Literature review on international best court support models for victim-survivors of sexual violence

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MINISTRY OF SOCIAL DEVELOPMENT
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Disclaimer

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Executive Summary

This literature review was completed to provide the Ministry of Social Development (MSD) with an overview of international psychosocial court support service models for victims-survivors of sexual violence going through the criminal justice system (CJS).

The New Zealand Law Commission's 2015 report, *The Justice Response to Victims of Sexual Violence,* identified several international court support models that are considered to represent best practice. This review provides an overview of these models and others. It explores the key commonalities of what is considered 'best practice', challenges for implementation and recommendations for the Aotearoa New Zealand context. Accessible academic and grey literature was reviewed and sorted by relevance, and the findings synthesised and summarised from the identified evidence.

Key findings of the review include:

- Victim-survivor-centred, integrated programmes, such as one-stop-shops and wrap-around service models, are perceived as best practice in responding to victims-survivors of sexual violence. These models enable victims-survivors to access a range of services and support at one location, including medical care, legal advice, counselling and advocacy, thus increasing access to justice and helping to reduce re-victimisation.
- Strong relationships, collaboration and communication between medical and legal services, police, counsellors, advocates and other support services can help better support victims-survivors throughout the justice process and ensure victims-survivors get access to the services and support they need.
- It is more challenging to implement multi-agency, wrap-around support programme because they are resource intensive and more expensive to run than stand-alone services. Furthermore, insufficient resources, including staff and services, can create a rural-urban divide.
- Victims-survivors feel more confident to participate in and cope with the challenging nature of the CJS when they have ongoing access to a qualified and/or specially trained sexual violence advisor/advocate, who can provide personalised and holistic support and advice throughout.
- It is important that service providers receive specialist training to respond effectively to the diverse and complex needs of victims-survivors of sexual violence. This includes the needs of indigenous people, ethnic communities (migrants and refugees), people with disabilities, people with mental health issues, and the LGBTQ community. Providing specialist care

and culturally appropriate services can help avoid the re-traumatisation and re-victimisation of victims-survivors.

- Recommendations for implementing a court support model in Aotearoa New Zealand will need to consider whether findings from 'best practice' international models are applicable to the local context, particularly for Māori victims-survivors of sexual violence and other ethnic groups in Aotearoa New Zealand (e.g. Pasifika, and migrant/refugee background communities). Other considerations include the scope of services available in New Zealand, such as the availability of specialist staff and regional resources.

Purpose and background

The process of going through criminal proceedings and the way court proceedings are conducted can cause psychological harm to the victims-survivors of sexual violence. This is known as secondary victimisation. This was highlighted in a Law Commission's 2015 report which found that New Zealand's justice system often fails to respond appropriately to victims of sexual violence, leading to low rates of reporting of sexual violence incidents and high rates of secondary victimisation.

To limit the harm caused to victims-survivors of sexual violence and to support their engagement with the criminal justice system, MSD piloted a psychosocial court support service in Auckland through Auckland Sexual Abuse Help Foundation (Auckland HELP) from June 2018 until July 2019. Further funding was sought through Budget 2019, which provided $6.348 million over four years to invest in court support services. This literature review was commissioned to inform the design of the service.

Specifically, the literature review seeks to understand what psychosocial support looks like in other parts of the world. The review examines literature on a range of court support models to understand what is considered 'best practice' in different jurisdictions. It identifies key commonalities and challenges, and makes recommendations for the Aotearoa New Zealand context.

Terminology

Sexual violence is defined by the World Health Organisation (2002) as any sexual act, attempt to obtain a sexual act, sexual harassment, or act directed against a person's sexuality, using coercion, by any person regardless of their relationship to the victim, and in any setting, including the home and work. Physical violence may or may not be involved. Other terms, such as sexual harm, sexual abuse, and sexual assault are used interchangeably (Cook, Cortina, Koss, 2018) with sexual violence. Although, abuse is most often used to refer to sexual violence against children and sexual assault is the legal definition of a criminal offence distinct from rape. Hence, 'sexual violence' is used as a non-legal, all-encompassing term throughout this report, except when referring to the name of a specific study, support model or organisation.

Victim-survivor is a term used to acknowledge that some who have experienced sexual violence will identify as a victim and others as a survivor (RTI International, n.d.); and that it is possible to simultaneously feel like both (Jordan, 2005). Victim is typically used to describe someone who has recently experienced sexual violence. It is also a legal term and necessarily used within the criminal justice system. The term victim, however, can be associated with

weakness and, so, the term survivor is used as a term of empowerment. Survivor can also convey that a level healing has occurred. Being a survivor, however, is not absolute, nor meant to downplay the experience of being victimised (see Mossman, Jordan, MacGibbon, Kingi, & Moore, 2009). Hence, both terms are used, and hyphenated, in this report, except when referring to the name of a specific study, support model or organisation.

Scope of the review

A psychosocial approach looks at individual need in relation to socio-environmental factors that impact on a person's physical and mental wellbeing. Psychosocial treatment addresses the psychological impact of a traumatic event by providing support for trauma recovery that involves the emotional care and wellbeing of victims-survivors (see Woodward, 2015).

Psychosocial support aims to address emotional, mental, spiritual and social needs by:

- Supporting and promoting human capacity
- Improving social connections and support through relationships and support systems
- Understanding how culture, value systems, individual and social expectations influence people.

Psychosocial support in this review will include:

- Support through the Criminal Justice System (CJS)
- Support provided by an individual with specialist expertise and understanding
- Trauma-informed and victim-survivor centred care
- Advocating for the clients' needs
- Holistic support and preparation for the criminal justice system.

The following population groups are of specific interest:

- Victims-survivors of sexual violence, with a case going through the criminal justice system who are being supported using psychosocial techniques
- International populations, including indigenous populations.

In scope:

- Understanding the various forms of court support service models internationally
- Understanding the benefits and any known negatives from these service models
- Understanding who provides the service, for instance, is this service provided by a trained professional or a person with lived experience AND

does this service sit within an established sexual violence organisation or is it an individualised service

- Any learnings on best practice for providing court support or understanding of the benefits of providing the service for victims-survivors
- An analysis of what has worked well and what hasn't in international service models
- Understanding cultural responsiveness within the court
- Understanding if international court support services employ court support service advocates to ensure sexual violence victims-survivors going through the criminal justice system are aware of the service
- Recommendations of the types of models which could be used in New Zealand, taking into consideration the New Zealand environment.

Out of scope:

- Court support service models which are not psychosocial
- Any research which looks at New Zealand psychosocial court support service models
- Any research on psychosocial support service models outside of court support services, e.g. psychosocial harmful sexual behaviour services
- Ways to commission, procure or implement the psychosocial court support service
- Services designed for children.

Review methods

To inform decision-making about the expansion of the court support pilot in Aotearoa New Zealand, the agreed method was a rapid narrative review. Haby et al. (2016) defines this as "a type of systematic review in which components of the systematic review process are simplified, omitted or made more efficient in order to produce information in a shorter period of time, preferably with minimal impact on quality. Further, they involve a close relationship with the end-user and are conducted with the needs of the decision-maker in mind" (p.8). Evidence suggests that in situations requiring a trade-off between timeliness and thoroughness, rapid reviews can offer similar conclusions to a more comprehensive or systematic review (Abou-Setta et al., 2016), with a comparable impact on decision-making (Haby et al., 2016).

In this case, the rapid review method involved an iterative approach to the search terms and only immediately relevant search results were screened for inclusion. The author searched Ebsco Discovery database, Google Scholar and Google using the terms shown in Table 1 below. Initial search strings were based on the scope of the review. Subsequent strings were informed by results of

previous searches (including a broader range of evidence). Search strings were deliberately specific to generate focused results.

Due to the number of unrelated search results (e.g. the initial search strings did not produce many results specifically related to court support models for victims-survivors of sexual violence/assault) and to the rapid nature of the review, not all search results were screened. Instead, search results were sorted by relevance and their titles and abstracts screened for inclusion until saturation was reached for each database and search string. In-text citations and reference lists of inclusion articles were screened to generate further article searches through snowballing.[1]

Table 1: Search strings used in the review

Initial search strings	Psychosocial court support models victims survivors sexual violence AND/OR assault
	Court support models victims survivors sexual violence AND/OR assault
	Court assistance victims survivors sexual violence AND/OR assault
	Court advisory service victims survivors sexual violence AND/OR assault
	Trauma informed AND/OR focused court support models victims survivors sexual violence AND/OR assault
	Client AND/OR victim centred court support models victims survivors sexual violence AND/OR assault
	Holistic court support models victims survivors sexual violence AND/OR assault
	Advocacy court support models victims survivors sexual violence AND/OR assault
Subsequent search strings	Sexual assault response centres AND/OR teams
	Independent Sexual Violence Advisors
	Centres of excellence AND/OR against sexual assault
	one-stop-shop AND/OR wraparound

[1] Snowballing refers to the review of reference lists and citations in relevant papers to identity new articles or relevance. A database search involves searching different databases using predefined search strings to identity relevant articles (Badampudi, Wohlin, & Petersen, 2015).

