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Balancing Risk in Sexual Violence Restorative Justice

Professional views on risk assessment for restorative justice processes addressing sexual violence.

A thesis presented in partial fulfilment of the requirements for the degree of

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Abstract

Sexual violence is an ongoing international human rights issue, often resulting in significant negative impacts, and not always well addressed within conventional criminal justice systems. Restorative justice following sexual violence (SVRJ) is a victim-centred justice process showing significant benefits for victim-survivors (including meeting justice needs and supporting recovery), perpetrators of harm (including insight, community reintegration, and reduced reoffending), and wider communities (encouraging accountability and addressing harmful beliefs). However, there is a risk of causing further harm through SVRJ, meaning professionals in this space have an obligation to manage risk as best as possible. Risk of further harm is one reason why SVRJ is not particularly common around the world, and why opinions are often divided regarding the appropriateness of its use. Currently, there are no standardised guidelines for assessing risk within SVRJ. Instead, professionals may rely on their judgement alone, which is the least reliable and valid method of risk assessment. The current research seeks to address this by investigating professional perspectives about the factors important within SVRJ risk assessment, and subsequently developing SVRJ risk assessment guideline recommendations, which could enable a structured and more reliable approach to SVRJ risk assessment. Professionals ($n=16$) experienced in the areas of SVRJ and RJ risk assessment were interviewed about their experiences of SVRJ risk assessment, particularly what they considered within their assessments and risk-related decisions. Interview data were analysed using reflexive thematic analysis, with four themes identified: perceived participant preparedness, safe support systems, culturally competent assessment, and participant alignment. These findings formed the basis for developed SVRJ risk assessment guideline recommendations. Wider implications of the findings for SVRJ risk assessment, policy and practice are discussed. It is hoped that this research provides important insight into SVRJ professional practice and risk assessment and contributes to the safe use of SVRJ both in Aotearoa New Zealand and

internationally, allowing more people to access the benefits of SVRJ in safe and considered ways.

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Finding The Research

In opening this thesis, I acknowledge the mana whenua¹ of the land where most of this work has been conducted (Te-Whanganui-a-Tara, Wellington city), as Te Ātiawa, Taranaki Whānui ki Te Upoko o Te Ika, Ngāti Toa Rangatira, me Muaūpoko iwi.

I have a long-standing interest in social justice and have been involved in intersectional activism and awareness raising around preventing sexual harm and improving institutional and community responses to such harm in the instances where it does occur. When considering my research topic for this thesis, I was driven by the desire to conduct research which would have practical beneficial application within the community. I began my search for a topic by reaching out to organisations who were doing important harm reduction work, asking if there was any psychological research that could be beneficial to them, an organisation who facilitate restorative justice process following sexual harm within Aotearoa New Zealand called Project Restore, was one of these.

I had first heard of restorative justice (RJ) as a concept, at a talk I attended discussing the “where to” for the “#MeToo” movement. I was intrigued and surprised to learn that restorative justice processes following sexual harm were officially available, given that even as someone with some involvement in the area, and my own experiences of sexual harm, I had never heard of this. Within the description of the RJ process, I recognised the way that I had dealt with an instance of harm, realising I had effectively walked myself through something similar to a restorative process in the past. I reflected on the massive benefits that process had had for me, and how much of a difference having professionals and community support involved would have made. Personally knowing the significant impacts of sexual harm and how commonplace it is within Aotearoa New Zealand society, as well as the potential benefits of restorative processes, I jumped at the opportunity when Project Restore

¹ Indigenous people with territorial rights

highlighted a potential research opportunity for me. My overall hope was that this research could contribute towards improving the safety, acceptability, and public awareness of sexual violence restorative justice (SVRJ), so that more victim-survivors might be able to access SVRJ in safe and considered ways. Further, in understanding professional practice and advocating for SVRJ within Aotearoa New Zealand, we might contribute towards promoting and encouraging the safe practice of SVRJ both here and internationally as well.

As a developing Intern Psychologist, I acknowledge my developing knowledge. Throughout my clinical training I have worked with individuals who have been affected by sexual harm and I have seen the short- and longer-term impacts of this. My interest in this area means I hope to continue developing my understanding of trauma and therapeutic ways to support people recovering from experiences of trauma.

In my internship year I had the opportunity to work within the Department of Corrections, where I worked with individuals who had caused harm and were engaging in group psychological treatment to reduce their risk of reoffending. Walking alongside these people as they reflected on their lives (including their own experiences of abuse), and the beliefs and coping mechanisms which had enabled the behaviours they now wanted to change, left a huge impact on me. Near the end of the treatment programme, the group reflected on how their actions may have impacted their victims, the victims' whānau², their own whānau and the wider community. During this process, I witnessed many individuals develop understandings they had not previously had. I saw them develop insight into the impacts of their actions and the significant ripple effects of harm. I saw them understand and express empathy, and double down on their expressed desire not to go back to their old ways of living.

² Extended family group

I believe that SVRJ offers similar opportunities to build such understanding, as perpetrators of harm can hear the impacts of their actions and reflect on their behaviour with an intention to take accountability and work towards making things right. Further, SVRJ offers an opportunity for victim-survivors to meet justice needs in ways that are often otherwise impossible. I am in awe of the work that restorative justice professionals across Aotearoa New Zealand do, and I hope that this research contributes in a positive way to their ongoing mahi³.

³ Work

Chapter One: Sexual Violence and Conventional Criminal Justice

Definition and Terminology

This research focuses on restorative justice following sexual violence. The World Health Organisation (WHO) defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” and acknowledges violence can be physical, sexual, or psychological (Krug et al., 2002, p. 5). The Aotearoa New Zealand Ministry of Justice defines sexual violence (SV) as any non-consensual sexual behaviour. The terminology of sexual assault includes some forms of SV, detailed as attempted or completed forced sexual intercourse, sexual acts, sexual touching, and threats of a sexual nature (Ministry of Justice, 2021a). SV is used in this thesis to indicate harmful sexual behaviour.

The terminology of “victim-survivor” is often used in the literature on SV, and strategically within SVRJ, to acknowledge that people can be victims and survivors of SV simultaneously and to support the experiences of both outrage and empowerment. The terminology of “offender” (more appropriate within the context of conventional criminal justice), “perpetrator” or “person responsible” is used interchangeably in this thesis to refer to the person who has caused harm through their acts of SV (Jülich, 2001; Jülich et al., 2010; Jülich et al., 2020; Koss & Achilles, 2008; Ministry of Justice, 2013).

Prevalence of Sexual Violence

The WHO acknowledges SV as a widespread human rights issue, with women’s lifetime prevalence of SV reported to be between 10-59% internationally (Garcia-Moreno et al., 2005). While most research into SV does not specifically consider or report sex, sexuality or gender diversity of the people involved, and most commonly portrays women as victims and men as perpetrators, it is important to note that this is not the only configuration in which SV occurs. People of all sexes and genders experience SV, and people belonging to the

LGBTQI+ community (trans and gender diverse people and people with diverse sexualities) experience higher levels of SV than the general population (Brown & Herman, 2015; Dickson, 2017; Langenderfer-Magruder et al., 2016). Prevalence and incidence rates of male SV have been under-researched, and it is likely that a significant proportion is unreported and undetected given societal factors such as stigma, gender stereotypes, and poor legal definitions (Catton & Dorahy, 2022; Fisher & Pina, 2013; Graham, 2006; Loxton & Groves, 2022; Scarduzio et al., 2018; Stemple & Meyer, 2014). In Aotearoa New Zealand, women (especially wāhine Māori⁴) are significantly more likely to experience violent victimisation (including SV) than men, and report significantly greater impacts of their victimisation (Ministry of Justice, 2023b; Ministry of Women's Affairs, 2006; Morris et al., 2003). Prevalence rates of childhood sexual abuse experiences of women in Aotearoa New Zealand have been reported to range from 13% to 28.2%, and prevalence rates of adult women's experiences of SV range between 9-12% and 33-39%, as perpetrated by non-partners and partners respectively (Fanslow & Robinson, 2004; Fanslow et al., 2007; Flett et al., 2012).

The New Zealand Crime and Victims Survey (NZCVS) provides the most comprehensive data on adult victimisation in Aotearoa New Zealand, including insight into the 80% of crime that is not reported to Police (Ministry of Justice, 2021a, 2023b). Across the NZCVS's five years of data, the 12 month prevalence of sexual assault has been reported to be around 2% of respondents (that was; 81,000 and 84,000 adults in cycles 5 and 4 respectively) (Ministry of Justice, 2023b). The data also indicates that around three quarters of assault victims are female, and that individuals with diverse sexualities, disabilities, or people experiencing a high - moderate level of psychological distress or a low level of safety, are at significantly greater risk of sexual assault, as are young women aged between 15-19 years old (Ministry of Justice, 2021a, 2023b). In the most recent cycle of the NZCVS, 27% of respondents (equal to 1.1 million adults) reported a lifetime experience of SV (Ministry of

⁴ Māori women

Justice, 2023b). Across ethnic groups, Māori experience the highest proportion of victimisations (Ministry of Justice, 2021a).

Aotearoa New Zealand's Accident Compensation Corporation (ACC) has been providing support, treatment and assessment for victim-survivors of SV since 2014 (ACC, 2020, 2022). In their response to an Official Information Act (1982) request⁵ ACC stated the number of total new sensitive claims lodged in the financial year 2016/2017 was 7,134, which had increased by 78% to 12,702 new claims by the year 2020/2021. In terms of active claims where ACC was providing financial support, the number in 2016/17 was 23,506 and had increased to 38,072 by 2022/2021, an increase of almost 62%. The ACC minister at the time, Carmel Sepuloni, acknowledged unacceptable rates of SV in Aotearoa New Zealand, which were among the highest rates for OECD countries (Radio New Zealand, 2021, October 3).

While SV is increasingly condemned in our society and law changes over decades have attempted to reduce incidences, there has been little to no change in the reported lifetime experiences of SV in Aotearoa New Zealand over the past century, and SV is still a common occurrence today (Daly, 2008, 2011; Fanslow et al., 2021; Fanslow et al., 2007; Garcia-Moreno et al., 2005; Koss et al., 2003; Ministry of Women's Affairs, 2006; Morris et al., 2003).

Impacts of Sexual Violence

SV can result in significant long term physical and psychological impacts, both personally and societally, negatively impacting on victim-survivor functioning and wellbeing (Fanslow & Robinson, 2004; Fanslow et al., 2007; Flett et al., 2012; Garcia-Moreno et al., 2005; Herman, 2005; Kingi & Jordan, 2009; Nada-Raja & Skegg, 2011; Read et al., 2003).

⁵ Reference: GOV-013704, 24.8.2021

Physiological and Psychological Impacts

Physiological issues associated with SV include menstrual irregularities, general somatic complaints (headaches, nausea, tension, dizziness), weight changes, pain from injuries, and risk of pregnancy or sexually transmitted disease (Casanovas et al., 2021; Maguire, 1991). Victim-survivors of SV tend to have a greater need of medical care, medication, and poorer physical health long term (Fanslow & Robinson, 2004; Garcia-Moreno et al., 2005; Ministry of Women's Affairs, 2012). The psychological impacts of SV (in both the short and long term) include depression/low mood, anxiety, irritability/tension, intrusive thoughts, sleep disturbance/nightmares, avoidance, increased arousal, concentration difficulties, suicidality, self-blame/guilt, self-disgust, fear, anger, interpersonal relationship difficulties, sexual difficulties, and increased substance use (Garcia-Moreno et al., 2005; Maguire, 1991; McHichi Alami & Kadri, 2004; Petrak et al., 1997). Victim-survivors of SV show significantly greater rates of psychopathology in both childhood and adulthood than non-victimised peers, over and above the effects of family background factors (Dworkin et al., 2017; Molnar et al., 2001; Nelson et al., 2002; Spataro et al., 2004). SV can psychologically alter the way individuals understand themselves, the world, and others, disrupting beliefs that are central to a sense of safety and wholeness (Herman, 1997; Zehr, 2005). Individuals who experience SV are at far greater risk of developing symptoms of Post-Traumatic Stress Disorder (PTSD) at significantly greater rates than the general population, or individuals who experience other types of trauma (American Psychiatric Association, 2013; Dworkin, 2020; Dworkin et al., 2021). Increased rates of suicidality, non-suicidal self-injurious behaviours, and experiences of hallucinations, delusions and disordered thought are also reported among SV victim-survivors (Bruffaerts et al., 2010; Fanslow & Robinson, 2004; Martin et al., 2004; Nada-Raja & Skegg, 2011; Read et al., 2003). Further, victim-survivors may be susceptible to developing a traumatic bond to the perpetrator (also known as Stockholm syndrome), as part of their survival and coping mechanisms, which can lead to

increases in victim-survivor self-blame and reluctance to report the abuse (Graham et al., 1994; Jülich, 2001; Jülich & Bowen, 2015).

Neurocognitive Impacts

SV in childhood is associated with general reductions in cognitive function, including reduced ability to inhibit automatic responses, suggesting attentional difficulties (Barrera et al., 2013; Jones et al., 2004). Sexually abused children display significantly lower scores on intelligence (IQ), executive functioning and memory assessment measures than their non-abused peers, with particular deficits noted in relation to working memory and cognitive flexibility (Gervasio et al., 2022).

Psychosocial Impacts

SV can lead to impaired educational performance, poorer interpersonal relationships, and increased stressful/negative life events (Flett et al., 2012; Nelson et al., 2002; Rothman et al., 2019). The significant breach of trust within SV, can impair victim-survivor ability to trust others in the future (Mercer & Sten Madsen, 2015). Communities are often shared between victim-survivors and perpetrators, thus, speaking out about victimisation may result in division of, or rejection from social groups as victim-survivors are met with disbelief or blame (Ministry of Women's Affairs, 2009; Shepp et al., 2020). SV commonly also impacts upon the wider social networks of those involved. The exposure to victim-survivor distress may traumatise others, and the impacts of the SV may result in relationship break downs or strong emotional or behavioural responses (e.g., getting angry, acting out) (Jülich & Bowen, 2015; Ministry of Women's Affairs, 2009).

Revictimisation

It is estimated a minimum of 50% of victim-survivors experience sexual revictimisation over their lifetime, and childhood victim-survivors are twice as likely as non-victimised peers to experience SV in later life (Davis et al., 2006; Ministry of Women's

Affairs, 2012). Victim-survivors of SV are also more likely to experience other forms of violent victimisation (Fanslow et al., 2007; Ministry of Women's Affairs, 2012). Victim-survivors who experience revictimisation are particularly vulnerable to further victimisation and have both high and complex support needs given the cumulative impacts of victimisation (Culatta et al., 2020; Ministry of Women's Affairs, 2009).

Financial Impacts

The financial costs of SV include medical, psychological, and legal costs, lost earnings, and costs of court-ordered restitutions (Waters et al., 2005). Internationally on average, sexual offences are thought to account for 9% of the total economic cost of crime; however, researchers caution this is likely an underestimate due to the limited reporting of SV (Waters et al., 2005; Wickramasekera et al., 2015). Australian estimates have calculated a total cost of SV of over \$720 million AUD per year (Rollings, 2005).

In Aotearoa New Zealand, the cost of crime was estimated at \$9.1 billion NZD per year over the 2003/2004 period. Interpersonal crimes made up only 19% of total crime but contributed to 45% of total costs of crime. Sexual offences were the costliest offence per criminal act at \$72,130 each, with an estimated total cost of \$1,192 million. The high cost of SV is attributed to the significant impact on victims (Roper & Thompson, 2006). More recently, Aotearoa New Zealand's Ministry of Women reported the estimated total cost of SV as \$1.2 billion each year (Ministry of Women, 2021). However, much higher estimates have also been made. In 2021, the ACC minister at the time, Carmel Sepuloni, reported the estimated cost of SV in Aotearoa New Zealand as being over \$6.9 billion each year (Radio New Zealand, 2021, October 3). The financial cost of active sensitive claims lodged with ACC was reported in response to an Official Information Act (1982) request⁶ as being \$100,088,824.00 in 2016/2017, which had increased to \$213,141,817.00 by 2020/2021, an

⁶ Reference: GOV-013704, 24.8.2021

increase of 113% across five years. These figures indicate the extensive financial costs of supporting victim-survivor recovery. Not all victim-survivors choose to engage with ACC, so these costs are not representative of the total financial cost.

Summary of Impacts of Sexual Violence

Victim-survivors commonly experience SV as a formative event with traumatic impacts on their lives (Dworkin et al., 2017; Herman, 2005). SV can result in negative physiological, psychological, neurocognitive, and psychosocial impacts, increases the risk of revictimisation, and has significant financial costs associated. These negative impacts affect society and the individual in both the short and long term, and are generally greater among socially disadvantaged people and minority groups (Barrera et al., 2013; Casanovas et al., 2021; Draper et al., 2008; Dworkin et al., 2021; Dworkin et al., 2017; Fanslow & Robinson, 2004; Fanslow et al., 2007; Flett et al., 2012; Garcia-Moreno et al., 2005; Gervasio et al., 2022; Jones et al., 2004; McHichi Alami & Kadri, 2004; Ministry of Women's Affairs, 2012; Molnar et al., 2001; Nada-Raja & Skegg, 2011; Petrak et al., 1997; Read et al., 2003; Roper & Thompson, 2006; Rothman et al., 2019; Spataro et al., 2004). Using Te Whare Tapa Whā; the Māori health model developed by Professor Sir Mason Durie, SV can be understood to impact on all aspects of an individual's hauora⁷, effecting their physical, mental, spiritual and social wellbeing (Ministry of Health, 2023, December 1).

Conventional Criminal Justice Responses to Sexual Violence

Reporting Sexual Violence

Most crimes (around 80% in Aotearoa New Zealand) are not reported to police, and of all crimes, SV is the least likely to be reported (with only 8-10% of SV thought to be officially reported) (Garcia-Moreno et al., 2005; Ministry of Justice, 2021a, 2023b; Ministry of Women's Affairs, 2006; Morris et al., 2003; Triggs et al., 2009). Feelings of shame,

⁷ Health

perceived lack of seriousness, low chances of conviction, not wanting the perpetrator to go to prison, and fear of making things worse or being blamed themselves, are all reasons why victim-survivors may choose not to report SV (Dine, 2022; Kingi & Jordan, 2009; Ministry of Justice, 2021b; Morris et al., 2003; New Zealand Law Commission, 2015; Orchowski et al., 2022; Strang, 2020). Furthermore, given social attitudes and understandings of SV, victim-survivors may not recognise their victimisation as a crime (Arnold, 2022, February 16; Ministry of Justice, 2021a; Strang, 2020). When victim-survivors do report SV, poor experiences often result in a hesitancy to seek further support, with some researchers reporting that almost half (46%) of victim-survivors express dissatisfaction and many find the process of reporting to police to be traumatic (Campbell & Raja, 2005; Martin & Powell, 1994; Mercer & Sten Madsen, 2015; Monroe et al., 2005; Morris et al., 2003). Furthermore, there are often unacceptable (at times debilitating) delays in responses to sexual crimes (Keenan, 2014; Ministry of Justice, 2023a). In Aotearoa New Zealand, New Zealand-Europeans are far more likely to report SV to police than Māori or Pasifika (Kingi & Jordan, 2009). The New Zealand Law Commission attributes underreporting of SV as in part due to fear and distrust of conventional responses and the limited likelihood of satisfactory outcomes (New Zealand Law Commission, 2015). Legal definitions of SV also cause issues with reporting and accessing justice. Aotearoa New Zealand legislation defines rape as non-consensual penetration of a penis into female genitalia, which is inherently problematic as it denies the fact of trans, intersex, and cis-male victim-survivors of rape (Section 128, McDonald, 2019; The Crimes Act 1961, NZ).

Secondary Victimisation

Involvement in the conventional criminal justice system commonly exacerbates victim experiences of trauma (Parsons & Bergin, 2010). Victim-survivors who have gone to trial often report significant negative impacts of the justice process above and beyond their initial victimisation (McDonald et al., 2020). The adversarial nature of conventional criminal

justice encourages offenders to deny their actions and limits validation of victim-survivor experiences and emotional harm (Curtis-Fawley & Daly, 2005; Keenan, 2014; Strang, 2001). Victim-survivors are commonly excluded or relegated to the role of “witness”, feel overlooked and secondary to offenders, and experience the system as unfair (Frazier & Haney, 1996; Herman, 2005; Keenan, 2014; McGlynn et al., 2012; Zehr, 2005). Despite progressive reforms to SV trials over the past three decades in Aotearoa New Zealand, significant concerns, particularly regarding questioning or cross-examination of victim-survivors remain (Kingi & Jordan, 2009; McDonald et al., 2020).

The victim-blaming treatment (including neglect or unhelpful actions) that victim-survivors often receive from legal, medical and community system personnel can result in secondary victimisation (also referred to as the “second rape” or “second assault”) as further traumatisation and psychological harm is induced (Campbell & Raja, 2005; Campbell et al., 2001; Kingi & Jordan, 2009; Koss, 2000; Lorenz et al., 2019; Maguire, 1991; Martin & Powell, 1994; Zehr, 2005). Secondary victimisation is positively correlated with symptoms of PTSD, psychological and physiological distress, and negatively impacts on recovery (Campbell & Raja, 2005; Campbell et al., 2001; Wemmers, 2013).

The Justice Gap

Low rates of SV convictions point to a failing for victim-survivors, referred to as the “justice gap” (Curtis-Fawley & Daly, 2005; Lonsway & Archambault, 2012). Victim-survivors report that a sense of justice is central to their recovery; as such, reluctance to report SV may indicate a lack of belief in conventional systems to provide that justice (Jülich, 2001, 2010; Jülich & Landon, 2017; Ministry of Women's Affairs, 2009). There is a high rate of attrition for SV internationally and in Aotearoa New Zealand, with only 11-13% of SV cases reported to police leading to a conviction (Daly, 2011; Ministry of Justice, 2019a, 2023a; Triggs et al., 2009). Keeping in mind that only a small proportion of SV is actually

reported (less than 10%), these low conviction rates are particularly concerning (Ministry of Justice, 2014a, 2023a; Triggs et al., 2009).

Summary: Conventional Criminal Justice System Responses to Sexual Violence

From reporting SV through to criminal trials, conventional justice processes expose victim-survivors to significant risk of further harm, with little likelihood of a satisfactory outcome (Curtis-Fawley & Daly, 2005; Kingi & Jordan, 2009). There is limited empirical support suggesting that the conventional system is effective in reducing offending or providing victim-survivors with justice (Daly, 2011; Jeffries et al., 2021; Koss, 2000).

Victim-survivors in Aotearoa New Zealand have been drawing public attention to their experiences of feeling ignored and unsupported, and what they have described as “significant failings” of the conventional criminal justice system (Arnold, 2022, February 16; Bradley, 2022, May 23; Harris, 2021, July 26; Radio New Zealand, 2022, April 12).

Justice Needs of Victim-Survivors

Understanding the justice needs of victim-survivors of SV may help bridge the justice gap seen within conventional criminal justice system responses (McGlynn & Westmarland, 2019). Victim-survivor justice needs have been reported to include: information (being kept informed throughout justice processes), compensation (practical and symbolic), emotional support, participation in justice processes (including choice, voice and empowerment), protection, perpetrator accountability-responsibility, community validation and support, and practical help in the aftermath of victimisation (Daly, 2017; Herman, 2005; Jeffries et al., 2021; Johnstone, 2011; Koss & Achilles, 2008; Maguire, 1991; McGlynn & Westmarland, 2019; Shepp et al., 2020; Wager, 2013; Wemmers, 2002). Victim-survivors are not necessarily supportive of SV perpetrators being harmed or imprisoned (Hudson, 2002; Shepp et al., 2020). Victim-survivors understand justice as a complex, nuanced, non-linear process and an ongoing experience (McGlynn & Westmarland, 2019). The WHO have recommended

conventional justice systems become sensitised to the needs of victim-survivors and offer more comprehensive and supportive justice approaches (Garcia-Moreno et al., 2005).

Chapter Two: Restorative Justice

Restorative Justice: An Alternative Approach to Justice

Social movements since the 1960s have called for changes to punitive conventional criminal justice systems, due to their concerns around the questionable benefits of the existing system, the significant (and rising) number of incarcerated people, and victim experiences of feeling side-lined and forgotten; or worse, put on trial themselves (Daly, 2008; Strang, 2001) These concerns (among others) have prompted the rise and revitalisation of alternative approaches to justice. The focus of the research in this thesis is restorative justice (RJ). Despite the emerging body of literature on RJ, most authors have referenced the same key authorities. I make no apology for in-depth reporting of these accepted authorities.

RJ can be thought of as a movement, a paradigm, or a way of thinking which questions the way society understands and responds to crime (Morris & Maxwell, 2001). Often RJ is discussed by comparing it to the more well-known retributive conventional criminal justice system. The conventional justice system understands crime as breaking the laws of the state, with offenders then consequentially punished by the state. In RJ however, the harm caused by one's actions is the central concern, therefore, restorative systems focus on acknowledging harm and creating obligations for the people responsible to make things right (Zehr, 2005). A singular definition of RJ has not been settled upon, rather RJ is commonly defined by its guiding values and processes (Carruthers, 2012; Roche, 2001). These values include the importance of centring victims in crime-response processes, focusing on reparation of harm, and enabling the personal involvement of the impacted people in justice approaches (Johnstone, 2011; Marshall, 1999; Pratt, 1996; Zehr, 2005). Characteristically, RJ processes involve victims (people harmed) and perpetrators (people responsible for harm) each with at least one supporter, meeting in a professionally facilitated RJ conference to discuss and repair the harm; with victims having the opportunity to express the impacts of their victimisation, perpetrators taking responsibility for their actions, and

participants collaboratively coming to a decision about appropriate penalties or reparations (Ministry of Justice, 2011b; Morris & Maxwell, 2001; New Zealand Police, 2016). RJ processes are flexible and take a problem-solving approach, with a focus on meeting victims' justice needs, and building (or restoring) relationships between victims, perpetrators, supporters, and the wider community (Daly, 2008; Johnstone, 2011; Marshall, 1999; Pratt, 1996; Zehr, 2005). RJ can be both an alternative or a complimentary process within conventional justice systems, and is also used outside the context of criminal justice (e.g., community responses, child protection, schools) (Carruthers, 2012; Ryan & Ruddy, 2015).

RJ allows victims to express the impacts of victimisation, question persons responsible for harm, be supported by their community, experience a sense of empowerment and meet their individual justice needs (Eaton & McElrea, 2003; Johnstone, 2011). Community involvement enables some collective responsibility taking, and acknowledgment of the social context enabling harmful behaviour, that should also be addressed (Consedine, 1995; Marshall, 1999; Pranis, 2002). The United Nations Economic and Social Council has endorsed and encouraged the use of RJ programmes in criminal justice (United Nations The Economic and Social Council, 2000). There are, of course, also limitations to RJ, including its voluntary nature, the common pre-requisite of admission of guilt, and the fact that some communities have limited resources and skills to facilitate a RJ process or respond to harm (Daly, 2008; Marshall, 1999).

RJ-type practices have been used by various cultures and people throughout history, and many restorative practices employed today are informed by indigenous and customary responses to harm (Consedine, 1995; Hyslop, 2005; Morris & Maxwell, 2001; Pratt, 1996; Zehr, 2005). A full review of the history and development of various RJ practices is outside the scope of this thesis, however it is acknowledged that many different forms of RJ are practiced around the world today including in Canada (e.g., Circles of Accountability and Support), the United States (e.g., Victim Offender Mediation), Aotearoa New Zealand and

Australia (e.g., Restorative Justice Conferences), the United Kingdom, South Africa and parts of Europe (Daly, 2001; Froestad & Shearing, 2007; McCold & Wachtel, 1998; Roche, 2002; Sherman et al., 2015; Umbreit et al., 2004; Young, 2001; Zernova, 2016).

Impacts of Restorative Justice: International Evaluations

Studies of the impacts of RJ processes on victims and offenders have been carried out internationally. These are reviewed below.

Participant Satisfaction

Research using randomised controlled trials indicate that both victims and offenders tend to report greater satisfaction with RJ than with conventional approaches (McCold & Wachtel, 1998; Poulson, 2003; Sherman & Strang, 2007; Sherman et al., 1999). The vast majority of studies report high participant satisfaction (mostly 90-100%) with restorative practices following criminal activities such as property crime, minor assault, and even severe violence and homicide (Bradshaw & Umbreit, 1998; Umbreit et al., 1999; Umbreit et al., 2004). There is, however, a self-selection bias in these studies, as both parties must agree to engaging in RJ before random assignment occurs, and between 40-60% of individuals who were initially offered RJ declined (Umbreit et al., 2004). Reviews of research involving RJ conferences have found extraordinarily high levels of victim satisfaction (Strang et al., 2006). The majority of individuals who take part in RJ (victims, perpetrators, and supporters) report being satisfied, and state they would recommend the process to others (Bolitho, 2015; McCold & Wachtel, 1998; Poulson, 2003; Sherman et al., 2015; Young, 2001). Victim dissatisfaction is most often reported within RJ when perpetrators fail to accept responsibility for their actions or meet their reparation obligations, which can result in revictimisation (Sherman & Strang, 2007).

Sense of Fairness and Justice

A greater sense of procedural justice, fairness, and of perpetrators being adequately held accountable, has been reported by both victims and perpetrators who have engaged in RJ processes, compared to conventional processes (Barnes et al., 2015; Poulson, 2003; Sherman et al., 1999; Sherman et al., 2015; Umbreit et al., 2004). Furthermore, offering RJ to offenders prior to them being charged with an offence has resulted in two to four times as many offences being brought to justice (Sherman & Strang, 2007). Australian research investigating post-sentencing RJ conferences found that the processes were able to meet the majority of victims' previously unmet justice needs (95% success rate), with the positive effects enduring over a five year follow up period (Bolitho, 2015).

Emotional Impacts for Victims

Victims of crime develop symptoms of PTSD at significantly greater rates than the general population. Reductions in PTSD symptoms have been found among individuals engaging in RJ, with victims assigned to RJ conferences in randomised controlled trials suffering significantly fewer PTSD symptoms than those assigned to conventional processes in both the short- and long-term (Angel et al., 2014; Lloyd & Borrill, 2020; Sherman et al., 1999; Sherman et al., 2015; Strang et al., 2006; Strang et al., 2013; Umbreit et al., 1999). Substantial emotional restoration has been reported by victims engaging with RJ as compared to conventional processes across crime type, social and cultural contexts, and race and nation (Sherman et al., 1999; Sherman et al., 2015; Strang et al., 2006). Victims who have engaged in RJ have been found to experience less emotional distress than those who have gone through conventional systems; reporting less anger, fear, confusion about offender motives, or desire for revenge, a greater belief that the perpetrator's behaviour had improved, and an improved ability to "get on with their lives" (Davis et al., 1980; Sherman & Strang, 2007, p. 23; Sherman et al., 1999; Sherman et al., 2015; Strang et al., 2006; Strang et al., 2013; Umbreit et al., 1999; Umbreit & Vos, 2000). Long-term (10 year) reductions in the negative

psychological and emotional impacts of victimisation have been found among individuals exposed to RJ conferences compared to controls, with about half as much anxiety around revictimisation, anger, and bitterness about the crime reported as being experienced (Sherman et al., 2015). A recent systematic review on the psychological impact of RJ on victims of crime, involving a total of 35 studies, concluded that RJ tends to have positive impacts for victims, namely a reduction in PTSD symptoms, reduced anxiety, distress, fear, and self-blame, and increased sense of empowerment, safety and self-esteem, supporting their overall psychological recovery (Nascimento et al., 2022).

Emotional Impacts for Perpetrators

Among perpetrators, engagement in RJ is associated with greater remorse and desire to make things right, and improved interpersonal and psychological functioning, compared to those in the conventional system alone (Evans et al., 2016; Kim & Gerber, 2012). RJ enables perpetrators to realise the impact of their harmful behaviour on victims and to be more likely to offer genuine apologies (Consedine, 1995; Daly, 2006; Sherman et al., 2015; Strang, 2001). Offenders (particularly violent offenders) who have participated in RJ have reported that they found the process to be fairer, that they felt greater forgiveness, and that they developed greater respect for the law compared to conventional criminal processes, with their changes in attitudes and emotions found to be long-lasting (Sherman et al., 1999; Sherman et al., 2015). People who have committed significant violent offences have reported that after engaging in RJ they have developed an increased empathy and awareness of the impact of their actions on others, as well as greater awareness of their own emotions (Umbreit et al., 1999; Umbreit & Vos, 2000).

Impacts on Reoffending

In general, offenders participating in RJ show significantly fewer reconvictions compared to controls (Evans et al., 2016; Shapland et al., 2008; Snyder & Sickmund, 2006;

Umbreit et al., 2004). Multiple meta-analyses involving random assignment have found significant reductions in reoffending following RJ in comparison to conventional processes for both adult and youth offenders, demonstrated with an up to 18-year follow up period (Bonta et al., 2006; Sherman & Strang, 2007; Sherman et al., 2015; Strang et al., 2013).. Recidivism reductions appear to be greater in RJ following violent and interpersonal crime (Sherman & Strang, 2007; Strang et al., 2013). No statistically significant findings have indicated potential criminogenic effects of RJ (Shapland et al., 2008). RJ processes also cost less in terms of convictions (including potential costs for future victims and criminal justice processes) than conventional processes, with seven UK based studies reporting an eight-fold benefit in crime reduction cost compared to the cost of hosting the RJ conferences (Shapland et al., 2008; Sherman & Strang, 2007; Strang et al., 2013).

