice.
- Jackson, M. (1988) *The Māori and the Criminal Justice System: a new perspective: He Whauipaanga Hou Part 2*. Study Series 18. Wellington: Department of Justice.
- Jackson, M. (1989) *Summary Produced by Project Waitangi of Moana Jackson's report. The Māori and the Criminal Justice System: a new perspective. He Whauipaanga Hou*. Wellington: Project Waitangi.
- Jackson, M. (1995) 'A colonial contradiction or a rangatiratanga reality', in F. W. M. McElrea (Ed.), *Re-thinking Criminal Justice. Volume I: Justice in the Community* (pp. 33–35). Wellington: Legal Research Foundation.
- Jackson, S., Cram, F., and Seymour, F. (2000) 'Violence and sexual coercion in high school students' dating relationships'. *Journal of Family Violence*, 15: 23–36.
- Jenner, L., Woolley, C., and Mortimer, R. (2006) *Consumer Focus Group and Key Informants Interviews (Pilot Report)*. Technical Report 3. Palmerston North: Psychology Centre, Massey University.
- Jensen, P., and Smith, K. (2006) 'Māori experiences of primary health care: Breaking down the barriers'. *New Zealand Family Practice*, 33(5): 298–300.
- Jewkes, R., Sen, P., and Garcia-Moreno, C. (2002) 'Sexual violence', in E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, and R. Lozano (Eds), *World Report on Violence and Health* (chapter 6). Geneva: World Health Organization.
- Jordan, J. (1998) *Reporting Rape: women's experiences with the police, doctors and support agencies*. Wellington: Institute of Criminology, Victoria University of Wellington.
- Jordan, J. (2001) 'Worlds apart? Women, rape and the police reporting process'. *British Journal of Criminology*, 41(4): 679–706.
- Jordan, J. (2002) 'Will any woman do? Police, gender, and rape victims'. *Policing: An International Journal of Police Strategies and Management*, 25(2): 319–324.
- Jordan, J. (2004) *The Word of a Woman: police, rape and belief*. Basingstoke: Palgrave MacMillan.
- Jordan, J. (2005a) *The Sex Industry in New Zealand: a literature review*. Wellington: Ministry of Justice.
- Jordan, J. (2005b) 'What would MacGyver do? The meaning(s) of resistance and survival'. *Violence against Women*, 11(4): 531–559.
- Jordan, J. (2006) 'Rape, reform and resistance'. *Journal for Women and Policing*, 17: 27–33.
- Jordan, J. (2008) *Serial Survivors: women's narratives of surviving rape*. Annandale, NSW: Federation Press.
- Kelly, L. (1988) *Surviving Sexual Violence*. Cambridge: Polity Press.

- Kelly, L. (2002) *A Research Review on the Reporting, Investigation and Prosecution of Rape Cases*. London: Her Majesty's Crown Prosecution Service Inspectorate.
- Kelly, L. (2005) *Promising Practices Addressing Sexual Violence*. Vienna, Austria: United Nations Division for the Advancement of Women.
- Kelly, L., Lovett, J., and Regan, L. (2005) *A Gap or a Chasm? Attrition in reported rape cases*. London: Home Office Research, Development and Statistics Directorate.
- Kelly, L., and Regan, L. (2003) *Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations*. Europe: Rape Crisis Network.
- Kennedy, H. (1992) *Eve was Framed: women and British justice*. London: Vintage.
- King, M., and Woollett, E. (1997) 'Sexually assaulted males: 115 men consulting a counselling service'. *Archives of Sexual Behavior*, 26(6): 579.
- Kingi, T., and Durie, M. (2004) *Hua Oranga: application guidelines*. Wellington: School of Māori Studies, Massey University.
- 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.
- Kingi, V., Paulin, J., and Porima, L. (2008) *Review of the Delivery of Restorative Justice in Family Violence Cases by Providers Funded by the Ministry of Justice*. Wellington: Ministry of Justice.
- Koloto, A. (2003) *The Needs of Pacific Peoples When They Are Victims of Crime*. Wellington: Ministry of Justice.
- Kong, R., Johnson, H., Beattie, S., and Cardillo, A. (2003) *Sexual Offences in Canada*. Ottawa: Canadian Centre for Justice Statistics.
- Koss, M. P. (2000) 'Blame, shame and community'. *American Psychologist*, 55(11): 1332–1343.
- Koss, M. P. (2006a) *Restorative Justice for Sex Crimes Outside the Context of Intimate Partner Violence*. Retrieved from <http://www.restoreprogram.publichealth.arizona.edu>
- Koss, M. P. (2006b) 'Restoring rape survivors: justice, advocacy, and a call to action'. *Annals of the New York Academy of Sciences*, 1087: 206–234.
- Koss, M. P., Bachar, K. J., Hopkins, C. Q., and Carlson, C. (2004) 'Expanding a community's response to sex crimes through advocacy, prosecutorial, and public health corroboration: Introducing the RESTORE program'. *Journal of Interpersonal Violence*, 19(12): 1435–1463.
- Koss, M. P., Bailey, J. A., Yuan, N. P., Herrera, V. M., and Lichter, E. L. (2003) 'Depression and PTSD in survivors of male violence: research and training initiatives to facilitate recovery'. *Psychology of Women Quarterly*, 27: 130–142.
- Krakow, B., Schrader, R., Tandberg, D., Hollifield, M., Koss, M., and Yau, C. (2002) 'Nightmare frequency in sexual assault survivors with PTSD'. *Journal of Anxiety Disorders*, 16: 175–190.