It became apparent that the term 'psychosocial' is not widely used in the international literature to describe court support models that aligned with the psychosocial approach described above. Instead, other terms are commonly used, such as: holistic, wraparound, victim-centred, trauma-focused, and one-stop-shop. Similar to the psychosocial approach, these court support models place victims-survivors at the centre of the response, supporting them throughout the criminal justice journey with the aim of avoiding re-traumatisation.

Being a rapid review, the emphasis was on synthesising the relevant literature and not assessing the rigour of the studies appearing in the literature. That said, much of the literature included in the review is published in academic journals, which operate their own peer review processes to assess scientific rigor. Moreover, summations and recommendations are derived from the 'weight' of the literature, thus, mitigating the influence of any single source.

Why the need for psychosocial court support?

Previous research has shown how the challenging and sometimes adversarial nature of the criminal justice system (CJS) can re-traumatise victims-survivors. Court processes can feel like a 'second assault' or 'second rape', leading victims-survivors to withdraw their participation from the criminal justice process, or not report sexual violence (Boyer, Allison, & Creagh, 2018; Campbell, 2006; Jordan, 2012; Konradi, 1996; Ministry of Justice, 2009; Ministry of Women's Affairs, 2009; Mossman, Jordan, MacGibbon, Kingi, & Moore, 2009; Patterson & Tringali, 2015; UN Women, 2011).

The New Zealand Law Commission's 2015 report, *The Justice Response to Victims of Sexual Violence,* identified gaps in meeting the support needs of victims-survivors of sexual violence going through the CJS. Victims-survivors are often re-traumatised by the justice process, and the extent to which they feel supported or not will impact on their willingness to engage with the CJS. Therefore, it is crucial that victims-survivors support needs are addressed and met before, during and after their engagement with the justice system. To increase victim-survivor engagement with the CJS, the Law Commission's report recommended several changes to the sexual violence support sector, including a wraparound support service for victims-survivors of sexual violence going through the justice process.

Currently in New Zealand, support and advocacy services for victims-survivors of sexual violence are predominantly delivered by community-based non-government organisations (NGOs). These include specialist sexual violence support services (e.g. Rape Crisis) and nationwide non-specialist support for victims-survivors (e.g. Victim Support). Community-based providers offer support, advocacy and counselling from point of victimisation, and can continue

throughout the police/court process if needed (Mossman et al., 2009). They can also provide support regardless of whether the victim-survivor engages with the justice process or not.

Victims-survivors going through the court system also have access to a specialised Court Victim Adviser (CVA). The CVA's role is to support victims-survivors during the court process, including providing information about their case, facilitating their safety in court, and liaising with police, prosecutors, the judiciary and community organisations (Law Commission, 2015; Mossman et al., 2009). They also inform the court of the victims-survivors' views and ensure that their rights are upheld under victims' legislation. Since 2010, the Ministry of Justice has also employed specialist Sexual Violence CVAs to support victims-survivors of sexual violence specifically (Law Commission, 2015).

However, the support services provided by CVAs are predominantly limited to the victims-survivors' interaction with the court system. Because CVAs are attached to the court system, they are only assigned to victims-survivors once charges are filed. Therefore, they cannot provide support at other key stages, such as when a complainant is deciding whether to report an incident of sexual violence to the police. Nor can they offer follow up support to victims-survivors who decide not to engage with the court process (Law Commission, 2015).

Research conducted by the Ministry of Justice in 2018 showed that the quality of CVA support was mixed, as they were meeting the needs of victims-survivors to varying degrees (Boyer et al., 2018). While some participants in the study found the CVA helpful and supportive, others had a less favourable experience, including receiving wrong or conflicting information, and a perceived lack of engagement and poor communication from the CVA (Boyer et al., 2018). Other participants felt that independent community-based support services (e.g. Rape Crisis or Victim Support) offered more practical and emotional support during and beyond the trial process.

In addition, the Ministry of Justice found that victims-survivors were often in contact with many people throughout the justice process, including multiple police officers, victim support agencies, CVAs, and prosecution. Coupled with the length of time their case took to come to trial, and the stress endured during the trial, victims-survivors were often left feeling overwhelmed and confused, and had to tell their story multiple times (Boyer et al., 2018).

Sexual violence can have severe traumatic effects on victims-survivors' physical and psychological health. Therefore, negative first encounters with the court and wider medical legal services can have long-term consequences for the recovery of victims-survivors of sexual violence (Campbell & Ahrens, 1998). A New Zealand Ministry of Justice Taskforce for Action on Sexual Violence (Ministry of Justice, 2009) found that policies, procedures and practices within the CJS needed to be informed by the needs of victims-survivors.

The Taskforce recommended specialist sexual violence court support to help victims-survivors during the court trial process. This role would provide emotional and psychological support by helping victims-survivors to liaise with criminal justice personnel, prepare for court, and provide support during the trial and post-court processes. Specialist court support focuses on the emotional and mental health needs of victims-survivors of sexual violence. It can help to empower victims-survivors, mitigate re-traumatisation, reduce 'victim withdrawal', and potentially lead to higher conviction rates (Konradi, 1996; Ministry of Women's Affairs, 2009).

A holistic approach to support for victims-survivors of sexual violence

Previous research on the needs of victims-survivors of sexual violence shows the desirability of support that 'wraps around' the victim-survivor from the beginning to the end, ensuring that the needs of victims-survivors are met (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). A coordinated and multidisciplinary approach that includes medical and legal services and other support agencies may help address the various needs and concerns of victims-survivors (Campbell & Ahrens, 1998).

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

Research suggests that specialised sexual violence advocates/counsellors have a positive impact on victims-survivors going through the legal process. For example, women supported by an advocate were more likely to report sexual violence to police and participate in the CJS, compared to those without advocacy support (Campbell, 2006; Ellison, 2007). In addition, specialist advocates can improve communication and collaboration across the legal system, thus improving the experience for victims-survivors and reducing the risk of re-victimisation (Campbell, 2006; Ellison, 2007; Robinson, Hudson, & Brookman, 2008).

Internationally, there are a range of multi-agency collaborative support services that are provided through government-funded initiatives and based in either a hospital or in the community (Mossman et al., 2009; Law Commission, 2015). The next section provides an overview of different international wraparound models (also described as 'one-stop-shops') that represent best practice in the support of victims-survivors of sexual violence going through the CJS.

International court support models for victims-survivors of sexual violence

UN Women (2011) describe multi-agency collaborative 'one-stop-shops' as a promising integrated approach to meet the needs of victims-survivors of sexual violence. Integrated services help to reduce attrition by cutting down the number of steps a woman must take to access justice. In addition, specialised advocates play an important role in supporting victims-survivors of sexual violence, helping to reduce the stress of dealing with different services and navigating police and health care systems (Campbell, 2006).

The 'one-stop shop' model aims to increase the effectiveness of support services to victims-survivors through interagency collaboration and the location of services under one roof (Mossman et al., 2009). According to Campbell and Ahrens (1998), a multidisciplinary and collaborative approach is beneficial for victims-survivors of sexual violence as it enables responding agencies to better support victims-survivors and hold offenders accountable.

There are a range of 'one-stop-shop' models internationally and are particularly common in developing countries as a way to maximise scarce resources. One-stop-shop models typically constitute a multi-agency response to sexual violence that coordinates forensics, police, and counselling support in the one location (Kelly, 2005; UN Women, 2011).

Another model of service provision is the integrated approach where sexual violence services are integrated within existing services for women, such as Rape Crisis Centres. Services offered include health, legal, welfare and counselling services in one location. This model is useful for maximising scarce resources (Kanon, 2018).

Multi-service centres offer another form of integrated service delivery, where sexual violence support services are merged with other related community agencies or services, such as domestic violence, drug and alcohol services. However, while multi-service centres can enhance services and reach more people there is also a risk of undermining or taking resources away from specialised sexual violence services (Mossman et al., 2009).

The Law Commission's 2015 report identified several international court support models that are considered to represent best practice. These include the Sexual Assault Response Centres in the UK, the Sexual Assault Response Team model in the United States, South African Thuthuzela Care Centres, Centres Against Sexual Assault in Australia, and Nordic Centres of Excellence. While not an exhaustive list, these models present a picture of what is viewed internationally as good practice, in terms of meeting the support needs of victims-survivors of sexual violence throughout the justice process. Reviewing court support models

in other countries can help to determine what improvements can be made to the sexual violence support system in New Zealand. These court support models are included in this literature review because they are noted as representing best practice. The next section provides an overview of these models, alongside other examples (see Appendix 1 for a table summary of the different court support models).