Restorative Justice in Aotearoa New Zealand

Significant social and political changes in Aotearoa New Zealand between the 1960s and 1990s, including a rise in neoliberalism, globalism, and resurgence of Māori cultural consciousness and resistance, provided the backdrop for the development and authorisation of RJ processes in the form of Family Group Conferences (FGCs) as a way to address youth offending (Mansill, 2013). FGCs are processes which address harm by bringing families of offenders and victims together to negotiate a resolution (Daly, 2001; Morris & Maxwell, 2001; Zernova, 2016). Dr Moana Jackson published a report in 1987 highlighting the endemic nature of racial bias within the conventional criminal justice system and recommending that Māori be supported to address offending in culturally appropriate ways by returning to pre-colonial practices (such as marae justice) (Jackson, 1987). This report coupled with pressure to indigenise the legal system, led to the passing of the Children, Young Persons and their Families Act in 1989 and the implementation of FGCs as an official response to juvenile offending. Now, only very serious juvenile offences are handled in the conventional justice system, while all others are referred to FGCs. FGCs were purported to

have origins in Māori customary practices (Consedine, 1995; Pratt, 1996), however, they were not intended to replicate processes that occur on marae⁸ or within whānau hui⁹, nor were they constructed by Māori or with RJ in mind (Mansill, 2013). As such, FGCs attempt to offer more culturally appropriate justice processes, rather than to re-establish indigenous models of pre-colonial justice (Mansill, 2013; Morris et al., 1993). FGCs are reported to work well in the youth justice system, with resolution agreements reached in 90% of cases (Consedine, 1995; Morris & Maxwell, 2001).

Incorporation of RJ principles with adult offenders began in the 1990s and were formalised with the passing of various legislation (notably the Sentencing Act 2002, Parole Act 2002, Victims' Rights Act 2002, Corrections Act 2004) (Carruthers, 2012; Mansill, 2013; Ministry of Justice, 2011b). Several pilot schemes diverting adult offenders to RJ conferences instead of court, proved to be effective in reducing both reoffending and the financial costs associated with justice processes (Ministry of Justice, 2019b). RJ processes are now available at several stages of the justice system process, including as part of a diversion process, pre-sentencing following admission of guilt, and post-sentencing as part of parole and community reintegration. The Sentencing Act and the Victims' Rights Act were both amended in 2014, and cases that meet the criteria set out in the legislation (see Sentencing Act 2024 s24A) must now be adjourned pre-sentencing and referred to RJ. Further, RJ processes must be considered within sentencing and parole decisions, and criminal justice professionals should be aware of and willing to enable RJ (Eaton & McElrea, 2003; Ministry of Justice, 2011b). This has put Aotearoa New Zealand in quite a unique position with RJ mandated by law. The most common RJ practices in Aotearoa New Zealand are funded by the government, occur before criminal sentencing, and are run by community groups called restorative justice

⁸ Māori meeting house

⁹ Family meetings

providers. Cases involving family harm or sexual violence are referred to specialist RJ providers (Jülich & Bowen, 2015; Ministry of Justice, 2011b).

RJ is not defined by Aotearoa New Zealand legislation, acknowledging that it is a developing concept, however, a hui¹⁰ in 2002 identified the values of RJ as “respect, humility, honesty, justice, whanaungatanga,¹¹ and aroha¹²” (Eaton & McElrea, 2003, p. 4; Ministry of Justice, 2011b). Several core values of RJ are highlighted by the Aotearoa New Zealand Ministry of Justice (2011b), including collaboration, truthfulness, developing relationships, creating safe spaces, showing respect (upholding mana/dignity), enabling self-determination and having empathy for others. Six principles are outlined for best practice; voluntary participation (with ongoing informed consent), victim and offender centrality, comprehension allowing for participation, offender accountability (accepted responsibility), flexible and responsive processes, and safe processes (Ministry of Justice, 2011b). These values and principles are taken as defining RJ as it is explored within this thesis. RJ fits well within the culture and context of Aotearoa New Zealand as, broadly speaking, Māori cultural values and customs align well with RJ values and practices (Carruthers, 2012; Ministry of Justice, 2019b). This indicates that RJ can often offer a more culturally appropriate way to respond to the harm caused by crime, than conventional criminal processes (Ministry of Justice, 2013).

RJ is arguably still underused in the adult justice system, with only around 6% of all eligible cases referred to RJ (Internal communication as cited by New Zealand Police, 2016). Use of RJ does appear to be increasing, with 2015 court records showing 1,569 pre-sentence RJ conferences completed, a number which increased to 3,500 in 2016 (New Zealand Police, 2016). Benefits of RJ highlighted by the Aotearoa New Zealand Police (2016) include a

¹⁰ Meeting

¹¹ Relatedness

¹² Love and caring

reduction of reoffending, cost-efficiency of processes (especially compared to court processes), and benefits for victims.

Evaluations of Restorative Justice: Aotearoa New Zealand

Within Aotearoa New Zealand, an evaluation of a RJ pilot study found that victims who participated in court-referred RJ conferences reported an increased sense of resolution and satisfaction compared to those who only engaged in the conventional system (Morris et al., 2005). Around three-quarters of victims felt the offender had understood the impacts of their offending, around two-thirds felt offenders had shown genuine remorse and been held accountable, and almost all victims reported having their needs at least partly met through outcome agreements. Most Māori and Pacific participants stated RJ processes had met cultural needs and many victims stated they would recommend or engage in RJ conferences again (Morris et al., 2005). Within this pilot study, offender reconviction rates were lower among those who engaged in RJ (32% vs. 36%), particularly among medium-high risk offenders, those who had been previously convicted, or those who had committed interpersonal crimes. Offenders reported satisfaction with the RJ process and were more likely to find agreements fair (Morris et al., 2005). Further research has found that in comparison to similar offenders who did not engage in RJ, offenders who participated in RJ conferences showed a lower rate of reoffending (i.e., 15% lower rate over the following 12 months, and a 7.5% lower rate over the following three years), committed fewer offences per offender (i.e., 26% fewer over the following 12 months, 20% fewer over the following three years), showed a 17% reduction in the likelihood of committing a high-level offence in the following 12 months (with a 10% reduction over the following three years), and were less likely to be imprisoned due to reoffending (i.e., 37% less likely in the following 12 months, 29% less likely over three years) (Ministry of Justice, 2011a, 2014b, 2016a). RJ was found to be as effective in reducing reoffending rates for Māori as non-Māori, and more effective in reducing the number of offences committed per offender for Māori (i.e., Māori engaging in

RJ committed 37% fewer offences in the following 12 months and 23% fewer over the following three years than comparable Māori offenders who did not engage in RJ; whereas non-Māori committed 18% fewer offences per offender within 12 months and 22% less over three years than comparable non-Māori offenders) (Ministry of Justice, 2011a, 2014b, 2016a).

Several RJ victim satisfaction surveys have been conducted in Aotearoa New Zealand (Gravitas Research and Strategy Ltd, 2018; GravitasOPG, 2021, 2023; Ministry of Justice, 2011c, 2016b). The most recent of these, conducted in 2023, found that the majority of victims were satisfied with their RJ conference and overall experience of RJ (79%), with 84% being likely to recommend RJ to others, and 67% reporting they felt better after the process (GravitasOPG, 2023). These findings align with those of earlier satisfaction surveys, which also found that most victims were satisfied with their RJ conference (82-86%) and the overall RJ process (77-84%), would recommend RJ to others (80-84%) and felt better afterwards (64-74%) (Gravitas Research and Strategy Ltd, 2018; Ministry of Justice, 2011c).

Restorative Justice and Risk

Research in the field of RJ generally indicates that there is a very low risk of harm to victims and communities (given reductions in reoffending). Evidence of negative impacts of RJ are rare and weak (i.e. statistically insignificant) and primarily related to offender recidivism rather than direct negative impacts on victims (Sherman & Strang, 2007).

However, a minority of victims who engage in RJ conferences are dissatisfied with their experiences and there is a risk of emotional harm or even revictimisation occurring within RJ processes (Morris et al., 1993; Sherman & Strang, 2007; Sherman et al., 1999; Strang, 2001; Strang et al., 2006). Within the most recent RJ victim satisfaction survey in Aotearoa New Zealand, around 10% of respondents reported being dissatisfied with their RJ conference or indeed the whole process, 10% reporting feeling “slightly” to “a lot” worse following the conference, and 8% stated they would be unlikely to recommend RJ to others (GravitasOPG,

2023). This risk of harm and possibility of feeling dissatisfied or worse off following RJ, implies that RJ and SVRJ is not suited to all circumstances or cases (Cheon & Regehr, 2006). The importance of good practice within RJ, including consideration of risks and implementation of strategies to manage these, is highlighted by survey evidence from Aotearoa New Zealand which shows negative outcomes are more likely for victims if RJ is poorly run, particularly if victim-survivors feel their concerns or questions are not taken seriously, if facilitators are not perceived as universally fair or do not follow-up with victim-survivors following the process, or if the offender does not complete the agreed upon reparations (New Zealand Police, 2016). Furthermore, international research shows victim dissatisfaction is more likely if victims are pressured to engage, do not have sufficient support to feel safe, perpetrators do not accept responsibility, and victims are not sufficiently informed about the process (Wemmers, 2002; Wemmers & Canuto, 2002).

Chapter Summary

In summary, research over the past few decades internationally and within Aotearoa New Zealand indicates that RJ results in greater victim and offender satisfaction with justice processes, has positive psychological impacts, and reduces rates of reoffending (Morris et al., 2005; Nascimento et al., 2022; Sherman & Strang, 2007). RJ may be able to offer justice and meet the needs of victims, while providing benefits for victims, perpetrators, and the wider community in ways that conventional justice processes cannot (Bolitho, 2015). However, it is also acknowledged that there are risks inherent in RJ, most notably the risk of causing further harm to victim-survivors.

Chapter Three: Sexual Violence Restorative Justice

The European Union Directive on the rights, support and protection of victims of crime states victims who chose to engage in RJ should have access to services which are delivered by competent providers and are safe to participate in (European Union, 2012: art. 12). There is, however, no consensus regarding the range of offences RJ can be unproblematically applied to, and the use of RJ following SV (SVRJ) is still a contentious topic (Hudson, 2002; McGlynn et al., 2012). SVRJ is not common practice, only officially recorded in a handful countries to date, however may often occur “under the radar” given the limitations of conventional responses to SV (Gang et al., 2021; Keenan et al., 2016; Mercer & Sten Madsen, 2015). Within Aotearoa New Zealand, SVRJ is offered through court-referred processes and also occurs within some community spaces to address SV outside of the conventional criminal justice system, including within universities (Jülich et al., 2010; Lindsey, 2017; Pointer, 2019).

Sexual Violence Restorative Justice Internationally

SVRJ occurs in a handful of jurisdictions around the world. A review in 2008 identified only four programmes in the world offering SVRJ (Koss & Achilles, 2008), while a more recent review reported at least 17 programs offering RJ processes following family or sexual violence (Gang et al., 2021). Across these programmes, only one evaluative study (that by Koss, 2014, discussed below) was identified within a systematic review (Gang et al., 2021).

Among European countries there is considerable variance in the use of restorative practices following SV, from some countries with well-established practices, to others where it is banned (Keenan et al., 2016). In the UK, best practice guidance states only highly skilled, preferably senior, restorative practitioners should manage sensitive and complex cases (including SV), and such cases should be subject to rigorous risk assessment, only

proceeding when practitioners are confident they can manage participant safety (Restorative Justice Council, 2011).

In the US, RESTORE (Responsibility and Equity for Sexual Transgressions Offering a Restorative Experience) was a RJ programme using community conferencing as a response to specified sexual offences (first-time nonpenetration or minimal force sexual offences referred through police), which began in Arizona and operated between 2003 and 2007 (Koss et al., 2003). An empirical evaluation of 22 cases completed through RESTORE was completed by Koss (2014). Participants within this research reported finding the SVRJ processes safe and experiencing satisfactory outcomes from them. Most participants (>90%) reported they felt sufficiently prepared, safe, listened to, supported, respected, and treated fairly. Victim-survivors who attended their conferences reported 100% satisfaction, as did their supporters, and over 90% of participants reported the conferences as being a success (Koss, 2014). Over 90% of all participants reported they would recommend RESTORE to others (Koss, 2014). Almost all consented conferences were completed (91%; 20 out of 22), with 80% of offenders completing the entire programme. These high rates of conferences and completed reparation agreements are in contrast to the 75% of cases in the criminal system which were closed with *no* repercussions. Victim-survivors who engaged in RESTORE rather than conventional justice systems were therefore far more likely to receive validation and witness offender accountability (Koss, 2014). A pilot study of community-based SVRJ in Australia also found support for SVRJ, as processes were able to meet victim-survivor justice needs, and all participants stated they would recommend the process to others (given they were fully informed and well-prepared to engage) (Bolitho & Freeman, 2016; Loff et al., 2019).

International Evaluations

SVRJ has promising effects of reducing reoffending and may be better able to meet victim-survivor needs than conventional criminal justice responses (Cheon & Regehr, 2006;

Curtis-Fawley & Daly, 2005; Daly, 2011; Jeffries et al., 2021). Critical analysis of SV justice responses suggest that restorative practices are better grounded in psychological theory, offer greater opportunity for emotional restoration and better support victims due to the flexible and non-adversarial approach (Koss, 2000; Parsons & Bergin, 2010; Strang, 2001; Wemmers, 2002). Benefits of SVRJ include the opportunity for victim-survivors to talk about their experiences (including asking questions and receiving answers), receive validation, and to collaboratively engage in finding solutions, all of which can improve survivors' sense of empowerment, safety, assertiveness and self-esteem while reducing common negative cognitions of guilt, blame, helplessness and fear (Curtis-Fawley & Daly, 2005; Freshwater et al., 2002; Hadar & Gal, 2023; Jeffries et al., 2021; Klar-Chalamish & Peleg-Koriat, 2021; Koss & Achilles, 2008; Mercer & Sten Madsen, 2015; Miller et al., 2020; Peleg-Koriat & Klar-Chalamish, 2020; Wager, 2013). Furthermore, victim-survivors report benefits in terms of building understanding and (re)connection with family or communities, and even perpetrators, who may only come to recognise the impacts of their actions through SVRJ (Klar-Chalamish & Peleg-Koriat, 2021; McGlynn et al., 2012; Wager, 2013). The insight perpetrators may gain from being held accountable in SVRJ, as well as their active involvement in determining restitution agreements, can help to reduce the likelihood of reoffending, and increase the likelihood that restitution agreements will be honoured, above and beyond conventional court orders (Marshall, 1999; Umbreit et al., 2004; Zehr, 2005). The community involvement within SVRJ can also help address survivor feelings of alienation or isolation, and reduce societal support for violence, as myths and misconceptions are challenged (Jeffries et al., 2021; Keenan, 2014; Koss, 2000; Pranis, 2002). SVRJ processes tend to be more efficient, more effective in reducing recidivism and are much less likely to be revictimising experiences than conventional justice processes (Daly, 2006). The flexible nature of RJ means processes can be victim-survivor-led and responsive to the needs of those

involved, enabling more context-specific and culturally appropriate justice responses (Curtis-Fawley & Daly, 2005; Jeffries et al., 2021).

International Opinions

Despite the promising evidence around SVRJ, the appropriateness of using RJ following SV continues to be debated internationally, with varying opinions, concerns and support reported (Curtis-Fawley & Daly, 2005; Jeffries et al., 2021; Miller et al., 2020). While most victim advocates, RJ and related professionals, and the general public show support for SVRJ, they also have significant concerns about potential risks within SVRJ (Curtis-Fawley & Daly, 2005; Keenan, 2014; Miller et al., 2020; Peleg-Koriat & Klar-Chalamish, 2020). Concerns around SVRJ most commonly relate to risks to victim-survivor safety within informal processes, likely power imbalances, the possibility for victim-survivors to feel pressured to engage or behave in certain ways, and the potential for revictimisation (Curtis-Fawley & Daly, 2005; Jeffries et al., 2021; Miller et al., 2020; Proietti-Scifoni & Daly, 2011).

Sexual Violence Restorative Justice in Aotearoa New Zealand

Aotearoa New Zealand Opinions and Debate

Aotearoa New Zealand currently has legislative support for SVRJ, and a recent Aotearoa New Zealand Law Commission (2015) review into SV responses concluded that further development of alternative justice mechanisms was needed in order to better support victim-survivors. Despite this, opinions on the appropriateness of SVRJ in Aotearoa New Zealand are varied (Strang, 2021). In research by Proietti-Scifoni and Daly (2011) 32% - 53% of opinion leaders interviewed had some degree of concern about the ability of SVRJ to ensure victim-survivor safety. This concern may in part originate from the lack of a standardised process for SVRJ risk assessment and management. In contrast, research involving the perspectives of victim-survivors, community service providers and criminal

justice groups in Aotearoa New Zealand have found support for the use of SVRJ and a desire to see this become a more prominent and accessible option (Jülich, 2001; Mossman et al., 2009). Participants with direct experiences of RJ have been found to be more supportive of SVRJ (Proietti-Scifoni & Daly, 2011). In 2020, Aotearoa New Zealand's Minister for Justice at the time, Andrew Little, acknowledged the need for improved services to support victim-survivors, stating he "wanted to see further work on restorative justice processes for sexual violence cases" (Strang, 2020).

Aotearoa New Zealand Practice and Evaluation

Project Restore is an incorporated society in Aotearoa New Zealand, created in 2004 which facilitates SVRJ processes for people referred through the district court system or from the community. Currently, Project Restore is the only organisation to which the Ministry of Justice refer people for court-referred SVRJ in Aotearoa New Zealand (Proietti-Scifoni & Daly, 2011). The development of Project Restore was directed by victim-survivors, and inspired by the research of Associate Professor Shirley Jülich (2001), the RESTORE programme (Koss et al., 2003), and the work of counsellors at Auckland Sexual Abuse Help (Jülich et al., 2010). Project Restore aims to provide a sense of justice to victim-survivors, help perpetrators grasp the impact of their actions, and facilitate the development of a plan to help them all move forward which often includes reparations for victim-survivors and support or treatment for perpetrators (Jülich et al., 2010).

In 2017, twelve cases of court-referred SVRJ processed through Project Restore were analysed retrospectively using Daly's (2014) Victimisation and Justice Model to examine the justice experiences of victim-survivors (Jülich & Landon, 2017). The study reported that most victim-survivors achieved their desired outcomes, all were able to tell their stories and be heard, most received desired validation, all received desired vindication, and most achieved desired accountability. Desired outcomes for offenders and supporters involved in the SVRJ were also mostly achieved, including making amends, apologising, facilitating

whānau reconciliation and having input into sentencing and treatment agreements (Julich & Landon, 2017). It is interesting to note that five of these reviewed SVRJ cases appeared to influence the sentences offenders were given, with judges ordering incarceration periods within the lower end of the acceptable sentencing range, which may have been due to the remorse and responsibility expressed by the offenders. This was calculated as a financial saving of almost \$60,000 NZD per case (Julich & Landon, 2017).

Recently, an evaluation of the experiences and perspectives of people who engaged in SVRJ through Project Restore was conducted by Julich et al. (2024). This study found that within the SVRJ process, most victim-survivors reported being able to ask their desired questions (97%), receive answers to their questions (91%), have a satisfactory level of input into the process (91%), feel the perpetrator had listened (or somewhat listened) to their stories (97%), and that their needs were considered within restitution agreements (85%) (Julich et al., 2024). Most victim-survivors reported that the perpetrator had offered an apology for the harm within the SVRJ process (91%); however, victim-survivors also indicated that not all perpetrators admitted their wrongful actions or were able to offer an explanation for their behaviour. Upon reflection, most victim-survivors reported gaining a “sense of closure” (91%) and/or a “sense of justice” (81%). However, of note, around half of the victim-survivors (43%) reported the perpetrator engaged in minimisation of the SV during the SVRJ process.

In terms of the perpetrators of harm, most (95%) reported a desire to take accountability for their actions and the harm caused and felt that they had done so within the SVRJ process. Most perpetrators reported the SVRJ process as being their most satisfying justice process (89%), and indicated they felt supported by the SVRJ professionals throughout the preparation (100%), during the process (95%) and afterwards (90%) (Julich et al., 2024). Overall, participants were noted to primarily have positive experiences and perspectives about their SVRJ processes and engagement with Project Restore.

Risk in Sexual Violence Restorative Justice

Both internationally and within Aotearoa New Zealand there is evidence supporting the use of SVRJ, but there are also significant concerns around risks associated with SVRJ. Risks within SVRJ refer to “restorative risk”; factors that have the potential to cause further harm for those involved in a RJ process. In terms of restorative risks, victim-survivor physical and emotional safety before, during and following RJ processes are the primary concern (Mercer & Sten Madsen, 2015). Risks within SVRJ include the possible retraumatisation of the victim-survivor; a considerable risk with potential for substantial negative impacts, which may occur due to potential power imbalances, minimisation or denial of harm, manipulation of processes, or experiences of pressure to engage in the processes or behave in certain ways (e.g. accept an apology they judge as insincere) (Cheon & Regehr, 2006; Curtis-Fawley & Daly, 2005; Daly, 2006; Hudson, 2002; Jeffries et al., 2021; Jülich et al., 2024; Mercer & Sten Madsen, 2015; Miller et al., 2020; Peleg-Koriat & Klar-Chalamish, 2020; Redman, 2019). Individuals and communities involved in SVRJ processes may hold mixed loyalties or unsupportive beliefs, which could result in the expression of harmful perspectives or justifications of the abuse, reinforce victim-blaming, and lead to revictimisation (Cheon & Regehr, 2006; Curtis-Fawley & Daly, 2005; Daly, 2006; Mercer & Sten Madsen, 2015). The social consequences beyond the SVRJ process itself should also be considered, which could include division of, or rejection from communities, families, or peer groups (Mercer & Sten Madsen, 2015).

Despite the substantial possible benefits detailed earlier, SVRJ has not become widely used around the world given the serious nature of both the offences in question and the potential risks to victim-survivors (Proietti-Scifoni & Daly, 2011). These concerns highlight the importance of approaching SVRJ with caution, and the need to carefully consider what must occur in order to offer safe practice in what can be considered “a risky operational environment” (Mercer & Sten Madsen, 2015, p. 13). However, it is important to appreciate

that while victim-survivor safety must be taken seriously, the notion of protecting survivors may perpetuate a stereotype of victim-survivors being weak and unable to take control of processes themselves. It is therefore important to reflect upon how to manage risk within the context of each individual case (Wager, 2013). In 2015, the Aotearoa New Zealand Law Commission declared that a future in which all victim-survivors are supported to experience justice would involve various options of processes, including conventional criminal justice, RJ, and other alternatives. The determination of the best justice pathways may require careful risk assessment, considering suitability for SVRJ, rather than just eligibility (Bolitho & Freeman, 2016). Currently, risk in SVRJ in Aotearoa New Zealand is managed through best practice guidelines, discussed below.

Aotearoa New Zealand: Sexual Violence Restorative Justice Best Practice

In Aotearoa New Zealand professionals require specialist knowledge, skills, processes, and supervision to work in SVRJ, and must work within a team (Curtis-Fawley & Daly, 2005; Ministry of Justice, 2013). Careful assessment and management of risk in SVRJ is essential, and collaboration with other professionals and support services is recommended (Jeffries et al., 2021; Koss, 2010; Ministry of Justice, 2011b, 2013). A recent scoping review into SVRJ best practice involving 15 articles, identified four components to best practice including an initial referral and intake period, a preparation period, a conference period and finally a period of accountability and reintegration. Within the first two periods, a process of risk assessment is undergone, involving informing participants about SVRJ and assessing the appropriateness of SVRJ, however, no use of standardised risk assessment guidelines were documented within this review (Burns & Sinko, 2023).

Court-referred SVRJ at Project Restore is guided by the Ministry of Justice's best practice principles, using a "three-legged stool" model of RJ conferencing involving a clinical team comprised of a survivor specialist, a harmful sexual behaviour specialist, and a trained RJ facilitator, who receive supervision from a clinical psychologist (Julich et al.,

2010; Ministry of Justice, 2011b; Morris et al., 2005; Project Restore NZ, 2005). Once a SVRJ referral is accepted, pre-conference assessment meetings are arranged. These meetings involve the SVRJ professionals meeting with participants and their support people, as appropriate. Participants receive detailed information about SVRJ, including discussion about the possible outcomes and risks. At least three pre-conference meetings are usually conducted, guided by the readiness of participants (Jülich et al., 2010). Professionals must decide whether to proceed with SVRJ or not. This typically involves consideration of several assessment criteria including both victim-survivor and perpetrator motivations, expectations, understanding of the SV, perpetrator demonstration of responsibility (admitted guilt), and possible cognitive distortions. However, standardised risk assessment guidelines for SVRJ have not yet been fully constructed and implemented within SVRJ practice.

The SVRJ process is planned collaboratively and usually involves the person harmed (victim-survivor), the person responsible for harm (perpetrator), support people for both, the two specialists, and the facilitator. Victim-survivors may opt to use a surrogate; meaning a third party would stand in for the victim-survivor during the SVRJ process (referred to as a panel rather than a conference). During the conference, the professionals are continually monitoring participants and will intervene as required to avoid possible revictimisation. Subsequently, post-conference meetings are offered and conducted based on participant needs. If offenders fail to enact the agreed actions, the case returns to court, or SVRJ professionals support the victim-survivor in pursuing appropriate action.

Within SVRJ the emotional and physical safety of victim-survivors is the top priority. To prevent harm or revictimisation from occurring, facilitators have in-depth knowledge of the impacts and the dynamics of SV (including power imbalances), and rape myths present within society, which enable them to be cognisant of survivor vulnerabilities, and challenge distorted views or respond to possible manipulative techniques (e.g. denial or victim-blaming) (Jülich, 2001; Jülich et al., 2010; Jülich et al., 2011). SVRJ professionals are

impartial, but not neutral as wrong-doing has been acknowledged and perpetrators are being held to account. Professionals treat participants fairly, but not equally, in acknowledgment of the differences in power and experiences between the victim-survivor and the perpetrator of harm (Jülich, 2010; Jülich & Thorburn, 2017; Quinn, 2019). Flexibility through the preparation and SVRJ processes, including ongoing consultation and collaboration allow SVRJ professionals to be actively responsive to the needs of participants (Jülich et al., 2010). Professionals also engage in careful pre-conference assessment and education of SVRJ supporters to manage risk of unhelpful beliefs or perspectives around SV (Jülich, 2001). If a potential SVRJ cases is assessed as being too risky it does not go ahead.

Hudson (2002, p. 631) argued that aspects of conventional justice systems such as “due process safeguards and standards” should be incorporated into RJ to better offer justice to victim-survivors of SV. Standardised risk assessment guidelines could play an important part of these safeguards. Much of the literature calls for SVRJ to be done in ways that ensure victim safety, with careful risk assessment and management, yet there is a lack of evidence and resources which specify how that risk can be assessed. This is where the current research hopes to contribute to improvements in SVRJ practice.

Chapter Four: Assessing Risk

Risk and Risk Assessment

Risk is defined in the Oxford Dictionary of English as a situation involving exposure to danger or a possibility that something unpleasant or unwelcome will happen (Soanes & Stevenson, 2005). Risk assessment is a process whereby the probability of an event or outcome occurring is estimated using available secondary information (risk and protective factors), known to have some form of relationship with the outcome variable. Risk factors increase, and protective factors decrease the likelihood of an undesirable outcome. Such factors may be static (historical, less likely to change e.g., age, ethnicity, gender) or dynamic (more changeable e.g., mental state, living situation, stressful life events) (Allnutt et al., 2010; Gottfredson & Gottfredson, 1988). As assessing risk relies on estimating the likelihood of a future event occurring, it is inherently uncertain (Hanson, 2009). Both risk and risk assessments are social constructs, however “they have significant practical and emotional implications” particularly in relation to risk of harm (Gulliver & Fanslow, 2015; Hoyle, 2008, p. 323). Risk assessment and management is integral to limiting harm, therefore assessment processes should be evidence-based, transparent, and of a high standard (Allnutt et al., 2010; Gulliver & Fanslow, 2015; Tower, 2009; Vaithianathan et al., 2012). As for any kind of clinical assessment, information should be gathered from as many sources as possible, including clinical interview with the individual being assessed and any collateral informants (e.g., relatives, friends, professionals involved with the individual), review of the individual’s records (medical, psychological, educational, criminal etc.), and consideration of the situational context (Allnutt et al., 2010). Risk assessment frameworks support reliable assessment and can provide common language for communicating risk (Gulliver & Fanslow, 2015).

Important Considerations in Risk Assessment

There are several important considerations that can contribute to accurate risk assessment discussed in the literature. First, there should be careful consideration of the perspectives involved in risk assessment (Gulliver & Fanslow, 2015). Research indicates that risk assessments following crime should centre the victim's perspectives and perceptions of possible future harm, which show good accuracy and can greatly improve risk predictions, especially when victims trust the assessment process and the assessor (Bowen, 2011; Gulliver & Fanslow, 2015; Jenney et al., 2014). What "risk" is, and which risks are most pertinent to an individual will differ based on their perspective and situation; for example, in an instance of family harm a victim may minimise impacts of their victimisation, for fear of losing access to their children. This can make objective risk assessment difficult, and hence the perspectives of all involved in assessment should be carefully considered (Jenney et al., 2014). Culture must also be taken into consideration, and evaluators should be aware of the beliefs, perspectives, and experiences of different cultural groups. Assessors can work towards ensuring they are adequately considering the impacts of culture by engaging in ongoing professional development, cultural supervision, and cultural competency training. Professionals making risk assessments need to hold a clear understanding of their own cultural beliefs and practices, in order to be aware of the perspectives that they themselves are introducing to the assessment (Brissett-Chapman, 2000; Smith, 2001).

Due to the changing nature of risk and dynamic risk factors, risk assessment must be an ongoing process, responsive to changing risk factors and profiles. Ongoing assessments are also important as the relationship between the individual being assessed and the assessor develops, as people commonly disclose different information within the context of a trusted relationship, which they may not reveal initially (Allnutt et al., 2010; Gulliver & Fanslow, 2015). The reliability (i.e. stability) and validity (i.e. accuracy) of risk assessments rely on the accuracy of information upon which assessments are based, therefore this must be carefully

considered (Gulliver & Fanslow, 2015). As stated by Gottfredson and Gottfredson (1988, p. 305) “No prediction can be better than the data upon which it is based.”.

Risk Assessment Approaches

The three broad approaches to risk assessment; unstructured professional judgment, actuarial measures, and structured professional judgement are described and discussed below.

Unstructured Professional Opinion

Unstructured professional opinion refers to risk assessments made through professional judgement alone. There are no guidelines, no specific risk factors of pre-established significance, no methods of combining those risks, and no standardisation of decisions (Hart et al., 2016). Risk factors may or may not be noted, however no formal approach is used to assess and interpret risk information. Instead, professionals base judgements on their own opinion or intuition, often guided by professional experience (Allnutt et al., 2010; Monahan, 1981; Mulvey & Iselin, 2008). The main benefit of this approach is the flexibility for the assessor, who can decide what information to consider and how important they deem that information to be. This flexibility facilitates idiosyncratic risk assessment and management plans (Allnutt et al., 2010; Douglas et al., 2013; Gottfredson & Gottfredson, 1988; Hart et al., 2016).

However, this approach shows very poor reliability and validity and is not well supported by empirical evidence due to the strong likelihood of subjectivity and cognitive bias (particularly confirmation bias), as predictions tend to be based on largely salient features and tend to ignore powerful predictive factors, which can thereby introduce significant sources of error (Allnutt et al., 2010; Carroll, 1977; Gottfredson & Gottfredson, 1988; Grove & Meehl, 1996; Hart et al., 2016; Kropp, 2004; Monahan, 1981). Professional judgment has been shown to be highly inaccurate, lacking in objective reliability and validity, subject to inconsistencies between assessors, and providing poor predictive efficacy (Allnutt

et al., 2010; Grove & Meehl, 1996; Guy et al., 2015; Hart et al., 2016; Kropp, 2004; Quinsey & Ambtman, 1979). Further, neither experience nor professional training appears to impact the accuracy of such predictions (Blenkner, 1954; Grove & Meehl, 1996; Quinsey & Ambtman, 1979). The unstructured professional judgement approach to risk assessment also lacks transparency, as the factors which have been considered and how conclusions have been reached may or may not be recorded, raising significant ethical and legal issues, as quality assurance and review of an assessor's decisions are limited (Douglas et al., 2013; Gottfredson & Gottfredson, 1988; Guy et al., 2015; Hart et al., 2016).

Unstructured professional opinion is the least accurate risk prediction approach and practitioners have been advised to move away from this (Hanson, 2009; Harris et al., 2015). Nevertheless, despite poor evidence and instances where this approach is considered unsuitable, it is still commonly employed (Gulliver & Fanslow, 2015; Jackson & Hess, 2007; Kropp, 2004; Mulvey & Iselin, 2008; Scottish Executive, 2000).

Actuarial Risk Assessment

Actuarial risk assessment is a contrasting risk assessment approach to that of unstructured professional opinion, which involves the use of specific tools incorporating statistical models and pre-specified risk factors, to predict risk. The presence of risk factors with empirically supported statistical relations to the outcome of interest allow for a risk score to be calculated, indicating a level of risk (e.g. high, moderate, low risk) present for the individual, and enabling broad predictive statements to be made (e.g. people with a "low level" of risk generally have a low probability of the outcome of interest occurring) (Allnutt et al., 2010; Tower, 2009). Actuarial approaches use pre-fixed, consistent, systematic methods, and allow risk probability estimates for groups to be calculated (Allnutt et al., 2010; Monahan, 1981; Mulvey & Iselin, 2008; Vaithianathan et al., 2012; Wald & Woolverton, 1990). Actuarial risk assessment is acknowledged as superior to the use of professional opinion alone, as there is a reduced potential for cognitive biases, and it shows moderate-high

reliability and moderate predictive validity (Allnutt et al., 2010; Andrews et al., 2006; Baird & Wagner, 2000; Baird et al., 1999; Bonta et al., 2001; Dawes et al., 1993; Dawes et al., 1989; Douglas et al., 2013; Dvoskin & Heilbrun, 2001; Hanson & Harris, 2001; Hanson & Morton-Bourgon, 2009; Hart et al., 2016). Actuarial assessment enables transparent, replicable, and defensible risk assessment, which is useful for monitoring or reviewing risk-related decisions (Allnutt et al., 2010; Bonta et al., 2001; Hart et al., 2016). This approach is particularly useful to screen for and identify higher risk cases as cut-off risk scores can be established, which can support resource allocation and enable targeted interventions to be employed with individuals at highest risk of negative outcomes (Coohey et al., 2013; Mulvey & Iselin, 2008).