- Lamb, S. (1999) 'Constructing the victim: popular images and lasting labels', in S. Lamb (Ed.), *New Versions of Victims: feminists struggle with the concept*. New York: New York University Press.
- Lang, K., and Brockway, S. (2001) *The Response to Sexual Assault: removing barriers to services and justice*. Michigan: Michigan Sexual Assault Systems Response Task Force.
- Lea, S., Lanvers, U., and Shaw, S. (2003) 'Attrition in rape cases: developing a profile and identifying relevant factors'. *British Journal of Criminology*, 43(3): 583–599.
- Ledray, L. E. (2001) 'Sexual Assault Nurse Examiner (SANE) program', in C. M. Renzetti, J. L. Edleson and R. K. Bergen (Eds), *Sourcebook on Violence against Women* (pp. 243–246). Thousand Oaks, California: Sage Publications.
- Lees, S. (1996) *Carnal Knowledge: rape on trial*. London: Hamish Hamilton.
- Lees, S. (1997) *Ruling Passions: sexual violence, reputation and the law*. Buckingham: Open University Press.
- Legal Aid Queensland (2007) *Working with Clients who Have Experienced Sexual Violence: best practice guidelines for lawyers*. Brisbane: Legal Aid Queensland.
- Leserman, J., Li, Z., Drossman, D. A., and Hu, Y. (1998) 'How multiple types of stressors impact on health'. *Psychosomatic Medicine*, 60: 175–181.
- Levanthal, B., and Lundy, S. (1999) *Same-Sex Domestic Violence*. Thousand Oaks, London, New Delhi: Sage Publications.
- Lewis, R., Dobash, R., Dobash, R., and Cavanagh, K. (2001) 'Law's progressive potential: the value of engagement with the law for family violence'. *Social and Legal Studies*, 10(1):105–130.
- Lewis, S. (2003) *Sexual Assault in Rural Communities*. Pennsylvania: National Resource Center on Domestic Violence and Pennsylvania Coalition Against Domestic Violence.
- Lexicon Ltd (2005) *Review of the Effectiveness of Specialist Courts in other Jurisdictions*. DCA Research Series 3/05. London: Department for Constitutional Affairs.
- Lievore, D. (2003) *Non-Reporting and Hidden Recording of Sexual Assault: an international literature review*. Canberra: Office of the Status of Women.
- Lievore, D. (2004) *Prosecutorial Decisions in Adult Sexual Assault Cases: an Australian study*. Canberra: Office of the Status of Women.
- Lievore, D. (2005) *No Longer Silent: a study of women's help-seeking decisions and service responses to sexual assault*. Canberra: Australian Government Department of Family and Community Services and Australian Institute of Criminology.
- Lievore, D., and Mayhew, P. (2007) *The Scale and Nature of Family Violence in New Zealand*. Wellington: Ministry of Social Development.
- Littel, K. (2001) *Sexual Assault Nurse Examiner (SANE) Programs: improving the community response to sexual assault victims*. Minneapolis: United States Department of Justice, Office for Victims of Crime Bulletin.