UK: Sexual Assault Response Centres (SARCs) and Independent Sexual Violence Advisers (ISVAs)

The first Sexual Assault Referral Centre (SARC) was established in 1986 to address serious shortcomings in the medical and legal response to sexual violence and to improve outcomes in the CJS (Lovett, Regan, & Kelly, 2004). Problems with the CJS response included the low reporting of rape; delays in locating a forensic examiner and a lack of examiners who are women; the poor treatment of victims-survivors during examination and follow-up support; lack of coordination between agencies; and limited support services for victims-survivors.

The 2004 evaluation of the SARC model (Lovett et al., 2004) identified the need for more flexible and practical forms of support for victims-survivors of sexual violence, including advocacy and information about the criminal process. In 2006, specially trained Independent Sexual Violence Advisors (ISVAs) were introduced to several locations in England and Wales to provide emotional and practical tailored support to victims-survivors of sexual violence who have reported to the police, or are considering reporting to the police (Robinson & Hudson, 2011; Robinson, 2009).

Recent research suggests that SARCs and ISVAs play an important role in enabling victims-survivors of sexual violence to seek help and/or justice by focusing on their individual needs and taking a victim-centred approach (Hester & Lilley, 2018).

Sexual Assault Referral Centres (SARCs)

The SARC model was adopted by the UK Home Office to provide an accessible, coordinated, multi-agency, one-stop-shop service to adult victims-survivors of sexual violence that includes crisis support, informal support and advocacy, and longer-term therapeutic counselling (Lovett et al., 2004; Robinson & Hudson, 2011). There are now around 41 SARCs across the UK, largely funded by the statutory health sector (Hester & Lilley, 2018).

SARCs are closely aligned with police and health centres and tend to be based at these locations, but they can also be based at other locations that are not part of statutory services (Robinson, 2009). The majority of SARCs are staffed by medical professionals, specially trained police, and other specialised workers,

such as ISVAs. SARCs provide an interface between the health and CJS, and other support agencies, to provide better support and care for victims-survivors of sexual violence under the one roof. This type of coordinated service aims to encourage and empower victims-survivors to engage with the CJS (Robinson & Hudson, 2011).

An evaluation of the SARC model by Lovett et al. (2004) found that victims-survivors appreciated the practical support and advocacy provided by SARCs, including the automatic provision of women medical and support staff, proactive follow-up of their case, and the availability of advice and information over the telephone. SARCs were also seen to combine the needs of victims-survivors and those of the CJS. The SARC model of care was described as 'safe', 'reassuring' and 'private'.

However, SARCs are relatively expensive to run in the UK and have effectively reduced the funding available to other sexual violence support services, such as rape crisis groups, resulting in Rape Crisis Centres (RCCs) closing or reducing services (Mossman et al., 2009).

Several countries have developed a SARC model to improve care and lessen the re-traumatisation of victims-survivors (e.g. access to services in the one location, reduce the number of times victims-survivors need to relay their experience) (Mossman et al., 2009). While models may differ between countries, they all share the same components of multiagency coordination (legal, medical, counselling, and other support service providers) and aim to provide a specialised wraparound service to support victims-survivors of sexual violence (Kanan, 2018; Mossman et al., 2009).

Independent Sexual Violence Advisers (ISVAs)

ISVAs are the central point of contact for victims-survivors accessing services within SARCs, as they coordinate the different services required on their behalf. However, ISVAs can also be based in voluntary organisations, such as RCCs. There are currently about 250 ISVAs across England and Wales situated within SARCs and RCCs (Lea, Falcone, & Doyle, 2015).

ISVAs provide crisis intervention and non-therapeutic support from time of referral, working with partner agencies to ensure victims-survivors access the services they need when they need them (Robinson & Hudson, 2011). ISVAs provide impartial advice about options open to victims-survivors within and beyond the CJS, including police reporting, prosecution procedures, seeking support from specialist sexual violence organisations, and other services (Kanan, 2018). Their main responsibilities include:

- providing non-therapeutic support to victims-survivors and other types of practical help and information
- supporting victims-survivors through the CJS, including giving information about the court process and police investigation

- liaising with partner agencies on behalf of the victim-survivor at the one location (Robinson, 2009).

An evaluation of the ISVA service (conducted October 2007 – March 2008) highlighted the importance victims-survivors place on the holistic support provided by an ISVA (Robinson, 2009). To the victims-survivors interviewed, the combination of emotional support, practical assistance, and signposting to other support services was vital in helping them survive the trauma of the sexual violence and cope with the court process (see also Lea et al., 2015). Victims-survivors appreciated having one key person to deal with who tailored support based on their individual needs, and who kept them informed about the criminal justice process.

The support provided by ISVAs throughout the court process was deemed crucial by both practitioners and victims-survivors interviewed in keeping victims-survivors engaged in the criminal justice process. In addition, it was found ISVAs provided a helpful interface between health and criminal justice agencies to the benefit of victim-survivor engagement with the CJS (Robinson, 2009).

ISVAs have the specialist knowledge and expertise to provide practical advice and information in a holistic way that considers the individual circumstances and needs of victims-survivors. ISVAs are professionally accredited[2], and adhere to professional guidelines developed by the UK Home Office in partnership with the sexual violence and abuse sector, including Rape Crisis England & Wales, The Survivors Trust, St Mary's SARC, and LimeCulture (Home Office, 2017). A key feature of the ISVA role is guiding victims-survivors through the CJS, including providing information about the court process, explaining what to expect when giving evidence, and how to draft a victim impact statement. This type of assistance was found to empower victims-survivors, making them feel less traumatised through the justice process (Robinson, 2009).

Victim-focused support is offered at all stages – crisis support, police reporting, pre-court, during court, post-court. ISVAs play a key role in enabling victims-survivors to start and continue through the justice process and keeping them safe throughout their court case. The consistency of ISVA support was considered vital through the often drawn-out criminal justice process. Empowering victims-survivors to make their own decisions and progress at their own pace was an important aspect of this support (Hester & Lilley, 2018).

However, the same evaluation found that most clients who self-refer or who are referred by police are white, women, young, English speaking, and with few disabilities (Robinson, 2009). This suggests that victims-survivors from ethnic minorities, including migrants and refugees, or those who have English as a

[2] Accreditation and specialist training available through LimeCulture (a leading specialist sexual violence training and development organisation in the UK) and The Survivors Trust (an umbrella agency for specialist rape and sexual abuse services in the UK).

second language, and victims-survivors with disabilities are either not reporting sexual violence, declining ISVA support, or are falling through a gap in service provision.

In addition, it was perceived by some stakeholders that victims-survivors may be more willing to access services from a voluntary agency, rather than from a SARC aligned with the statutory sector, such as police and health authorities (Robinson, 2009). Therefore, providing ISVA services within voluntary organisations, such as RCCs, was viewed as a key benefit for victims-survivors who may be anxious about reporting sexual violence to the police.

Funded by the UK Home Office, ISVAs are viewed as key workers in both SARCs and voluntary sector organisations as they help to reduce fear and uncertainty of the CJS, thus encouraging victim-survivor participation (Robinson & Hudson, 2011). Some voluntary agencies expressed concerns that ISVAs duplicated their work and took away already limited resources and funding. However, the evaluation found that ISVAs provided a complementary, rather than conflicting service, expanding the support available for victims-survivors. ISVAs provided non-therapeutic support and practical advice, such as referrals to other services and support in court, whereas other voluntary sexual violence agencies provided qualified counselling sessions. Their ability to liaise with multi-agency partners and coordinate services for victims-survivors was seen to add value to a range of organisations (Robinson, 2009).

The *Stern Review* (2010) into rape cases in England and Wales suggested that ISVAs make an enormous difference to the experiences of victims-survivors of sexual violence in the CJS. The evaluation by Robinson (2009) found ISVAs in both SARCs and RCCs deliver important services that go beyond criminal justice outcomes. Individual victims-survivors felt ISVAs were essential for their own recovery, and multi-agency partners saw ISVAs as adding value to statutory responses to sexual violence. However, more research is needed to understand this perception from the perspective of victims-survivors (Lea et al., 2015).