However, there are significant limitations to the actuarial approach. Actuarial assessments commonly place a greater importance on static (unchangeable) factors rather than dynamic (changeable) factors, limiting the ability to see changes in risk over time, and providing limited information about the imminence or severity of predicted outcomes or the circumstances that may alter risk (Allnutt et al., 2010; Bouch & Marshall, 2005; Hart et al., 2016; Vaithianathan et al., 2012). Furthermore, there is a lack of attention to relative strengths or protective factors which may moderate the impact of the risk factors present (Griffin et al., 2008). Due to their pre-fixed nature, actuarial assessments are not flexible nor adaptable, and do not allow for consideration or incorporation of idiosyncratic factors impacting on the individual's level of risk (Allnutt et al., 2010; Broadhurst et al., 2010; Douglas et al., 2013; Gillingham, 2006; Gillingham & Humphreys, 2010; Hart et al., 2016). Actuarial measures are also sample dependent (all the risk factors and weightings are determined from an original sample), and can therefore only reliably and validly answer the specific prediction questions within the specific population for which they were designed and validated (as a different groups cannot be assumed to have the same characteristics) (Douglas et al., 2013; Gottfredson & Gottfredson, 1988; Hanson & Morton-Bourgon, 2009;

Vaithianathan et al., 2012). The scores derived from actuarial measures provide indications of risk group levels, rather than specific individual risk levels, and measures may not necessarily be appropriately normed with the specific populations with whom a professional is working, introducing concerns about the cultural appropriateness of measures (Hart et al., 2016; Monahan, 1981).

Reliability across actuarial measures has not been shown to be very good (Barbaree et al., 2006). Professionals commonly do not have the statistical knowledge necessary to appropriately select reliable actuarial measures, such as an understanding of the instrument's specificity, sensitivity, and the applicable base rates (Broadhurst et al., 2010; Gottfredson & Gottfredson, 1988). Actuarial methods rely on accurate application of the assessment measure and adherence to the responses determined by the measure, however assessment tools are commonly used in ways other than those specified, and workers may use clinical override, introducing systematic errors and biases (Bonta et al., 2001; Broadhurst et al., 2010; Flores et al., 2006; Gillingham & Humphreys, 2010; Hanson, 2009; Hanson et al., 2007; Lonne et al., 2009; Lyle & Graham, 2000). While the transparency of actuarial measures is beneficial in ethical and legal terms, there are also concerns that workers or organisations may come to rely on the tools to protect them from their own professional accountability (Gillingham, 2006). Despite actuarial measures being considered superior to unstructured professional judgment with their structured approach and empirical basis, actuarial methods do not always predict risk more accurately than other approaches (Bowen, 2011; Litwack, 2001; Monahan, 1981; Vaithianathan et al., 2012).

Structured Professional Judgement

Structured professional judgement (SPJ) is the integration of actuarial and clinical approaches; using both evidence-based guidelines (at times in conjunction with actuarial measures) and professional judgement together (Allnutt et al., 2010; Andrews et al., 2006; Hart et al., 2016). SPJ usually requires the assessment of risk factors which are considered in

conjunction with the assessor's knowledge of the specific case and their own professional experience, to make the full assessment of risk (Douglas & Kropp, 2002). SPJ guidelines are generally comprehensive guidelines which provide guidance and recommendations for the whole process of risk assessment, including consideration of both empirically supported risk factors and protective factors. Further, SPJ guidelines and assessments tend to be risk management-oriented, that is, focused on preventing future negative outcomes (Childs et al., 2014; Douglas et al., 2013; Guy et al., 2015; Hart et al., 2016; Kropp, 2004; New York State Office of Children and Family Services, 2017). The structure of SPJ assessment allows for less subjective and more consistent assessment, with good reliability (including good inter-rater reliability), predictive accuracy, and risk management ability (Guy, 2008; Guy et al., 2015; Hart et al., 2016; Mulvey & Iselin, 2008). Research indicates that SPJ approaches are as accurate, or more accurate, than actuarial or unstructured approaches to risk assessment (Bowen, 2011; Childs et al., 2014; Douglas et al., 2013; Guy, 2008).

The SPJ approach to risk assessment is efficient, flexible, and builds upon the examiner's knowledge and expertise; retaining the strengths of clinical approaches (e.g., unstructured professional judgement) while systematising and grounding decision-making in the empirical evidence (Guy et al., 2015; Hart et al., 2016). SPJ enables a more holistic assessment of risk than actuarial approaches allow for, as comprehensive information gathering using both assessment measures (e.g., psychometric assessments) and interviews are encouraged, facilitating consideration of the individual's context and idiosyncratic factors impacting on their risk (Allnutt et al., 2010). The risk factors detailed within SPJ guidelines tend to be broadly selected to provide comprehensive coverage, rather than statistically determined and weighted based on a particular sample. This means that SPJ models are not sample dependent, and can therefore allow for individual-specific identification of risk as well as facilitate risk management for that particular individual (Childs et al., 2014; Douglas et al., 2013; Guy et al., 2015; Hart et al., 2016). Ethically and culturally, this approach is

often favourable as clients (and their whānau) should be fully involved with the assessment, incorporating considerations of client culture and identity, and the factors which have been considered to reach decisions should be transparently recorded (Allnutt et al., 2010; Brissett-Chapman, 2000; Guy et al., 2015; Hart et al., 2016; Smith, 2001).

Concerns with the use of SPJ include the possible influence of cognitive bias; which could lead to professionals relying more heavily on the factors which are more common or those specified in guidelines, at the detriment of considering potentially less overt, idiosyncratic risk factors (Allnutt et al., 2010; Childs et al., 2014; Guy et al., 2015). Further, given the flexible, individualised nature of SPJ, inter-rater reliability is generally less than is seen with actuarial tools, and assessments may be less reliable when completed by professionals with less experience (Allnutt et al., 2010; Baird, 2017; D'Andrade et al., 2008; Kang & Poertner, 2006).

Risk Assessment in Action in Aotearoa New Zealand

A SPJ approach to risk assessment is widely recommended and used across various professional bodies within Aotearoa New Zealand, including within clinical practice and courts of law (Archer et al., 2006; Hart et al., 2016). A review of current risk assessment process in Aotearoa New Zealand within domains holding similar risks to those within SVRJ, such as mental health settings, child safety, and intimate partner violence revealed that a SPJ approach to risk assessment using risk assessment guidelines along with professional judgement, was commonly advised (Fanslow et al., 2016; Louwers et al., 2014; Ministry of Health, 1998; Ministry of Justice, 2017; New Zealand Guidelines Group and Ministry of Health, 2003; Newton et al., 2010; Oranga Tamariki Ministry for Children, 2014; Sittig et al., 2014; Woodman et al., 2010).

Several aspects important for effective SPJ risk assessment were noted within reviewed risk assessment recommendation guidelines and the wider SPJ literature. These

include taking a holistic approach to risk assessment, with professionals considering a wide range of factors, and gathering information from multiple sources using multiple methods to determine overall level of risk present (Allnutt et al., 2010; Holder, 2000). The individual being assessed should be fully involved in risk assessment and their contextual environment as well as their culture and identity should be considered, with appropriate services offered where possible (Holder, 2000). Professional decisions around the risk levels must be justified with supporting evidence (Holder, 2000). Further, decisions around risk should never be made by one person alone, and that whenever possible, senior staff and experienced professionals should be consulted and risk-related decisions made as a team (Fanslow et al., 2016). Finally, as risk is known to fluctuate, assessments should reflect this by being ongoing over time (Allnutt et al., 2010).

Risk Assessment and Restorative Justice

Risk assessments can help RJ practitioners identify situations where there is a significant risk of adverse outcomes for potential RJ participants. While broad best practice guidelines for RJ and SVRJ are available, there is a lack of standardised guidelines used to assess risk within both general RJ and SVRJ in Aotearoa New Zealand. Programmes offering RJ tend to have their own forms of risk and readiness assessment that they use, the reliability and validity of which may be unspecified and untested (Allnutt et al., 2010; Baird & Wagner, 2000; Baird et al., 1999).

In the area of family violence RJ, the Ministry of Justice have provided SPJ risk assessment guidelines. These guidelines involve checklists of evidence-based risk factors to consider in conjunction with professional judgement, to determine the overall level of risk present (Ministry of Justice, 2019c). The decision to proceed to conference or not, should then be based on victim and perpetrator risk assessment, and the overall summary of risk, with cases that proceed to conference being guided by a risk management plan (Ministry of Justice, 2019c).

An informal review of risk assessment within RJ services in Aotearoa New Zealand was carried out by the author, in which RJ providers were asked how they assessed risk. A total of nine providers responded. Most services (seven) reported using the Ministry of Justice family violence risk assessment guidelines (even for non-family harm conferences), and some had also adapted these guidelines to create risk assessment checklists (three providers) (Ministry of Justice, 2019c).

Risk Assessment and Sexual Violence Restorative Justice

In Aotearoa New Zealand, neither the Ministry of Justice nor specialist SVRJ providers have produced structured risk assessment guidelines or processes to be used by SVRJ professionals. Best practice standards are, however, available (Ministry of Justice, 2013). These standards state that screening and assessment must focus on victim-survivor safety and must assess the willingness of both parties to participate in SVRJ, the seriousness of the offence(s) in question, and the relationship between the victim-survivor and offender (including likely ongoing relationship or future contact). Several considerations around the offender's ability to participate safely in SVRJ must also be made, including their attitudes, their insight, the level of remorse and responsibility accepted, their willingness to engage in treatment and work to repair the harm caused, and any ongoing psychological needs they may have, including substance abuse and the potential of risk to themselves or others. Risk assessment considerations recommended for victim-survivors include the sufficiency of internal and external coping and support resources, ensuring the voluntary and informed nature of their engagement through a genuine desire and ability to engage in RJ, and making sure their expectations of SVRJ are reasonable. Additionally, the suitability and understanding of SVRJ supporters should also be considered. (Ministry of Justice, 2013). While best practice standards within SVRJ reduce risk, the lack of available SVRJ risk assessment guidelines results in SVRJ professionals using an unstructured professional judgement approach to risk assessment.

Risk Assessment Summary

In a hui on the critical issues in RJ in Aotearoa, “a growing need for an association to standardise ethics and administrative issues” in RJ was recognised (Jülich, 2003, p. 11). Standardisation of practices such as initial and on-going risk assessment processes would support and improve RJ practices, helping to ensure SVRJ processes proceed only when there is limited or manageable risk of harm present, and that people who access SVRJ are all equally protected and supported by standardised procedures. In their review of RJ evidence, Sherman and Strang (2007, p. 62) acknowledged that RJ is not beneficial for all victims, and stated that “at present we do not have the tools to predict for which victims RJ is likely to be beneficial and for the (probably rare) cases in which it will be counterproductive”.

Researchers and professionals within SVRJ, have called for further research into SVRJ, and the further development of best practice and risk assessment guidelines (S. Jülich, personal communication, March 3, 2021, Burns & Sinko, 2023; Jeffries et al., 2021; Jülich et al., 2010; Redman, 2019). Careful risk assessments (also referred to as eligibility assessments or screening processes) within SVRJ could help manage risk to victim-survivor safety within the RJ process (Cheon & Regehr, 2006; Keenan, 2014; Miller et al., 2020). The New Zealand Law Commission (2015, p. 143) stated “there are currently no mechanisms that are completely appropriate or readily adaptable” for risk assessment in SVRJ, and “a standardised mechanism is needed”.

Chapter Five: Methodology, Method, and Ethics

Research Aims

The reviewed evidence provides strong rationale for the relevance of the current research, which aims to explore professional perspectives on SVRJ risk assessment, from which SVRJ risk assessment guideline recommendations can be developed. The research will look at professionals' approach towards risk assessment and ask what they consider within assessments to develop an understanding about possible risk. The particular factors that professionals include within their SVRJ risk assessments, including what they believe increases or decreases the likelihood of a negative outcome and aspects they highlight as important to consider when making risk-related decisions, will be investigated. SVRJ risk assessment guideline recommendations will then be constructed, informed by the insights of these professionals.

This research hopes to contribute to the wider SVRJ literature knowledge base by exploring professional opinions, perspectives, and experiences of SVRJ risk assessment. Further, the research hopes to improve SVRJ practice by providing a basis for further development, refinement, and implementation of standardised risk assessment processes. SVRJ risk assessment guidelines would facilitate more reliable, valid, and standardised assessments of risk within SVRJ, by enabling a structured professional judgement (SPJ) approach to risk assessment. There is also a hope that this research, alongside the ongoing work of SVRJ professionals and academics, contributes towards increasing public awareness of, and therefore the occurrence of SVRJ in appropriate cases; enabling more people to access the benefits of a safe and well-managed SVRJ process.

To achieve the aims of the research, semi-structured interviews were conducted with professionals holding relevant knowledge and experience in the assessment of risk within RJ and, more specifically, SVRJ.

Study Design

Participants were professionals with relevant knowledge and experience of assessing risk within SVRJ and working in the areas of RJ and/or SVRJ. The interview structure was guided by the findings of the literature review, with the interview protocol being discussed below. Reflexive thematic analysis of the interview data resulted in the construction of four themes highlighting areas important within SVRJ risk assessment (presented in chapters seven – ten). Based on the findings from these interviews, and in consideration of the wider research literature, SVRJ risk assessment guideline recommendations were developed and presented in chapter eleven.

Study Design Rationale

A qualitative approach to this research was selected so that the understanding, experiences and processes of professionals in relation to SVRJ risk and risk assessment could be captured and evaluated, in a way that would likely not be possible through a quantitative approach (Denzin & Lincoln, 2013). Only a limited number of published studies investigate the perspectives and experiences of professionals, victim advocates and opinion leaders within the SVRJ field (Curtis-Fawley & Daly, 2005; Jeffries et al., 2021; Miller et al., 2020; Proietti-Scifoni & Daly, 2011). The inclusion of SVRJ professionals is a strength of the current research, helping to ensure the identification of factors relevant to risk in SVRJ, and that the risk assessment guideline recommendations are developed based on the experiences of people working in the field.

The sample size of this research could be considered relatively small, however the amount of information relevant to the research gathered from this sample of experienced professionals is high, thus the concept of information power (the more information relevant to the research a sample holds, the smaller the number of participants required) supports the assertion that this sample is sufficient for the in-depth qualitative analysis (Malterud et al.,

2016). Further, qualitative research is about discovering and understanding the dynamics and dimensions of the topic of interest (e.g., risk factors in SVRJ), and how they are understood, rather than determining exact quantities and proportionate relationships between such factors. As such, the intensity and depth of analysis, rather than the number of cases analysed, is the key to quality qualitative research (Crouch & McKenzie, 2006).

Ethics

The code of ethical conduct for research involving human participants, as described in the Massey University code of ethics was consulted to identify potential ethical issues with the proposed research project. Ethical issues identified were discussed with the co-supervisors of this research. The board of an Aotearoa New Zealand SVRJ provider were also consulted throughout the development of the research, and they expressed their support. The research project was reviewed and given ethical approval by the Massey University Human Ethics Committee: Northern, Application NOR 21/65.

Participants

Participant Recruitment

Participant recruitment began through SVRJ providers, with the research information shared with staff via email and at an online meeting. Subsequently SVRJ professionals were invited to participate via an introductory email from the researcher. Relevant professionals were contacted and invited to participate via email, based primarily on recommendations from research participants using a snowballing method. The researcher had also been conducting an informal survey of risk assessment processes used by RJ providers around Aotearoa New Zealand. This led to contact with a group who shared that they had recently re-worked the Ministry of Justice guidelines for family violence to be more applicable for their practice and felt their experiences in developing risk assessment guidelines would be valuable for the research. Three professionals from this group opted to participate in the research in a

group interview following discussion with the researcher. Two of these three professionals also had some experience working with SV in the context of RJ.

The introductory emails inviting participation explained the purpose of the research, with the relevant research information sheet and consent forms attached (see appendices A and B). Professionals who expressed interest in participating organised a time to meet with the researcher to conduct the interview, either in person or online via Zoom, depending on their preference.

Participant Details

People with professional experience in RJ or SVRJ, and relevant knowledge and experience with risk assessment in these areas were eligible to participate in this study. Initially, professional participants were only sought from within a single SVRJ provider, but as this greatly limited the available pool of potential participants an amendment was sought and approved to expand eligibility criteria to all professionals with relevant experience in the fields of RJ or SVRJ and risk assessment within these fields.

Demographic information consisting of gender and ethnic identity, and relevant professional experience was collected through the interviews. This is minimally presented in order to protect participants' identities. A total of 16 professional participants were interviewed, 10 self-identified as women, six as men. Ethnicity was reported as New Zealand European/ Pākehā or being of European descent by 13 participants, two participants were Māori, and one participant was of Asian descent. There was a significant range of experiences with SVRJ reported. Professional experience in SVRJ ranged from having been involved in one up to 400 cases of SVRJ and working in SVRJ for between one and 22 years. Several participants reported experience in developing or redesigning risk assessment guidelines for their own practice of RJ (e.g., with family violence) or SVRJ. In terms of professional experience, seven individuals had worked within court-referred SVRJ, and nine

had gained relevant professional experience within universities, community practice, in overseas jurisdictions, and/or in general RJ practice where so-called “low level” SV had been uncovered.

Semi-Structured Interview Protocol

Introduction and Interview Process

The interview process began with an introduction section. The introduction focused on building rapport and connections between the researcher and interviewee, in line with tikanga Māori¹³ and the concept of whakawhanaungatanga¹⁴. Culturally appropriate openings and closings to the sessions were offered (e.g., karakia¹⁵, blessing, whakatauki¹⁶, grounding exercises such as shared breaths). The researcher offered some background information about themselves including aspects of their whakapapa¹⁷, and self-disclosing their status as a victim-survivor, then provided space for the interviewee to share whatever background information felt pertinent to them, hoping to facilitate rapport and trust, again in line with tikanga and a feminist research approach (Reinharz & Davidman, 1992; Smith, 2001). The research objectives and rationale behind the research methods were then explained, and the upcoming full interview discussed in terms of what participation would involve. Informed consent was discussed, ensuring participant awareness of the voluntary nature, purpose, procedure, potential risks and benefits of participation in the research, and how their anonymity would be protected (Groenewald, 2004). Informed consent was verbally re-affirmed prior to beginning any recordings.

Interviews were conducted either in person or online via Zoom, depending on participant preference (and Covid-19 restrictions). In person interviews were held either in a

¹³ Correct procedures

¹⁴ Establishing relationships

¹⁵ Incantation, ritual chant

¹⁶ Proverb

¹⁷ Genealogy

private room at Massey University psychology clinic in Wellington, or at the participant's office. Online meetings were also offered as these were more convenient and comfortable for some participants. Allowing for online Zoom interviews helped facilitate participation, and qualitative interviews conducted via Zoom have been reported to be highly satisfactory (Archibald et al., 2019; McGlynn et al., 2012). Best practices for secure Zoom meetings were followed as outlined by Zoom Video Communications Inc (2021a), including use of a waiting room, randomly generated meeting IDs and passcodes, and locking of the meeting once participants had arrived. Privacy was ensured for online meetings through Zoom's end-to-end encryption involving specific cryptographic keys known to only the device of the researcher and device of the participant, which meant that third parties were unable to access these private meetings. Zoom meetings were audio and video recorded and stored with password protection in Zoom's cloud (Zoom Video Communications Inc, 2021b).

Semi-Structured Interview Protocol

The research interview schedules (see Appendix A: Professional Information Sheets) were developed by considering the broad area of SVRJ risk assessment and the factors of likely importance, as identified within the literature review. This helped to ensure that interviews covered the areas relevant to SVRJ risk assessment and participant opinions and differing perspectives on important matters in this area were gathered. Interview questions were sequenced to allow for a logical flow and phrased to ensure that questions were asked in a manner that was sensitive, open, and easily understood. Interview questions started off broad and remained open, to enable professionals to consider and discuss all of the factors that shape their assessments of risk in SVRJ, and participants were encouraged with prompts to speak freely and in-depth about their experiences and perspectives (Dicicco-Bloom & Crabtree, 2006; Smith et al., 2009). All interviews were audio-recorded and then transcribed either fully manually, or initially through Zoom or the transcription service Otter.ai, with manual checking and correction of transcription following this. Participants who had

indicated on their consent forms that they would like a copy of their interview transcript were provided with this as it came available via email. All participants were offered a grocery voucher (with a value of \$50 NZD) in acknowledgment of their time and travel reimbursement.

Data Storage

In-person data and audio files were stored on a password protected computer, with online interview recordings stored on Zoom's cloud (accessible to only the researcher) under password protection. All files and transcripts were anonymised with codes. A separate password protected document aligning codes to identities was accessible to only the researcher and main supervisor (Dr Richard Fletcher). Upon completion of the thesis all data will be sent to Dr Richard Fletcher who will ensure appropriate storage/deletion.

Data Analysis

The interview transcript data were analysed through reflexive thematic analysis (TA), an approach used to analyse qualitative data particularly focused on finding, analysing, and reporting themes or patterns within the research data (Braun & Clarke, 2022; Joffe, 2012). TA is an iterative, recursive process, where the researcher becomes very familiar with the research material through reading and re-reading of the transcripts. This process enables the researcher to look for patterns (codes) and to draw out the prominent themes present. This often involves multiple phases of revision of codes, themes and understanding (Braun & Clarke, 2022). Reflexive TA acknowledges the wider context within which research is conducted and the active role of the researcher within qualitative analysis, acknowledging that their research contexts and perspectives will inherently affect and bias interpretations. This allows for more transparent research and delivers insights into both surface level reality and deeper lived experiences (Braun & Clarke, 2022; Frost, 2011). TA can be understood as the foundation of all qualitative methods, as organising information into themes is one of few

techniques shared across qualitative methods (Holloway & Todres, 2003). Critiques of TA (and qualitative analysis more broadly) commonly centre around the idea that “anything goes” given the flexibility and historical lack of clarity around TA processes (Antaki et al., 2003). To counteract these concerns, guidelines on the use of TA were developed by Braun and Clarke (2022), aiming to clarify the processes of TA. These guidelines have shaped the analysis process of the current research. In accordance to these guidelines, the theoretical position of the research and analysis, researcher positioning (including lived experience), the analytic methods used, and any assumptions made about the data are transparently reported below to help enable research evaluation and comparisons, and facilitate future research (Attride-Stirling, 2001; Braun & Clarke, 2022; Holloway & Todres, 2003).

Analysis Considerations

This study used TA in an inductive and reflexive manner, aiming to discover themes within the data at a semantic (explicit) and latent (interpretative) level (Braun & Clarke, 2022; Ezzy, 2002). A theoretical analytical approach to analysis was applied, in which the researcher’s theoretical knowledge helped determine the importance of particular aspects of data and guide theme development, which, given that this research is driven by a specific research question of risk assessment guideline development was decided to be most applicable (Braun & Clarke, 2022). Researcher judgement (rather than strict prevalence rules) was used to identify themes, defined as patterned or meaningful responses within the data related to risk within SVRJ (Braun & Clarke, 2022). Analysis was conducted guided by the research’s feminist standpoint and post-positivist epistemology (discussed below).

Subjectivity and Interpretation in Qualitative Research

Qualitative research involves interpretation, which inherently brings an element of subjectivity. Due to the perceived inadequacy of subjectivity, psychology has historically avoided qualitative interpretation, preferring quantitative research, which was viewed as

being objective and therefore more scientific. However, over the years, this viewpoint has shifted, as it is acknowledged that quantitative analysis involves interpretation and researcher decisions, and therefore, also involves subjectivity (Willig, 2012). Nevertheless, given the subjectivity of interpretation, a self-reflective practice is necessary to gain a fuller understanding of how the raw data and subsequently developed interpretations relate to each other. In the current research the concern of subjectivity has been mitigated by the researcher ensuring that the voice of participants has maintained a central place in the research interpretations and findings (Willig, 2012).

Theoretical Position: Feminist Standpoint and Epistemology

A feminist standpoint is taken in this research, guiding how the research is conducted and how the results are interpreted and reported (Jülich, 2001). The authority of experience is central to a feminist standpoint and to accessing of “tacit knowledge”; the things people inherently know through their lived experiences (Polanyi, 1962; Smith, 1997). Qualitative interview research results in non-standardised information, allowing researchers to examine the inter-individual differences in experience and to centre people’s lived experiences (Ezzy, 2002; Reinharz & Davidman, 1992); in this case, their professional experiences related to SVRJ risk assessment.

Feminist research must also focus on social and political change, especially in the face of oppression and inequality (Ezzy, 2002; Jülich, 2001). In exploring risk within SVRJ, the researcher has attempted to promote the interests and support the needs of victim-survivors, by improving understandings of risk and risk assessment in SVRJ. The researcher and the participants engaged in the research with the goal of contributing to both the academic literature around SVRJ, and to broader social change. These aspects of the research project align with the framework of feminist research.

In terms of epistemology (the theory/understanding of knowledge), this research is based upon post-positivist beliefs; this perspective conceptualises knowledge as being situated within the context and standpoint of the knower, meaning it is also influenced by their past experiences, beliefs, relationships and position within society (Collins, 1997; Hayes, 1997; New, 1998; Teherani et al., 2015). This epistemological approach disposes of the positivist beliefs that there is a single “true” reality and is more aligned with indigenous worldviews (Ezzy, 2002; Smith, 2001; Teherani et al., 2015). Such an approach was deemed to be the most effective for this research as issues of risk within SVRJ are complex and often challenging concepts, and a qualitative feminist post-positivist research approach has allowed for deeper meanings to be interpreted from the data gathered, based on the lived experiences of the research participants (Smith et al., 2009).

Reflexivity: The Researcher’s Position

The researcher also holds a place within feminist research, with their position of power and the relationships between the researcher and the researched participants being acknowledged (Jülich, 2001; Willig, 2012). The researcher’s own experiences have affected all parts of the research, and as such their own experiences with SV and RJ must be explored. It is also acknowledged that the various aspects of a researcher’s identity are also important, as “every aspect of a researcher’s identity can impede or enhance empathy” (Reinharz & Davidman, 1992, p. 26), and therefore affect the ways in which the researcher can connect, understand, and interpret the experiences of interviewees.

The researcher has their own lived experience as a repeat victim-survivor of SV, who had both been denied the opportunity to confront the person responsible in one instance and empowered and supported by their community to confront the responsible party in another instance. These experiences have shaped their positioning and views in relation to SVRJ. In neither of these instances did reporting to Police feel like a viable option. The researcher’s experience of confronting the person responsible was informal and private, as they were

unaware of the concept or availability of RJ at that time. Reflecting upon these experiences and analysing the impact these differing experiences have had, made the researcher want to investigate how such confrontation and conversation could occur in a way that is structured, involves the wider community (facilitating accountability), and enhances the safety of all involved, which is something they believe SVRJ can achieve. The researcher has chosen to conduct their dissertation on this topic given their own experiences of SV and due to a desire to see victim-survivors have safe options in terms of how they choose to seek justice or closure for themselves, with the knowledge that current conventional criminal justice responses commonly do not provide that opportunity. The sensitive nature of this topic strengthened the researcher's determination to ensure they were not exposing participants to further harm. Feminist principles and the researcher's own experiences as a victim-survivor of SV have guided the research approach and implementation throughout.

The researcher also acknowledges their cultural background as a Pākehā person, which has shaped and influenced their experiences within society and the perspective from which they have approached this research. They acknowledge their perspective will have blind spots. The method used of inviting participants with professional experience in SVRJ and creating guideline recommendations based off their knowledge was designed to ensure a broader perspective than the researcher's alone was taken. This approach will help to ensure that developed SVRJ risk assessment guideline recommendations are in line with professional experiences and are practically applicable within SVRJ risk assessment.

Data Analysis Process

NVivo software was used to assist the analysis process. Analysis began with the researcher becoming familiar with the interview data. Each interview recording was re-listened to, transcribed verbatim, and the transcript was actively read and re-read to ensure familiarisation. Initial insights and ideas for possible coding or insights on patterns of meaning which may have been of interest, were recorded early on. Initial coding was "open"

using an exploratory process, looking for various codes or categories which could explain and fit the concepts or issues expressed by the participants, encompassing features of interest related to risk and risk assessment in SVRJ within the data. This inductive approach to analysis allowed for codes and eventually themes to come from the data itself and for the research data to highlight important areas or issues the researcher may not have predicted. Initial codes (succinct summary labels) were assigned to encompass the features of interest (factors related to risk and risk assessment for SVRJ). All transcripts were coded in a reiterative process, where codes were initially assigned, and then through reading and re-reading, new codes arose, and old codes transformed. Codes were supported by relevant extracts from the data, the contexts of which were also noted (Braun & Clarke, 2022; Byrne, 2022; Ezzy, 2002).

Codes were compared and similarities and differences among instances in the data considered (Ezzy, 2002). Codes were then organised and collated into groups representing broader themes across the data, referred to as candidate themes and subthemes. Themes represented a pattern of shared meaning underpinned by a central concept or idea, subthemes represented related but distinct patterns of meaning found within the overarching theme (Braun & Clarke, 2022; Byrne, 2022; Joffe, 2012). Relationships between the various codes and candidate themes and subthemes were considered. A group of candidate themes and subthemes, supported by data extracts was developed (Braun & Clarke, 2022).

Candidate themes and subthemes were refined, considering Patton's (1990) dual criteria for judging categories: namely internal homogeneity and external heterogeneity; this involved evaluating whether each theme was internally cohesive and was clearly distinct from the other identified themes. Candidate themes, subthemes and coded data extracts were reworked to increase coherency of these patterns and ensure consistency between coded data extracts and the dataset as a whole. The researcher employed a reflexive, recursive process throughout, moving between the data set in its entirety, coded extracts of data, candidate

themes and subthemes, and the written analysis being produced (Braun & Clarke, 2022; Ezzy, 2002). The overall dataset and the validity of themes and subthemes relative to the data were reviewed, checking whether themes and subthemes truly represented the data, if they were answering the research questions, and if they were telling a convincing story. Candidate themes or subthemes lacking supporting data were rejected or combined with other candidate themes and subthemes, conversely, some candidate themes or subthemes with diverse data were separated into multiple themes or subthemes. This interactive process led to the researcher developing a solid understanding of the themes present in the data, how they fit together and what they had to say about the data (Braun & Clarke, 2022).

The scope of each theme and the subthemes within it was described with a sentence or two, and concise informative names were developed for each. A table of themes and subthemes was constructed, with interview excerpts from the data supporting each identified theme and subtheme and providing context. Supervisors read over this initial analysis and provided feedback, which led to revision and further refinement of themes and subthemes. Themes and subthemes identified through this process are presented with evidence in the form of data extracts in the following chapters exploring identified themes and implications thereof, within an analytic narrative of the data related to the research question of risk assessment within SVRJ.

Chapter Six: Introduction to Analysis Results

This chapter provides an overview of the themes and subthemes identified through the reflexive thematic analysis of interviews with professionals experienced in RJ and SVRJ, investigating their experiences and opinions of risk assessment for SVRJ. The identified themes and subthemes are presented in Table 1.

Table 1

Themes and Subthemes

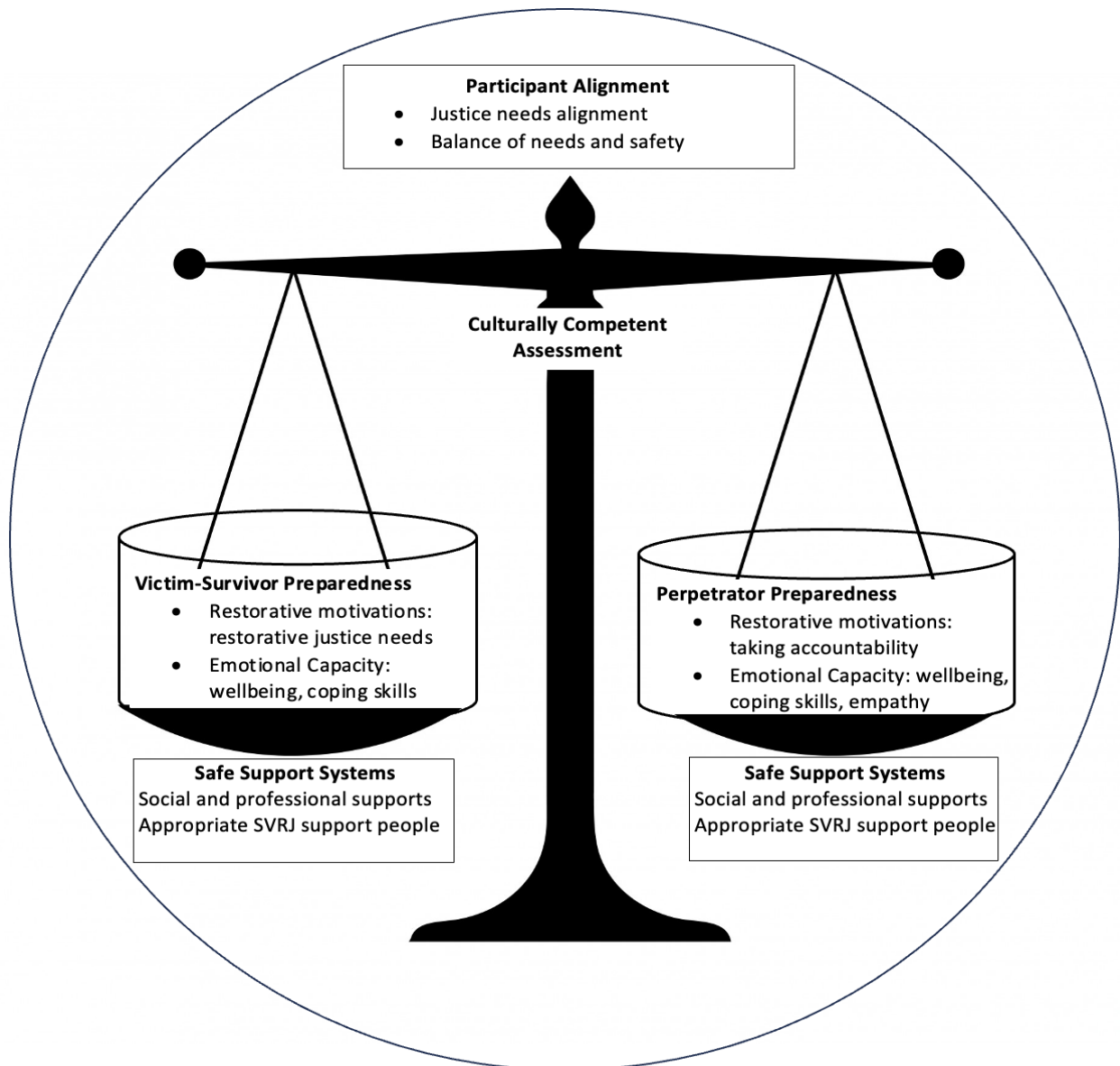
Theme	Subtheme
Perceived Participant Preparedness	Restorative Motivations
	Emotional Capacity
Safe Support Systems	Social Support
	External Professional Support
	SVRJ Support People Appropriateness
Culturally Competent Assessment	
Participant Alignment	Justice Needs Alignment
	Balance of Needs and Safety

The identified themes and subthemes are discussed in subsequent chapters, with supporting evidence in the form of data excerpts. Within each analysis chapter the views of professionals are unpacked and explored, comparing and contrasting them to the relevant literature and considering the implications of the findings. Aspects of the risk assessment which apply to both parties are discussed, as well as differences in assessment for victim-survivors and perpetrators of harm. The “SVRJ Risk Scales” diagram below was developed as a visual representation of the current study’s findings (see Figure 1). These findings are

briefly outlined here with reference to the SVRJ risk scales diagram and discussed in more detail in the subsequent chapters.