- Logan, T., Cole, J., and Capillo, A. (2007) 'Sexual Assault Nurse Examiner program characteristics, barriers, and lessons learned'. *Journal of Forensic Nursing*, 3(1): 24–34.
- Lord, V., and Rassel, G. (2000) 'Law enforcement's response to sexual assault: a comparative study of nine counties in North Carolina'. *Women and Criminal Justice*, 11(1): 67–88.
- Lovett, J., Regan, L., and Kelly, L. (2004) *Sexual Assault Referral Centres: developing good practice and maximising potentials*. London: Home Office Research, Development and Statistics Directorate.
- Mangnell, K. (2008) 'Victim centre will give support and prevention'. *Manukau Courier*, 27 May.
- Marchbanks, P., Lui, K., and Mercy, J. A. (1990) 'Risk of injury from resisting rape'. *American Journal of Epidemiology*, 132: 540.
- Mayhew, P., and Reilly, J. (2007) *New Zealand Crime and Safety Survey 2006*. Wellington: Ministry of Justice.
- McDonald, E. (1994) 'Gender bias and the law of evidence: the link between sexuality and credibility'. *Victoria University of Wellington Law Review*, 24: 175–188.
- McDonald, E. (1997) "'Real rape" in New Zealand: women complainants' experience of the court process'. *Yearbook of New Zealand Jurisprudence*, 1(1): 59–80.
- McDonald, E. (2009) 'And still we must talk about real rape: a review of Jennifer Temkin and Barbara Krahe, sexual assault and the justice gap: a question of attitude'. *Pace Law Review (Winter)*.
- McElrea, F. W. M. (1995) 'Accountability in the community: taking responsibility for offending', in F. W. M. McElrea (Ed.), *Re-Thinking Criminal Justice. Volume I: Justice in the Community* (pp. 61–82). Wellington: Legal Research Foundation.
- Memmot, P., Stacy, R., Chambers, C., and Keys, C. (2001) *Violence in Indigenous Communities*. Canberra: Attorney-General's Department.
- Metropolitan Police Service (2005) *A Review of Rape Investigations in the MPS: final report*. London: Deputy Commissioner's Command, Directorate of Strategic Development and Territorial Policing, Project Sapphire.
- Mikaere, A. (2006) 'Māori women as leaders and decision makers'. Presentation at the Ministry of Women's Affairs Noho Marae, 27 June.
- Milne, P. (2001) 'Book reviews: therapy guidelines'. *New Zealand Association of Counsellors Newsletter*, (September): 49.
- Milne, P. (2005) 'Statistics that harm'. *New Zealand Association of Counsellors Newsletter*, 25(3).
- Minister of Health (2005) *Te Tāhuhu – Improving Mental Health 2005–2015: the second New Zealand mental health and addition plan*. Wellington: Ministry of Health.
- Minister of Health and Associate Minister of Health (2002) *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health (1998) *Consent in Child and Youth Health: information for practitioners*. Wellington: Ministry of Health.