US: Sexual Assault Response Team (SART)

In the early 1970s, the United States experienced a paradigm shift in the way service providers supported rape victims, with the creation of community-based Sexual Assault Response Teams (SARTs) across the US (Campbell, 2006). SARTs were developed to address problems associated with the community response to sexual violence, including negative treatment of victims-survivors by the legal and medical systems, and low service utilisation, reporting and prosecution rates (Zajac, 2006). In addition, lack of coordination and communication between sexual violence response agencies was common, leading to victims-survivors and their cases falling through the cracks in some communities (Campbell & Ahrens, 1998).

SARTs seek to address these issues by building positive working relationships between police, prosecutors, medical/forensic examiners, rape victim advocates, and other sexual violence responders. Instead of asking victims-survivors to seek help from multiple agencies, service providers moved towards a collaborative model where professionals offered treatment and support at one centralised location (Bramsen, Elklit, & Nielsen, 2009).

The SART model is an example of a comprehensive post-rape care integrated delivery model that incorporates medical, forensic, and psychosocial support services and referrals to community-based providers. SARTs are generally located within a hospital, health centre or clinic and comprise of a nurse examiner, a counsellor, case manager or advocate, police officer, and a prosecutor (Harris & Freccero, 2011). Most SARTs are located in communities that also have a sexual assault nurse examiner (SANE) programme (Greeson & Campbell, 2014).

SARTs seek to improve the experiences of victims-survivors of sexual violence in the CJS. This includes addressing barriers to seeking help, improving how sexual violence responders treat victims-survivors, and ensuring comprehensive and appropriate service delivery (Greeson & Campbell, 2012). The two main objectives of the SART model are:

a) to improve service provision to victims-survivors of sexual violence by providing sensitive, efficient, interagency services, and
b) to increase reporting rates and ensure successful prosecution of perpetrators through accurate evidence collection (Bramsen et al., 2009; Greeson & Campbell, 2012, 2014).

The SART model is victim-centred and trauma-informed, prioritising victims-survivors' rights and wellbeing, and ensuring that victims-survivors are respected and treated with sensitivity and consideration by all agencies/providers involved throughout the criminal justice process. There is often a strong advocacy programme attached to each SART, available to victims-survivors the moment they attend a centre. This advocacy service is usually provided through RCCs, with staff and volunteers assisting with crisis intervention, medical and legal advocacy, and counselling (Campbell, 2006). Several SARTs also have integrated pro-active follow up within the first week victims-survivors make contact (Kanan, 2018).

The integrated approach reduces the number of times a victim-survivor is required to provide an account of the incident. In addition, advocates provide emotional support throughout the process (medical examination, police statement, prosecution questioning) and coordinate access to legal and other services as need be.

In her research on the effectiveness of rape advocacy, Campbell (2006) looked at the training staff and volunteer advocates from one urban RCC received.

Before assisting victims-survivors, advocates completed a 40-hour training programme that included victims-survivors' legal rights, the legal prosecution journey, process of medical forensic evidence collection, and the psychological impact of sexual violence. They also learned how to assess the needs of victims-survivors during the medical and legal process, and how to intercede on behalf of victims-survivors if they became distressed during the medical examination or police questioning (Campbell, 2006).

Some studies suggest that SARTs can improve how sexual violence support agencies respond to victims-survivors of sexual violence by increasing coordination, communication and relationships between agencies, and as a result reduce re-traumatisation and increase victim-survivor participation in the CJS (Campbell & Ahrens, 1998; Greeson & Campbell, 2012, 2014). However, there has been very little research to understand the effectiveness of SARTs in relation to conviction rates and victim-survivor experiences.

Developing a SART can be a challenging process requiring commitment and collaboration from many different agencies (Johnston, 2005). Challenges can include organisational barriers, difficulty obtaining broad participation and collaboration from key stakeholders, coordinating efforts across multiple agencies/jurisdictions, conflicting goals (e.g. how to improve victim-survivor experiences and legal outcomes), information sharing and coordination, confusion and conflict over roles (e.g. 'turf wars', a reluctance to collaborate) (Greeson & Campbell, 2012).

In addition, SARTs need sufficient funding to promote collaborative efforts. Some SARTs are supported through federal or state funding for victim services or through health care budgets (Kelly, 2005). However, in many communities, SARTs rely on different agencies' own time and resources to fund the services provided by SARTs. Therefore, resources spent on collaborative efforts may result in resources taken away from other agencies/services (Greeson & Campbell, 2012).

A national study of SARTs found that a coordinated multi-agency response to sexual violence seems to be working (Greeson & Campbell, 2014). However, gaps in service provision remain - SARTs are promising but not yet shown to be universally effective. This may be because SARTs were created and designed by multiple communities, meaning there is no one standardised/universal SART model. A variety of SART resources have been produced to help communities implement SART models, but more resources are needed (e.g. a toolkit or handbook) that provide advice on how to develop and sustain an effective and successful SART (Greeson & Campbell, 2014).

They can also vary on the agencies involved, how the SART team is organised, and how they work together to respond to victims-survivors (Greeson & Campbell, 2014). As a result, SART implementation varies from community to

community, which may impact on effectiveness of services and collaboration between agencies (Zajac, 2006, 2009). However, all SARTs share a key commonality – a collaborative multi-agency effort to improve community response to sexual violence.

Canada: Trauma-informed victim service responses

In Canada, all provinces and territories offer support services to victims-survivors of sexual violence. However, each jurisdiction has developed its own model of service delivery, including court-based, police-based, community-based and system-based models, or a combination of models (Canadian Intergovernmental Conference Secretariat, 2018). A number of Canadian jurisdictions have established SARTs, and while each SART looks slightly different, the key partners involved are similar to the United States model, incorporating health, policing, victim advocacy, counselling, and sexual violence service centres.

A promising practice of service support for victims-survivors of sexual violence can be found in Québec province, including designated sexual violence support centres and a 24/7 toll-free bilingual support, assistance and referral phoneline. Designated centres are staffed by a multidisciplinary team of social workers, nurses and doctors who provide a range of medical and psychological support to victims-survivors (Québec, 2019). These centres are often located in hospitals and are open 24 hours a day, 7 days a week.

Victims-survivors can also be referred to crime victims' assistance centres (CAVACs). These services provided by CAVACs are funded by the Québec provincial government and include information about victims'/survivors' rights, support throughout the court process, counselling, and referrals to specialised services. Services are offered in French, English and several Indigenous languages, and are available at 167 service points throughout the province, including all Québec courthouses (Canadian Intergovernmental Conference Secretariat, 2018).

Also of note is the Surrey Women's Centre's Surrey Mobile Assault Response Team (SMART) in British Columbia, which provides 24-hour crisis response over the phone and in-person. Partnering with Surrey Memorial Hospital, the SMART team assists with safety planning, hospital accompaniment, and provides outreach services such as help accessing housing, income assistance, and legal aid (Canadian Intergovernmental Conference Secretariat, 2018).

Canadian models of service provision for victims-survivors of sexual violence face the same challenges as the United States SART model, including multi-agency cooperation and information sharing, differing goals and mandates of the agencies involved, and a lack of sustainable funding. However, with joint agency

training on trauma-informed approaches and information-sharing protocols, Canadian collaborative models can enhance access justice for victims-survivors of sexual violence (Canadian Intergovernmental Conference Secretariat, 2018).

However, it is important to consider the context of ongoing colonisation in relation to Indigenous peoples' experiences of sexual violence and their access to justice through the court system. Many Indigenous victims-survivors of sexual violence perceive the formal court system as doing 'more harm than good', based on historical colonial trauma and ongoing discrimination, and therefore does not provide them a meaningful platform through which to seek justice (Barkaskas & Hunt, 2017). Barriers to justice within the formal court system include the colonial culture of the Canadian justice system, and other state institutions, that perpetuate colonial racist and sexist stereotypes, and fear and mistrust of statutory agencies.

Additionally, Indigenous victims-survivors face barriers within their own communities, including feelings of shame and embarrassment, and fear of not being believed or receiving backlash from family and community members (Barkaskas & Hunt, 2017). Barkaskas and Hunt (2017) suggest service providers should incorporate a decolonial trauma-informed framework that includes grassroots community voices and Indigenous-led efforts to address sexual violence to understand and improve access to justice for Indigenous victims-survivors of sexual violence.

South Africa: Thuthuzela Care Centres

Thuthuzela Care Centres (TCCs), named after the Xhosa word for "comfort" are a good example of a one-stop-shop model managing the needs of victims-survivors of sexual violence (Harris & Freccero, 2011). Established in 2000, TCCs aim to address the medical and social needs of sexual violence victims-survivors, supporting them through the whole justice process, from initial medical/forensic care to court preparation. This type of wrap-around service is designed to treat victims-survivors with dignity and compassion throughout the medical and legal process (Barberton & Grieve, 2004).