Figure 1

SVRJ Risk Scales Diagram



SVRJ Risk Scales Diagram

The symbol of the scales was chosen to present these findings as a reflection of the scales of justice, a long-standing symbol of the balance between truth and fairness pursued within justice systems and the weighing up of information to reach a just conclusion. In this

context, the scales depict the various considerations within SVRJ risk assessment that professionals discussed as important for their risk-related decisions, which were therefore identified as themes and subthemes within the current analysis. This includes considering individual factors for both the victim-survivor and perpetrator (depicted as the weights), their available supports (depicted as the pans holding up the weights), within the context of a culturally competent assessment (represented by the foundational beam of the scales), and the overall alignment of the participants and the balance between respecting and empowering victim-survivors while professionals also do their utmost to ensure participant safety (depicted by the alignment of scales).

Chapters seven to eleven explore the current study's findings in more depth in the context of the wider literature and in consideration of the implications of these findings for the field of SVRJ risk assessment.

Chapter Seven: Theme One Analysis and Implications

Perceived Participant Preparedness

“Although it may be hurtful to hear the honesty, that's how healing can begin.” (P3)

The theme of **perceived participant preparedness** was derived from factors discussed by professionals regarding individual readiness for SVRJ processes. This theme is comprised of two subthemes: **restorative motivation** and **emotional capacity** to engage in SVRJ. These were considered as important for both victim-survivors and perpetrators. This chapter discusses each subtheme as it relates to both parties, followed by the aspects more specific to victim-survivors and then to perpetrators. The literature surrounding these ideas and the implications for policy, practice and guidelines are discussed.

Perceived Participant Preparedness Subtheme One: Restorative Motivation

The first subtheme of **restorative motivation** encompasses professional discussions about ensuring participants understand what they were engaging in and that they are doing so for appropriate reasons. Participant motivation was described by professionals as the overarching concept of what was driving participant decisions to engage in SVRJ, namely their individual justice needs, in line with Maslow's (1943) needs theory which proposes behaviour is motivated by needs. Professionals discussed the importance of assessing whether participants' motivation to engage in SVRJ was indeed restorative, aligning with the values of RJ. Potential non-restorative motivations (discussed further below) could, for example, include participants wanting contact with the other party in order to perpetuate harm.

Restorative Motivation for both parties

Ensuring participants had restorative motivation to engage in SVRJ was discussed as beginning with informed consent; that is, participants having a good understanding of what SVRJ involves and making an informed and individual choice to engage. This was noted to include consideration of participant capacity to give informed consent, and the importance of

being confident that participants were not being subjected to outside pressure and feeling coerced into engaging in SVRJ.

“The issue of voluntariness is a tricky one because there's always pressure... when it comes to these kinds of issues.” (P13)

“Having somebody’s informed consent is absolutely critical to going forward... We need to be thinking... about whether someone really has capacity to give consent fully and freely.” (P6)

This subtheme is in line with one of the key tenets of RJ which is that participants engage voluntarily and are not coerced or pressured to engage (Sherman & Strang, 2007). It is therefore vital that participants have a full understanding of what the restorative process will involve prior to giving their informed consent, and so discussion and exploration of SVRJ and assessment of participant capacity to provide consent must be undertaken by professionals within SVRJ risk assessment (Suzuki & Wood, 2017).

Pressure to engage in SVRJ was discussed by professionals in the current research as something which could affect either the victim-survivor’s or the perpetrator’s choice to participate in SVRJ. Professionals discussed how victim-survivors or persons responsible for harm may experience pressure from different factions (discussed separately below), including from the other party, from friends or family members, or indeed from the conventional criminal justice system. Pressures to engage in SVRJ were considered something that should be assessed in conjunction with the assessment of participant restorative motivation to engage in SVRJ, in order to get a full sense of why a person is choosing to engage and to ensure voluntary engagement. For both victim-survivors and perpetrators, professionals reported that understanding the reasons *why* someone wants to engage in SVRJ helped to develop a fuller understanding of their genuine desire to engage, and the role that possible coercion or pressure may be playing. Investigating participants’ motivations, and ensuring they were

restorative was described as an important aspect of risk assessment and ensuring that participants were on the right justice pathway. Ensuring participants do have restorative motivation, increases the likelihood that their expectations and justice needs underlying those motivations, can be met within an SVRJ process, thereby enhancing the safety of the process.

Victim-survivor Restorative Motivation

Professionals described pressures to engage in SVRJ for victim-survivors as commonly stemming from social pressures, victim-survivor beliefs and values, or experiencing a sense of “now or never”. Pressures could also include concerns around letting others down, coercion from perpetrators or others in the social network, feelings of needing to forgive others (commonly stemming from religious or cultural values), or a desire to comply with authority figures who have suggested the RJ process.

“Within different contexts... there's different social pressures to participate in a restorative process or not.” (P7)

“[I'm] looking for the social pressures in the system... If it's a family dynamic then it can be very complex.” (P5)

The various external and internal pressures that professionals described as possibly influencing victim-survivors' motivations within the current research were commonly in line with the concerns reported in the literature, including social pressures stemming from shared social networks, perceived time pressures, or pressures stemming from personal or cultural values which lead to the victim-survivor sensing that SVRJ is the “right” thing to do (Daly, 2006; Dickson-Gilmore, 2014; Gareth & Sean, 2015; Hudson, 2002; Jeffries et al., 2021; Suzuki & Wood, 2017; Wallis, 2014). The sense of pressure to engage in SVRJ stemming from the above factors could result in victim-survivors taking on a burden of responsibility, and in wanting to reduce harm (e.g. sentence severity) to offenders, feeling they *should* engage in a process that they don't really want, or are not ready for (Curtis-Fawley & Daly,

2005; Jeffries et al., 2021; Redman, 2019). Such pressures can be inconducive to victim-led processes or result in victim-survivors engaging in processes that they do not wish to. This is important to be aware of as victim dissatisfaction and risk of harm to victim-survivors is more likely if victims feel pressured to engage in RJ (Ministry of Justice, 2016b; Wemmers, 2002; Wemmers & Canuto, 2002). In line with RJ values and in order to reduce the risk of harm to victim-survivors, the influence of external and internal pressures on victim-survivor motivation to engage in SVRJ should be considered within risk assessment.

Professionals reported that understanding what was driving victim-survivors to engage in SVRJ, enabled them to ensure that victim-survivor motivations, and therefore underlying justice needs, were indeed restorative, meaning the SVRJ process could be an appropriate way for these needs to be met.

“We're collecting the survivor's hopes for the meeting ... [to] see if their needs are restorative in nature... whether they have the restorative needs in terms of accountability, having a voice, wanting to ask questions, wanting to tell a person how they feel about what they (the perpetrator) have done and how its impacted on them (the victim-survivor).” (P1)

“There are lots of reasons why people want to go forward [with RJ], but commonly; to feel safe again, to be able to say what they want to say, to vent, for accountability, to find a way to move forward, those kinds of things that we could call 'justice needs' or 'motivations', the main reason, driving force. Generally, without one of those (motivations) the person's not motivated to do restorative, and why would they?” (P6)

Professionals acknowledged, however, that victim-survivors may also have non-restorative motivations, including using SVRJ as a stepping-stone towards a retributive justice approach. Such motivations would cause professionals to think SVRJ may not be appropriate.

“If we think that they are in a punitive kind of space then we won't go ahead, because that's what the court's for, that's not what we're here for.” (P14)

“I would say if they were only driven to challenge and confront... I'd be less inclined to see that as being a good use... it's not really the point” (P13)

“It's just not the right path... the role of a facilitator is not just to meet the needs of the clients, which is the primary objective, but it's also to preserve the integrity of the process.” (P7)

Concerns of victims having retributive or vengeful motivations behind their desire to engage in justice processes are documented in the research literature (Doak & O'Mahony, 2006; Erez et al., 1997). However, such concerns are unlikely to represent the majority of victims, who in fact tend to seek restitution or compensation and often hold desires to help the person responsible for causing harm (Doak & O'Mahony, 2006; Hudson, 2002; Shepp et al., 2020).

Perpetrator Restorative Motivation

It is important to appreciate that there are also various pressures and motivations that may influence a perpetrator's decision to engage in SVRJ. Professionals asserted that the main motivation for perpetrators to engage in SVRJ *must* be their desire to be accountable, through allowing transparent evaluation of, and by accepting responsibility for, their behaviour. Professionals discussed that for perpetrators referred through the court system, there is a real possibility of pressure or coercion to engage in SVRJ coming from the context of the conventional justice system and the possibility of lesser penal repercussions due to their SVRJ engagement.

“We use the term ‘restorative under the shadow of the law’ which means that if you don't do restorative, well, you're going to go to court and you're going to get the usual kind of adversarial response, and so there is coercion.” (P6)

“There's always a degree of pressure, coming from somewhere... if the offending hadn't been disclosed, would the person be with us owning up to it? Probably not.” (P3)

There is significant concern and debate in the literature around using RJ in the context of conventional criminal justice systems, and in particular ethical debate about RJ occurring pre-sentencing, as offenders may be led to participate in processes or behave in certain ways, under an expectation or hope for a reduced sentence or diversion from the courts, rather than genuine restorative motivations (Gareth & Sean, 2015; Gavrielides, 2007; Pfander, 2020; Rossner & Bruce, 2018; Saulnier & Sivasubramaniam, 2015; Strang, 2021). Offenders may believe they will be worse off for choosing not to engage in RJ, or that they do not have a choice (Abrams et al., 2006; Suzuki & Wood, 2017). The concern around perpetrators being coerced into SVRJ is significant, as without a genuine desire to engage in SVRJ there is an increased risk of harm for victim-survivors, as evidenced by the increased likelihood of perpetrators experiencing and conveying less remorse or feelings of guilt, seeing less potential for dispute resolution, and being less likely to offer genuine apologies if not driven by restorative motivations (Gareth & Sean, 2015; Saulnier & Sivasubramaniam, 2015).

However, professionals in the current research reported that the context of the conventional justice system and associated pressures would not necessarily rule out SVRJ, as long as perpetrators also displayed restorative motivations of accountability.

“Some [perpetrators] will be honest and say, ‘Well, I did wrong, and I want to make it right, but also it looks good at the Court.’ And that's an okay place to start because they're owning it, that's being honest, and it gives us something to work with to get them to a better place.” (P3)

There is some suggestion in the literature that even if perpetrators are initially motivated by potential benefits within conventional justice systems (e.g. reduced sentences), RJ processes can still have significant beneficial impacts for those involved, particularly when perpetrators

have concurrent restorative motivations as well (Gareth & Sean, 2015; Pfander, 2020).

Therefore, the possibility of other non-restorative motives should also be considered within SVRJ risk assessment of the perpetrator, as manipulation of restorative processes in order to access victim-survivors and potentially cause more harm, is a significant concern (Cheon & Regehr, 2006; Loff et al., 2019; Mercer & Sten Madsen, 2015; Miller et al., 2020; Peleg-Koriat & Klar-Chalamish, 2020).

Professionals felt that evaluating the perpetrator's desire to be accountable and take responsibility for their actions, indicated their level of restorative motivation to engage in SVRJ, and many discussed this as being essential in order to mitigate risk within SVRJ.

"I wouldn't do a restorative justice process unless there was a high level of taking responsibility, to me it's the vital thing... I'm constantly looking for how much responsibility they're taking. I fully accept that there'll be motivating factors outside of just taking responsibility. But... for me [responsibility taking's] got to be the [main] motivation." (P3)

"One of the key things, I think, is does the person who caused the harm accept responsibility for their actions?" (P5)

Professionals reported that responsibility-taking and accountability could be assessed by looking for either blame shifting, a lack of remorse, or cognitive distortions including minimisations or denial of the harm. Professionals clarified that while perpetrators don't need to fully understand the impacts of their actions prior to SVRJ, they must at least acknowledge their actions *could* have harmed the other party and not be blaming the victim-survivor.

"I don't need like 'I'm the most sorry I've ever been', I need 'I accept that my actions could have caused harm.'" (P7)

“Where the offender may be blaming the victim still... [there] would be too high risk that the survivor’s going to be blamed in a restorative justice process.” (P3)

Behavioural change could also provide some indication of accountability. This could include being open with those around them, engaging in therapy or treatment, their behaviour within the conventional justice systems (e.g., pleading guilty), or other evidence that the person has committed to change going forward.

“It’s not that they’ve completed a program... but [that they] are actually on a journey, so something’s changed... for me the question is ‘What’s changed since this significant harm event occurred?’” (P12)

Professionals reported that part of accountability involves the person responsible for causing harm being able to account for their actions and explain what happened and why. This was considered particularly important because victim-survivors often have questions about motives and may be experiencing self-blame for their victimisation. Therefore, hearing perpetrators taking responsibility for their actions can help shift the blame-narrative.

“The metric for accountability is being able to talk about what you did.” (P6)

“The main question is ‘Why did you do this?’... What I’m encouraging the offender to do is be open and honest because... although it may be hurtful to hear the honesty, that’s how healing can begin.” (P3)

“That stuff is actually good to come out in a conference. So that it’s like ‘You did this to me. What did I do that deserved this? How could I have acted any differently?’ And then hearing from the person who caused the harm ‘Actually it wasn’t about you, it was about me. And there was nothing you could have done.’” (P14)

Professionals discussed how restorative motivation from the perpetrator, as indicated by their willingness to take accountability for their actions, could act as a protective factor against

risk. In contrast, a lack of restorative motivation may mean that engaging in SVRJ would be too risky.

“Ideally, you would have someone that understands what this process is and is thinking ‘this is going to be really healing for me and for the person that I’ve harmed’, and is looking to get some kind of growth, out of it... [If] you can see the motivation waning... there’s no way you can let this go ahead. It’s just going to be unsafe for everyone there.”

(P14)

“When the harm doer is... low on motivation and taking responsibility and genuineness... we wouldn’t go ahead.” (P1)

Professionals discussed that assessment of the perpetrator’s restorative motivations in SVRJ risk assessment should include consideration of the possible pressures on them to engage in SVRJ and their level of desire to take accountability. It was discussed that their desire to take accountability could be evidenced by their words, behaviours, and commitment to change going forward.

Perceived Participant Preparedness Subtheme Two: Emotional Capacity

The subtheme of **emotional capacity** covers the concepts that professionals described the importance of assessing with both victim-survivors and perpetrators, in order to understand their emotional ability to participate in SVRJ. This included considering their emotional resilience or vulnerability, the emotional coping mechanisms available to both parties, their general lifestyle and wellbeing (including any significant substance abuse or mental health concerns), and the ability of the perpetrator to empathise with the experience of the victim-survivor. In the following section the aspects of assessment for this subtheme which professionals discussed as applying to both parties are first explored, followed by discussion of the aspects which differed for victim-survivors and perpetrators.

Emotional Capacity for Both Parties

Professionals discussed the importance of considering both parties' emotional capacity to engage in SVRJ. Emotional capacity in this context is understood as an individual's ability to cope with their emotions or distress that arises from stressful situations, as well as their level of awareness of their own (and others') emotions and their ability to regulate these emotions in an adaptive (or helpful) way. The emotional capacity of both parties was discussed as important to understand prior to engaging in SVRJ, as intense emotions may arise for various reasons throughout the process. Strategies for coping with such strong emotions, both during and after the conference, were described by professionals as something that would be discussed and questioned throughout assessment with both victim-survivors and perpetrators.

“How's this person coping despite this happening in their lives and the pressure this is putting on, what are they doing?” (P3)

Coping strategies could range from adaptive techniques such as making time for self-care, to maladaptive techniques such as harmful substance use to suppress emotions. Professionals reported it was important to assess for both adaptive and maladaptive coping strategies. Checking for potentially harmful coping strategies was discussed as important in terms of ensuring that participants would be able to attend a SVRJ process in sound mind (i.e., sober), and in connecting participants to support or treatment as required.

“A restorative process is a process of rational dialogue and so someone needs to be of, essentially, rational mind.” (P12)

“If [the offending is linked to] drugs and alcohol... then maybe treatment [for that] is appropriate and needs to be provided.” (P4)

While all coping strategies can be understood as functional in initially reducing distress, coping strategies can be conceptualised as adaptive or maladaptive when considering the likelihood of negative consequences associated with them (Stallman, 2020). Adaptive coping

strategies include activities which soothe, relax, or distract an individual, as well as accessing social or professional support. Maladaptive coping strategies include withdrawal, negativity, and harmful activities including suicidality (Stallman, 2020). Use of maladaptive coping strategies are more likely to result in greater distress and poorer wellbeing, while the greater use of adaptive coping strategies is related to improved wellbeing and reduced psychological distress (Meng & D'Arcy, 2016). Shame arising from sexual victimisation (or sexual offending) may increase the risk of maladaptive coping strategies (Halpern et al., 2018). However; use of adaptive coping skills contributes to greater resilience following trauma, higher self-efficacy and less emotional reactions to intrusive thoughts related to trauma, which could be triggered by SVRJ processes (McBride & Ireland, 2016). Adaptive coping strategies may therefore reduce an individual's overall risk and susceptibility to harm caused by distress within SVRJ.

Professionals reported that participant wellbeing, including consideration of their current mental health, lifestyle, and stressors should be conducted within SVRJ risk assessment. While professionals discussed that mental health issues need not result in participant exclusion, they clarified that they would hope to ensure participants' mental health was stable enough for them to participate in SVRJ without significant risk to themselves or others. Physical and psychological safety of participants was described as a top priority, which meant consideration of suicide risk or risk of causing physical harm to self or others within risk assessments.

“Safety, of course, but not just physical safety; emotional and psychological safety, is always top of your brain.” (P10)

“The top of the risk factor is suicide or physical harm... if someone's going to be so distraught through this process, that they've increased their risk of suicide, that's an absolute no go zone.” (P8)

Stressful life events are known to exacerbate psychological vulnerability and contribute causally to experiences of psychological distress (Ensel & Lin, 1991; Hammen & Watkins, 2018; Kendler et al., 1999; Sayali & Swati, 2020). It is therefore important that risk assessment considers the potential participants' wider lifestyle, including the presence of any stressors and their current mental health. The ability of the participants to use adaptive coping strategies will impact on this assessment and may reduce concerns around mental health related risk or life stressors, by reassuring professionals that participants can manage their difficult emotions and experiences in adaptive ways. Ensuring participants have sufficient adaptive coping strategies and emotional resources is aligned with the Ministry of Justice's standards for SVRJ (Ministry of Justice, 2013).

Victim-survivor Emotional Capacity to Engage

Professionals commonly felt that assessing victim-survivor emotional capacity to engage in SVRJ included considering whether the timing was right for them in terms of their place on their recovery journey, and whether they were in a stable enough emotional space that SVRJ would not be likely to cause harm.

“[We look at] how far from the trauma they've come, because it's... like having a wound... there needs to be a little bit of scar tissue there to be able to stand scratching at it.” (P14)

Professionals discussed how victim-survivors experiencing and expressing difficult emotions throughout the SVRJ preparation and process was normal, and not something that would necessarily mean SVRJ was inappropriate. However, some professionals spoke about a limit at which difficult emotions (e.g., fear, shame) from either participant may mean SVRJ was not appropriate at the that time. Professionals felt it was particularly important to gain an idea of the victim-survivor's ability to regulate their emotions and self-soothe (i.e., their adaptive coping skills) within the assessment of emotional capacity to engage in SVRJ.

“It’s probably as much about your ability to hold a conversation which is inevitably about a difficult issue and be able to tolerate that. Which is not the absence of emotion, but simply that they can kind of self-soothe, or you know, seem like they’re doing okay with it.” (P13)

“Resilience is a key factor... being able to come back from an emotional space and come back into the room, being able to express emotion, being able to breathe through it and stay present.” (P8)

Emotional impacts of victimisation can include negative impacts on mood, and experiences of anxiety, fear, anger, and shame, to name a few (Garcia-Moreno et al., 2005; Maguire, 1991; McHichi Alami & Kadri, 2004; Petrak et al., 1997). The essence of trauma following victimisation are experiences of disempowerment, disconnection, and a feeling of not being safe (Herman, 1998). Recovery from trauma involves re-establishing safety and control, an important part of which is the capacity to regulate one’s own emotional and physiological responses, notably the responses of the autonomic nervous system, which is often dysregulated by trauma (Herman, 1997, 1998; Zaleski et al., 2016; Zehr, 2005). The SVRJ process involves remembering the trauma, a process which, if survivors are early in their recovery, is likely to activate sympathetic arousal in the form of a fight, flight, or freeze response (Van der Kolk, 2015). Further, SVRJ may elicit strong emotional responses which could be associated with the SV itself, risking retraumatisation if victim-survivors are not well prepared (Mercer & Sten Madsen, 2015). The ability for survivors to manage such reactions, and remain present in the conversation, feeling safe and in control of their bodies is important for safe SVRJ (Jülich & Bowen, 2015; Zaleski et al., 2016). As discussed by professionals, victim-survivors do not need to be fully emotionally restored or recovered from trauma prior to SVRJ processes, however an ability to self-regulate is important. The SVRJ process itself may be an important aspect of their recovery, with research suggesting memory reconsolidation within RJ processes may enable victims to rewrite emotional

memories in ways that are more adaptive and supportive of wellbeing (Bolitho, 2017). RJ is often associated with the concept of emotional transformation, helping reduce the effects of trauma and emotional harm (Angel et al., 2014; Bolitho, 2017; Klar-Chalamish & Peleg-Koriat, 2021; Miller, 2011). Ensuring SVRJ participants are far enough along their recovery journey, and have the emotional capacity to cope with reactions that may arise reduces the risk of retraumatisation and is an important part of safety within SVRJ (Herman, 1997, 1998; Jülich & Bowen, 2015; Zaleski et al., 2016).

Perpetrator Emotional Capacity to Engage

Timing was also discussed as important for the perpetrator, in terms of understanding their current emotional state and overall emotional capacity to engage in SVRJ. For the perpetrator, an ability to empathise with the victim-survivor, in terms of having some understanding of the impacts of their behaviour, was discussed by some professionals as being a particularly important aspect of SVRJ risk assessment.

“I’m always looking for empathy, I’m always looking for a sense of what they think a survivor or a victim of sexual harm might need.... The sense that they actually understand the enormity of the impact.” (P13)

“What I’m looking for is not... some amazing level of insight... it’s... have they got an awareness of their own behaviour and their own impact?” (P12)

Professionals discussed how perpetrators may also experience significant negative emotions within SVRJ and emphasised the importance of assessing their ability to manage their emotional reactions (e.g., use adaptive coping skills) through the SVRJ process within the conference.

“When you’re really hearing the impact of your actions, that’s like a punch in the stomach.” (P4)

“Can they hold themselves hearing really hard stuff about how people feel about what they did? Are they able to stay present, are they able to not move into an attacking and defensive space?” (P8)

Professionals in the current research also emphasised the necessity of assessing whether the person responsible for harm had the emotional capacity to be able to witness and understand the harm that they had caused to another person. Taking responsibility for causing harm is an emotionally difficult thing to do, particularly in the presence of those directly involved, and perpetrators can experience a lot of fear and anxiety around engaging in RJ (Abrams et al., 2006; Gareth & Sean, 2015; Wallis, 2014). Professionals need to assess how emotionally ready a perpetrator is to accept responsibility and hear about the harm they have caused. Expressing some level of understanding of what victim-survivors have experienced, in the form of empathy, was discussed by professionals as an important part of perpetrator emotional capacity for SVRJ. Perpetrators of harm may not be aware of the full impact of their actions and having to confront this through the SVRJ process can trigger significant negative emotional experiences, including an increased sense of guilt or shame (Abrams et al., 2006; Jonas et al., 2022; McGlynn et al., 2012; Wager, 2013). In an attempt to reduce such feelings of guilt or shame and avoid social rejection, they may engage in ‘pseudo self-forgiveness’ which could present as minimisation or denial of the harm they have caused (Woodyatt & Wenzel, 2013). Assessing the capacity of the perpetrator to bear the emotional burden of shame that may come along with the SVRJ process, without resorting to reactions such as minimisation, may help avoid victim-survivor retraumatisation (Cheon & Regehr, 2006; Mercer & Sten Madsen, 2015). It is also important to note that while learning about the experience of the harm can be the most difficult aspect of restorative processes, it can also be the most valuable, and help transform feelings of guilt or shame into restorative action, greater insight, increased empathy for others, and reduced likelihood of reoffending (Abrams et al., 2006; Braithwaite, 1989; Evans et al., 2016; O’Connell, 1998; Rodogno, 2008; Umbreit

et al., 1999; Umbreit & Vos, 2000; Van Stokkom, 2002). Emotional capacity of perpetrators to manage intense emotions is also important in light of the consideration that they may themselves have experienced sexual victimisation or other forms of abuse, and, like victim-survivors, may be at risk of retraumatisation, particularly if they lack the emotional capacity and skills to manage their reactions (Hanson & Slater, 1988; Jespersen et al., 2009).

Professionals should have a sense of the perpetrator's emotional capacity to manage such intense emotional experiences, and hold empathy for victim-survivors, both during and after the SVRJ process, in order to reduce risk to all participants (Wallis, 2014).

Theme One Summary

This first analysis theme of **perceived participant preparedness** has discussed the aspects of individual participant preparedness for SVRJ that professionals reported as important to assess prior to SVRJ processes. The theme of perceived participant preparedness comprises two subthemes: **restorative motivation** and **emotional capacity**. Based on professional experience and supported by the empirical literature, SVRJ risk assessment should include consideration of both victim-survivor and perpetrator restorative motivations and emotional capacity to engage in SVRJ.

Restorative motivation was described as something that could be assessed through consideration of participant capacity, understanding and informed decision making to engage in SVRJ, as well as consideration of whether they held restorative motivations for doing so; that is, that victim-survivors reported restorative justice needs, and perpetrators demonstrated a desire to take accountability for their behaviour. Professionals must ensure participants have both the capacity to give consent and have an understanding of SVRJ in order to provide informed consent. In the current research professionals also highlighted the importance of assessing for potential coercion or pressure to engage in SVRJ. A thorough and well-documented assessment of motivations and relevant potential pressures applicable to a given situation is required to ensure that these factors have been well considered for the individuals

involved. Further, an exploration of participants' individual motivations to engage in SVRJ must be conducted to ascertain whether motivations are restorative in nature; as if they are not, SVRJ is not likely to be an appropriate process for them. As such, assessment of participants' ability to provide informed consent to engage in SVRJ as well as explicit discussion of potential pressures and motivations driving their decision to engage, is incorporated into the developed recommended SVRJ risk assessment guidelines.

Emotional capacity was described as something that could be assessed by considering participants' place on their recovery or accountability journey, their emotional resilience, and strategies for managing difficult emotions through available adaptive and maladaptive coping skills, their current lifestyle and wellbeing, and perpetrator ability to experience and express empathy towards the victim-survivor. Professionals in the current research emphasised the need to assess the participants' emotional wellbeing, ongoing life stressors, and available coping strategies. Participants currently experiencing poor overall wellbeing, lacking in adaptive emotional coping skills, or with ongoing stressful life events may not be considered appropriate for SVRJ at that time. Such participants should be referred to external professional support to help them manage these difficulties and learn adaptive coping skills and may be able to return for SVRJ at a more appropriate time in the future. Professionals in the current research also described the importance of assessing perpetrator ability to empathise with the victim-survivor. Again, this may be something that perpetrators can develop further with external professional supports (discussed further in the following chapter). As such, developed SVRJ risk assessment guideline recommendations will include prompts for professionals to consider the participants' current wellbeing, including the presence of any stressful life events, their available emotional coping skills, and the perpetrator's ability to express or demonstrate empathy for the victim-survivor.

Chapter Eight: Theme Two Analysis and Implications

Safe Support Systems

“Harm happens in isolation; healing happens in relationship.” (P5)

The theme of **safe support systems** arose from professional discussions about the importance of understanding participant access to and engagement with others who could provide support for them through SVRJ and beyond. Three subthemes were identified within this theme: **social support**, **external professional support**, and **SVRJ support people appropriateness**. Professionals described assessing the presence of both social (e.g., family, whānau, friends) and external professional (e.g., therapists, support organisations, social workers) support systems for both victim-survivors and perpetrators, and considering the possible dynamics and impacts of shared social networks between the participants. Professionals also highlighted the importance of risk assessment being carefully conducted with the SVRJ support people who would be involved in the SVRJ process. These three subthemes are discussed in terms of how they apply to both parties and, where relevant, the differences in how they apply to victim-survivors or perpetrators are also explored.

Safe Support Systems Subtheme One: Social Support

The subtheme of **social support** covers the professionals’ discussions around assessing and understanding participant access to and engagement with social supports, which were considered to include the people with whom participants had emotionally supportive relationships, in a non-professional context such as their friends, family/whānau, and wider communities.

Social Support for both parties

Professionals discussed social support as highly preferred, if not necessary, for both parties involved in a SVRJ process. Social supports were understood to play multiple roles, including providing parties with emotional support, and holding perpetrators accountable

(discussed in more detail below). Many professionals felt the presence of social support was essential for participant safety, acted as a particularly strong protective factor against risk of a poor outcome, and was a central tenant of RJ.

“We always would ask that question like ‘Is there someone you can turn to, is there someone at the end of a phone if you need it?’” (P9)

“If somebody really hasn't got a lot of support at all... [SVRJ's] unlikely to be a safe process for them.” (P1)

“This is the nature of restorative process, it's community focused... one of the key things we're doing is extending that cloak of safety into the future, and certainly making sure, at the very least, we're handing over the baton” (P12).

When social supports were lacking, for example, when participants did not have anyone in their life who knew about the SVRJ process, professionals discussed encouraging participants to build their social supports up, and typically reported not being comfortable with proceeding with SVRJ until they felt reassured there was adequate social support available for participants.

“If I don't think they have got the supports around them, then I won't proceed until I've helped them build those supports... what I need to do is open up the doors.” (P5)

SV and associated shame are known to sometimes have significant detrimental effects on social relationships, causing or exacerbating disconnection and causing interpersonal difficulties (MacGinley et al., 2019; Maniglio, 2009; McHichi Alami & Kadri, 2004; Petrak et al., 1997). As identified by professionals, supportive social relationships act as protective factors against the negative impacts of SV by lessening the likelihood of associated psychological distress for both victim-survivors and persons responsible (Cagney &

McMaster, 2013; Carr et al., 2020; Ensel & Lin, 1991; Huang et al., 2020; Johnson et al., 2011).

Professionals also highlighted the importance of considering how social support systems that were shared between the victim-survivor and the perpetrator may have been impacted by the harm. This included considering potential relational and power dynamics at play, and whether there would be ongoing relationships between the participants after the SVRJ process (e.g., in cases of intrafamilial SV). Professionals highlighted that in instances of shared social supports, there is often a lot of complex relational dynamics ongoing, and care must be taken to ensure that support is available and indeed appropriately supportive of the participants involved.

“Is the relationship ongoing and likely to be ongoing?...If it’s a family dynamic, then it can be very complex... there’s just a whole raft of really complex dynamics that you need to be aware of.” (P5)

“[In] family systems you’ve got people taking sides within the family or ostracising people from the family and there’s a lot more work that needs to happen.” (P14)

It has previously been reported that validation from the social support system is particularly important for recovery and psychological adjustment of victim-survivors in instances where social ruptures have occurred (Elliott & Carnes, 2001; Klar-Chalamish & Peleg-Koriat, 2021). Specific issues associated with shared social support systems for victim-survivors and perpetrators are discussed separately in more detail below.

Social Support for Victim-Survivors

Professionals discussed that assessment of social support for victim-survivors, should consider how social systems had been impacted by the SV, including how they responded to the victim-survivor when they learnt about the abuse, the impacts the abuse had on them, and how they were currently able to support the victim-survivor. The impact on social supports

was discussed as particularly important in instances of shared social systems, where social supports may have been “groomed” to think a certain way by perpetrators, which may influence their reactions towards the victim-survivor, and the quality of support the victim-survivor receives from them.