- Ministry of Health (2001) *Refugee Health Care: a handbook for health professionals*. Wellington: Ministry of Health.
- Ministry of Health (2002) *Family Violence Intervention Guidelines: child and partner abuse*. Wellington: Ministry of Health.
- Ministry of Health (2008) *Pacific Cultural Competences: literature review*. Wellington: Ministry of Health.
- Ministry of Justice (2001) *He Hinatore ki to Ao Māori – A Glimpse into the Māori World: Māori perspectives on justice*. Wellington: Ministry of Justice.
- Ministry of Justice (2004) *Restorative Justice in New Zealand: best practice*. Wellington: Ministry of Justice.
- Ministry of Justice (2008) *Improvements to Sexual Violence Legislation in New Zealand: public discussion document*. Wellington: Ministry of Justice.
- Ministry of Justice (no date). *Information for Victims: Victims Charter pamphlet – what I need to know about the Victims Charter for people affected by crime*. <http://www.justice.govt.nz/pubs/victims-information/charter-pamphlet.html>.
- Ministry of Social Development (2002) *Te Rito: New Zealand Family Violence Prevention Strategy*. Wellington: Ministry of Social Development
- Minister of Social Development (2008) 'Supporting a sustainable NGO social services sector.' Cabinet paper. Retrieved from <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/pathway-to-partnership/key-information/key-information-background.html>
- Ministry of Women's Affairs (2007) *Report on Wellington Workshop for Ethnic, Migrant and Refugee Communities*. Retrieved from <http://www.mwa.govt.nz/our-work/svrproject/EMRWellington>
- Ministry of Women's Affairs (2008) *Court Advocates: report to the taskforce*. Wellington: Ministry of Women's Affairs.
- Ministry of Women's Affairs (no date) *Sexual Violence Research Project*. <http://www.mwa.govt.nz/our-work/svrproject>
- Morris, A. (2002) 'Critiquing the critics: a brief response to critics of restorative justice'. *British Journal of Criminology*, 42: 596–615.
- Morris, A., and Gelsthorpe, L. (2000) 'Re-visioning men's violence against female partners'. *Howard Journal of Criminal Justice*, 39: 412–428.
- Morris, A., Kingi, V., Poppelwell, E., Robertson, J., and Triggs, S. (2005) *Court-referred restorative justice pilot evaluation*. Wellington: Ministry of Justice.
- Morris, A., Reilly, J., Berry, S., and Ransom, R. (2003) *The New Zealand National Survey of Crime Victims 2001*. Wellington: Ministry of Justice.
- Morrison, A., Ellsberg, M., and Bott, S. (2007) 'Addressing gender-based violence: A critical review of interventions'. *World Bank Research Observer*, 22(1): 25–51.
- Mossman, E., MacGibbon, L., Kingi, V., and Jordan, J. (2009b) *Responding to sexual violence: Environmental scan of New Zealand agencies*. Wellington: Ministry of Women's Affairs.
- Moult, K. (2000) 'The court doors may be open, but what lies behind those doors? An observation of the workings of the Wynberg Sexual Offences Court'. Honours Thesis, University of Cape Town, Cape Town.

- Murphy, W. (2001) 'The victim advocacy research group'. *Journal of Social Distress and Homeless*, 11(1): 123–138.
- National Collaborating Centre for Mental Health (2005) *Post-Traumatic Stress Disorder: the management of PTSD in adults and children in primary and secondary care*. London: Gaskell and the British Psychological Society.
- Neale, J., and Gray, A. (1990) *Evaluation of Victim Support Schemes in New Zealand to August 1990*. Wellington: Grey Matter.
- Neame, A., and Heenan, M. (2004) *Responding to Sexual Assault in Rural Communities*. ACSSA Briefing No. 3. Melbourne: Australian Centre for the Study of Sexual Assault.
- Neave, M. (2004) 'Restorative justice: when is it appropriate?' Paper presented at Victorian Law Reform Commission, La Trobe University Law School, 6 October.
- New Zealand Police (1998) 'Adult Sexual Assault Investigation Policy'. Policy pointer 1998/1. Ten-One, 159: 11–15.
- New Zealand Police (2006) 'Dedicated unit for investigating sexual assaults'. Police Ten One (August). Retrieved 5 June 2008 from <http://www.police.govt.nz/news/tenone/20060818-288>
- New Zealand Police (2008) *New Zealand Police 2007/08 Annual Report*. Wellington: New Zealand Police.
- Nosek, M. A., Howland, C. A., and Hughes, R. B. (2001) 'The investigation of abuse and women with disabilities: Going beyond assumptions'. *Violence against Women*, 7(4): 477–499.
- Nosek, M. A., Hughes, R., Taylor, H., and Howland, C. (2004) 'Violence against women with disabilities: the role of physicians in filling the treatment gap', in S. Welner and F. Haseltine (Eds), *Welner's Guide to Care of Women with Disabilities*. Philadelphia: Lippincott, Williams and Wilkins.
- Obinna, J., Krueger, S., Osterbaan, C., Sadusky, J. M., and DeVore, W. (2005) *Understanding the Needs of the Victims of Sexual Assault in the Deaf Community*. Minneapolis: Council on Crime and Justice.
- Office for Criminal Justice Reform (2006) *Convicting Rapists and Protecting Victims: justice for victims of rape: a consultation paper*. London: Office for Criminal Justice Reform.
- Olle, L. (2005) *Mapping Health Sector and Interagency Protocols on Sexual Assault*. ACSSA Issues No. 2. Melbourne: Australian Centre for the Study of Sexual Assault.
- Orth, U. (2002) 'Secondary victimization of crime victims by criminal proceedings'. *Social Justice Research*, 15(4): 313–325.
- O'Shea, A. (2006) *Sexual Assault Treatment Services: a national review*. Dublin: National Steering Committee on Violence against Women.
- Osterman, J., Barbiaz, J., and Johnson, P. (2001) 'Emergency interventions for rape victims'. *Psychiatric Services*, 52(6): 733.
- O'Sullivan, E., and Carlton, A. (2001) 'Victim services, community outreach, and contemporary rape crisis centers: a comparison of independent and multiservice centers'. *Journal of Interpersonal Violence*, 16: 343–360.
- Parkinson, D. (2008a) 'Partner rape and rurality'. *ACSSA Newsletter*, 16: 21–22.