The victim-centred approach of TCCs help to minimise re-traumatisation, improve the coordination and quality of services for victims-survivors of sexual violence, reduce the length of time they spend in the CJS, and improve conviction rates[3] (Barberton & Grieve, 2004; Bougard & Booyens, 2015; Harris & Freccero, 2011). The TCC one-stop-shop model has been described as an international best practice model, commended by former UN Secretary General

[3] For example, conviction rates for rape cases dealt with by the TCC in Soweto reached up to 89% in 2011, compared to a national average of 7%" (UN Women, 2011, p. 119).

Kofi Annan for its successful integrated approach to prevention, care and response to sexual violence, with other countries including Ethiopia and Chile adopting similar models (UN Women, 2011; UNICEF, 2006).

Located within health facilities, TCCs coordinate the involvement of all relevant stakeholders in the provision of services for victims-survivors of sexual violence, including the collection of forensic evidence, legal advice, health care and other support (Bougard & Booyens, 2015). Victims-survivors receive trauma counselling from an on-site coordinator or nurse, an explanation of the medical and court procedures, and a medical examination, including the gathering of forensic evidence. An on-site investigator collects a statement from the victim-survivor, and if they decide to file a police report a prosecutor will meet them at the centre to discuss next steps. A social worker is also available if needed to help victims-survivors develop a safety plan, organise referrals to community-based psychosocial services, and find shelter (Harris & Freccero, 2011).

TCCs are managed in partnership with the Departments of Health, Education, Correctional Services, Safety and Security, Social Development, and non-governmental organisations (NGOs). They are also located near specialised sexual violence courts staffed with people specially trained to handle sexual violence cases, including prosecutors, social workers, magistrates, and investigating officers (Harris & Freccero, 2011). Twenty-one NGOs are responsible for delivering services in 70% of the TCCs, including keeping TCCs open 24/7 and providing continuous support for victims-survivors, raising awareness and support for TCCs in the community, and providing supplies and resources (Louwrens et al., 2016).

TCCs have helped to streamline care and judicial processes for victims-survivors of sexual violence through increased coordination and cooperation across the medical and legal sectors (Louwrens et al., 2016). A study into the perspectives of adult women rape survivors found that the TCC model inspired the confidence of victims-survivors in the CJS and service providers, suggesting that the TCC model plays a positive and constructive role in helping victims-survivors of sexual violence (Bougard & Booyens, 2015).

One of the greatest strengths of the TCC model is the integrated approach that brings all services and stakeholders together in one location. However, a recent evaluation of the programme identified this as also one of its greatest weaknesses, as stakeholder engagement, responsibilities and accountability varied across and within provinces (Louwrens et al., 2016). In addition, Louwrens et al. identified some challenges regarding the relationships between NGO staff, TCC staff and Department of Health staff, with NGO staff reporting feeling undervalued and overworked.

The same evaluation identified several issues that influence the quality of the services provided, including the lack of adequate debriefing and counselling for

staff; the availability of emergency health services and staff 24/7; and inadequate numbers of social workers and psychologists affecting the ability of TCCs to provide long-term psychosocial support. Transport was also a major barrier for victims-survivors to access TCCs and to receive follow-up psychosocial support, influencing their ability to attend court proceedings. Louwrens et al. (2016) found that sustainable and consistent funding for all TCCs was pivotal to ensure victims-survivors have access to the services they need throughout the justice process.

Australia: Centres Against Sexual Assault (CASAs - Victoria) and The Sexual Assault Reform Program (SARP – Australian Capital Territory)

In Australia, victims-survivors of sexual violence have access to different support services depending on the state or territory they live in. Programmes of support range from multidisciplinary centres, specialist prosecution units and courts, victim support services and advocacy, and restorative justice processes (Daly, 2011). This literature review looks at two multidisciplinary programmes that have been identified as best practice: Centres Against Sexual Assault (CASAs) in Victoria, and the Sexual Assault Reform Program (SARP) in the Australian Capital Territory (ACT).

Centres Against Sexual Assault (CASAs), Victoria

In Victoria, the CASA Forum Inc coordinates the state's 15 Centres Against Sexual Assault (CASAs) and the Victorian Sexual Assault Crisis Line (afterhours). CASAs are non-profit, government funded organisations that provide free and confidential short, medium and long-term counselling and support services to women, children and men who are victims-survivors of sexual violence (CASA Forum, 2018). This includes 24-hour crisis care support, follow up counselling and advocacy support services, access to medical care and legal and social services, as well as counselling support for adult victims-survivors of historical sexual abuse. CASAs are found in rural, regional and metropolitan settings and may be located within a Multidisciplinary Centre (MDC), hospital or a community-based agency (CASA Forum, 2014).

CASAs strive to ensure victims-survivors of sexual violence have access to confidential and culturally appropriate services that are responsive to their needs and concerns and empower them to make informed choices (CASA Forum, 2018). CASAs are also involved in professional and community education, ensuring that the education and training of health workers, legal personnel and allied service providers reflects an understanding of and a sensitivity to the needs and concerns of victims-survivors of sexual violence. They also seek to

inform government policy, advocate for law reform, and facilitate research to increase community understanding of sexual violence (Daly, 2011).

The CASA Forum is a member of the national body for sexual violence services – the National Association of Services Against Sexual Violence (NASASV) (CASA Forum, 2014). All Victorian CASAs maintain accreditation against the Human Services Standards, which have been developed by the Victorian Government Department of Health & Human Services (DHHS). These standards focus on ensuring compliance in four key areas: Empowerment, Access & Engagement, Wellbeing, and Participation (CASA Forum, 2018). Counsellors and advocates working for CASA need to be members of a relevant professional organisation.

The CASA model allows for innovation and agility across the state of Victoria and within regions, meaning they can be responsive to the unique geographic and community needs of each region (CASA Forum, 2018). CASA staff provide advocacy in relation to legal choices, physical health concerns and safe accommodation. Advocacy/support is also provided for clients going through the court system.

CASAs follow a Victims' Rights Model of service provision that focuses on the physical, health, emotional and social needs of victims-survivors. The counsellors/advocates who work with CASA are social workers or psychologists who provide counselling and therapy for victims-survivors of sexual violence. They also see their role as advocating for justice for their clients (Worth, 2016). The primary role for counsellors/advocates is to enable victims-survivors to make informed decisions throughout the medical and legal process (CASA Forum, 2014). This includes providing information about their legal, medical and social options and rights, arranging follow-up counselling and support, and advocating on behalf of the victim-survivor to ensure they receive accurate information about available support and services.

The multi-disciplinary approach to sexual violence promotes a close working relationship between different agencies working with victims-survivors of sexual violence (e.g. rape crisis centres). CASA counsellor/advocates work closely with the Victoria Police Sexual Offences and Child Abuse Investigations Team (SOCIT), forensic services, and other support agencies at MDCs across the region where key services involved in responding to sexual assault are co-located (CASA Forum, 2018).

MDCs aim to deliver coordinated, efficient and specialised responses to sexual violence, thus increasing victim-survivor reporting, lowering attrition rates and re-traumatisation, and fostering victim-survivor recovery (Powell & Wright, 2012). They offer a streamlined response that places the emotional wellbeing of victims-survivors at the centre of support (e.g. dealing with one police person throughout whole process and reducing the number of times victims-survivors need to repeat their experience) (Victoria Police, 2017).

A 2008 evaluation of the MDC pilot in Victoria found that a multidisciplinary response provided greater continuity of care, ensuring victims-survivors were well informed about the status of their case and supported throughout the justice process (Powell & Wright, 2012). Stakeholders expressed that the adoption of a multi-agency, victim-centred, one-stop-shop model of service delivery created a neutral, safe, confidential and less stressful space for victims-survivors to report sexual violence, thus helping to maximise justice outcomes and victim-survivor wellbeing (Powell & Wright, 2012).

However, several challenges were highlighted in the evaluation of the MDC pilot, including:

- funding sustainability – MDCs are resource-intensive (infrastructure and staffing)
- disparities in resources between regional and urban centres – allocation of resources based on population size may disadvantage smaller regions and remote areas
- inadequate resourcing may lead to cut corners and/or staff burnout, continuity of staff
- communication/cohesiveness between agencies (e.g. insufficient communication, different perspectives/perceptions).

Powell and Wright (2012) suggested that strong strategic and centralised management is essential to ensure consistency and high-quality service delivery in MDCs. While there is no indication that MDCs have increased the conviction rate, evidence suggests that they have increased the reporting rates and victims-survivors feel supported and informed throughout the justice process (Worth, 2016). There are currently 7 MDCs across Victoria.