“If we talk about childhood sexual abuse, what often happens is the survivor is kind of more isolated and the family support and social network has come around the person that's done harm... Often the person that's done the harm in childhood sexual abuse has groomed the rest of the family to make the survivor look like the ‘crazy’ one, look like the person that's got the problem.” (P1)

“[What was] the initial response of the people that were around them? How did they respond to it? Were they believed when they first came with this, or did it take a lot of work for them to get say, a parent, to believe them? ... It's around ‘Okay, so who can you go to and what kind of messaging are you going to get? And is that going to be helpful to you or harmful to you?’” (P14)

Professionals reported that support systems may be struggling with feelings of guilt for not keeping the victim-survivor safe, particularly in instances where the victim-survivor was a child when harm occurred. Professionals discussed how such emotions could impact on the social support network’s ability to support the victim-survivor, and so awareness of these dynamics can support comprehensive risk assessment into the availability and suitability of social support.

“(Social support systems) often struggle more with their shame and guilt about not keeping the person safe.” (P5)

“It's really important to understand family systems... how can we strengthen the family to be able to step back from taking sides... and in coming alongside each of the parties in a

way that's going to be helpful and healing... with the survivor in the centre of this process.” (P1)

Social support throughout the SVRJ process is recognised as having an important function in helping to meet the justice needs of the victim-survivor, including community recognition and validation of their experiences (Daly, 2017; Herman, 2005; Jeffries et al., 2021). As highlighted by professionals, the scientific literature stresses that the reactions and ability of social supports to offer support to victim-survivors should be carefully considered, as they may experience a multitude of reactions including disbelief, denial, self-blame, guilt, traumatisation and general distress as they learn about the SV that has occurred to their loved one (Abu-Baker, 2013; Elliott & Carnes, 2001; McElvaney & Nixon, 2020; Regehr, 1990). Understanding these psychological responses may provide greater insight into their ability to support the victim-survivor throughout SVRJ.

Social Support for Perpetrators

For the perpetrator, social support was discussed as important for their safety, but also important in terms of supporting them to take accountability. Professionals felt that in instances where social support systems are shared between parties, the perpetrator’s level of honesty with the social network was particularly important, as victim-survivors were often disbelieved, and networks were divided by taking sides.

“If it’s in a family type situation, who else knows is really, really important.” (P2)

Professionals noted that it is often particularly challenging for perpetrators to acknowledge they have caused harm to their social support system, as they often fear upsetting them, and experiencing shame or rejection. This can lead to perpetrators wanting to engage in SVRJ without having acknowledged their harmful sexual behaviour to their support networks. However, professionals highlighted that if perpetrators were open with their social support systems, they can help them stay accountable going forward into SVRJ and beyond.

“Support comes to not only safety, but it also speaks to accountability.” (P16)

“[Often, perpetrators] don't want to have support; ‘Can't I do this by myself?’ and it's like ‘No, you need a support person; one to hold you accountable and two to make sure that it's a safe process for you.’ ... Working with a support person... you've got someone supporting them through the process of making some healthy changes.” (P3)

For perpetrators, the social network has previously been reported to be a strong resource for successful societal reintegration, accountability taking, and can be protective against sexual reoffending (Farrall, 2004; Göbbels et al., 2014; Hadar & Gal, 2023; Hochstetler et al., 2010; Keenan et al., 2016; Maruna & Toch, 2005; McNeill, 2006; Richards, 2022; Yoon et al., 2011). Further, it has been reported that social support systems of perpetrators can play a supervisory role, helping to ensure that reparation agreements and positive lifestyle changes are kept, by identifying potential warning signs or lapses that may occur (Bohmert et al., 2018; Cumming & McGrath, 2000). A sense of social support and connection encourages perpetrator accountability, whereas ongoing fear of social rejection can lead to minimisation or denial which could further harm victim-survivors (Hadar & Gal, 2023; Woodyatt & Wenzel, 2013). Social supports for the perpetrator therefore have an important role in the SVRJ process, facilitating accountability taking and supporting meaningful engagement in SVRJ processes (Woodyatt & Wenzel, 2013). Professionals in the current research emphasised the need for perpetrators to have honest communication with their supports to avoid misunderstandings or attributions of blame towards the victim-survivor. The impact of the harmful behaviour on the support network of perpetrators may also be something that should be considered in assessment. Research indicates that members of a perpetrator's social support network may experience secondary stigmatisation, and commonly report feelings of self-blame, guilt, loss, isolation, social rejection, or fear of judgement and blame from others, which may impact on their ability to offer support (Cumming & McGrath, 2000; Evans et al., 2023).

Safe Support Systems Subtheme Two: External Professional Support

The subtheme of **external professional support** constitutes professionals' discussions around assessing participant access to and engagement with additional professional supports, external to the SVRJ process, within their risk assessments.

External Professional Support for Both Parties

Most professionals in the current research felt that participant engagement with external professional supports (e.g., therapists, support agencies), was an important protective factor against risk in SVRJ. This was highlighted as especially important in instances where social support was somewhat lacking.

“I do think that they have to be linked into [external professional support] somewhere before, during and after.” (P6)

“That they're engaged with a support agency... is highly, highly preferred.” (P10)

“[Protective factors include] things like; has the person been engaged in therapy for a long time and... [has] a bit more distance from the harm? And that would apply to both parties.” (P4)

“If they're not engaged [with other professional support] somewhere, then quite often I'd say, 'Well I can't proceed here unless... ’” (P5)

Working with external supports such as therapists, was discussed as something that could help participants heal from trauma, and develop insight, as well as helping to strengthen their emotional capacity (as discussed in the previous chapter), all of which would enable safer engagement in SVRJ. Working with external professional supports was also discussed as something that could improve participant awareness of how SVRJ might impact on them, and therefore help participants be more emotionally prepared for the SVRJ process. Further, such relationships meant that there was an extra layer of safety and support provided by

professionals, who could help participants should the SVRJ process elevate their distress. External professional support relationships were also highlighted as an important way to reduce risk within SVRJ, given their ongoing nature.

“If we thought there was any risk of the person being destabilised by the process, we would need them to have a therapist who they could connect up with, either in the meeting, or available to them outside of the meeting that could help them in those moments.” (P8)

“I just generally encourage everyone to have a therapist to provide that ongoing support as well, because once the conference is done, I'm kind of out of the picture.” (P7)

However, professionals did also note, that external professional support was not always accessible to participants; both victim-survivors and persons responsible alike.

“Sometimes accessing that type of clinical support can be difficult... there's so many limits and barriers.” (P4)

“My experience has been that everyone wants it (professional support) and just struggles to find someone.” (P7)

“It's very difficult for most persons responsible to access the right clinical support because most of it's not available through the public health system and that actually becomes a true barrier to much restorative work getting done at all.” (P6)

External Professional Support for Victim-Survivors

For victim-survivors in particular, professionals discussed access to and engagement with external professional supports as helpful in terms of building up emotional capacity (or resilience) following the experience of trauma, and in ensuring participants had extra support available, were the SVRJ process to cause unexpected distress.

“Survivors judge how well they are themselves and they're the experts in it. But we also see that there are times where all of a sudden something's going to just come up and slap you in the face and you're not going to be okay... so we want to make sure that this person is as stable and supported as possible.” (P14)

“If there's a lack of resilience, then we would... suggest that they had more therapy until they got themselves in a stronger position.” (P8)

Professionals understand the impacts and dynamics of SV and can therefore help normalise and validate the experiences of victim-survivors. Such professional support can help ensure victim-survivors are well prepared for SVRJ and understand the impacts of their experiences. It can also help them build the skills to cope with ongoing impacts or reactions that may arise through SVRJ (Daniels, 2016; Hadjiioannou, 2021; Herman, 1998; Van der Kolk, 2015).

External Professional Support for Perpetrators

For perpetrators, external professional support may take the form of psychological treatment prior to SVRJ. This was generally discussed as important in instances where individuals were engaging in minimisation or lacking understanding of the harm caused (e.g., lacking in emotional capacity as discussed in the previous chapter), and were therefore deemed to not yet be ready for SVRJ.

“The restorative justice process may be better placed after some of those more clinical interventions have happened... it might be that they (perpetrators) need to receive a treatment program before it's appropriate to progress with restorative justice.” (P4)

“If their (the perpetrator's) responsibility taking was too low and they're not going to be able to answer the questions or they're not going to be safe, then we might suggest they go and do some treatment. And then when they've done treatment, come back.” (P8)

Professionals highlighted how choosing to engage in such psychological treatment may indicate some genuine commitment to accountability and desire to change from the person responsible, however should not be taken as totally indicative of readiness for SVRJ.

“While the treatment program itself is... not not a positive, it's also not enough, necessarily.” (P13)

Effective professional support in the form of psychological treatment for perpetrators can reduce possible cognitive distortions and increase their awareness and understanding of themselves, others, and the impacts of their actions. Further, it can enhance acceptance of responsibility, enhance prosocial sexual attitudes, help to build positive self-esteem, and may also increase empathetic abilities (Eastman, 2004; Wakeling et al., 2005). Hence the current research and scientific literature indicate that external professional support can help prepare perpetrators for SVRJ, enabling them to better understand victim-survivor experiences, manage their own adverse emotional and physiological reactions (e.g. shame or vulnerability), or possible experiences of rejection and stigmatising attitudes and behaviour from society or social networks (Scheela, 2001; Wakeling et al., 2005). Furthermore, it has been reported that psychological treatment of SV perpetrators reduces the likelihood of both sexual and general recidivism (Bourget & Bradford, 2008; Hanson et al., 2002). Perpetrators often view treatment as particularly important towards their recovery and prevention of reoffending, and it has been reported that they generally report positive experiences of treatment. However, it is also recognised that engaging in psychological treatment for harmful sexual behaviour is a difficult and stressful process (Blagden & Perrin, 2016; Day, 1999; Levenson et al., 2009; Wakeling et al., 2005).

External professional support was acknowledged as important for perpetrators given the potential emotional difficulty of the SVRJ process and awareness that may come out of it, as well as the consideration that they themselves may have also suffered abuse. Professional

support for perpetrators was discussed as helping to ensure ongoing continuation of care, so that supportive relationships with professionals could continue after the SVRJ process was completed, and people were well supported through the emotionally tough experience and into lasting behavioural change.

“Are they going to be well supported? Is the environment going to be setting them up for success in the changes that they're indicating that they want to make?” (P12)

“[We're] making sure that they at least know about agencies that can support them, because we're not always going to be there.” (P10)

External professional support can help perpetrators learn and practice skills and coping strategies to manage distress that may arise in their general life, within treatment, or within SVRJ processes (Levenson et al., 2009; Wakeling et al., 2005). Again, this can help ensure they are ready to engage in SVRJ and reduces the risk of harm or distress being caused to them or to victim-survivors. Professional treatment and support systems are well recognised important aspects of rehabilitation and successful societal reintegration of those who have sexually offended (Cumming & McGrath, 2000; Göbbels et al., 2014).

Safe Support Systems Subtheme Three: SVRJ Support People Appropriateness

“Support people are often the wildcards” (P8)

Professionals discussed assessing **SVRJ support people appropriateness**; those who will be directly involved in SVRJ processes, as a crucial element of SVRJ risk assessment for both victim-survivors and perpetrators, as such, this subtheme is discussed as applicable to both parties.

SVRJ Support People Appropriateness for Both Parties

Professionals affirmed the important role SVRJ support people have within the SVRJ process; however, they also emphasised the challenges and additional risks introduced by SVRJ support people.

“In terms of support people, I have some strong views that this is the heart, a key feature of restorative work... (but) if I think about challenging moments, I've had in conferences over the years... the most significant issues have come from support people.” (P12)

“Sometimes the support people are the hardest to deal with.” (P16)

As with broader social support, the relationships between participants and SVRJ support people were discussed as being an important factor to consider in the SVRJ risk assessment process. As shared social systems are not uncommon, professionals stressed the value of victim-survivors being given the chance to have their say on who will be in the SVRJ conference.

“We always make sure that the support they (the perpetrator) are going to be bringing is acceptable to the other person (the victim-survivor).” (P9)

The relational dynamics between people in the SVRJ process, including the possibility of mixed loyalties to the victim-survivor and the perpetrator, and the views that SVRJ supporters might be bringing along were also discussed as being important to consider within risk assessment. Professionals explained that this included considering the impact of the harmful behaviour on SVRJ supporters themselves, as well as their beliefs around the harm that had occurred and on SV in general, which, if unhelpful, could lead to collusion with the perpetrator or revictimising statements being made within the SVRJ process.

“We need to look at what they (SVRJ support people) are bringing into the process... Are they going to be there and be helpful and supportive and kind of understand this kaupapa¹⁸ that we're actually working in?” (P12)

“Unfortunately, our communities have all sorts of various views around what is okay around consent and what is the sexual violence spectrum.” (P6)

“Ensuring that they (SVRJ support people) don't condone the behaviour... that they're not going to collude with them (the perpetrator).” (P3)

It was noted that preparation work with the SVRJ support people was an important aspect of the SVRJ preparation processes. Professionals discussed working with and challenging various unhelpful behaviours or views from nominated SVRJ support people. The consensus was that if gentle challenging of unhelpful views didn't work, the risk of involving them in the SVRJ process was too great, and alternative support people would have to be arranged.

“Anytime I hear something that's a little bit concerning to me... I'm going to just ask them to reflect on it... If it's completely minimising, then I might recommend we not have them be part of it.” (P7)

“We'll be very frank about what are our concerns are... and kind of say 'Okay now I need you to hear the survivor, and this is what they want, are you able to support them through that without doing this, this, this, and this? Because if you're not, you're actually going to damage the person that you're here saying that you love very much and want to support.’” (P14).

“In some cases, we may go back and say 'Hey, look, we think you need to find another support person.’” (P2)

¹⁸ Purpose, topic

The literature also states that SVRJ support people are an important aspect of SVRJ, with a particularly important role in supporting perpetrator accountability, both within the SVRJ process and beyond (Hadar & Gal, 2023; Jülich et al., 2010; Mercer & Sten Madsen, 2015). It is however, recognised that harmful beliefs such as acceptance of rape myths are not uncommon within society and occur within the context of other oppressive prejudices including sexism, racism, and classism (Burt, 1980; Persson, 2022). Hence the views and beliefs of the community may play a significant role in facilitating or enabling SV; which can include minimising the impacts, or normalising the occurrence of SV (Gavey, 2019). The professionals in the current research highlighted the importance of evaluating the beliefs that SVRJ support people hold within risk assessment. This is in agreement with the wider literature, which reports that supporters holding incorrect and unhelpful beliefs (e.g., rape myths) can bring harmful perspectives into the SVRJ process and risk revictimising the victim-survivor (Cheon & Regehr, 2006; Daly, 2006; Jülich, 2001; McDonald et al., 2020; Mercer & Sten Madsen, 2015). The relational context and dynamics of proposed SVRJ support people and participants is also important to consider, as it is acknowledged that some SVRJ support people may escalate conflict between parties and cause further harm, and that such persons would therefore be inappropriate to allow into the process (Jülich et al., 2010; Mercer & Sten Madsen, 2015).

Given that the SVRJ process is likely to be an emotional experience for all involved, the emotional responses and general emotionality of SVRJ support people was also discussed as something that need be considered in risk assessment. Professionals explained that in their experience, support people could often hold more anger about the harm that occurred than the people more directly involved in that harm.

“When harm has happened to someone we love, one of the ways we express that love is to be angry for them, or to hold that more punitive element. Usually, they're more angry than the people that have been harmed.” (P7)

“Often the support person for the person harmed is angrier than the person harmed is, often less restorative in their thinking, and often out to attack the other person... So, they're actually often the hardest to manage in the process.” (P8)

Professionals emphasised assessing whether a SVRJ support person would be able to hold their own emotions, be present through the SVRJ process, and be supportive of what the SVRJ participants needed.

“[SVRJ support people] might have their own emotional reactions to what's happened and so they may be in a much more adversarial space that's going to create a lot of animosity in the conference, and so that will be too much of a distraction from the survivor's needs.” (P4)

“If their support people are in a punitive space still, then those are people that are not going to be helpful for the survivor because the survivor is looking for healing... Are they (the SVRJ support people) going to really be able to allow this process to not focus on them?... What [do] their own emotional regulation skills look like? Is this going to be harmful for them? Is this going to be appropriate for them?” (P15)

“[Can the SVRJ support person] really understand how they (the victim-survivor) are feeling, or are their own feelings so strong that they can't do that?” (P5)

Professionals described appropriate SVRJ support people as people who had some understanding of the harm that had happened, could prioritise the needs of the victim-survivor over their own emotional responses during the SVRJ, and understood their role as supporting participants through the SVRJ process and continuing to support and hold the perpetrator of harm accountable going forward.

“[An appropriate support person is] someone who knows, who's heard the full story... and who sees themselves there to both support and hold to account.” (P13)

“[We’re] making sure... that the support person... has their (the participants’) best interests at heart.” (P6)

There is little research exploring the role and experiences of SVRJ support people specifically, nor the impacts on them of being involved in SVRJ (Hadar & Gal, 2023). In the RESTORE program research it was noted that SVRJ supporters made punitive or blaming comments towards the person responsible in half of the conferences examined, and that SVRJ support people of the perpetrator were the group most dissatisfied with the process (Koss, 2014). SVRJ processes are recognised to have the potential to stir up strong feelings among support people, including anger, sadness, or guilt (Mercer & Sten Madsen, 2015). Given that SVRJ is an emotional process which requires SVRJ support people to bear witness to participant (victim-survivor) experiences and likely distress, SVRJ support people need to be confident in their ability to safely be part of the SVRJ process (Ministry of Women's Affairs, 2009).

Theme Two Summary

The theme of **safe support systems** covered professional discussions around the importance of understanding participant engagement (or lack thereof) with a broad network of supports as a crucial aspect of SVRJ risk assessment. This theme was comprised of three subthemes: **social support**, **external professional support**, and **SVRJ support people appropriateness**.

Social support and **external professional supports** were identified as being important protective factors against risk within SVRJ and professionals acknowledged that when such support is lacking, they worked to encourage participants to build this up, and may ultimately deem SVRJ inappropriate if support remained insufficient. **Social support** was defined as people who are aware of the SV and harm that has occurred and were able to offer appropriate emotional support to participants engaging in SVRJ. Such support could help to

ensure participants had ongoing, wrap-around emotional support during and after SVRJ processes. For perpetrators, these supports were also noted to play an important role in their accountability taking and in helping to enhance meaningful engagement in SVRJ.

Professionals also highlighted that complex dynamics that may be present in cases of shared social networks should be carefully considered in risk assessment, as well as the impacts of the SV and subsequent harm on the social support systems themselves. Given the demonstrated importance of social supports for participants in SVRJ, social support is considered an important aspect of SVRJ risk assessment and should be included in recommended risk assessment guidelines.

External professional supports were also identified as being important to consider within SVRJ risk assessments, particularly in instances where social supports may be lacking. Professionals identified that external professional support can help participants prepare for SVRJ by helping them increase their emotional capacity to engage in SVRJ, and by increasing perpetrator insight into the harm they had caused, which could reduce both the likelihood of reoffending and/or revictimising victim-survivors within SVRJ. External professional support offers an extra layer of safety for participants, provided by people with strong understandings of the dynamics and significant impacts of SV. Professionals within the current research emphasised the ongoing nature of external professional support as being particularly valuable for participants, enabling access to continued support during and after the SVRJ process, particularly if unexpected distress should arise. Assessing participant access to and engagement with external professional supports is therefore considered an important factor of SVRJ risk assessment for both victim-survivors and perpetrators and is included in developed SVRJ risk assessment guidelines.

The subtheme of **SVRJ support people appropriateness** explored professional discussions around assessing the risk of support people involved in the SVRJ process and ensuring that proposed SVRJ support people could play their supporting role appropriately.

Assessing SVRJ support people appropriateness was understood to involve consideration of victim-survivor preference, considering the nature and dynamics of relationships across participants, the support people's ability to participate without bringing stigmatising or harmful beliefs into the SVRJ process, and their ability to manage their own emotional experiences. Given the important role of SVRJ support people and the level of risk they contribute to SVRJ, it is obvious that careful assessment of their appropriateness must be included within the developed SVRJ risk assessment guidelines.

Chapter Nine: Theme Three Analysis and Implications

Culturally Competent Assessment

“Talking about the moon, the stars and the sky.” (P11)

The theme of **culturally competent assessment** captures professional discussions about the importance of ensuring SVRJ risk assessment appropriately incorporates and considers cultural differences and needs. This was understood as a single theme covering the importance of culturally responsive risk assessment processes, acknowledging professionals’ limits of cultural awareness, and recognising the importance of collaborating with participants and cultural supervisors to ensure culturally safe and accurate assessment. Professionals discussed culturally competent risk assessment as applying to all participants within SVRJ, so these findings are discussed as applicable to both victim-survivors and perpetrators in this chapter.

Culturally Competent Assessment Theme

The theme of **culturally competent assessment** became evident in analysis as professionals affirmed the importance of assessing participant cultural identity and needs, emphasising culture as vital to understanding the full risk profile of the SVRJ participants. When asked whether cultural differences impact SVRJ risk assessment, one professional stated:

“Definitely... More often than not and more than I think most people think.” (P15)

Psychological assessments have often been criticised due to cultural bias, which predominantly results in negative impacts for people belonging to minority groups (Reynolds & Suzuki, 2012). In line with best practice and ethical responsibilities there is increasing acknowledgment that assessment should involve consideration of individuals in the context of their cultural background and that culture should inform the whole assessment process (Brach & Fraserirector, 2000; Brissett-Chapman, 2000; Holder, 2000; Shepherd, 2016;

Smith, 2001; Woldgabreal, 2023). Such assessments can be understood as being made in a culturally competent manner. Definitions of cultural competence commonly stem from Cross et al. (1989, p. iv) who defined cultural competence as “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations”. Therapist multicultural competence has been theorised to involve professionals who work to expand their knowledge of others’ cultures and perspectives, develop and use approaches which are culturally appropriate for clients, develop awareness of their own assumptions shaped by their cultural standpoint, and acknowledge the influence of culture on their own and their clients’ behaviour (Sue et al., 1992; Sue, 1998; Whaley & Davis, 2007). These aspects of cultural competence will be explored further throughout this chapter. Culturally competent professionals are widely considered to be an important aspect of addressing racial or cultural disparities seen for minority groups in many aspects of society, including within justice systems (Frisby & O’Donohue, 2018; Sue et al., 2009).

Many professionals acknowledged culture as a broad concept and reported that it could impact on SVRJ participants and their experience of SVRJ in many ways. Professionals stated that developing an understanding of participants’ cultural perspectives helped provide insight into their way of thinking about and understanding themselves, others, and the world around them.

“Culture has such wide possible interpretations... For me, it's needing to understand; what are the core assumptions and beliefs that they carry.” (P12)

“When we're doing the risk assessment I would ask ‘Where do you come from?’ I would do what I call ‘Talking about the moon, the stars and the sky’ because I want to find out where you're coming from, and that would tell me in some way, what you're kind of

thinking... What is a risk in the European society may not be a risk in an ethnic society.”

(P11)

Professionals were, however, quick to clarify that differences in cultural norms and understanding could not excuse harmful sexual behaviour.

“Culture’s not an excuse for offending... sexual abuse is not acceptable in any culture.”

(P3).

Culture contributes to the formation of worldviews based on generations of experience, which can help one make sense of the world, their place in it, and their interactions with others (Note et al., 2009). Culture therefore influences the ways in which situations and emotions are labelled, interpreted, experienced, reacted to, or expressed (Boiger et al., 2018; de Groot et al., 2021; Lim, 2016; Turner & Stets, 2005). This includes experiences of emotions such as shame, guilt, or remorse, and both the act of giving and the meaning interpreted from an apology (de Groot et al., 2021; Maddux et al., 2011). Risk assessment within SVRJ should involve professionals developing some understanding of participant cultural perspectives which will influence their participation in, and experience of SVRJ, as differences in these viewpoints could cause misunderstandings and increase risk of harm in SVRJ processes, particularly if culture is not shared between participants.

Professionals discussed the importance of assessment of participant cultural positioning and needs being collaborative, and not relying on assumptions which could be misplaced.

“One of the risks in doing RJ is that the survivor may end up feeling like they’ve just lost control of this whole process, that somebody or other has taken over the process and this isn’t what they actually want... From the point of view of the person who is leading that process this is being done culturally right. But is it being done culturally right for that particular survivor?” (P2)

“The important thing is to try and establish... what is going to be helpful for you? Where are you... spiritually, physically, and emotionally? And how does that connect in with your cultural heritage?” (P1)

Through a collaborative exploration of cultural standpoint, professionals explained how certain cultural tendencies, norms and values may come to light, which could then be considered and incorporated within SVRJ risk assessment processes. Professionals in the current research discussed the influence of particular cultural perspectives that may be especially relevant in the context of SVRJ, including the role of forgiveness (e.g., victim-survivors feeling they “should” forgive), shame (e.g., around sex or victimisation), or gendered expectations (e.g., the role of women). The cultural differences in the way people behaviourally express emotions or show respect was also highlighted as being important to understand and considered within the context of risk assessments. An example of this from one professional follows:

“Māori and Pasifika, generally, if they're feeling ashamed, won't look at somebody in the eyes, and they would consider that a disrespectful position to hold. So, for a Pākehā or European person, looking somebody in the eye means you're telling the truth and if you can't look them in the eye, it means you're lying. So that's a different cultural expectation that we would have to manage” (P8)

For many professionals a key example of cultural differences was acknowledging more collectivist tendencies of Māori and Pasifika cultures compared to the more individualistic tendencies of Pākehā culture, which could mean that culturally competent assessment with Māori and Pasifika participants may involve a broader, more holistic approach to the SVRJ risk assessment process.

“[For Māori or Pasifika] working with a wider whānau aspect is really important...it becomes not an individual process but a family process... an individual shamed a family,

and it's dealing with that in more of a family way or whānau way than perhaps we do in a European style one.” (P3)

One Māori professional in the current research explained some of these cultural impacts for Māori and Pasifika in the following way:

“Working with Māori, and often Pasifika, there's just this kind of real sense of whakamā¹⁹ when it comes to the offending, and it's not something that they alone hold, it's a whānau thing. So often you'll see lots of secrecy... they're ostracised, isolated and... it's a collective mamae²⁰, rather than just that person's... If I could be super general, the harm that's caused and sustained for both sides, the victim and the perpetrator, is not just for one person, it's a collective harm that we hold because as indigenous people we do everything in community.” (P15)

It has previously been reported that professionals can avoid relying on stereotypes or culture based generalisations which may lead to misunderstandings, by collaboratively discussing and exploring client cultural views and needs with the specific participants (Jongen et al., 2018). By taking a broader, collaborative approach, assessment is often more culturally appropriate and more accurate as the influence of family/whānau and the wider social and cultural context are considered (Allnutt et al., 2010; Bronfenbrenner, 1977; Dirik et al., 2017; Dutton, 1995; Dutton et al., 2006; Pitama et al., 2007; Spencer et al., 2019). A holistic approach, including the gathering of information from a variety of sources and involving whānau, is in line with assessment recommendations from various Aotearoa New Zealand agencies (Fanslow et al., 2016; Holder, 2000; Ministry of Health, 1998; Oranga Tamariki Ministry for Children, 2014). Research indicates that a more holistic approach can

¹⁹ Shame, embarrassment

²⁰ Pain, injury

also significantly increase satisfaction and improve outcomes for service users (Hartmann et al., 2010; Jackson et al., 2019).

Professionals discussed being flexible and open to the cultural needs of participants in SVRJ as part of culturally competent risk assessment, and mitigation of risk in SVRJ. This could include procedural differences in the way meetings are opened, who is involved, or where the process is held.

“[Using] cultural practices around helping people settle and be in the room.” (P8)

“Being led by the participant... asking the person in front of me if there was anything in particular that felt relevant to them, that felt important?” (P7)

Some professionals discussed how having processes on a marae for whānau Māori could be appropriate, however the many complications and risks associated with this were also raised including considerations about who is involved and how cultural processes would be appropriately managed, as highlighted by a Māori professional:

“When it's in a wharenuī²¹ you need to know how is that tikanga operating in the space? Who's operating it? And who are the people that are going to be in there?... how's the whakatau²² or powhiri²³ process going to be handled? What about the karakia? ... What about the order of storytelling? What about different kaumātua who might want to stand up and talk? ... There's a lot that can go wrong if you don't know what you're doing, or if you haven't done the preparation.” (P16).

Ultimately, professionals discussed that SVRJ should be responsive and flexible to the needs of the participants, while still holding on to the values of RJ:

²¹ Meeting house

²² Greeting

²³ Welcoming

“I think we need to be really culturally considerate and mindful, but I also think if we are being fully restorative and following the needs of the people in front of us, then we will be culturally competent or considerate... because a restorative process is inherently flexible and based on responding to those needs” (P4).

“[We’re] trying to find a path for our (restorative justice) culture and the culture that we’re working with to work together to get to the conclusion that we want to get to, which is the person taking responsibility and owning the offending... holding our kaupapa, but being flexible enough to work within another culture.” (P3)

Adhering to the Ministry of Justice’s practice frameworks (2011b, 2013) and in line with Te Tiriti o Waitangi (1840), RJ professionals practicing in Aotearoa New Zealand have a responsibility to ensure processes are conducted in a culturally competent manner, responsive to the cultural needs of participants. Greater professional cultural competence is positively associated with client satisfaction, the therapeutic alliance or working relationship that develops, general impacts of the work done together, and the client’s perception of professional skill (Castro & Ruiz, 2009; Tao et al., 2015). RJ is a flexible process which should be responsive to the needs of participants. Professionals in the current research highlighted that there is a balance between ensuring professionals work in a flexible, and culturally competent way, and are responsive to the needs of participants, while still holding on to the guiding values that characterise RJ (Ministry of Justice, 2019b).

Professionals agreed on the importance of SVRJ risk assessments being completed by assessors with some awareness or knowledge about the culture of the person with whom they were working.

“Knowing about people’s cultural norms and values is really important.” (P8)

“Certainly understanding what the different cultural variants are and therefore what that might mean for a process.” (P12)

Many professionals highlighted the importance of understanding their own cultural perspectives, in order to question how their perspectives might impact on their understanding and assessment of people from other cultures. This included being aware of the limits of their understanding of other cultures, and an awareness of their own cultural blind spots.

“[Being] as culturally safe as possible... is about being aware of who I am, and who I am not.” (P13)

“Recognising the limits that I would have as a white Pākehā facilitator. Recognising that there's some things that will be in my blind spot and that I won't be aware of.” (P4)

A Māori professional highlighted the importance of cultural knowledge and understanding as follows:

“There are times when I see Māori groups doing something, and a different assessor might say ‘Yeah, actually, that doesn't look safe’, but if you know what they're doing and you understand the tikanga of things, you can say ‘Okay, I can see what's happening here, and it's safe... and the other way of doing it actually wouldn't be safe in this space.’” (P16)

Having some level of knowledge of other cultures, as well as one's own, is commonly acknowledged to be an important aspect of cultural competence (Brissett-Chapman, 2000; Smith, 2001; Sue, 1998; Sue et al., 2009). A self-reflexive practice is therefore an important aspect of professional cultural competency, as professionals continue to develop their understandings of their own cultural perspectives and the impacts of these on their assessments within SVRJ (Woldgabreal, 2023).

The importance of cultural knowledge demonstrates the importance of cultural supervision and guidance within SVRJ risk assessment. Professionals discussed seeking

cultural consultation, guidance, and supervision from people culturally knowledgeable including whānau, elders, cultural supervisors, or specific organisations.

“Including appropriate cultural supervision or kind of cultural guidance is also really important.” (P4)

“[Being] informed in our practice by somebody who is culturally knowledgeable.” (P11)

“I would say that the person facilitating... would really need to take a lead from whānau... I think if you're not from that culture... you need to have someone that is, that can help guide you... And just be led by them.” (P15)

Professionals also felt that, where possible, offering SVRJ professionals who are from the same culture as participants could help improve cultural safety and understanding of risk.

“When people are given a choice, they’ll obviously gravitate to someone who they perceive will ‘Get it’... We’re in much safer ground if we... can offer... a culture and gender match.” (P13)

“Where possible, let people know that you have a facilitator who’s from the same culture, or has experience with that culture, anyway... Because, you know, things that might be safe in a non-Māori environment... might not be safe in the Māori environment, and vice versa.” (P16)

However, it was noted also that offering professionals with the same cultural background was not always possible.

“We don’t have enough Indigenous psychologists or the people doing the risk assessment, or even the RJ facilitating, we don’t reflect the diversity of the population and yeah, I think that it’s a pity and potentially a whole lot of unnoticed biases might creep in.” (P6)

Specialist professional supervision, including cultural supervision and consultation with cultural advisors is required as per the Ministry of Justice practice framework for SVRJ

(Ministry of Justice, 2013). The literature confirms that matching clients with professionals of similar ethnic or cultural backgrounds is another way to minimise differences in cultural perspectives and knowledge, which can lead to lower rates of client attrition and improved treatment outcomes within therapeutic relationships (Cabral & Smith, 2011; Ibaraki & Hall, 2014; Kim & Kang, 2018; Presley & Day, 2019; Shin et al., 2005; Weekes, 2010; Whitfield et al., 2010). Matching clients with professionals of a similar background can help build initial rapport and connection, may increase participant sense of safety, and may also be a motivating factor for professionals (Leung et al., 2022). Clients with stronger non-majority cultural identification tend to have greater preferences towards cultural matching with professionals, and accommodating such preferences can lead to improved outcomes (Ilagan & Heatherington, 2022; Swift et al., 2018). There can, however, also be disadvantages for cultural-matching, including an increased reluctance to discuss topics which are culturally taboo (Ibaraki & Hall, 2014; Leung et al., 2022).

Theme Three Summary

The theme of **culturally competent assessment** has involved reflection on many aspects of cultural competence raised by professionals within the current research. Professionals in the current research agreed that in order to accurately assess risk and engage in a culturally safe manner, SVRJ risk assessment must be conducted in a culturally competent manner. Professionals highlighted the importance of having a level of cultural understanding, both of their own cultural background and of the cultures of the people with whom they were working. Assessment was conceptualised as needing to include collaboration with participants to develop an understanding of their cultural views, values and needs for SVRJ. Further, professionals highlighted the importance of considering the ways in which culturally influenced interpretations of experiences or behavioral expressions of emotions or values (e.g., shame or respect) may impact on SVRJ processes, particularly in cases where participants are of differing cultural backgrounds. As such, the developed SVRJ

risk assessment guideline recommendations will prompt professionals to consider whether alternative approaches or procedural differences are needed for the assessment, to consider whether participants would like to be matched with professionals from similar cultural backgrounds (when possible), to reflect on their level of relevant cultural competence, and to consider whether cultural supervision should be sought to support accurate assessment.