- Parkinson, D. (2008b) 'Where is care in the country? Let's provide rural victim survivors of sexual assault with after-hours crisis care.' *ACSSA Newsletter*, 16: 18–20.
- Parnis, D., and Du Pont, J. (2003) 'Forensic nursing in the context of sexual assault: Comparing the opinions and practices of nurse examiners and nurses'. *Applied Nursing Research*, 16(3): 173–183.
- Patterson, D., Campbell, R., and Townsend, S. M. (2006) 'Sexual Assault Nurse Examiner (SANE) program goals and patient care practices'. *Journal of Nursing Scholarship*, 38(2):180–186.
- Paua Enterprises Ltd (2006) 'Māori women in leadership: scoping report'. Unpublished paper prepared for the Ministry of Women's Affairs.
- Paulin, J., Kingi, V., and Huirama, T. (2005) *The Rotorua Second Chance Community Managed Restorative Justice Programme: an evaluation*. Wellington: Crime and Justice Research Centre.
- Penfold, C., Hunter, G., Campbell, R., and Barham, L. (2004) 'Tackling client violence in female street prostitution: inter-agency working between outreach agencies and the police'. *Policing and Society*, 14(4): 365–379.
- Petersilia, J. (2001) 'Crime victims with developmental disabilities: a review essay'. *Criminal Justice and Behavior*, 28: 655–694.
- Petrak, J. (2002) 'The psychological impact of sexual assault', in J. Petrak and B. Hedge (Eds), *The Trauma of Sexual Assault: treatment, prevention and practice*. West Sussex: John Wiley and Sons.
- Pike, D. L. (1992) 'Women in police academy training: some aspects of organizational response', in I. Moyer (Ed.), *The Changing Roles of Women in the Criminal Justice System: offenders, victims, and professionals* (2nd ed.) Illinois: Waveland Press.
- Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., and Kallas-Katoa, W. (2007) 'Meihana model: a clinical assessment framework'. *New Zealand Journal of Psychology*, 36(3): 118–125.
- Pitts, M. K., Couch, M. A., and Smith, A. M. (2006) 'Men who have sex with men (MSM): How much to assume and what to ask?' *Medical Journal of Australia*, 185(8): 450–452.
- Plichta, S. B., Clements, P., and Houseman, C. (2007) 'Why SANEs matter: models of care for sexual violence victims in the emergency department'. *Journal of Forensic Nursing*, 15(9): 15–23.
- Pollock, J. M. (1995) 'Gender, justice and social control: a historical perspective', in A. V. Merlo and J. M. Pollock (Eds), *Women, Law, and Social Control*. Boston: Allyn and Bacon.
- Prostitution Law Review Committee (2008) *Report of the Prostitution Law Review Committee on the Operation of the Prostitution Reform Act 2003*. Wellington: Ministry of Justice.
- Quadara, A. (2008) *Sex Work and Sexual Assault in Australia: prevalence, risk and safety*. ACSSA Issues No. 8. Melbourne: Australian Institute of Family Studies.