Sexual Assault Reform Program, ACT

Introduced in 2007, the Sexual Assault Reform Program (SARP) aims to reform the way sexual assault cases are handled in the ACT CJS. This includes improving processes and support for victims-survivors of sexual violence going through the CJS, and coordination and collaboration among agencies involved in sexual violence cases (Anderson, Richards, & Willis, 2012). By increasing support for victims-survivors and better coordination between agencies, the SARP reforms seek to encourage victims-survivors to participate and remain in the CJS, thus reducing attrition.

Relevant legal, medical, and support services work together to provide a coordinated wraparound approach to support victims-survivors through the criminal process. The agencies involved include ACT Policing, the Director of Public Prosecutions, Canberra Rape Crisis Centre (CRCC), the Forensic and Medical Sexual Assault Care, and Victim Support ACT (VSACT) (Daly, 2011). The primary function of the wraparound service is to provide a coordinated counselling and support service that responds to the individual needs of victims-

survivors from the moment they contact police or forensic/medical services (Anderson et al., 2012). The wraparound approach seeks to engage with victims-survivors early in the process and to deliver effective and appropriate services throughout the court process without duplicating services. In addition, a collaborative wraparound approach seeks to avoid over servicing some victims-survivors while ensuring others do not fall through any gaps in service delivery (underservicing).

Victims-survivors in the ACT predominantly enter a wraparound service via the police. Once referred to the wraparound service, victims-survivors are assigned a Victim Liaison Officer (VLO) who is their primary support and contact throughout the court process. The wraparound service is designed to provide information and communication throughout their involvement in the CJS, and ensure they have access to appropriate and adequate support. Even if victims-survivors decide not to progress through the CJS, counselling support is still provided via other agencies involved with the wraparound service, such as CRCC and VSACT (Anderson et al., 2012).

As part of the wraparound service, victim-survivor support agencies, such CRCC and VSACT, generally participate in every phase of the court process and may also be involved pre and post-trial. For example, CRCC provide long-term support and counselling services for victims-survivors for those who require ongoing assistance. VSACT help prepare victims-survivors for the trial ahead, providing information on court processes and the criminal justice system, and the support options available throughout (Anderson et al., 2012). In addition, the Witness Assistance Service (WAS) guides victims-survivors through the prosecution process, providing information about their rights and the progress of their case, and generally advocating on their behalf around the court process.

Despite the level of information available to victims-survivors about the court process, victims-survivors interviewed for an evaluation of the programme in 2010 felt the provision of information could be improved (Anderson et al., 2012). Most felt insufficiently informed and that the information provided was paternalistic and sugar-coated, particularly about the probability of delays in the trial process. While service providers try to inform victims-survivors without alarming them unnecessarily or causing them to withdraw, victims-survivors noted that they greatly appreciated honest and realistic information. Some gaps in the provision of information was also noted by stakeholders, such as not always knowing if victims-survivors have been notified about court delays (Anderson et al., 2012). This suggests that either communication between different stakeholders needs to be improved, and/or the number of support providers involved in informing victims-survivors needs to be reduced.

However, stakeholders interviewed noted how the collaborative approach had improved communication between law enforcement personnel and the victim support sector, and helped them understand the roles of the agencies that

provide services to victims-survivors of sexual violence (Anderson et al., 2012). Stakeholders believed that the SARP reforms greatly improved the working relationships of agencies that respond to and/or provide services to victims-survivors of sexual violence in the ACT – giving them greater appreciation of the role each agency provides in the wraparound service. As a result, this collaborative working environment has positively benefited victims-survivors, increasing their confidence in the system and helping them access the services they need (Anderson et al., 2012).

A key weakness identified by stakeholders was the lack of a key driving agency to assist with the implementation of reforms and to streamline processes. However, victims-survivors interviewed for the evaluation welcomed the collaboration and felt services were fairly streamlined, which meant they did not have to repeatedly tell their story to multiple service providers (Anderson et al., 2012).

Other gaps identified by agencies involved in the wraparound service included a lack of support services available for male victims-survivors of sexual violence and disabled victims-survivors, and continuity of staff support (Anderson et al., 2012). Turnover of staff and the loss of expertise can negatively impact on victims-survivors and lead them to lose confidence in the process.

Supporting victims through the legal process: The role of sexual assault service providers in Australia

In research with Australian sexual assault counsellors[4], participants described their role in helping victims-survivors navigate the complex CJS, including preparing them for court, teaching them about the court process, and helping them build their skills and confidence to testify (Parkinson, 2010). The counsellor works closely with other key players in the CJS, building positive working relationships/collaborations with prosecution lawyers, police, victim liaison officers and court registrars, forensic doctors and nurses, and other support services (Parkinson, 2010).

Participants highlighted the importance of good relationships, which rely on the approach, experience and skills of individual counsellors, police officers, prosecutors, and other court professionals. They found that good working relationships can lead to a more streamlined service and a better experience for clients. However, the sexual assault counsellors interviewed sometimes felt marginalised or that their role was often not formally recognised within the hierarchy of the CJS (Parkinson, 2010).

More broadly, across Australia there is a lack of Aboriginal and/or Torres Strait Islander counsellors, counsellors from diverse ethnic groups, and/or culturally

[4] Ten people were interviewed for their expertise. They represented different parts of the legal and sexual assault sectors, and different geographic locations across Australia (both rural and metropolitan).

appropriate support groups (Allimant & Ostapiej-Piatkowski, 2011; Taylor & Putt, 2007). Additionally, few indigenous and culturally and linguistically diverse (CALD) victims-survivors report sexual violence or seek support. This can be for several reasons, including cultural, religious and language barriers, socio-economic disadvantage, social isolation, lack of knowledge about their rights, mistrust of the police and CJS, stigma and shame around sexual violence, and fear of reprisal from their family and/or community (Allimant & Ostapiej-Piatkowski, 2011; Taylor & Putt, 2007).

To encourage victims-survivors from indigenous and CALD backgrounds to report sexual violence, Taylor & Putt (2007) highlight the need for a culturally sensitive and appropriate response, including access to women police and service providers and professional interpreters. It is also important to build trust and confidence in the police and the CJS, provide information about their rights, and establish community networks and culturally appropriate support groups.

Nordic model: Centres of Excellence

In the late 1980s and 1990s, inspired by the US SART model, the Nordic countries (namely Norway, Iceland, Sweden and Denmark) established 'centres of excellence' that employ a multidisciplinary and victim-centred approach. These centres are based in hospitals (usually in the capital city), have strong links with other agencies such as the police and prosecutors, and are funded by central government (Kanan, 2018). Specialised staff trained in dealing with sexual violence cases support victims-survivors through the entire medical and legal process and provide psychological support in the aftermath and follow-up of the event.

A distinguishing feature of these centres is their focus on research and evaluation, including service satisfaction surveys for victims-survivors, treatment assessment outcomes, psychological readjustment, and family coping. They also publish research findings in academic journals. These centres are recognised nationally and internationally as holding extensive expertise in medical and social support services for victims-survivors of sexual violence (Kanan, 2018).

In Denmark, the Center for Rape Victims (CRV) in the city of Aarhus, established in 1999, is regarded as one of the leading service models for victims-survivors of sexual violence, and has contributed to the development of guidelines for other rape trauma centres nationally (Bramsen et al., 2009). It has also created more public awareness and education around sexual violence, improved the treatment and care of victims-survivors, developed and implemented prevention programmes, and helped increase national funding to support victims-survivors of sexual violence (Bramsen et al., 2009).

The main objective of the CRV is to gather relevant specialists and professionals (including specially trained nurses and licensed psychologists) in one location to avoid re-traumatisation of victims-survivors; provide medical treatment, forensic examination, counselling and follow-up support; and to increase understanding of the consequences of sexual violence through research (Bramsen et al., 2009; Ingemann-Hansen, 2006). The CRV is open 24/7, supports both male and female victims-survivors aged 12 years and older, and offers overnight accommodation if needed. Counselling is provided by licensed psychologists.

The CRV receives public funding from the Ministry of the Interior and Public Health and from private organisations. The CRV is run by a steering committee consisting of academics (medical and psychology), hospital personnel, the Institute of Forensic Medicine, and the police.

CRV staff members complete a mandatory two-day introductory training course in CRV procedures around victimisation, rape, and sexual trauma, and learn about and keep up-to-date on current practices in other disciplines relating to sexual violence. Maintaining a high level of training and expertise is considered a top priority. Staff receive training from licensed psychologists, nurses who have participated in programmes similar to the SANE programme in the United States, and police officers trained in dealing with victims-survivors of sexual violence. Formal supervision, mentoring and coaching are available to all staff members. Staff work in close collaboration with different agencies and departments involved in sexual violence cases, striving to understand the work performed in other departments and agencies (Bramsen et al., 2009).