Chapter Ten: Theme Four Analysis and Implications

Participant Alignment

“[It’s] the hand in the glove.” (P12)

The theme of **participant alignment** explores professional discussions about the overall “match” between the potential SVRJ participants. This involved considering the likelihood of a successful SVRJ process, against the risk of causing harm by engaging in SVRJ for these participants. Two subthemes were identified within this theme. Firstly, the subtheme of **justice needs alignment**, which involves consideration of the likely ability of the perpetrator to meet the victim-survivor’s justice needs. Secondly, the subtheme **balance of needs and safety**, captures professional discussions around weighing up potential risk against the desire to respect victim-survivor wishes in instances where victim-survivors want to proceed with SVRJ despite a lack of demonstrated accountability from the perpetrator. Where theme one (explored in chapter seven) discusses risk assessment considerations around individual participant preparedness for SVRJ, this theme explores how those individual participants and their readiness for SVRJ are aligned; how they may act and react within the SVRJ process together. Note that as this theme explores the match between participants, the subthemes are discussed as relevant to both parties.

Participant Alignment Subtheme One: Justice Needs Alignment

The subtheme of **justice needs alignment** arose through professional discussions about the importance of considering the match between the participants in SVRJ risk assessment. Evaluation of the alignment between participants was discussed as involving consideration of the restorative justice needs and expectations for SVRJ of the victim-survivor, and the perceived capacity of the perpetrator to meet those needs and expectations within a SVRJ process. This included consideration of the alignment between their respective individual

emotional capacities and restorative motivations for engaging in SVRJ (which were discussed in theme one).

“It's all about what the survivor needs, and can the offender's degree of responsibility meet the survivor's needs?” (P3)

“[Considering] what are they wanting to get out of it, is it realistic, and then is it likely to be something that will be achieved, knowing the particular individuals involved?” (P13)

In terms of the alignment between the participants' individual emotional capacities, professionals considered the emotion and communication styles of the participants and how these might play out in tandem. Professionals expressed that differences in this alignment between participants must be carefully considered and could result in SVRJ being considered either appropriate or inappropriate, depending on the level of risk, particularly to the victim-survivor.

“I've had restorative justice conferences where I haven't felt the offender is... being particularly accountable... but where the victim-survivor is saying 'I'm now feeling strong... I know what he's likely to say and I don't care about that... I want him to have to look me in the eye while I tell him what he did to me.' ... and so, on that basis, those two things are more aligned. Whereas, if you've got a victim-survivor who's... still sort of almost blaming themselves... that to me is not going to be appropriate.” (P12)

“Where people can express their anger in a healthy way, and the person who's at the receiving end of that has the ability to hold themselves in that space, then it can be really a really powerful thing. But if the person who's on the receiving end is just going to come back being defensive and argumentative, then that just becomes a shit fight, it's not going to be helpful for anyone, so those are the things that don't go together.” (P8)

Part of alignment between participants might also involve considering how participants' stories of the harm match up. Most professionals stated that stories did not need to totally align with each other, and commonly did not for various reasons.

“There's no such thing as objective truth... we all perceive things differently, and so... they never have the same story.” (P7)

“It is incredibly common for guys who have sexually offended to be able to say, ‘I can acknowledge this, but to actually acknowledge that is a lot more difficult.’” (P2)

However, professionals did report that there needed to be enough of a match between the stories, so that victim-survivors would not be retraumatized by denial of aspects that were important to them. Ensuring that there was enough alignment between stories could be done by collaborating with both participants, and checking with victim-survivors if agreement was sufficient for them to want to proceed with a SVRJ process.

“If there is a matching that's good, and if there isn't again there's that kind of negotiation to see if there's enough matching.” (P1)

“[I'd ask the victim-survivor] ‘Is that enough for you? Because if it's not then we're not going to go ahead... because you're not going to get what you need out of it, and that's what this is all about.’” (P14)

Major differences in stories, or a lack of alignment between victim-survivor needs and what the perpetrator would be able to offer, suggests the victim-survivor may not get what they need from the SVRJ process, and the process may therefore not be appropriate.

“The cases that I've seen screened out of restorative, for good reason in my view, are cases where there is no match between what a person can offer and what a person wants to hear.” (P6)

“For me it doesn't have to perfectly align, I guess it's around what is material, particularly to the victim-survivor... if there's an absolute denial of something that's important to the victim-survivor, then I would truly question; is this the right process?”

(P12)

“If there's no matching at all, then we can't go ahead with the restorative justice process.” (P1)

An important part of preparation prior to SVRJ processes involves professionals and participants developing a shared conception of what the offending entailed; that is, a shared story of the harm. Ensuring professionals understand the victim-survivor's story (particularly the important aspects they need validated), enables them to compare this with the perpetrator's story and to consider whether misaligned elements are likely to cause the victim-survivor harm in SVRJ (Jeffries et al., 2021).

Professionals reported trying to give victim-survivors an idea of what they should expect within the SVRJ process, by providing them with a sense of how the perpetrator is likely to act and respond. This was framed as part of a collaborative assessment of justice needs alignment, helping to ensure that participants, particularly victim-survivors, had reasonable and realistic expectations for the SVRJ conference. This was noted by many professionals as being particularly important for mitigating risk, as unmet expectations could cause harm to victim-survivors.

“Sometimes we might have to help the person who's been harmed have a realistic picture, so that they don't expect more than what they're going to receive... If they have an unrealistic expectation, and then that isn't actualised, that's going to cause them harm and destabilise... and put them back in their healing and recovery.” (P8)

“Being really clear [about] what is possible and what isn't it, you know. If you want the person to take hundred percent responsibility and find lots of words and be able to show

great empathy, then, in some cases, that's not going to happen. So, what's the least you could get that would help you, and what's enough?" (P5)

It was noted that expectations or hopes for SVRJ need not perfectly align with likely capacity for these to be met, but as part of mitigating risk within SVRJ, professionals aimed to work with participants to keep expectations at least somewhat realistic.

"I think having a sense of realism about what's going to come out of it is really important." (P13)

"[It's] the hand in the glove... is there an alignment of expectations on both sides of the equation?... it's the alignment piece that feels, to me, a crucial thing here." (P12)

"[We're] keeping the expectations of both clients at a level that connects or that is close to matching." (P3)

Alignment of expectations extended to having realistic expectations of restitution agreements, which professionals highlighted must be realistically achievable for perpetrator, so further harm is not caused by the perpetrator's later inability to meet agreements.

"Restitution is a big issue. How do you sort out a sum of money that compensates people for the harm they've done?... You have to have dealt with that as much as you can beforehand so there is some realistic understanding, because what you don't want to do... is to wreck the whole process by not being able to agree restitutions." (P2)

"There's expectations all over the place... Stuff around money or around what they're saying they need, or what they can offer, [making sure] that those are realistic." (P16)

"Don't say 'I can pay \$5,000' because it's going to look good that you paid \$5,000; what can you afford?" (P3)

The scientific literature and the findings of the current research, encourages professionals to explore participant expectations of what may occur within SVRJ through the risk

assessment and preparation process, including their predictions of how other parties may act or react both in and following the process (Freshwater et al., 2002). Such a practice helps professionals develop a greater understanding of possible or likely occurrences, putting them in a better position to weigh up risk. Professionals in the current research discussed checking expectations and trying to ensure that they were realistic considering the individuals involved, by feeding information back to victim-survivors, so as to provide them with a sense of the perpetrator's level of accountability taking and likely responses to questions. This was considered important as it helps to ensure that victim-survivors are not entering SVRJ with expectations that are very unlikely to be met and could therefore result in revictimisation and harm. Such a practice of checking and shaping participant expectations to ensure reasonable expectations for SVRJ is recommended by the Aotearoa New Zealand Ministry of Justice (2011b) and is in line with the practices used in court-referred SVRJ in Aotearoa New Zealand (Jülich et al., 2010; Jülich & Landon, 2017).

Participant Alignment Subtheme Two: Balance of Needs and Safety

The subtheme **balance of needs and safety** summarises the discussions professionals had around making an overall decision about the level of risk present, and whether to proceed with SVRJ. This was described as weighing up the victim-survivor's justice needs and the likelihood of these being met against the risk of harm occurring from engaging in a SVRJ conference in each specific case.

"It's my role to hear from them both... and then figure out, am I happy... that there's not going to be harm on top of harm in the first place, in any direction, and that there's value in it for these people going ahead." (P16)

"In all this work we're not talking about perfect, it's always going to be a balancing of, you know, risks versus potential rewards, versus the risks of not doing something in terms

of what's the harm that we leave there? And of course, the victim-survivor needs to be at the centre of that.” (P12)

In making the overall decision about going ahead with SVRJ, professionals emphasised the importance of collaboration within SVRJ risk assessment. Collaboration was highlighted to include feeding back information and discussing opinions and options, with participants (particularly victim-survivors), as well as making sure that risk decisions were made in collaboration with other involved professionals.

“[Risk assessment] feels like something that we need to collaborate on and be determined on together... it doesn't feel like a set of criteria that they need to accomplish, it feels like something we're working towards together to make sure that they got all the support they need, as identified by them.” (P7)

“Always coming back to the person who's been harmed to say, ‘Okay, here's what it looked like. What do you want to do?’ Instead of us making decisions for them... What can we do to ensure that you get the best out of this process, and what's the safest route here for you to take?” (P15)

“We're all looking at the risk from a different perspective... So, it's not just one person's sole responsibility, it's a shared responsibility.” (P8)

“I'm not relying on just ... my professional instincts, there's someone else.” (P3)

The inclusion of victim-survivors within risk assessment and decision-making was explained as particularly important given the disempowering experience of victimisation, and the need to respect victim-survivor's perspectives.

“There is a danger in us assuming, always, that people are fragile and broken and don't have some degree of autonomy and ability to make decisions.” (P12)

“We can be over-protective, and then we can take away voice and agency of the participant.” (P8)

“It's their life, and it's their harm, and it's their story. And I'm there to keep them safe through whatever they want to do. But it's up to them. It's not up to me.” (P7)

Previously, victim predictions of risk (particularly in intimate partner violence) have been shown to be a strong predictor of re-assault (Heckert & Gondolf, 2004; Weisz et al., 2000). Victim predictions can add significant information to professional assessments of risk, and improve risk prediction (Bowen, 2011; Cattaneo et al., 2007; Connor-Smith et al., 2011; Heckert & Gondolf, 2004; Jenney et al., 2014; Weisz et al., 2000). Often the person responsible for perpetrating harm is known to the victim-survivor, meaning they may have a far greater understanding of their patterns of behaviour, and may be more sensitive to dynamic risk factors than outside professionals or actuarial assessments (Connor-Smith et al., 2011; Schaller & Aebi, 2022). Including victim perspectives within risk assessment helps victims feel heard, which can increase the likelihood of them reaching out to support services in the future, should they be required (Schaller & Aebi, 2022). One of the significant benefits of SVRJ is the space and opportunity it provides to empower victim-survivors, by giving control back to them, and listening to and respecting their wishes (Keenan, 2014; Miller et al., 2020). This centring of the victim-survivor is also a key value of RJ (Jeffries et al., 2021; Zehr, 2005). Trusting and valuing victim-survivor opinions and wishes is in line with restorative aims of empowering victim-survivors, in contrast to the often disempowering, paternalistic nature of conventional justice systems. Practitioners must however, balance empowering victim-survivors and respecting their choices with the overall safety of SVRJ participants (Mercer & Sten Madsen, 2015). Unfortunately, well-meaning concerns about going ahead with SVRJ, particularly in academic or theoretical circles, can result in the wishes of victim-survivors to proceed with SVRJ being ignored, as others try to protect them. While it is acknowledged that harm has been done, victim-survivors may not feel in need of

‘protection’, and the idea that they need special care may perpetuate a harmful stereotype of victim-survivors as being weak, unfit to speak for themselves, or make their own decisions around engaging in SVRJ (Koss et al., 2017; Wager, 2013). The risk assessment literature agrees that making decisions in teams, with senior professional oversight is the safest way to make risk decisions, and this is in line with processes used in court-referred SVRJ in Aotearoa New Zealand at Project Restore (Fanslow et al., 2016; Jülich et al., 2010).

Professionals had divided opinions about proceeding with SVRJ when a victim-survivor wanted to confront a perpetrator who was not demonstrating accountability. Some professionals described working with victim-survivors whose main justice need is voice and choosing to go ahead with SVRJ, even in cases where they are aware the person responsible for causing harm may not be taking full accountability.

“Sometimes we have a survivor who just really wants to have their say and get across how they have been impacted and that's the most important thing to them... as long as they understand where the harm-doer is, so that it's realistic and they are not being surprised by that in the meeting, we have gone ahead.” (P1)

“Sometimes the decision about whether to go ahead is very much about what the survivor’s needs are, rather than, necessarily, whether the offender is fully ready and acknowledging.” (P2)

“I think it just depends on... how that person (the perpetrator) is going to respond... Are they going to throw a chair or punch someone? No? Kei te pai²⁴. Are they going to be really mad? That's fine. Because this needs to be victim-led and if that's what this person (the victim-survivor) needs then that's what we're going to do our best to facilitate in the safest way that we can.” (P15)

²⁴ That’s alright

One professional went as far as to say:

“If the program is victim oriented and survivor led ... then really the only thing that matters is if that survivor gets what they need, and in some ways... it doesn't matter what's going on for the person responsible, I mean, as long as it's not harmful...but to some extent it doesn't really matter, as long as they give the victim what they need. So... if someone says, ‘Well I want the chance for voice.’ And that's provided then that's, then that's brilliant” (P6).

However, other professionals had alternate viewpoints, and described being uncomfortable going ahead in situations where victim-survivors wished to proceed, but alleged perpetrators were being minimally accountable, reporting that for them such processes were not necessarily restorative in nature and could risk harm to participants.

“I'm not in the slightest bit interested in facilitating a conversation with someone who's not taking responsibility for their actions for two reasons: One, because it could be true, they didn't do it, and they've been accused of something that they didn't do... And secondly... if someone's bullshitting and lying, I don't want to deal with them... For me why I like restorative justice is it's where someone is... willing to front up and take responsibility and face whatever is coming to them; I'm up there 100% supporting them in their endeavour. But if they're not, go away” (P8).

One professional also emphasised that SVRJ is not appropriate for everyone, and so it was important to really consider the potential benefit of any process that might go ahead.

“We also run into some people, some survivors that just are not in a space where this is going to be helpful... nothing is really going to help that unless the offender takes complete responsibility, and even then, it might not be useful.” (P14)

Other professionals discussed the importance of also considering risk in choosing not to go ahead with SVRJ, when considering the balance of justice needs and safety. The risk of not proceeding with SVRJ could include perpetuated relational divisions, ongoing or new victimisation, increased likelihood of re-offending for perpetrators, and not meeting victims' justice needs which could impede recovery from victimisation.

Professionals did however emphasise that final safety and risk decisions lie with the RJ professionals, rather than participants or other people involved.

“We can pull the plug and override the survivor if we think there's risk... if we think that it's not helpful to the survivor... we won't go ahead.” (P14)

“The victim needs to want to do this, the offender needs to want to do this, but we, the facilitators, decide whether it proceeds or not. And that's safety for victims as well.”
(P10)

“Our key principle is that if this process is not in the survivor's interests, then it should not be done, because it could easily cause a lot of harm.” (P2)

In discussing their ability to have the final say on decisions around going ahead with SVRJ or not, professionals often highlighted alternative options available, emphasising that if SVRJ conferences were not appropriate, there might still be other avenues for participants to meet their justice needs.

“If the survivor feels very strongly that they just want to be heard we've got another option where it's a community panel, so that it's the survivor not actually being at the conference... We also have kind of a shuttle mediation that can be done, where it's not, again not face to face, which seems to sometimes help.” (P14)

The safety of participants throughout SVRJ is the primary concern in terms of risk (Mercer & Sten Madsen, 2015). Professionals have an ethical and professional responsibility to do no

harm, and to ensure the safety of participants, particularly victim-survivors in consideration of the harm they have already experienced and the power differentials inherent in SV (Miller et al., 2020). It is ultimately the role of the professional to weigh up the potential risk of proceeding against the potential benefits of proceeding, and decide whether or not SVRJ with these particular individuals is appropriate in this instance (Jeffries et al., 2021; Miller et al., 2020; Ministry of Justice, 2013). This careful decision making can be considered as an important skill or ‘art’ that SVRJ professionals develop (Bolitho & Bruce, 2017). As professionals in the current research highlighted, it is also important to bear in mind that SVRJ is not the only option for victim-survivors to engage in a process that can support them to gain a sense of justice, and further, there are multiple ways of engaging in SVRJ beyond a face-to-face conference with the perpetrator. Alternative options still within the scope of SVRJ could include using a representative at the conference, having a community panel, writing letters, or having a shuttle conference (in separate rooms); professionals described thinking creatively of ways for victim-survivors to have their justice needs met, without exposing them to unnecessary or undue harm (Jülich et al., 2010). Beyond SVRJ, alternative means of justice could include engaging in marae justice, or the conventional criminal justice system. Researchers have previously suggested a “menu” of justice options could be created for victim-survivors, who once informed of various available justice mechanisms could choose the option best suited to them (Daly, 2011). The Aotearoa New Zealand Law Commission (2015) has affirmed that a future in which victim-survivors have fair access to experience justice would involve having a range of different justice processes available.

Theme Four Summary

The theme of **alignment between participants**, consisting of two subthemes; **justice needs alignment** and **balance of needs and safety**, has been analysed within this chapter. This theme discussed the overall alignment between individual SVRJ participants, specifically how likely it was that SVRJ would meet victim-survivor justice needs and how

likely it was that participants would be harmed within a SVRJ process. The aspects considered within participant alignment included the match between participants' emotional capacities to engage in SVRJ, their stories of the SV, their restorative motivations, and the likelihood of victim-survivor justice needs being met given the level of accountability demonstrated by the perpetrator. This theme has highlighted how the ideas explored in theme one of individual perceived participant preparedness, must also be considered in the context of the participants together. That is, risk assessment must consider both the participants in isolation and in conjunction with one another. These findings also highlight the importance of SVRJ risk assessment involving ongoing collaboration with participants, particularly victim-survivors to ensure they have a realistic sense of what to expect within the SVRJ process, and still wish to proceed with these realistic expectations in mind.

Considerations of participant alignment also led professionals to discuss the value of weighing up the balance between victim-survivor justice needs and a desire to engage in SVRJ, against the overall possible risk of harm. Professionals were divided on whether SVRJ should go ahead in instances where perpetrators were showing limited accountability, but victim-survivors still wished to proceed with SVRJ. Professionals emphasised the importance of respecting and empowering victim-survivors' choices, however, they also acknowledged a professional ethical obligation to limit the risk of harm occurring within SVRJ. The important role of feedback, discussion, and collaboration with victim-survivors and within professional teams was emphasised by professionals.

Given these findings the developed recommended SVRJ risk assessment guidelines will prompt professionals to reflect on the alignment of participants in terms of the likelihood that victim-survivors will be able to have their justice needs met by a SVRJ process with the perpetrator. This will include consideration of emotional capacities, participants' story and acknowledgement of the harm, and their desire to take accountability (perpetrators) or have their restorative justice needs met (victim-survivors). Professionals will be prompted to

consider the likelihood of justice needs being met against risk of harm occurring in SVRJ, and whether alternative processes may be more appropriate for participants. Further, professionals will be encouraged to work collaboratively, involving victim-survivors in risk decision and considerations, and working within a team of other professionals with whom they can reflect and discuss risk inherent within any particular case.

Chapter Eleven: Overall Discussion, Implications, and Conclusions

Summary of Key Findings

Using reflexive thematic analysis, four main themes were identified: **perceived participant preparedness, safe support systems, culturally competent assessment, and participant alignment**, along with their respective subthemes. Within SVRJ risk assessment, professionals discussed several important factors of individual participant readiness for SVRJ; this was understood as the theme **perceived participant preparedness**. The first subtheme within this was **restorative motivations**, which included consideration of participants' ability to freely give informed consent to engage and whether they held restorative motivations for engaging. **Emotional capacity** was the second subtheme identified, which included ensuring participants were emotionally well enough and had adequate adaptive coping skills, and that the perpetrator had an adequate ability to demonstrate empathy, before entering into SVRJ.

The second theme related to assessment of the presence, availability, and supportiveness of others around SVRJ participants, this was labelled **safe support systems**. Three subthemes were identified; the first involved understanding the **social support** around participants, the second subtheme related to **external professional support**, and the third involved considering the nominated **SVRJ support people appropriateness**.

The third theme covered professional discussions around **culturally competent assessment**. This theme explored professional opinions around the importance of considering and incorporating culture within risk assessment, and professional acknowledgements of their own limitations and unintentional biases which highlighted the need for collaborative assessment with participants and engagement in cultural supervision.

The fourth and final theme was **participant alignment**, which involved professional discussions about considering the overall match between the potential SVRJ participants. The

first subtheme within this covered the professional considerations about the likelihood of victim-survivor justice needs being met by a SVRJ process with the perpetrator; labelled **justice needs alignment**. The second subtheme captured professional discussions about balancing the desire to empower victim-survivors with their professional responsibility to keep participants safe; labelled as the **balance of needs and safety**.

Study Implications

The current research advances the knowledge base of how to assess risk within SVRJ, by exploring the perspectives and opinions of a range of professionals experienced in areas of SVRJ and RJ risk assessment. The findings of this research suggest that SVRJ risk assessment should include consideration of the factors identified by professionals, including participant preparedness, safe support systems, culturally competent assessment processes, and overall participant alignment. Given the current study's findings, recommendations for potential SVRJ risk assessment guidelines have been compiled and are presented below.

Recommendations for Potential SVRJ Risk Assessment Guidelines

SVRJ risk assessment guideline recommendations include professional assessment and consideration of:

1. Informed consent: Participants giving free and informed consent to engage in SVRJ.
2. Restorative motivations for engaging in SVRJ.
 - a. Victim-survivors: restorative justice needs (i.e., voice, accountability etc.)
 - b. Perpetrators: primary motivation of wanting to take accountability
3. Emotional Capacity
 - a. Considering participant general wellbeing, mental health, and current adaptive and maladaptive coping skills
 - b. Perpetrators: ability to express/demonstrate empathy for the victim-survivor

Note: Consider if referral to external professional support is appropriate to help participants improve their emotional capacity

4. Safe Support Systems

- a. Social Support (whānau/family, friends; people who know about the SVRJ process and the harm that has occurred and can provide emotional support)
- b. External Professional Support (access to and engagement with external professional support (e.g., therapists, community organisations etc.))
- c. Appropriate SVRJ Support people: Consider relational dynamics (particularly with shared social networks) and ability of support people to manage their own emotionality within the SVRJ process.

5. Culturally Competent Assessment

- a. Consider cultural background factors for participants involved, how these might affect the process and what can be done to ensure cultural needs are respected and met? (e.g., procedural differences, mitigating potential cultural clashes in perspectives/understandings between participants)
- b. Consider assessor's own cultural limitations and whether cultural supervision would support this assessment?

6. Participant Alignment

- a. Alignment between the victim-survivor's restorative needs and perpetrator's accountability taking; Is the victim-survivor likely to get what they need from this process, knowing the individuals involved?
- b. Balance between honouring victim-survivors wishes and safety: Is there going to be undue risk in proceeding with a conference?
- c. Consider alternative processes; is there a better way that justice needs could be met in this case?

In line with preferred risk assessment practices, it is recommended that professionals using these proposed risk assessment guidelines clearly document the evidence related to each assessed factor, any risk management interventions implemented to reduce risk, and their overall risk findings, along with their decision to proceed or not with SVRJ. Further, professionals should work in a way that is responsive to participants' needs, and collaboratively with participants and other professionals, not making risk assessments or decisions in isolation. An example SVRJ risk assessment form based on these guideline recommendations is presented in appendix C.

These recommendations are in line with risk assessment considerations outlined within the relevant Ministry of Justice best practice guidelines, within the processes of Project Restore for court-referred SVRJ in Aotearoa New Zealand, and with the wider literature around assessments of risk (Allnutt et al., 2010; Hanson, 2009; Heilbrun et al., 2004; Holder, 2000; Jülich et al., 2010; Ministry of Justice, 2013, 2017, 2019c).

Implications for Clinical Practice

The findings of this thesis provide insight into professional perspectives, experiences, and opinions of assessing risk in SVRJ. These professional insights can be used to inform risk assessment processes in SVRJ, and potentially related fields. The developed recommended risk assessment guidelines could be used within professional practice to assess SVRJ risk in a more standardised and reliable manner. This could be useful for professionals working with both court-referred SVRJ participants and within community spaces offering SVRJ or similar justice processes in response to sexual harm.

Further Overall Implications

A major overall finding of this research is the affirmation of the complexity of risk assessment in SVRJ. Professionals emphasised the need to make comprehensive and culturally responsive assessments of SVRJ participants, their support systems (including

SVRJ support people), and the overall alignment between the prospective SVRJ participants. This was understood to include collaboration with participants, other relevant professionals, and cultural supervisors. Within this collaborative approach to assessment there is a need for significant flexibility, as SVRJ professionals must work responsively with multiple other people and will require time to compile and reflect on the information gathered for the assessment and management of risk. Professionals commonly stated they would work with participants to improve their readiness for SVRJ if this appeared initially lacking or insufficient. This was discussed as including work to improve participant emotional capacity, and build up supports, as well as work with the participants' support people. Assessment of one potential SVRJ participant could therefore involve relationship building, assessment, and interventions with multiple people across multiple meetings. Assessment processes must also be flexible enough to enable culturally appropriate assessment approaches, which may involve greater time building rapport, consulting with important figures, or facilitating additional culturally important processes within SVRJ. It is therefore acknowledged that SVRJ risk assessment is a process that involves much more than a simple tick box exercise and instead necessitates a highly flexible and individualised approach. As such, SVRJ processes and the funding models which support them must be as adaptable and flexible as the professionals working in this field.

The acknowledgement of the complexity of SVRJ risk assessment also highlights the importance of ongoing training and development for SVRJ professionals. Funding models for SVRJ should include scope for professionals to engage in specialised professional development trainings, as well as comprehensive professional and cultural supervision (New Zealand Law Commission, 2015). Ongoing development and supervision is of particular importance in the realm of cultural competence, to support accurate SVRJ risk assessment with individuals from diverse cultures. There are a variety of interventions designed to improve professional cultural competency, including specific trainings, learning via

immersion, engaging in cultural supervision/mentoring, and administrative and organisational accommodations being made (Brach & Fraserirector, 2000; Jongen et al., 2018).

Additionally, professionals in the current research discussed cultural matching of professionals and participants as a helpful way to mitigate cultural differences (depending on participant preference); however, they also highlighted the current need for more SVRJ professionals from a variety of cultural backgrounds, but particularly of whakapapa Māori. SVRJ organisations could improve their cultural competence by recruiting and retaining more staff from minority cultures, collaborating with relevant cultural figures (e.g., elders, healers), and involving family/whānau, or language interpreters as appropriate (Brach & Fraserirector, 2000; Jongen et al., 2018). It is therefore suggested that work to recruit professionals from a range of cultural backgrounds occur, and that the professionals who are bringing specific cultural knowledge be recognised for that important contribution. Research has also indicated that characteristics above and beyond pure skill and knowledge are required for SVRJ professionals, with facilitation of RJ described as an ‘art’, and the use of specialised experts acknowledged as important for good outcomes (Bolitho & Bruce, 2017; Bolitho & Freeman, 2016). Funding models and financial compensation of SVRJ professionals should therefore include recognition of their level of professional expertise, facilitation skills, cultural knowledge, and the time involved.

External professional support was often conceptualised in the current research as being of particular benefit to both victim-survivors and perpetrators of harm. External professional support was discussed as being highly preferred, however, professionals often noted that participants struggled to access this support. Barriers to accessing professional support in Aotearoa New Zealand include long wait times, limited services with often over-worked professionals, financial costs to service users, and issues such as stigma/shame (Fraser, 2020; Government Inquiry into Mental Health and Addiction, 2018; Kulshrestha & Shahid, 2022). Assistance with accessing external professional support to facilitate participant engagement

in SVRJ could be incorporated into SVRJ participant support and funding models in the future. Improving participant access to external professional supports, and perhaps suggesting engagement in such supports (e.g., therapy, sexually harmful behaviour treatment programs) prior to SVRJ could help streamline SVRJ processes.

Another major implication of this research comes from reflecting on the significant impact of societal stigma and shame around SV, and the ongoing societal belief in rape myths. This research supports the importance of ongoing work to reduce societal stigma and shame in order to support victim-survivors to gain justice and work towards recovery, and to reduce the occurrence of SV by increasing societal awareness and encouraging accountability and corrective action from perpetrators and communities. Work on reducing societal stigma around experiences of SV and belief in rape myths has been occurring and arguably making positive impacts, for example, the #MeToo movement, yet the pervasiveness of such beliefs means there is an ongoing need for such efforts (McDonald et al., 2020; Mendes et al., 2018; Persson, 2022; Stubbs-Richardson et al., 2023). Many professionals discussed their experiences of working with participants who had never told anyone close to them about their victimisation experiences, often due to internalised shame and fears of stigma (Harmer & Lewis, 2022). Research indicates that societal stigma is indeed damaging for victim-survivors and perpetuates unhelpful cycles of silence, shutting down the very conversations that we, as a society, need to be having (Ministry of Women's Affairs, 2009; Temple et al., 2024). If societal stigma and shame surrounding SV were no longer the burden of victim-survivors, it would be easier for them to share their experiences and access support. This would reduce the harmful cycles which are maintained by silence and which enable harmful behaviour to continue unaddressed. A wider understanding of SV and sexual consent may also help curb instances of SV. Conversations around sexual consent, the harm of SV, and dispelling rape myths should be incorporated into sexual education within schools, so that future generations grow up with a fundamental awareness of their rights and their responsibility not to harm

others in this way. Such education fits within the current Aotearoa New Zealand Curriculum set by the Ministry of Education, in alignment with the sexuality and relationships education guidelines introduced in 2020 (Ministry of Education Te Tāhuhu o Te Mātauranga, 2020a, 2020b). However, it is critical that these guidelines continue to be followed and young people have the opportunity to engage with this important information, given the significant and wide-reaching impacts of sexual harm and the current indications of intent to remove such education by the Aotearoa New Zealand government (1News Reporters, 2023; Dexter, 2024; Huston, 2023; Tyson, 2023). Perpetrators of harm might also be more likely to take accountability, acknowledge their wrong-doing and take action to repair the harm caused, if such accountability were more socially encouraged and supported. In a world where there was less stigma attached to SV, the social supporters of SVRJ participants might also be entering processes with less unhelpful beliefs, a better understanding of what harm had occurred, and a better sense of what was needed of them to help hold the perpetrator accountable and to support the victim-survivor. This would in turn reduce the work required of SVRJ professionals in the preparation and assessment processes of SVRJ.

Further, greater societal awareness of RJ and more specifically SVRJ itself would also be beneficial for SVRJ risk assessments. Public understandings of RJ are often limited, may be misinformed, and may skew towards a negative perception of RJ without consideration of the research data (Vaandering & Reimer, 2019). There is limited awareness among the public of Aotearoa New Zealand about RJ in general, and more specifically about SVRJ (Ministry of Justice, 2023c). This means many victim-survivors do not have access to this (or other alternative justice mechanisms) as they are unaware alternatives to the conventional criminal justice system exist. Increasing public understanding of SVRJ, what it entails, and the general benefits and risks involved, could help potential participants weigh up whether SVRJ is something they may be interested in or not. With an initial awareness of SVRJ, participants could likely judge their interest in SVRJ at an earlier stage of engagement than is possible if

they are offered SVRJ with no prior knowledge. An increased awareness of SVRJ could also help supporters have a better understanding of their role, as they enter the SVRJ preparation process. Finally, improved public awareness of SVRJ may also help with recruiting more professionals into the field, which in turn, may increase the availability and accessibility of SVRJ, meaning more victim-survivors interested in the process could engage with SVRJ professionals and potentially access the benefits of a SVRJ process.

As discussed in chapter four, risk is inherently uncertain and difficult to predict in any field. SVRJ risk assessment is confirmed to be a complicated process involving many considerations, weighing up the potential benefit of a SVRJ process against the possibility of harm occurring. Professionals in the current research acknowledged that SVRJ is not appropriate in all situations, and at times the best way they can support participants is to refer them to alternative processes that may be better able to meet their justice needs, and/or may be safer for them to engage in. This demonstrates the need for clear pathways into alternative processes (such as marae justice), if SVRJ is indeed deemed to not be appropriate and another process could be beneficial.

Overall, the research found that while professionals generally agreed on considering the aspects detailed within the developed SVRJ risk assessment guideline recommendations, SVRJ risk assessment was ultimately considered as something that needed always to be flexible and responsive to the individuals involved. It is argued in this discussion, that the wider implications of the current research findings include the need for flexible funding models for SVRJ, increased public awareness of SVRJ, ongoing work to reduce societal stigma around SV victimisation, improved access to external professional support, and clear pathways to alternative justice processes should SVRJ be deemed inappropriate.

Study Limitations

A limitation of the current research relates to the non-random sample of participants. Selection bias may have occurred in the sample of professional participants recruited, as professionals who did not like the idea of risk assessment guidelines may have chosen not to participate in the research, whereas those who thought the research important may have been more inclined to engage. This could suggest that professionals within SVRJ who perhaps view more structured or standardised risk assessment processes as inhibitory to their practice may not have their perspectives on risk assessment reflected in this research. Further, while it was hoped there would be a wide range of cultural backgrounds among recruited participants, most participants reported being of European descent (e.g., Pākehā), only two were Māori, and only one was of Asian descent. While all professionals affirmed the importance of considering cultural background within SVRJ risk assessment processes, exploring the perspectives of professionals from a broader range of cultural backgrounds may have provided further insights within the analysis. Of note, no Pasifika professionals were interviewed, despite professionals often relating anecdotes of working with Pasifika when highlighting the importance of cultural considerations in SVRJ risk assessments. In the context of a bi-cultural society, where Māori voices and perspectives should continue to be highlighted and respected as treaty partners, having only two Māori professional participants recruited to this study may mean some of the differences in perspectives (e.g., from a Te Ao Māori worldview) may not have been fully captured.