- Radford, J. (1987) 'Policing male violence: policing women', in J. Hanmer and M. Maynard (Eds), *Women, Violence, and Social Control*. Basingstoke, Hampshire: MacMillan.
- Rape Crisis (England and Wales) and Women's Research Centre (2008) *The Crisis in Rape Crisis: a survey of Rape Crisis (England and Wales) centres*. London: Women's Research Centre.
- Rape Crisis Network Europe (2003) *Best Practice Guidelines for NGOs Supporting Women Who Have Experienced Sexual Violence*. Galway, Ireland: Rape Crisis Network Europe.
- Rasool, S. (2000) 'Sexual offences courts: do more courts mean better justice?' *Nedbank ISS Crime Index*, 4(2): 11–14.
- Regan, L., and Kelly, L. (2003) *Rape: still a forgotten issue*. London: Child and Woman Abuse Studies Unit.
- Regan, L., Lovett, J., and Kelly, I. (2004) *Forensic Nursing: an option for improving responses to reported rape and sexual assault*. Online Report 28/04. London: Home Office.
- Savage, J. (2003) 'Refugee women, sexual assault, and communities'. Paper presented at Practice and Prevention: Contemporary Issues in Adult Sexual Assault NSW Conference, New South Wales, 12–14 February.
- Schollum, M. (2005) *Investigative Interviewing: the literature*. Wellington: Police National Headquarters.
- Schonteich, M. (2001) 'Focused and multiskilled: specialised directorates and units', in *Lawyers for the People: the South African Prosecution Service* (chapter 5), Monograph No. 53. Pretoria: Institute for Security Studies.
- Scutt, J. (1997) *The Incredible Woman: power and sexual politics*. Melbourne: Artemis.
- Scutt, J. (1998) 'Character, credit, context: women's lives and judicial 'reality'', in P. Eastaugh (Ed.), *Balancing the Scales: rape, law reform and Australian culture*. Leichhardt, Sydney: Federation Press.
- Second Māori Taskforce on Whānau Violence (2002) *Whānau Violence: a Māori conceptual framework*. Wellington: Second Māori Taskforce on Whānau Violence.
- Sobsey, D., and Doe, T. (1991) 'Patterns of sexual abuse and assault'. *Journal of Sexuality and Disability*, 9(3): 243–259.
- Smart, C. (1989) *Feminism and the Power of Law*. London: Routledge.
- Special Rapporteur (1996) *Women and Violence*. New York: United Nations Department of Public Information.
- Standards New Zealand (2006) *Screening, Risk Assessment and Intervention for Family Violence Including Child Abuse and Neglect*. Wellington: Standards New Zealand.
- Strang, H., and Braithwaite, J. (Eds) (2002) *Restorative Justice and Family Violence*. Cambridge: Cambridge University Press.
- Stubbs, J. (2002) 'Family violence and women's safety: feminist challenges to restorative justice', in H. Strang and J. Braithwaite (Eds), *Restorative justice and Family Violence*. Cambridge: Cambridge University Press.

- Stubbs, J. (2004) *Restorative Justice, Domestic Violence and Family Violence Issues*. Paper No. 9. Sydney: Australian Domestic and Family Violence Clearinghouse: University of New South Wales.
- Stubbs, J. (2007) 'Beyond apology? Domestic violence and critical questions for restorative justice'. *Criminology and Criminal justice*, 7(2): 169–187.
- Task Force of Division 12 (Clinical Psychology) (1993/2008 update) *Task Force on Promotion and Dissemination of Psychological Procedures*. Retrieved 25 August 2008 from <http://www.apa.org/divisions/Div12/est/chamble2.pdf>
- Taslitz, A. (1999) *Rape and the Culture of the Courtroom*. New York: New York University Press.
- Te Puni Kōkiri (2008) *Realising Māori Potential: annual report*. Wellington: Te Puni Kōkiri.
- Temkin, J. (1997) 'Plus ça change: reporting rape in the 1990s'. *British Journal of Criminology*, 37(4): 507–528.
- Temkin, J., and Krahé, B. (2008) *Sexual Assault and the Justice Gap: a question of attitude*. Oxford: Hart Publishing.
- Thomas, E. (1994) 'Was Eve merely framed; or was she forsaken?' *New Zealand Law Journal*, (Parts 1 and 2): 368–373 and 426–432.
- Tiatia, J. (2008) *Pacific Cultural Competencies: a literature review*. Wellington: Ministry of Health.
- Tjaden, P., and Thoennes, N. (1998) *Stalking in America: Findings From the National Violence Against Women Survey*. Washington, DC: U.S. Department of Justice, National Institute of Justice.
- Tjaden, P., and Thoennes, N. (2000) *Full Report of the Prevalence, Incidence, and Consequences of Violence against Women: findings from the National Violence against Women Survey*. Washington, DC: United States Department of Justice.
- Tjaden, P., and Thoennes, N. (2006) *Extent, Nature, and Consequences of Rape Victimization: findings from the National Violence against Women Survey*. Washington, DC: National Institute of Justice.
- Toner, B. (1982) *The Facts of Rape*. London: Arrow Books.
- Triggs, S., Mossman, E., Jordan, J., and Kingi, V. (2009) *Responding to Sexual Violence: attrition in the New Zealand criminal justice system*. Wellington: Ministry of Women's Affairs.
- Tutty, L. M., Weaver, G., and Rothery, M. A. (1999) 'Residents views of the efficacy of shelter services for assaulted women'. *Violence against Women*, 5: 898–925.
- Tyiska, C. G. (1998) *OVS Bulletin: working with victims of crime with disabilities*. Washington, DC: United States Department of Justice, Office of Justice Programs, Office for Victims of Crime.
- van de Zandt, P. (1998) 'Heroines of fortitude', in P. Easta (Ed.), *Balancing the Scales: rape, law reform and Australian culture*. Leichhardt, Sydney: Federation Press.
- Vetten, L. (2001) 'While women wait (2) ... Can specialist sexual offences courts and centres reduce secondary victimisation?' *Nedbank ISS Crime Index*, 5(3).