The CRV works closely with the University of Aarhus to carry out research to foster greater understanding of sexual violence, develop prevention programmes and best treatment practice guidelines. As part of their research agenda, the CRV collects survey data on an ongoing basis to evaluate the treatment and services offered to victims-survivors through the CRV (Bramsen et al., 2009).

Despite the perceived success of Nordic 'centres of excellence', concentrating resources in main urban centres has meant limited development and provision of services provided elsewhere, especially in rural areas (Kanan, 2018). In regard to the CRV in Aarhus, funding problems have forced the CRV to impose a 72-hour rule, meaning that they can only support victims-survivors if they contact the CRV within 72 hours of their assault (Bramsen et al., 2009). Future goals to expand support services include engaging grassroots groups to create community-based support systems that address the needs of victims-survivors of sexual violence across the country.

Malaysia: One Stop Crisis Centre (OSCC)

The Malaysia One Stop Crisis Centre (OSCC) model was developed in collaboration with health professionals and women's NGOs as a comprehensive, integrated multi-sector response to sexual and domestic violence against both women and children. OSCCs are based in public hospitals and aim to provide round-the-clock victim-centred care, including access to medical care, counselling, police and legal aid, and social support in one location (Colombini, Mayhew, Ali, Shuib, & Watts, 2012). Counselling is provided by medical social workers at specialised hospitals and upon referral by women's NGOs or social workers from the Department of Social Welfare (Colombini et al., 2012).

The first OSCC was established in 1994 in the Accident and Emergency (A&E) department of the General Hospital in Kuala Lumpur. In 1996, after a second OSCC was set up in the main regional hospital in Penang, the Ministry of Health directed all state hospitals throughout Malaysia to establish OSCCs (Colombini, Ali, Watts, & Mayhew, 2011; Colombini et al., 2012). The OSCC model has been subsequently replicated in other countries in the South East Asian region (Kelly, 2005).

Although the principles behind OSCCs are the same across hospitals, implementation has differed across facilities due to the diverse actors involved, differing hospital structures and organisation, and local context and resources, creating disparities of services between regions (Colombini, et al., 2012). In addition, the Ministry of Health did not develop guidelines or procedures about how the centres should be created and managed, or how the OSCC model should be implemented in regional areas with no specialised care and few NGOs (Colombini et al., 2012). Hospitals also did not receive extra resources to establish OSCCs.

The implementation of OSCCs relied heavily on NGOs providing counselling and support services, but there were not enough specialised women's NGOs that could staff every centre, especially in rural areas. NGOs gradually pulled their support from OSCCs because they could not sustain on-site advocacy services in the long term without additional funding (Colombini et al., 2011). Policy makers had presumed that women's NGOs would provide support and counselling in the centres, with women's advocate volunteers on call 24/7 to assist victims-survivors when they arrive at the hospital. Whereas women's NGOs thought that their role was only temporary until full time social workers were stationed at OSCCs (Colombini et al., 2011).

A lack of understanding of the roles and responsibilities between NGOs, hospitals, and government agencies negatively impacted the long-term implementation and expansion of the OSCC model (Colombini et al., 2011). Inadequate funding from the Ministry of Health, alongside the withdrawal of NGO support, hindered the ability of hospitals in many regions to establish OSCCs and provide adequate support to victims-survivors of sexual violence. Instead of being a 'one-stop-shop', services became fragmented and inefficient, especially

at district facilities, where there were no specialists available on site and little collaboration between external agencies.

If properly resourced, the OSCC model has the potential to provide effective care and support to victims-survivors of sexual violence, especially in rural areas where there may be a lack of other services outside the local hospital (Colombini et al., 2011). While the multi-agency one-stop approach may not be feasible in regional areas, it could be adapted to reflect local resources and context (Colombini et al., 2012).

Key commonalities: What does good practice look like?

This literature review has given an overview of some of the different international court support models for victims-survivors of sexual violence. While models may differ between countries, an approach to court support which places the rights and dignity of victims-survivors of sexual violence at the centre generally include the following elements:

- a victim-survivor-centred, holistic approach that focuses on meeting the varied and complex needs of victims-survivors, and tailors support to the individual (e.g. interpreting, cultural considerations, etc.).
- a collaborative and coordinated response to sexual violence that brings together medical and legal services, police, counsellors, advocates and other support services to help victims-survivors in the one location, and decrease the need for the victim-survivor to repeat their account.
- ongoing support that considers the potential long-term needs of victims-survivors throughout the justice process.
- support that involves and informs victims-survivors of the criminal justice process and their choices, provides follow up support, and if necessary develops a safety plan.
- considers culture/gender/age/ethnicity and other factors
- links in with other services in the community, e.g. hospitals, support providers, churches, etc.

Integrated programmes, such as one-stop-shop models, are perceived as best practice in addressing sexual violence, as they enable victims-survivors to access a range of services at one location providing specialised medical care, legal advice, counselling and advocacy, thus increasing access to justice for victims-survivors and helping to reduce re-victimisation (Harris & Freccero, 2011).

Strong relationships and communication between service providers and other stakeholders in the justice system help service providers to better support victim-survivor participation in the CJS. It is also important for understanding what services exist, where and how they are delivered, and how key stakeholders work together to ensure victims-survivors get access to the services and support that they need (Law Commission, 2015).

Important features of a one-stop-shop approach are "availability, continuity and quality of adequately funded support" (McDonald, 2012, p. 214). The care and support provided by this type of court support model wraps around the victim-survivor, focusing on their needs. Having one source of advice and support can help victims-survivors feel like they have more control over the process. It has

also been linked to increased conviction rates, as victims-survivors feel more prepared to participate in the CJS (e.g. with Thuthuzela Care Centres, South Africa).

Using qualified sexual violence victim advisers is another way to provide a wraparound service, such as the ISVA model in the UK, which has been described as "an example of a reform to a system that is effective, cost-effective and affordable" (Stern, 2010, p. 105). Another example is the SANE model in the United States.

Research has shown that advocates can help foster victim-survivor confidence and positively influence their participation in the CJS (Campbell, 2006; Patterson & Campbell, 2010). In a study into the reasons why rape survivors participate in the justice system, Patterson and Campbell (2010) found positive interactions with formal supports (police, specially trained forensic nurses, advocates) helped victims-survivors feel more confident about their participation in the criminal justice process. As a result, victims-survivors felt stronger and more confident in their ability to cope with the challenging nature of the judicial process.

Early intervention is key. Providing victims-survivors with good access to support services as early as possible after the sexual violence has taken place can help reduce re-traumatisation through the CJS. Early interventions tailored to individual support needs will help place victims-survivors in a stronger position when engaging with the CJS (Law Commission, 2015).

Looking after the emotional wellbeing of victims-survivors, treating them with respect and dignity, providing information and giving emotional support throughout the justice process can encourage victims-survivors to engage with and endure the CJS, and increase their confidence about participating in the criminal justice process (Patterson & Tringali, 2015).

Challenges in providing a one-stop-shop wraparound service

While the wraparound care provided by service providers through a one-stop-shop approach has proved to be effective overseas, a one-stop-shop model may not necessarily lead to greater engagement of victims-survivors with the CJS. There are several challenges to implementing a multi-agency wraparound programme. Things to consider before creating a localised one-stop-shop model include:

- they are more expensive to run than stand-alone services – 24/7 support is resource intensive (i.e. staffing and administrative costs) and needs sustainable funding

- the rural/urban divide – resources may depend on geographic location and the ability to attract qualified staff to rural areas, thus providing consistent specialised sexual violence services to rural populations
- developing culturally responsive and/or appropriate care, and awareness of issues commonly faced by victims-survivors from specific populations, e.g. ethnic minorities, migrants/refugees, people with disabilities, learning difficulties and mental health issues, LGBTQ community, young adults (16-18), etc.
- adequately trained staff with specialist skills to deal with victims-survivors of sexual violence
- the availability of support and information 24/7, e.g. a national helpline staffed by trained crisis workers.

Funding/resources

Investing limited funding into creating specific one-stop-shop facilities may cause other services to lose funding, which was one of the criticisms directed at the SARC system in the UK (Tinsley, 2011). One-stop-shop models have been criticised for their high cost, creating a strain on local resources, while providing highly specialised services to a small percentage of the population (Louwrens et al., 2016). Therefore, it is important that existing service providers be given appropriate funding and assistance to provide co-ordinated wraparound care for victims-survivors (Law Commission, 2015).

A one-stop-shop model may be more appropriate and/or feasible in urban centres where there are more available resources. For example, an evaluation of the Malaysian model found that the implementation of the model outside the metropolitan areas of Penang and Kuala Lumpar often lacked vital services, funding, and specialised staff (Hawa, 2000, as cited in Kelly, 2005, p. 8).