A further limitation of the research is its limited scope. This research focused on professional perspectives and experiences of risk assessment within SVRJ. However, during interviews, professionals raised discussions around general issues in RJ and SVRJ within Aotearoa New Zealand including funding models, ethical dilemmas in SVRJ within community practices, and difficulties of SVRJ practices with the correctional system. These

topics were outside the scope of this research but worthy of research and are suggested as avenues for future research.

Recommendations for Future Research

The current research has begun investigating professional assessments of risk in SVRJ and developed risk assessment guideline recommendations. Future research is required to test out the developed guideline recommendations. This could include investigating professional opinions on the developed SVRJ risk assessment guideline recommendations, or indeed monitoring the implementation and efficacy of the developed guideline recommendations. Exploration of professional perspectives on these guidelines, and research into the effects of implementation of such guidelines could help with further development of guidelines and help progress towards standardised use of risk assessment guidelines within SVRJ in Aotearoa New Zealand. Further, ensuring that the perspectives of professionals with a range of cultural backgrounds and views are incorporated into future research on risk assessment in SVRJ could help ensure that any developed guidelines implemented in the future are applicable and appropriate to use with diverse communities.

Incorporation of professional and service user perspectives and feedback is essential for developing tools which can adequately and accurately be used to assess risk, and there have been calls for SVRJ participant experiences to be considered in research (Broadhurst et al., 2010; Jeffries et al., 2021). While it was ultimately outside the scope of the current research to explore SVRJ participant experiences of risk within SVRJ, this would be an interesting and valuable avenue for future research. Risk assessment in this area could benefit from understanding contributing factors from a participant point of view to both successful and less successful SVRJ processes; learning what to look for, what to enhance, and what to avoid. Little research in this field has included participant (victim-survivor and perpetrator) experiences within SVRJ or focused specifically on participant experiences of risk and

readiness (Jülich et al., 2024; Klar-Chalamish & Peleg-Koriat, 2021; McGlynn et al., 2012; Wager, 2013).

Research into processes of SVRJ risk assessment in other countries where SVRJ practices occur could also benefit and contribute to a growing understanding of risk assessment in this area. This could include inviting international SVRJ professionals to review and provide feedback on developed risk assessment guidelines recommendations. Such research could help improve international practice of SVRJ, increase public awareness and palatability of these processes, and thereby enhance accessibility of SVRJ for victim-survivors who may benefit from engaging in the process.

Concluding Summary

The aim of the current study was to investigate professional opinions about risk assessment in SVRJ and to subsequently develop SVRJ risk assessment guideline recommendations from the professional insights gathered.

In summary, the key findings of this research identified four main areas of SVRJ risk assessment. These were considerations of individual participant preparedness for SVRJ (including possessing restorative motivations and sufficient emotional capacity), safe support systems (comprised of social and external professional supports and appropriate SVRJ support people), culturally competent assessment (including awareness and incorporation of cultural variance and accessing cultural supervision), and the overall participant alignment (considering likelihood of justice needs being met, and weighing up the balance of potential benefit against potential risk of harm). These findings are presented in the SVRJ Risk Scales Diagram and in the recommended SVRJ risk assessment guidelines.

The current research adds to both Aotearoa New Zealand's knowledge base and the international SVRJ knowledge base. It is hoped this research will contribute to improving the safety of SVRJ practice both in Aotearoa New Zealand and internationally. It is also hoped

that this start towards developing and refining SVRJ risk assessment guidelines will better promote SVRJ as an option for victim-survivors seeking justice following harm and facilitate participation in SVRJ in safe and considered ways.

References

- 1News Reporters. (2023, 28 November). Govt's plan to axe sex, gender guidelines in schools 'concerning'. <https://www.1news.co.nz/2023/11/28/govts-plan-to-axe-sex-gender-guidelines-in-schools-concerning/>
- Abrams, L. S., Umbreit, M., & Gordon, A. (2006). Young offenders speak about meeting their victims: Implications for future programs. *Contemporary Justice Review*, 9(3), 243-256. <https://doi.org/10.1080/10282580600827835>
- Abu-Baker, K. (2013). Arab parents' reactions to child sexual abuse: A review of clinical records. *Journal of Child Sexual Abuse*, 22(1), 52-71. <https://doi.org/10.1080/10538712.2013.744378>
- ACC. (2020, 12.06.2020). *ACC; What we do*. Retrieved 9.2.2022 from <https://www.acc.co.nz/about-us/who-we-are/what-we-do/>
- ACC. (2022, 4.02.2022). *Evolving the Integrated Services for Sensitive Claims*. Retrieved 9.2.2022 from <https://www.acc.co.nz/for-providers/provide-services/sensitive-claims/evolving-integrated-services-for-sensitive-claims/>
- Allnutt, S., O'Driscoll, C., Ogloff, J. R. P., Daffern, M., & Adams, J. (2010). *Clinical risk assessment & management: A practical manual for mental health clinicians*. Justice Health.

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5 ed.). American Psychiatric Association.
- Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, 52(1), 7-27.
<http://dx.doi.org/10.1177/0011128705281756>
- Angel, C. M., Sherman, L. W., Strang, H., Ariel, B., Bennett, S., Inkpen, N., Keane, A., & Richmond, T. S. (2014). Short-term effects of restorative justice conferences on post-traumatic stress symptoms among robbery and burglary victims: A randomized controlled trial. *Journal of Experimental Criminology*, 10(3), 291.
<https://doi.org/10.1007/s11292-014-9200-0>
- Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1.
<https://doi.org/10.5565/rev/athenea.64>
- Archer, R. P., Buffington-Vollum, J. K., Stredny, R. V., & Handel, R. W. (2006). A survey of psychological test use patterns among forensic psychologists. *Journal of Personality Assessment*, 87(1), 84-94. https://doi.org/10.1207/s15327752jpa8701_07
- Archibald, M. M., Ambagtsheer, R. C., Lawless, M., & Casey, M. G. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods*, 18.
<https://doi.org/10.1177/1609406919874596>

- Arnold, N. (2022, February 16). My rapist was found not guilty - Young woman horrified and revictimised during trial. *Radio New Zealand*.
<https://www.rnz.co.nz/news/national/461616/my-rapist-was-found-not-guilty-young-woman-horrified-and-revictimized-during-trial>
- Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405. <https://doi.org/10.1177/146879410100100307>
- Baird, C. (2017). *Structured professional judgment models*. https://evidentchange.org/wp-content/uploads/2017/03/structured_professional_judgment_models.pdf
- Baird, C., & Wagner, D. (2000). The relative validity of actuarial- and consensus-based risk assessment systems. *Children and Youth Services Review, 22*(11-12), 839-871.
[https://doi.org/10.1016/S0190-7409\(00\)00122-5](https://doi.org/10.1016/S0190-7409(00)00122-5)
- Baird, C., Wagner, D., Healy, T., & Johnson, K. (1999). Risk assessment in child protective services: Consensus and actuarial model reliability. *Child Welfare, 78*(6), 723-748.
- Barbaree, H. E., Langton, C. M., & Peacock, E. J. (2006). Different actuarial risk measures produce different risk rankings for sexual offenders. *Sexual Abuse: A Journal of Research and Treatment: Official Journal of the Association for the Treatment of Sexual Abusers (ATSA), 18*(4), 423-440. <https://doi.org/10.1007/s11194-006-9029-9>

Barnes, G. C., Hyatt, J. M., Angel, C. M., Strang, H., & Sherman, L. W. (2015). Are restorative justice conferences more fair than criminal courts? Comparing levels of observed procedural justice in the Reintegrative Shaming Experiments (RISE).

Criminal Justice Policy Review, 26(2), 103-130.

<https://doi.org/10.1177/0887403413512671>

Barrera, M., Calderón, L., & Bell, V. (2013). The cognitive impact of sexual abuse and PTSD in children: A neuropsychological study. *Journal of Child Sexual Abuse*, 22(6), 625-

638. <https://doi.org/10.1080/10538712.2013.811141>

Blagden, N., & Perrin, C. (2016). 'Relax lads, you're in safe hands here': Experiences of a sexual offender treatment prison. In C. Reeves (Ed.), *Experiencing imprisonment: Research on the experience of living and working in carceral institutions* (First ed.).

Routledge. <https://doi.org/10.4324/9781315764177>

Blenkner, M. (1954). Predictive factors in the initial interview in family casework. *Social Service Review*, 28(1), 65-73.

Bohmert, M. N., Hipple, N. K., & Duwe, G. (2018). Evaluating restorative justice circles of support and accountability: Can social support overcome structural barriers?

International journal of offender therapy and comparative criminology, 62(3), 739-

758-758. <https://doi.org/10.1177/0306624X16652627>

Boiger, M., Ceulemans, E., De Leersnyder, J., Uchida, Y., Norasakkunkit, V., & Mesquita, B. (2018). Beyond essentialism: Cultural differences in emotions revisited. *Emotion*, 18(8), 1142-1162. <https://doi.org/10.1037/emo0000390>

Bolitho, J. (2015). Putting justice needs first: A case study of best practice in restorative justice. *Restorative Justice*, 3(2), 256-281. <https://doi.org/10.1080/20504721.2015.1069531>

Bolitho, J. (2017). Inside the restorative justice black box: The role of memory reconsolidation in transforming the emotional impact of violent crime on victims. *International Review of Victimology*, 23(3), 233-255-255. <https://doi.org/10.1177/0269758017714549>

Bolitho, J., & Bruce, J. (2017). Science, art and alchemy: Best practice in facilitating restorative justice. *Contemporary Justice Review*, 20(3), 336-362. <https://doi.org/10.1080/10282580.2017.1348896>

Bolitho, J., & Freeman, K. (2016). *The use and effectiveness of restorative justice in criminal justice systems following child sexual abuse or comparable harms* <https://www.childabuseroyalcommission.gov.au/sites/default/files/file-list/Research%20Report%20-%20Restorative%20justice%20following%20child%20sexual%20abuse%20or%20comparable%20harms%20-%20Government%20responses.pdf>

Bonta, J., Bogue, B., Crowley, M., & Motiuk, L. (2001). Implementing offender classification systems: Lessons learned. In G. A. Bernfeld, D. P. Farrington, & A. W. Leschied (Eds.), *Offender rehabilitation in practice*. <https://epdf.tips/offender-rehabilitation-in-practice-implementing-and-evaluating-effective-progra83a8687975b616d4dc1caac70e6404c092562.html>

Bonta, J., Jesseman, R., Rugge, T., & Cormier, R. (2006). Restorative justice and recidivism: Promises made, promises kept? In D. Sullivan & L. Tifft (Eds.), *Handbook of restorative justice: A global perspective*. Routledge.
<https://doi.org/10.4324/9780203346822>

Bouch, J., & Marshall, J. J. (2005). Suicide risk: Structured professional judgement. *Advances in Psychiatric Treatment*, 11, 84-91.
<http://library.nhsggc.org.uk/media/222954/84.pdf>

Bourget, D., & Bradford, J. M. W. (2008). Evidential basis for the assessment and treatment of sex offenders. *Brief Treatment and Crisis Intervention*, 8(1), 130-146.
<https://doi.org/10.1093/brief-treatment/mhm022>

Bowen, E. (2011). An overview of partner violence risk assessment and the potential role of female victim risk appraisals. *Aggression and Violent Behavior*, 16(3), 214-226.
<https://doi.org/10.1016/j.avb.2011.02.007>

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(SUPPL. 1), 181-217-217. <https://doi.org/10.1177/1077558700057001s09>

Bradley, A. (2022, May 23). 'It's a cop-out' - MPs reject call to extend ACC cover to image-based online abuse. *Radio New Zealand*.
<https://www.rnz.co.nz/news/national/467651/it-s-a-cop-out-mps-reject-call-to-extend-acc-cover-to-image-based-online-abuse>

Bradshaw, W., & Umbreit, M. S. (1998). Crime victims meet juvenile offenders: Contributing factors to victim satisfaction with mediated dialogue. *Juvenile & Family Court Journal*, 49(3), 17. <https://doi.org/10.1111/j.1755-6988.1998.tb01482.x>

Braithwaite, J. (1989). *Crime, shame and reintegration*. Cambridge University Press.
<https://doi.org/10.1017/CBO9780511804618>

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE Publications Ltd.

Brissett-Chapman, S. (2000). How do I consider cultural factors when assessing risk and safety? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice*. SAGE Publications, Inc.
<https://doi.org/https://doi.org/10.4135/9781452205489>

- Broadhurst, K., Hall, C., Wastell, D., White, S., & Pithouse, A. (2010). Risk, instrumentalism and the humane project in social work: Identifying the "informal" logics of risk management in children's statutory services. *The British Journal of Social Work*, 40(4), 1046-1064. <https://doi.org/https://doi.org/10.1093/bjsw/bcq011>
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513. <https://doi.org/10.1037/0003-066X.32.7.513>
- Brown, T., N, T., & Herman, J. L. (2015). *Intimate partner violence and sexual abuse among LGBT people: A review of existing research*. <https://williamsinstitute.law.ucla.edu/publications/ipv-sex-abuse-lgbt-people/>
- Bruffaerts, R., Demyttenaere, K., Borges, G., Haro, J. M., Chiu, W. T., Hwang, I., Karam, E. G., Kessler, R. C., Sampson, N., Alonso, J., Andrade, L. H., Angermeyer, M., Benjet, C., Bromet, E., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Horiguchi, I., Hu, C., Kovess, V., Levinson, D., Posada-Villa, J., Sagar, R., Scott, K., Tsang, A., Vassilev, S. M., Williams, D. R., & Nock, M. K. (2010). Childhood adversities as risk factors for onset and persistence of suicidal behaviour. *The British Journal of Psychiatry*, 197(1), 20-27. <https://doi.org/10.1192/bjp.bp.109.074716>
- Burns, C. J., & Sinko, L. (2023). Restorative justice for survivors of sexual violence experienced in adulthood: A scoping review. *Trauma, Violence & Abuse*, 24(2), 340-354. <https://doi.org/10.1177/15248380211029408>

- Burt, M. R. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology*, 38(2), 217-230-230. <https://doi.org/10.1037/0022-3514.38.2.217>
- Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality and Quantity*, 56(3), 1391-1412-1412. <https://doi.org/10.1007/s11135-021-01182-y>
- Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, 58(4), 537-554. <https://doi.org/10.1037/a0025266>
- Cagney, M., & McMaster, K. (2013). The next step: A resolution approach to dealing with intimate partner violence. *Ending Men's Violence Against Women and Children: The No To Violence Journal*, Spring, 29-50.
- Campbell, R., & Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences with military and civilian social systems. *Psychology of Women Quarterly*, 29(1), 97-106. <https://doi.org/10.1111/j.1471-6402.2005.00171.x>
- Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the 'second rape': Rape survivor's experiences with community service providers. *Journal of Interpersonal Violence*, 16(12), 1239-1259. <https://doi.org/10.1177/088626001016012002>

Carr, A., Duff, H., & Craddock, F. (2020). A systematic review of the outcome of child abuse in long-term care. *Trauma, Violence, & Abuse, 21*(4), 660-677.

<https://doi.org/10.1177/1524838018789154>

Carroll, J. S. (1977). Judgments of recidivism risk: Conflicts between clinical strategies and base-rate information. *Law and Human Behavior, 1*(2), 191-198.

<https://doi.org/10.1007/BF01053438>

Carruthers, D. (2012). Restorative justice: Lessons from the past, pointers for the future.

Waikato law review: Taumauri, 20.

Casanovas, M., Kramer, T., Clarke, V., Goddard, A., Elena, G. M., & Khadr, S. (2021).

Somatic symptoms following sexual assault in adolescents: A prospective longitudinal study. *Psychology, Health & Medicine.*

<https://doi.org/10.1080/13548506.2021.1874437>

Castro, A., & Ruiz, E. (2009). The effects of nurse practitioner cultural competence on Latina patient satisfaction. *Journal of the American Academy of Nurse Practitioners, 21*(5),

278-286. <https://doi.org/10.1111/j.1745-7599.2009.00406.x>

Cattaneo, L. B., Bell, M. E., Goodman, L. A., & Dutton, M. A. (2007). Intimate partner violence victims' accuracy in assessing their risk of re-abuse. *Journal of Family*

Violence, 22(6), 429-440. <https://doi.org/10.1007/s10896-007-9097-8>

Catton, A. K. H., & Dorahy, M. J. (2022). Blame attributions against heterosexual male victims of sexual coercion: Effects of gender, social influence, and perceptions of distress. *Journal of Interpersonal Violence*, 37(9/10), NP7014-NP7033.
<https://doi.org/10.1177/0886260520967153>

Cheon, A., & Regehr, C. (2006). Restorative justice models in cases of intimate partner violence: Reviewing the evidence. *Victims & Offenders*, 1(4), 369-394.
<https://doi.org/10.1080/15564880600934138>

Childs, K., Lingonblad, A., Frick, P. J., Ryals Jr, J. S., & Villio, M. J. (2014). A comparison of empirically based and structured professional judgment estimation of risk using the structured assessment of violence risk in youth. *Youth Violence and Juvenile Justice*, 12(1), 40-57. <https://doi.org/10.1177/1541204013480368>

Collins, P. H. (1997). Comment on Hekman's "Truth and method: Feminist standpoint theory revisited": Where's the power? *Signs*, 22(2), 375-381.

Connor-Smith, J. K., Henning, K., Moore, S., & Holdford, R. (2011). Risk assessments by female victims of intimate partner violence: Predictors of risk perceptions and comparison to an actuarial measure. *Journal of Interpersonal Violence*, 26(12), 2517-2550. <http://dx.doi.org/10.1177/0886260510383024>

Consedine, J. (1995). *Restorative justice: Healing the effects of crime*. Ploughshares Publications.

Coohey, C., Johnson, K., Renner, L. M., & Easton, S. D. (2013). Actuarial risk assessment in child protective services: Construction methodology and performance criteria.

Children and Youth Services Review, 35(1), 151-161.

<https://doi.org/10.1016/j.chilyouth.2012.09.020>

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*.

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social Science Information*, 45(4), 483-499-499.

<https://doi.org/10.1177/0539018406069584>

Culatta, E., Clay-Warner, J., Oshri, A., & Boyle, K. M. (2020). Sexual revictimization: A routine activity theory explanation. *Journal of Interpersonal Violence*, 35(15-16),

2800-2824. <https://doi.org/10.1177/0886260517704962>

Cumming, G. F., & McGrath, R. J. (2000). External supervision: How can it increase the effectiveness of relapse prevention? In T. Ward, D. R. Laws, & S. M. Hudson (Eds.),

Remaking relapse prevention with sex offenders: A sourcebook. SAGE.

<https://doi.org/10.4135/9781452224954>

- Curtis-Fawley, S., & Daly, K. (2005). Gendered violence and restorative justice: The views of victim advocates. *Violence Against Women, 11*(5), 603-638.
<https://doi.org/10.1177/1077801205274488>
- D'Andrade, A., Austin, M. J., & Benton, A. (2008). Risk and safety assessment in child welfare: Instrument comparisons. *Journal of Evidence-Based Social Work, 5*(1/2), 31-56. https://doi.org/10.1300/J394v05n01_03
- Daly, K. (2001). Conferencing in Australia and New Zealand: Variations, research findings and prospects. In A. Morris & G. M. Maxwell (Eds.), *Restorative justice for juveniles: Conferencing, mediation and circles*. Hart.
<https://doi.org/10.1057/palgrave.cpcs.8140142>
- Daly, K. (2006). Restorative justice and sexual assault: An archival study of court and conference cases. *The British Journal of Criminology, 46*(2), 334-356.
<https://doi.org/10.1093/bjc/azi071>
- Daly, K. (2008). Seeking justice in the 21st century: Towards an intersectional politics of justice. In H. V. Miller (Ed.), *Restorative justice: From theory to practice (Sociology of crime, law and deviance, Vol. 11)* (pp. 3-30). Emerald Group Publishing Limited.
[https://doi.org/10.1016/S1521-6136\(08\)00401-6](https://doi.org/10.1016/S1521-6136(08)00401-6)
- Daly, K. (2011). *Conventional and innovative responses to sexual violence*. Australian Institute of Family Studies Australian Centre for the Study of Sexual Assault.
<https://apo.org.au/sites/default/files/resource-files/2011-09/apo-nid26507.pdf>

- Daly, K. (2014). Reconceptualizing sexual victimization and justice. In I. Vanfraechem, A. Pemberton, & F. M. Ndahinda (Eds.), *Justice for victims: perspectives on rights, transition and reconciliation* (pp. 378-395). London: Routledge.
- Daly, K. (2017). Sexual violence and victims' justice interests. In E. Zinsstag & M. Keenan (Eds.), *Restorative responses to sexual violence: Legal, social and therapeutic dimensions*. Routledge. <https://doi.org/10.4324/9781315630595>
- Daniels, S. J. (2016). *Working with the Trauma of Rape and Sexual Violence: A Guide for Professionals*. Jessica Kingsley Publishers.
- Davis, R. C., Guthrie, P., Ross, T., & O'Sullivan, C. (2006). *Reducing sexual revictimization: A field test with an urban sample*. <https://www.ojp.gov/pdffiles1/nij/grants/216002.pdf>
- Davis, R. C., Tichance, M., & Grayson, D. (1980). Mediation and arbitration as alternatives to prosecution on felony arrest cases. An evaluation of the Brooklyn dispute resolution center (first year) [(Report No. 72619)]. https://www.vera.org/downloads/publications/Mediation_and_Arbitration_as_Alternatives_to_Prosecution_of_Felony_Arrest_Cases.pdf
- Dawes, R., Faust, D., & Meehl, P. (1993). Statistical prediction versus clinical prediction: Improving what works. In G. Keren & C. Lewis (Eds.), *Handbook for data analysis in*

the behavioral sciences: Methodological issues (pp. 351-367). Lawrence Erlbaum.

<https://doi.org/10.4324/9781315799582>

Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. *Science*, 243(4899), 1668-1674. <https://doi.org/10.1126/science.2648573>

Day, A. (1999). Sexual offender views about treatment: A client survey. *Journal of Child Sexual Abuse*, 8(2), 93-103-103. https://doi.org/10.1300/J070v08n02_06

de Groot, M., Schaafsma, J., Castelain, T., Malinowska, K., Mann, L., Ohtsubo, Y., Wulandari, M. T. A., Bataineh, R. F., Fry, D. P., Goudbeek, M., & Suryani, A. (2021). Group-based shame, guilt, and regret across cultures. *European Journal of Social Psychology*, 51(7), 1198-1212. <https://doi.org/10.1002/ejsp.2808>

Denzin, N. K., & Lincoln, Y. S. (2013). *Collecting and interpreting qualitative materials* (Edition 4 ed.). SAGE Publications.

Dexter, G. (2024, 10 January). Government accused of 'conspiracy' thinking in changes to sex ed. *Radio New Zealand*. <https://www.rnz.co.nz/news/political/506348/government-accused-of-conspiracy-thinking-in-changes-to-sex-ed>

Dicicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, 40(4), 314-321. <https://doi.org/10.1111/j.1365-2929.2006.02418.x>

Dickson, S. (2017). *Trans and gender diverse responses: Building rainbow communities free of partner and sexual violence*. Hohou Te Rongo Kahukura.

<https://www.kahukura.co.nz/wp-content/uploads/2017/07/Trans-and-Gender-Diverse-People-2017.pdf>

Dickson-Gilmore, J. (2014). Whither restorativeness? Restorative justice and the challenge of intimate violence in Aboriginal communities. *Canadian Journal of Criminology & Criminal Justice*, 56(4), 417-446. <https://doi.org/10.3138/cjccj.2014.S02>

Dine, J. (2022, 31.10.22). Sexual assaults going unreported as victims fear they will be blamed. *Radio New Zealand*. <https://www.rnz.co.nz/news/national/477739/sexual-assaults-going-unreported-as-victims-fear-they-will-be-blamed>

Dirik, A., Sandhu, S., Giacco, D., Barrett, K., Bennison, G., Collinson, S., & Priebe, S. (2017). Why involve families in acute mental healthcare? A collaborative conceptual review. *BMJ OPEN*, 7(9), e017680. <https://doi.org/10.1136/bmjopen-2017-017680>

Doak, J., & O'Mahony, D. (2006). The vengeful victim? Assessing the attitudes of victims participating in restorative youth conferencing. *International Review of Victimology*, 13(2), 157-177. <https://doi.org/10.1177/026975800601300202>

Douglas, K. S., Hart, S. D., Groscup, J. L., & Litwack, T. R. (2013). Assessing violence risk. In R. K. Otto & I. B. Weiner (Eds.), *The handbook of forensic psychology* (Fourth edition ed.). Wiley.

- Douglas, K. S., & Kropp, P. R. (2002). A prevention-based paradigm for violence risk assessment: Clinical and research applications. *Criminal Justice and Behavior*, 29(5), 617-658. <https://doi.org/10.1177/009385402236735> (Risk assessment)
- Draper, B., Pfaff, J. J., Pirkis, J., Snowden, J., Lautenschlager, N. T., Wilson, I., & Almeida, O. P. (2008). Long-term effects of childhood abuse on the quality of life and health of older people: Results from the depression and early prevention of suicide in general practice project. *Journal of the American Geriatrics Society*, 56(2), 262-271. <https://doi.org/10.1111/j.1532-5415.2007.01537.x>.
- Dutton, D. G. (1995). *The domestic assault of women: Psychological and criminal justice perspectives*. UBC Press. [https://doi.org/10.1002/1098-2337\(1989\)15:6<458::AID-AB2480150608>3.0.CO;2-5](https://doi.org/10.1002/1098-2337(1989)15:6<458::AID-AB2480150608>3.0.CO;2-5)
- Dutton, M. A., Goodman, L., Lennig, D., Murphy, J., & Kaltman, S. (2006). *Ecological Model of Battered Women's Experience over Time*. W. National Institute of Justice, DC. <https://www.ncjrs.gov/pdffiles1/nij/grants/213713.pdf>
- Dvoskin, J. A., & Heilbrun, K. (2001). Risk assessment and release decision-making: Toward resolving the great debate. *JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW*, 29(1), 6-10.

Dworkin, E. R. (2020). Risk for mental disorders associated with sexual assault: A meta-analysis. *Trauma, Violence & Abuse, 21*(5), 1011-1028.

<https://doi.org/10.1177/1524838018813198>

Dworkin, E. R., Jaffe, A. E., Bedard-Gilligan, M., & Fitzpatrick, S. (2021). PTSD in the year following sexual assault: A meta-analysis of prospective studies. *Trauma, Violence & Abuse, 15248380211032213*. <https://doi.org/10.1177/15248380211032213>

Dworkin, E. R., Menon, S. V., Bystrynski, J., & Allen, N. E. (2017). Sexual assault victimization and psychopathology: A Review and meta-analysis. *Clinical Psychology Review, 56*, 65-81. <https://doi.org/10.1016/j.cpr.2017.06.002>

Eastman, B. J. (2004). Assessing the efficacy of treatment for adolescent sex offenders: A cross-over longitudinal study. *The Prison Journal, 84*(4), 472-485-485.

<https://doi.org/10.1177/0032885504269346>

Eaton, J., & McElrea, F. W. M. (2003). *Sentencing: The new dimensions*. New Zealand Law Society.

Elliott, A. N., & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: A review of the literature. *Child Maltreatment, 6*(4), 314-331.

<https://doi.org/10.1177/1077559501006004005>

Ensel, W. M., & Lin, N. (1991). The life stress paradigm and psychological distress. *Journal of Health and Social Behavior*, 32(4), 321-341. <https://doi.org/10.2307/2137101>

Erez, E., Roeger, L., & Morgan, F. (1997). Victim harm, impact statements and victim satisfaction with justice: An Australian Experience. *International Review of Victimology*, 5(1), 37-60. <https://doi.org/10.1177/026975809700500103>

European Union. (2012). *Directive 2012/29/EU of the European parliament and of the council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing council framework decision 2001/220/JHA*. <https://www.legislation.gov.uk/eudr/2012/29/contents>

Evans, C. B. R., Smokowski, P. R., Barbee, J., Bower, M., & Barefoot, S. (2016). Restorative justice programming in teen court: A path to improved interpersonal relationships and psychological functioning for high-risk rural youth. *Journal of Rural Mental Health*, 40(1), 15-30. <https://doi.org/10.1037/rmh0000042>

Evans, D., Trahan, A., & Laird, K. (2023). Shame and blame: Secondary stigma among families of convicted sex offenders. *Criminology & Criminal Justice: An International Journal*, 23(1), 78-97. <https://doi.org/10.1177/17488958211017391>

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. Routledge.
<https://doi.org/10.4324/9781315015484>

- Fanslow, J. L., Hashemi, L., Gulliver, P., & McIntosh, T. (2021). A century of sexual abuse victimisation: A birth cohort analysis. *Social Science & Medicine*, 270.
<https://doi.org/10.1016/j.socscimed.2020.113574>
- Fanslow, J. L., Kelly, P., & Ministry of Health. (2016). *Family violence assessment and intervention guideline: Child abuse and intimate partner violence (2nd edn)*.
https://www.health.govt.nz/system/files/documents/publications/family-violence-assessment-intervention-guideline-jun16_0.pdf
- Fanslow, J. L., & Robinson, E. (2004). Violence against women in New Zealand: Prevalence and health consequences. *New Zealand Medical Journal*, 117(1206).
<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.536.2039&rep=rep1&type=pdf>
- Fanslow, J. L., Robinson, E. M., Crengle, S., & Perese, L. (2007). Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. *Child abuse & neglect*, 31(9), 935-945. <https://doi.org/10.1016/j.chiabu.2007.02.009>
- Farrall, S. (2004). Social capital and offender reintegration: Making probation desistence focused. In S. Maruna & I. Russell (Eds.), *After crime and punishment: Pathways to offender reintegration*. Willan. <https://doi.org/10.1093/bjc/azm046>
- Fisher, N. L., & Pina, A. (2013). An overview of the literature on female-perpetrated adult male sexual victimization. *Aggression and Violent Behavior*, 18(1), 54-61.
<https://doi.org/10.1016/j.avb.2012.10.001>

- Flett, R., Kazantzis, N., Long, N., MacDonald, C., Millar, M., Clark, B., Edwards, H., & Petrik, A. (2012). The impact of childhood sexual abuse on psychological distress among women in New Zealand. *Journal of Child and Adolescent Psychiatric Nursing*, 25(1), 25-32. <https://doi.org/10.1111/j.1744-6171.2011.00311.x>
- Flores, A. W., Lowenkamp, C. T., Holsinger, A. M., & Latessa, E. J. (2006). Predicting outcome with the level of service inventory-revised: The importance of implementation integrity. *Journal of Criminal Justice*, 34(5), 523-529. <https://doi.org/10.1016/j.jcrimjus.2006.09.007>
- Fraser, G. (2020). *Rainbow experiences of accessing mental health support in Aotearoa New Zealand: A community-based mixed methods study*. Te Herenga Waka-Victoria University of Wellington. https://openaccess.wgtn.ac.nz/articles/thesis/Rainbow_experiences_of_accessing_mental_health_support_in_Aotearoa_New_Zealand_A_community-based_mixed_methods_study/17147873
- Frazier, P. A., & Haney, B. (1996). Sexual assault cases in the legal system: Police, prosecutor, and victim perspectives. *Law and Human Behavior*, 20(6), 607-628. <https://doi.org/10.1007/BF01499234>
- Freshwater, K., Ainscough, C., & Toon, K. (2002). Confronting abusers: The opinions of clinicians and survivors. *Journal of Child Sexual Abuse*, 11(4), 35-52. https://doi.org/10.1300/j070v11n04_03

Frisby, C. L., & O'Donohue, W. T. (2018). *Cultural competence in applied psychology: An evaluation of current status and future directions*. Springer International Publishing.

<https://doi.org/10.1007/978-3-319-78997-2>

Froestad, J., & Shearing, C. (2007). Conflict resolution in South Africa: A case study. In G. Johnstone & D. W. Van Ness (Eds.), *Handbook of restorative justice*. Willan.

<https://doi.org/10.4324/9781843926191>

Frost, N. (2011). *Qualitative research methods in Psychology: Combining core approaches*. Open University Press.

<https://www.mhebooklibrary.com/doi/book/10.1036/9780335241521?contentTab=true>

[e](https://www.mhebooklibrary.com/doi/book/10.1036/9780335241521?contentTab=true)

Gang, D., Loff, B., Naylor, B., & Kirkman, M. (2021). A call for evaluation of restorative justice programs. *Trauma, Violence & Abuse*, 22(1), 186-190.