- Victorian Government (2006) *Building Partnerships between Mental Health, Family Violence and Sexual Assault Services*. Melbourne: Department of Human Services.
- Walker, S. P., and Louw, D. (2003) 'The South African court for sexual offences'. *International Journal of Law and Psychiatry*, 26: 73–85.
- Walker, S. P., and Louw, D. (2005a) 'The Court for Sexual Offences: perceptions of the victims of sexual offences'. *International Journal of Law and Psychiatry*, 28: 231–245.
- Walker, S. P., and Louw, D. (2005b) 'The Court for Sexual Offences: perceptions of the families of the victims of sexual offences'. *International Journal of Law and Psychiatry*, 28: 418–429.
- Walker, S. P., and Louw, D. (2007) The Court for Sexual Offences: Perceptions of the professionals involved. *International Journal of Law and Psychiatry*, 30: 136–146.
- Walklate, S. (1995) *Gender and Crime: an introduction*. London: Prentice Hall.
- Waller, I. (2003) *Crime Victims: doing justice to their support and protection*. Helsinki: European Institute for Crime Prevention and Control (affiliated with the United Nations).
- Wampold, B. (2001) *The Great Psychotherapy Debate: models, methods, and findings*. Mahway, NJ: Lawrence Erlbaum Associates.
- Wang, S. K., and Rowley, E. (2007) *Rape: how women, the community and the health sector respond*. Geneva: World Health Organization.
- Wasco, S. (2003) 'Conceptualizing the harm done by rape: applications of trauma theory to experiences of sexual assault'. *Violence, Trauma and Abuse*, 18(3) 399–414.
- Wasco, S., Campbell, R., Howard, A., Mason, R., Staggs, S. L., Schewe, P., and Riger, S. (2004) 'A state wide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence*', 19(2): 252–263.
- Watkins, T. (2008) 'Unease at rape victims "victimized by system"'. *The Dominion Post*, 13 June, p. 3.
- Weeks, W. (2001) 'Access and equity in services against sexual violence'. Paper presented at Seeking Solutions Conference, Gold Coast, Australia, 5–7 September. Retrieved 5 December 2008 from <http://www.austdvclearinghouse.unsw.edu.au/Conference%20papers/Seek-soln/Weeks,Wendy.pdf>
- WHO (2003) *Guideline for Medico-Legal Care for Victims of Sexual Violence*. Geneva: World Health Organization.
- Young, A. (1998) 'Violence as seduction: enduring genres of rape', in A. Howe (Ed.), *Sexed Crime in the News*. Leichhardt, New South Wales: Federation Press.
- Young, W. (1983a) *Rape Study, Volume 1: a discussion of law and practice*. Wellington Department of Justice and the Institute of Criminology, Victoria University.
- Young, W. (1983b) *Rape Study, Volume 2: research reports*. Wellington: Department of Justice.

References

- Zehr, H. (2007) 'Hearing victims' voices: is restorative justice listening?'. Paper presented at a seminar at the Wellesley Club, Wellington, 17 August.
- Zweig, J., and Burt, M. (2007) 'Predicting women's perceptions of domestic violence and sexual assault agency helpfulness'. *Violence against Women*, 13(1): 1149–1178.

Print 978-0-478252-43-9

Digital 978-0-478252-44-6

Ministry of Women's Affairs, 48 Mulgrave Street, Thorndon, Wellington
PO Box 10 049, Wellington 6143
tel: (04) 915 7112 fax: (04) 916 1604
email: mwa@mwa.govt.nz

www.mwa.govt.nz