Rural/urban divide

The resources and facilities available to victims-survivors of sexual violence may depend on geographic location. One-stop-shops offer specialist support with police, medical and counselling services under one roof, but may be limited to geographic location and/or well-resourced areas (Parkinson, 2010). Generally located in major city centres, one-stop-shop models may make uneven service provision across regions an issue (Kanan, 2018). For example, an evaluation of the UK SARC model highlighted the challenges to service provision in rural or remote areas (e.g. many parts of Scotland). The interaction between funding/budget and density of need may mean a "one size fits all" approach is not necessarily appropriate in all locations (Kanan, 2018).

The idea of a 'hub and spoke' model may overcome this challenge, where larger regional 'hubs' provide support to smaller local 'spokes' (e.g. local health services). England and Denmark are currently using this type of model to try to reduce costs while maintaining consistency of service. The smaller 'spokes'

provide a degree of service provision, albeit in a potentially limited capacity (e.g. operate on a needs-based approach). For example, rural/remote areas of the United States and Australia use Forensic Nurse Examiners (Kanan, 2018).

Specialist training

It is important for service providers to be specially trained and educated to provide the most effective care to victims-survivors of sexual violence and avoid re-traumatisation. The international literature points to the importance of ensuring staff involved in multidisciplinary centres are specially trained to deal with victims-survivors of sexual violence. Most staff at one-stop-shop centres bring together experts in their own fields (e.g. police, prosecution, nurses, doctors, forensics, etc.), but they do not necessarily know how best to treat victims-survivors of sexual violence in a way that does not re-traumatise them.

Campbell and Ahrens (1998) found that coordinated community-based rape victim programmes were more successful in meeting the needs of victims-survivors if the programme incorporated inter-agency training programmes, i.e. learning about the work performed in other departments and agencies.

Therefore, the proper training of staff involved in handling cases of sexual violence is critical. Trained and well-educated clinicians provide better care to victims-survivors of sexual violence (Martin, Young, Billings and Bross, 2007, cited in Bramsen et al., 2009). Hence the need for centres that are specifically staffed to support victims of sexual violence (e.g. SANE in the US, ISVAs in UK), and the need for professional training, e.g. ISVA accredited training in UK.

Cultural considerations

Research on effective support for those who have experienced sexual violence tends to discuss victims-survivors as a homogenous group (Mossman et al., 2009). However, it is important to consider the diverse needs of different cultural groups to ensure they receive appropriate support and care throughout the justice process. It is also important to consider the needs of individuals and not make assumptions regarding the type of cultural approach that is appropriate or even desirable for that person.

Victims-survivors from non-English-speaking migrant/refugee backgrounds, for example, face many challenges reporting sexual violence and reaching out for support, including language/communication difficulties, cultural shame, social isolation, etc. (Mossman et al., 2009).

Recommendations for a court support model in New Zealand

The New Zealand Ministry of Justice Taskforce for Action on Sexual Violence (Ministry of Justice, 2009) recommended the need for specialist sexual violence court support to provide emotional and psychological support to victims-survivors during the court trial process.

When reviewing the effectiveness of different international court support services for victim-suvivors of sexual violence, it is important to consider the Aotearoa New Zealand context. The learnings garnered from the evaluations and research of programmes and initiatives in overseas jurisdictions may not necessarily translate across. Therefore, it is important to consider whether these findings are applicable to the New Zealand context, and in particular for Māori victims-survivors (Mossman et al., 2009).

It is also important to understand and consider the differences between Māori worldviews of justice, health and well-being, and dominant European/Pākehā worldviews in Aotearoa New Zealand (Mossman et al., 2009). It is important that Māori victims-survivors have access to culturally appropriate services, either run by or in partnership with Māori.

Services must also be able to meet the needs of victims-survivors from diverse ethnic groups (e.g. Pacific women, and women from migrant/refugee backgrounds) (Mossman et al., 2009). As with diverse ethnic groups, it is important to consider the diverse needs of male, LGBTQ, and intersex victims-survivors of sexual violence, and victims-survivors with disabilities (Mossman et al., 2009). Services and support that may work for one group may not be culturally appropriate for another.

Another issue to consider is the scope of services available in Aotearoa New Zealand. Resources, especially attracting and training enough specialist staff, may vary from region to region, and between urban and rural locations. In addition, the provision of a wraparound, one-stop-shop service should not come at the expense of other specialist sexual violence support agencies.

Lastly, it is important that staff are qualified. They do not need to be legally trained but should be familiar with the court process and be specially trained to support victims-survivors of sexual violence (Law Commission, 2015). They need to be able to communicate and coordinate with different sexual violence sector service providers, and may need training on cultural sensitivity, age appropriateness, and disability awareness.

Appendix 1: Summary of International Court Support Models

Court Support Model	Strengths	Weaknesses
Sexual Assault Response Centres (United Kingdom)	Multi-agency coordination (legal, medical, counselling) in one location Includes crisis support, advocacy and counselling Staffed by specially trained police and health professionals Provide an interface between health and justice systems Victim-centred, wrap around service	Expensive to run Reduced funding available to other support services, e.g. Rape Crisis Centres (RCCs)
Independent Sexual Violence Advisers (United Kingdom)	Provide crisis intervention and non-therapeutic support Support victims-survivors through the CJS Liaise with partner agencies on behalf of victims-survivors Professionally accredited Aligned with both SARCs and RCCs Provide complementary support to counselling services	Perception that alignment with SARCs may deter some victims-survivors from accessing ISVAs Reduced funding available to other support services, e.g. RCCs
Sexual Assault Response Teams (United States)	Multi-agency coordination (legal, medical, counselling) in one location	Coordination of different agencies challenging – requires organisation buy-in and information sharing

	Increased communication and collaboration between agencies Victim-centred, integrated, trauma-informed support Advocacy support attached, e.g. through RCCs Specially trained staff	Insufficient funding an issue; resources may be taken away from other agencies/services No one standardised/universal SART model, resulting in differing levels of services between communities
Trauma-informed victim service responses (Canada)	All provinces and territories offer support services – mixture of court-based, police-based, community-based models Several jurisdictions use the US SART model Québec province – multidisciplinary sexual violence support centres and toll-free bilingual phoneline provide 24/7 support for victims-survivors	Challenges include multi-agency cooperation, information sharing, lack of sustainable funding Indigenous people face many barriers to justice, including racism, shame, and fear/distrust of the judicial system and statutory agencies
Thuthuzela Care Centres (South Africa)	Victim-centred, wrap-around support helps to streamline care and judicial process and minimise re-traumatisation Multi-agency coordination (legal, medical, counselling) in one location Specially trained staff NGOs help keep TCCs open 24/7, deliver services	Coordination and collaboration vary across and within provinces – disparate services Over reliance on NGOs to deliver services – NGO staff feel undervalued and overworked Inadequate numbers of trained staff – ability to provide long-term support Sustainable and consistent funding
Centres Against Sexual Assault (Victoria, Australia)	24-hour crisis care support, access to medical, legal and social support	Funding sustainability – inadequate resourcing may

	(counselling and advocacy) from accredited professionals Flexible model responsive to community needs Victim-centred approach focuses on the physical, emotional and social needs of victims-survivors Multi-disciplinary approach promotes close working relationship between agencies Operate in rural, regional and metropolitan centres Located in MDCs (one-stop-shops), hospitals or community-based agencies	lead to cut corners and staff burnout/shortage Disparities in resources between regional and urban centres Lack of culturally diverse and indigenous counsellors and support groups
Sexual Assault Reform Program (ACT, Australia)	Wrap-around, multi-agency (legal, medical, counselling) collaboration provides coordinated counselling and support throughout court process Work in conjunction with Canberra Rape Crisis Centre and Victim Support ACT	Gaps in information sharing and communication between agencies Lack of key driving agency to assist with streamlining of processes Lack of support services available for male, disabled, indigenous and culturally diverse victims-survivors
Centres of Excellence (Nordic countries)	Multi-disciplinary and victim-centred approach 24/7 service based in hospitals with strong links to other agencies Specialised staff trained in dealing with sexual violence cases	Services concentrated in main urban centres – limited services in rural areas Insufficient funding restricts services in some areas

	Strong research focus – expertise in medical and social support services	
One Stop Crisis Centre (Malaysia)	Integrated multi-sector service developed in collaboration with health professionals and women's NGOs (medical care, counselling, police and legal aid, social support) 24/7 victim-centred care based in public hospitals Counselling provided by trained professionals (social workers)	Lack of resources, funding and standardised guidelines and procedures has created disparities of services between regions Heavy reliance on NGOs to provide counselling and support services – not enough specialists available, especially in rural areas Miscommunication and coordination between NGOs, hospitals and government agencies has impacted implementation and scaling up of model

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