<https://doi.org/10.1177/1524838019833003>

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses*.

https://www.who.int/gender/violence/who_multicountry_study/Introduction-Chapter1-Chapter2.pdf

- Gareth, J., & Sean, C. (2015). Incentive for insincerity – pre-sentence restorative justice: In whose interests? *Safer Communities*, 14(3), 126-137. <https://doi.org/10.1108/SC-05-2015-0018>
- Gavey, N. (2019). *Just sex?: The cultural scaffolding of rape* (Second edition ed.). Routledge. <https://doi.org/10.4324/9780429443220>
- Gavrielides, T. (2007). *Restorative justice theory and practice: Addressing the discrepancy*. HEUNI. https://bibliographie.uni-tuebingen.de/xmlui/bitstream/handle/10900/82708/HEUNI_report_52.pdf?sequence=1
- Gervasio, M., Beatty, A., Kavanaugh, B., Cancilliere, M. K., & Holler, K. (2022). The association between neurocognition and sexual abuse within a children's psychiatric inpatient program. *Clinical Neuropsychologist*, 36(1), 189-206. <https://doi.org/10.1080/13854046.2020.1781932>
- Gillingham, P. (2006). Risk assessment in child protection: Problem rather than solution? *Australian Social Work*, 59(1), 86-98. <https://doi.org/10.1080/03124070500449804>
- Gillingham, P., & Humphreys, C. (2010). Child protection practitioners and decision-making tools: Observations and reflections from the front line. *The British Journal of Social Work*, 40(8), 2598-2616. <https://doi.org/10.1093/bjsw/bcp155>

- Göbbels, S., Willis, G. M., & Ward, T. (2014). Current re-entry practices in sex offender treatment programmes: desistance facilitating or hindering? *Journal of Sexual Aggression*, 20(3), 354-366. <https://doi.org/10.1080/13552600.2013.820850>
- Gottfredson, S. D., & Gottfredson, D. M. (1988). Violence prediction methods: Statistical and clinical strategies. *Violence and victims*., 3(3), 303-324.
- Government Inquiry into Mental Health and Addiction. (2018). *He ara oranga: Report of the Government Inquiry into Mental Health and Addiction*. Government Inquiry into Mental Health and Addiction. <https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf>
- Graham, D., Rawlings, E. I., & Rigsby, R. K. (1994). *Loving to survive: Sexual terror, men's violence, and women's lives*. New York University Press.
- Graham, R. (2006). Male rape and the careful construction of the male victim. *Social & Legal Studies*, 15(2), 187-208. <https://doi.org/10.1177/0964663906063571>
- Gravitas Research and Strategy Ltd. (2018). *Ministry of Justice - Restorative Justice Survey Victim Satisfaction Survey 2018*. Ministry of Justice. <https://www.justice.govt.nz/assets/Restorative-Justice-Victim-Satisfaction-Survey-Report-Final-TK-206840.pdf>

GravitasOPG. (2021). *Ministry of Justice - Restorative Justice Survey Victim Satisfaction Survey 2021*. Ministry of Justice. <https://www.justice.govt.nz/assets/FINAL-Restorative-Justice-Survey-Report-September-2021.pdf>

GravitasOPG. (2023). *Ministry of Justice - Restorative Justice Survey Victim Satisfaction Survey 2023*. Ministry of Justice. <https://www.justice.govt.nz/assets/Documents/Publications/Restorative-Justice-Victim-Satisfaction-Survey-2023-Report.pdf>

Griffin, H. L., Beech, A., Print, B., Bradshaw, H., & Quayle, J. (2008). The development and initial testing of the AIM2 framework to assess risk and strengths in young people who sexually offend. *Journal of Sexual Aggression, 14*(3), 211-225. <https://doi.org/10.1080/13552600802366593>

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 42-55. <https://doi.org/10.1177/160940690400300104>

Grove, W. M., & Meehl, P. E. (1996). Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical–statistical controversy. *Psychology, Public Policy, and Law, 2*(2), 293-323. <https://doi.org/10.1037/1076-8971.2.2.293>

- Gulliver, P., & Fanslow, J. L. (2015). *Risk assessment: What is it and how can it be applied in family violence?* <https://nzfvc.org.nz/sites/nzfvc.org.nz/files/issues-paper-9-risk-assessment.pdf>
- Guy, L. S. (2008). *Performance indicators of the structured professional judgment approach for assessing risk for violence to others: A meta-analytic survey* [Doctor of Philosophy, Simon Fraser University]. <https://core.ac.uk/download/pdf/56373467.pdf>
- Guy, L. S., Douglas, K. S., & Hart, S. D. (2015). Risk assessment and communication. In B. L. Cutler & P. A. Zapf (Eds.), *APA handbook of forensic psychology, Vol. 1: Individual and situational influences in criminal and civil contexts*. (pp. 35-86). American Psychological Association. <https://doi.org/10.1037/14461-003>
- Hadar, N., & Gal, T. (2023). Survivors' paths toward forgiveness in restorative justice following sexual violence. *Criminal Justice and Behavior, 50*(6), 911-928-928. <https://doi.org/10.1177/00938548231162108>
- Hadjiioannou, E. (2021). *Psychotherapy with survivors of sexual violence: Inside and outside the room*. Routledge. <https://doi.org/10.4324/9781003202943>
- Halpern, S. C., Schuch, F. B., Scherer, J. N., Sordi, A. O., Pachado, M., Dalbosco, C., Fara, L., Pechansky, F., Kessler, F., & Von Diemen, L. (2018). Child maltreatment and illicit substance abuse: A systematic review and meta-analysis of longitudinal studies. *Child Abuse Review, 27*(5), 344-360. <https://doi.org/10.1002/car.2534>

Hammen, C. L., & Watkins, E. (2018). *Depression* (Third ed.). Routledge.

<https://doi.org/10.4324/9781315542805>

Hanson, R. K. (2009). The psychological assessment of risk for crime and violence.

Canadian Psychology, 50(3), 172-182. <https://doi.org/10.1037/a0015726>

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment: Official Journal of the Association for the Treatment of Sexual Abusers (ATSA)*, 14(2), 169-194. <https://doi.org/10.1023/a:1014624315814>

Hanson, R. K., & Harris, A. (2001). *The Sex Offender Need Assessment Rating (SONAR): A method for measuring change in risk levels 2000-1*. Corrections Research, Department of the Solicitor General of Canada.

Hanson, R. K., Harris, A. J. R., Scott, T., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The dynamic supervision project (User report no 2007-05)*. <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/ssssng-rsk-sxl-ffndrs/ssssng-rsk-sxl-ffndrs-eng.pdf>

Hanson, R. K., & Morton-Bourgon, K. E. (2009). The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis of 118 prediction studies. *Psychological Assessment*, 21(1), 1-21. <https://doi.org/10.1037/a0014421>

- Hanson, R. K., & Slater, S. (1988). Sexual victimization in the history of sexual abusers: A review. *Annals of sex research*, 1(4), 485-499. <https://doi.org/10.1007/bf00854712>
- Harmer, E., & Lewis, S. (2022). Disbelief and counter-voices: A thematic analysis of online reader comments about sexual harassment and sexual violence against women. *Information, Communication & Society*, 25(2), 199-216. <https://doi.org/10.1080/1369118X.2020.1770832>
- Harris, G. T., Rice, M. E., Quinsey, V. L., & Cormier, C. A. (2015). *Violent offenders: Appraising and managing risk* (3rd ed ed.). American Psychological Association. <https://doi.org/https://doi.org/10.1037/14572-000>
- Harris, K. (2021, July 26). "Failed by the system": Indecent assault victim hits out after offenders avoid conviction. *NZ Herald*. https://www.nzherald.co.nz/nz/failed-by-the-system-indecent-assault-victim-hits-out-after-offenders-avoid-conviction/UM5UGFNULCWERURBTM5CVMWSZE/?fbclid=IwAR2s76fPN1wYfDF5urCR32JIjesIoWZ_5QPAR8TxxHLHQJPxvdG8EtikbOI
- Hart, S. D., Douglas, S. K., & Guy, L. S. (2016). The structured professional judgment approach to violence risk assessment: Origins, nature, and advances. In L. Craig & M. Rettenberger (Eds.), *The Wiley handbook on the theories, assessment, treatment of sexual offending: Volume II. Assessment*. Wiley. <https://doi.org/10.1002/9781118574003.wattso030>

Hartmann, M., Bänzner, E., Wild, B., Eisler, I., & Herzog, W. (2010). Effects of interventions involving the family in the treatment of adult patients with chronic physical diseases: A meta-analysis. *Psychotherapy and Psychosomatics* 76, 136-148.

<https://doi.org/10.1159/000286958>

Hayes, N. (1997). *Doing qualitative analysis in psychology*. Psychology Press.

<https://doi.org/10.4324/9781315804552>

Heckert, D. A., & Gondolf, E. W. (2004). Battered women's perceptions of risk versus risk factors and instruments in predicting repeat reassault. *Journal of Interpersonal Violence*, 19(7), 778-800. <https://doi.org/10.1177/0886260504265619>

Heilbrun, K., O'Neill, M. L., Stevens, T. N., Strohman, L. K., Bowman, Q., & Yi-Wen Lo, Q. (2004). Assessing normative approaches to communicating violence risk: A national survey of psychologists. *Behavioral Sciences & the Law*, 22(2), 187-196.

<https://doi.org/10.1002/bsl.570>

Herman, J. L. (1997). *Trauma and recovery* (Rev. ed.). BasicBooks.

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry & Clinical Neurosciences*, 52, S145-S150. <https://doi.org/10.1046/j.1440-1819.1998.0520s5S145.x>

Herman, J. L. (2005). Justice from the victim's perspective. *Violence Against Women, 11*(5), 571-602. <https://doi.org/10.1177/1077801205274450>

Hochstetler, A., DeLisi, M., & Pratt, T. C. (2010). Social support and feelings of hostility among released inmates. *Crime & Delinquency, 56*(4), 588-607.
<http://dx.doi.org/10.1177/0011128708319926>

Holder, W. (2000). How do I assess risk and safety? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice*. SAGE Publications, Inc.
<https://doi.org/https://doi.org/10.4135/9781452205489>

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345-357.
<https://doi.org/10.1177/1468794103033004>

Hoyle, C. (2008). Will she be safe? A critical analysis of risk assessment in domestic violence cases. *Children and Youth Services Review, 30*(3), 323-337.
<https://doi.org/10.1016/j.childyouth.2007.10.009>

Huang, Y., Wu, R., Wu, J., Yang, Q., Zheng, S., & Wu, K. (2020). Psychological resilience, self-acceptance, perceived social support and their associations with mental health of incarcerated offenders in China. *Asian Journal of Psychiatry, 52*.
<https://doi.org/10.1016/j.ajp.2020.102166>

Hudson, B. (2002). Restorative justice and gendered violence: Diversion or effective justice?

The British Journal of Criminology, 42(3), 616-634.

<https://doi.org/https://doi.org/10.1093/bjc/42.3.616>

Huston, J. (2023, 28 November). Axing sexuality, relationship education guidelines would be

'huge mistake' warns co-writer. *Radio New Zealand*.

<https://www.rnz.co.nz/news/national/503418/axing-sexuality-relationship-education-guidelines-would-be-huge-mistake-warns-co-writer>

Hyslop, D. J. (2005). *A literature review on restorative justice as an alternative to the*

adversarial system of law: A study of the key theoretical concepts of restorative

justice [Master Degree of Social Work (Applied), Massey University].

Ibaraki, A. Y., & Hall, G. C. N. (2014). The components of cultural match in psychotherapy.

Journal of Social and Clinical Psychology, 33(10), 936-953-953.

<https://doi.org/10.1521/jscp.2014.33.10.936>

Ilagan, G. S., & Heatherington, L. (2022). Advancing the understanding of factors that

influence client preferences for race and gender matching in psychotherapy.

Counselling Psychology Quarterly, 35(3), 694-717.

<https://doi.org/10.1080/09515070.2021.1960274>

Jackson, H., Wray, J., Gardiner, E., & Flanagan, T. (2019). Involving carers in risk

assessment: a study of a structured dialogue between mental health nurses and carers.

Journal of Research in Nursing, 24(5), 330-341-341.

<https://doi.org/10.1177/1744987119851533>

Jackson, M. (1987). *The Maori and the criminal justice system: A new perspective = He whaipanga hou*. Policy and Research Division, Dept. of Justice.

<https://www.ojp.gov/pdffiles1/Digitization/108675NCJRS.pdf>

Jackson, R. L., & Hess, D. T. (2007). Evaluation for civil commitment of sex offenders: A survey of experts. *Sexual Abuse: A Journal of Research and Treatment: Official Journal of the Association for the Treatment of Sexual Abusers (ATSA)*, 19(4), 425.

<https://doi.org/10.1007/s11194-007-9062-3>

Jeffries, S., Wood, W. R., & Russell, T. (2021). Adult restorative justice and gendered violence: Practitioner and service provider viewpoints from Queensland, Australia.

Laws, 10(13), 13-13. <https://doi.org/10.3390/laws10010013>

Jenney, A., Mishna, F., Alaggia, R., & Scott, K. (2014). Doing the right thing? (Re) Considering risk assessment and safety planning in child protection work with domestic violence cases. *Children and Youth Services Review*, 47(Part 1), 92-101.

<https://doi.org/10.1016/j.chilyouth.2014.07.015>

Jespersen, A. F., Lalumière, M. L., & Seto, M. C. (2009). Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis. *Child abuse & neglect*, 33(3),

179-192. <https://doi.org/10.1016/j.chiabu.2008.07.004>

- Joffe, H. (2012). Thematic Analysis. In A. R. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. John Wiley & Sons. <https://doi.org/10.1002/9781119973249>
- Johnson, J. E., Esposito-Smythers, C., Miranda, R., Jr., Rizzo, C. J., Justus, A. N., & Clum, G. (2011). Gender, social support, and depression in criminal justice– involved adolescents. *International journal of offender therapy and comparative criminology*, 55(7), 1096-1109. <https://doi.org/10.1177/0306624X10382637>
- Johnstone, G. (2011). *Restorative justice: Ideas, values, debates* (2nd ed.). Routledge. <https://doi.org/https://doi.org/10.4324/9780203804841>
- Jonas, J., Zebel, S., Claessen, J., & Nelen, H. (2022). The psychological impact of participation in victim-offender mediation on offenders: Evidence for increased compunction and victim empathy. *Frontiers in Psychology*, 12, 1-13. <https://doi.org/10.3389/fpsyg.2021.812629>
- Jones, D. A., Trudinger, P., & Crawford, M. (2004). Intelligence and achievement of children referred following sexual abuse. *Journal of Paediatrics and Child Health*, 40(8), 455-460. <https://doi.org/10.1111/j.1440-1754.2004.00427.x>
- Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Services Research*, 18(1), 1-15. <https://doi.org/10.1186/s12913-018-3001-5>

- Jülich, S. (2001). *Breaking the silence: Restorative justice and child sexual abuse* [Massey University, Albany, New Zealand]. Massey University Library Catalogue.
- Jülich, S. (2003). *Critical issues in restorative justice: Advancing the agenda in Aotearoa New Zealand*. Centre for Justice and Peace Development, Massey University.
- Jülich, S. (2010). Restorative justice and gendered violence in New Zealand. In J. Ptacek (Ed.), *Restorative justice and violence against women*. Oxford University Press.
<https://doi.org/10.1093/acprof:oso/9780195335484.001.0001>
- Jülich, S., & Bowen, H. (2015). Restorative Justice in Aotearoa, New Zealand: Improving Our Response to Sexual Violence. *Revista de Asistentă Socială; Bucharest*(4), 93-104.
- Jülich, S., Brady-Clark, M., Yeung, P., & Landon, F. (2024). Restorative justice responses to sexual violence: Perspectives and experiences of participating persons responsible and persons harmed. *Victims & Offenders*.
<https://doi.org/10.1080/15564886.2024.2333311>
- Jülich, S., Buttle, J., Cummins, C., & Freeborn, E. V. (2010). *Project Restore: An exploratory study of restorative justice and sexual violence*. Auckland University of Technology.
https://www.academia.edu/274691/Project_Restore_An_Exploratory_Study_of_Restorative_Justice_and_Sexual_Violence

Jülich, S., & Landon, F. (2017). Achieving justice outcomes: Participants of Project Restore's restorative processes. In E. Zinsstag & M. Keenan (Eds.), *Sexual violence and restorative justice: Legal, social and therapeutic dimensions* (pp. 192-211). Routledge. <https://doi.org/10.4324/9781315630595>

Jülich, S., McGregor, K., Annan, J., Landon, F., McCarrison, D., & McPhillips, K. (2011). Yes, there is another way! *Canterbury Law Review*, 17, 222-228.

Jülich, S., Molineaux, J., & Green, M. D. (2020). The strategic use of terminology in restorative justice for persons harmed by sexual violence. *The International Journal of Restorative Justice*, 3(2), 215-234. <https://doi.org/10.5553/IJRJ.000032>

Jülich, S., & Thorburn, N. (2017). Sexual violence and substantive equality: Can restorative justice deliver? *Journal of Human Rights and Social Work*, 2(1-2), 34-44. <https://doi.org/10.1007/s41134-017-0029-0>

Kang, H., & Poertner, J. (2006). Inter-rater reliability of the Illinois structured decision support protocol. *Child abuse & neglect*, 30(6), 679-689. <https://doi.org/10.1016/j.chiabu.2005.12.004>

Keenan, M. (2014). *Sexual trauma and abuse: Restorative and transformative possibilities? A collaborative study of restorative justice in sexual crime in Ireland*. [https://researchrepository.ucd.ie/bitstream/10197/6247/1/Sexual Trauma and Abuse Restorative and Transformative Possibilities.pdf](https://researchrepository.ucd.ie/bitstream/10197/6247/1/Sexual%20Trauma%20and%20Abuse%20Restorative%20and%20Transformative%20Possibilities.pdf)

- Keenan, M., Zinsstag, E., & O'Nolan, C. (2016). Sexual violence and restorative practices in Belgium, Ireland and Norway: A thematic analysis of country variations. *Restorative Justice*, 4(1), 86-114. <https://doi.org/10.1080/20504721.2016.1148466>
- Kendler, K. S., Karkowski, L. M., & Prescott, C. A. (1999). Causal relationship between stressful life events and the onset of major depression. *The American Journal of Psychiatry*, 156(6), 837-841. <https://doi.org/10.1176/ajp.156.6.837>
- Kim, E., & Kang, M. (2018). The effects of client–counselor racial matching on therapeutic outcome. *Asia Pacific Education Review*, 19(1), 103-110. <https://doi.org/10.1007/s12564-018-9518-9>
- Kim, H. J., & Gerber, J. (2012). The effectiveness of reintegrative shaming and restorative justice conferences: Focusing on juvenile offenders' perceptions in Australian reintegrative shaming experiments. *International journal of offender therapy and comparative criminology*, 56(7), 1063-1079. <https://doi.org/10.1177/0306624X11418916>
- Kingi, V., M., & Jordan, J. (2009). *Responding to sexual violence: Pathways to recovery*. Ministry of Women's Affairs. https://www.women.govt.nz/sites/default/files/2023-10/pathways-to-recovery-pdf_0.pdf

- Klar-Chalamish, C., & Peleg-Koriat, I. (2021). From trauma to recovery: Restorative justice conferencing in cases of adult survivors of intrafamilial sexual offenses. *Journal of Family Violence*, 1. <https://doi.org/10.1007/s10896-020-00239-0>
- Koss, M. P. (2000). Blame, shame, and community: Justice responses to violence against women. *American Psychologist*, 55(11), 1332–1343. <https://doi.org/10.1037/0003-066X.55.11.1332>
- Koss, M. P. (2010). Restorative justice for acquaintance rape and misdemeanor sex crimes. In J. Ptacek (Ed.), *Restorative justice and violence against women*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195335484.001.0001>
- Koss, M. P. (2014). The RESTORE program of restorative justice for sex crimes: Vision, process, and outcomes. *Journal of Interpersonal Violence*, 29(9), 1623-1660. <https://doi.org/10.1177/0886260513511537>
- Koss, M. P., & Achilles, M. (2008). *Restorative justice responses to sexual assault*. VAWnet: The National Online Resource Center on Violence Against Women http://vawnet.org/sites/default/files/materials/files/2016-09/AR_RestorativeJustice.pdf
- Koss, M. P., Bachar, K. J., & Hopkins, Q. C. (2003). Restorative justice for sexual violence: Repairing victims, building community, and holding offenders accountable. *Annals of the New York Academy of Sciences*(989), 384-396. <https://doi.org/10.1111/j.1749-6632.2003.tb07320.x>

Koss, M. P., Lopez, E. C., & White, J. W. (2017). Victim voice in reenvisioning responses to sexual and physical violence nationally and internationally. *American Psychologist*, 72(9), 1019-1030-1030. <https://doi.org/10.1037/amp0000233>

Kropp, P. R. (2004). Some questions regarding spousal assault risk assessment. *Violence Against Women*, 10(6), 676-697. <https://doi.org/10.1177/1077801204265019>

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. World Health Organization.
https://iris.who.int/bitstream/handle/10665/42495/9241545615_eng.pdf?sequence=1

Kulshrestha, V., & Shahid, S. M. (2022). Barriers and drivers in mental health services in New Zealand: Current status and future direction. *Global Health Promotion*, 29(4), 83-86. <https://doi.org/10.1177/17579759221099312>

Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2016). Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: Comparing rates of cisgender and transgender victimization. *Journal of Interpersonal Violence*, 31(5), 855-871. <https://doi.org/10.1177/0886260514556767>

Leung, V. W. Y., Tan, W., Chuang, D., Tsang, K. T., & Lai, D. W. L. (2022).

Multidimensional approach to explore the experiences with ethnic matching amongst

chinese social service practitioners in the greater Toronto area. *British Journal of Social Work*, 52(3), 1592-1611. <https://doi.org/10.1093/bjsw/bcab122>

Levenson, J. S., MacGowan, M. J., Morin, J. W., & Cotter, L. P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: Journal of Research and Treatment*, 21(1), 35-56.

<https://doi.org/10.1177/1079063208326072>

Lim, N. (2016). Cultural differences in emotion: Differences in emotional arousal level between the East and the West. *Integrative Medicine Research*, 5(2), 105-109.

<https://doi.org/10.1016/j.imr.2016.03.004>

Lindsey, P. (2017). Building a Restorative University. *Journal of Australian and New Zealand Student Services Association (ANZSSA)*, 25(2).

<https://doi.org/10.30688/janzssa.2017.17>

Litwack, T. R. (2001). Actuarial versus clinical assessments of dangerousness. *Psychology, Public Policy, and Law*, 7(2), 409-443. <https://doi.org/10.1037/1076-8971.7.2.409>

Lloyd, A., & Borrill, J. (2020). Examining the effectiveness of restorative justice in reducing victims' post-traumatic stress. *Psychological Injury and Law*, 13(1), 77.

<https://doi.org/10.1007/s12207-019-09363-9>

- Loff, B., Naylor, B., & Bishop, L. (2019). *A community-based survivor-victim focussed restorative justice – A pilot* (Criminology Research Grants; Grant: CRG 33/14-15, Issue. <https://www.aic.gov.au/sites/default/files/2020-05/CRG-33-14-15-Final-Report.pdf>
- Lonne, B., Parton, N., Thomson, J., & Harries, M. (2009). *Reforming child protection*. Routledge. <https://doi.org/10.4324/9780203894675>
- Lonsway, K. A., & Archambault, J. (2012). The 'justice gap' for sexual assault cases: Future directions for research and reform. *Violence Against Women, 18*(2), 145-168. <https://doi.org/10.1177/1077801212440017>
- Lorenz, K., Kirkner, A., & Ullman, S. E. (2019). A qualitative study of sexual assault survivors' post-assault legal system experiences. *Journal of Trauma & Dissociation, 20*(3), 263-287. <https://doi.org/10.1080/15299732.2019.1592643>
- Louwers, E. C. F. M., Korfage, I. J., Affourtit, M. J., Ruige, M., van den Elzen, A. P. M., de Koning, H. J., & Moll, H. A. (2014). Accuracy of a screening instrument to identify potential child abuse in emergency departments. *Child abuse & neglect, 38*(7), 1275-1281. <https://doi.org/10.1016/j.chiabu.2013.11.005>
- Loxton, A., & Groves, A. (2022). Adult male victims of female-perpetrated sexual violence: Australian social media responses, myths and flipped expectations. *International Review of Victimology, 28*(2), 191-214. <https://doi.org/10.1177/02697580211048552>

- Lyle, C. G., & Graham, E. (2000). Looks can be deceiving: Using a risk assessment instrument to evaluate the outcomes of child protection services. *Children and Youth Services Review*, 22(11-12), 935-949. [https://doi.org/10.1016/S0190-7409\(00\)00119-5](https://doi.org/10.1016/S0190-7409(00)00119-5)
- MacGinley, M., Breckenridge, J., & Mowll, J. (2019). A scoping review of adult survivors' experiences of shame following sexual abuse in childhood. *Health & Social Care in the Community*, 27(5), 1135-1146. <https://doi.org/10.1111/hsc.12771>
- Maddux, W. W., Kim, P. H., Okumura, T., & Brett, J. M. (2011). Cultural differences in the function and meaning of apologies. *International Negotiation*, 16(3), 405-425. <https://doi.org/10.1163/157180611X592932>
- Maguire, M. (1991). The needs and rights of victims of crime. *Crime and Justice*, 14, 363-433.
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753-1760. <https://doi.org/10.1177/1049732315617444>
- Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review*, 29(7), 647-657. <https://doi.org/10.1016/j.cpr.2009.08.003>

- Mansill, D. B. (2013). *Community empowerment or institutional capture and control? The development of restorative justice in New Zealand's adult systems of social regulation, control and punishment* [Doctor of Philosophy, Auckland University of Technology].
- Marshall, T. F. (1999). *Restorative justice: An overview*.
http://www.antonioacasella.eu/restorative/Marshall_1999-b.pdf
- Martin, G., Bergen, H. A., Richardson, A. S., Roeger, L., & Allison, S. (2004). Sexual abuse and suicidality: Gender differences in a large community sample of adolescents. *Child abuse & neglect*, 28(5), 491-503. <https://doi.org/10.1016/j.chiabu.2003.08.006>
- Martin, P. Y., & Powell, R. M. (1994). Accounting for the "second assault": Legal organizations' framing of rape victims. *Law & Social Inquiry*, 19(4), 853-890.
<https://doi.org/10.1111/j.1747-4469.1994.tb00942.x>
- Maruna, S., & Toch, H. (2005). The impact of imprisonment on the desistance process. In J. Travis & C. Visser (Eds.), *Prisoner Reentry and Crime in America*. Cambridge University Press. <https://doi.org/10.1017/CBO9780511813580>
- Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, 50, 370-396.
<https://doi.org/10.1037/h0054346>

- McBride, H., & Ireland, C. (2016). The impact of coping style, self-efficacy, emotional reaction and resilience on trauma related intrusive thoughts. *Journal of Forensic Practice, 18*(3), 229-239. <https://doi.org/10.1108/JFP-06-2015-0036>
- McCold, P., & Wachtel, B. (1998). *Restorative Policing Experiment: The Bethlehem Pennsylvania Family Group Conferencing Project*.
<https://www.iirp.edu/images/pdf/BPD.pdf>
- McDonald, E. (2019). Gender neutrality and the definition of rape: Challenging the law's response to sexual violence and non-normative bodies *University of Western Australia Law Review, 45*(166).
<http://www4.austlii.edu.au/au/journals/UWALawRw/2019/16.pdf>
- McDonald, E., Benton-Greig, P., Dickson, S., & Souness, R. (2020). *Rape myths as barriers to fair trial process: Comparing adult rape trials with those in the Aotearoa Sexual Violence Court Pilot*. Canterbury University Press.
<http://www.nzlii.org/nz/journals/NZLFRRp/2020/5.pdf>
- McElvaney, R., & Nixon, E. (2020). Parents' experiences of their child's disclosure of child sexual abuse. *Family Process, 59*(4), 1773-1788. <https://doi.org/10.1111/famp.12507>
- McGlynn, C., & Westmarland, N. (2019). Kaleidoscopic justice: Sexual violence and victim-survivors' perceptions of justice. *Social and Legal Studies, 28*(2), 179-201.
<https://doi.org/10.1177/0964663918761200>

- McGlynn, C., Westmarland, N., & Godden, N. (2012). 'I just wanted him to hear me': Sexual violence and the possibilities of restorative justice. *Journal of Law & Society*, 39(2), 213-240. <https://doi.org/10.1111/j.1467-6478.2012.00579.x>
- McHichi Alami, K., & Kadri, N. (2004). Moroccan women with a history of child sexual abuse and its long-term repercussions: A population-based epidemiological study. *Archives of Women's Mental Health*, 7(4), 237-242. <https://doi.org/10.1007/s00737-004-0061-9>
- McNeill, F. (2006). A desistance paradigm for offender management: What lies beyond? Problems, prospects and possibilities for life after punishment. *Criminology & Criminal Justice: An International Journal*, 6(1), 39-62. <https://doi.org/10.1177/1748895806060666>
- Mendes, K., Ringrose, J., & Keller, J. (2018). #MeToo and the promise and pitfalls of challenging rape culture through digital feminist activism. *European Journal of Women's Studies*, 25(2), 236-246-246. <https://doi.org/10.1177/1350506818765318>
- Meng, X., & D'Arcy, C. (2016). Coping strategies and distress reduction in psychological well-being? A structural equation modelling analysis using a national population sample. *Epidemiology and Psychiatric Sciences*, 25(4), 370-383-383. <https://doi.org/10.1017/S2045796015000505>

Mercer, V., & Sten Madsen, K. (2015). *Doing restorative justice in cases of sexual violence: A practice guide*. https://www.euforumrj.org/sites/default/files/2019-11/doing-restorative-justice-in-cases-of-sexual-violence_practice-guide_sept2015-1.pdf

Miller, S. L. (2011). *After the crime: The power of restorative justice dialogues between victims and violent offenders*. NYU Press. <https://doi.org/10.5235/20504721.1.1.146>

Miller, S. L., Hefner, M. K., & Iovanni, L. (2020). Practitioners' perspectives on using restorative justice with crimes of gendered violence. *Contemporary Justice Review: Issues in Criminal, Social, and Restorative Justice*, 23(1), 65-90. <https://doi.org/10.1080/10282580.2019.1700372>

Ministry of Education Te Tāhuhu o Te Mātauranga. (2020a). *Relationships and sexuality education: A guide for teachers, leaders, and boards of trustees. Years 1-8*. <https://hpe.tki.org.nz/assets/healthpe/pdfs/RSE+Guide+y1-8.pdf>

Ministry of Education Te Tāhuhu o Te Mātauranga. (2020b). *Relationships and sexuality education: A guide for teachers, leaders, and boards of trustees. Years 9-13*. <https://hpe.tki.org.nz/assets/healthpe/pdfs/RSE+Guide+y9-13.pdf>

Ministry of Health. (1998). *Guidelines for clinical risk assessment and management in mental health services*

Ministry of Health. (2023, December 1). *Māori health models – Te whare tapa whā*.

Retrieved 18.10.24 from <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha>

Ministry of Justice. (2011a). *Re-offending analysis for restorative justice cases: 2008 and*

2009. <https://www.justice.govt.nz/assets/Documents/Publications/rj-Reoffending-Analysis-for-RJ-Cases.pdf>

Ministry of Justice. (2011b). *Restorative justice: Best practice framework*.

<https://www.justice.govt.nz/assets/RJ-Best-practice.pdf>

Ministry of Justice. (2011c). *Victim satisfaction with restorative justice: A summary of*

findings. <https://www.justice.govt.nz/assets/Documents/Publications/Restorative-Justice-Victim-Satisfaction-Survey-Summary-of-Findings.pdf>

Ministry of Justice. (2013). *Restorative justice standards for sexual offending cases*.

<https://www.justice.govt.nz/assets/Restorative-justice-standards-for-sexual-offending-cases.pdf>

Ministry of Justice. (2014a). *2014 New Zealand crime and safety survey: Te rangahau o*

Aotearoa mō te taihara me te haumarutanga. Ministry of Justice.

<https://www.justice.govt.nz/assets/NZCASS-201602-Main-Findings-Report-Updated.pdf>

Ministry of Justice. (2014b). *Reoffending analysis for restorative justice cases 2008-2011*.

<https://thehub.swa.govt.nz/assets/documents/rj-reoffending-results-report-20140403.pdf>

Ministry of Justice. (2016a). *Reoffending Analysis for Restorative Justice Cases 2008-2013: Summary Results*.

<https://www.justice.govt.nz/assets/rj-Reoffending-Analysis-for-Restorative-Justice-Cases-2008-2013-Summary-Results.pdf>

Ministry of Justice. (2016b). *Restorative justice victim satisfaction survey*.

<https://www.justice.govt.nz/assets/Documents/Publications/20170303-RJ-Victim-Report.pdf>

Ministry of Justice. (2017). *Family violence risk assessment and management framework: A common approach to screening, assessing and managing risk*.

<https://www.justice.govt.nz/assets/Documents/Publications/family-violence-ramf.pdf>

Ministry of Justice. (2019a). *Attrition and progression: Reported sexual violence victimisations in the criminal justice system*. Ministry of Justice.

<https://www.justice.govt.nz/assets/sf79dq-Sexual-violence-victimisations-attrition-and-progression-report-v1.0.pdf>

Ministry of Justice. (2019b). *Restorative justice in New Zealand: Best practice*

(0478201893). <https://www.justice.govt.nz/assets/Restorative-Justice-Practice-Framework-August-2019.pdf>

Ministry of Justice. (2019c). *Restorative justice practice resources for family violence cases.*

<https://www.justice.govt.nz/assets/Restorative-Justice-Family-Violence-Practice-Standards-August-2019.pdf>

Ministry of Justice. (2021a). *New Zealand crime and victims survey. Key Findings, descriptive statistics. May 2021. Results drawn from Cycle 3 (2019/20) of the New Zealand crime and victims survey.* Ministry of Justice, Tāhū o te Ture.

<https://www.justice.govt.nz/assets/Cycle-3-Core-Report-20220224-v1.9.pdf>

Ministry of Justice. (2021b). *Research & data.* Retrieved 21/02/2022 from

<https://www.justice.govt.nz/justice-sector-policy/research-data/justice-statistics/data-tables/#offence>

Ministry of Justice. (2023a). *Attrition and progression of reported sexual violence victimisations in the criminal justice system: Victimisations reported April 2017– March 2022.* Ministry of Justice.

<https://www.justice.govt.nz/assets/Documents/Publications/Attrition-and-progression-of-reported-sexual-violence-victimisations-in-the-criminal-justice-system-2017-to-2022.pdf>

Ministry of Justice. (2023b). *New Zealand Crime and Victims Survey. Key findings – Cycle 5 report Descriptive statistics. June 2023. Results drawn from Cycle 5 (2021/22) of the New Zealand Crime and Victims Survey.* (Ministry of Justice, Ed.). Ministry of Justice, Tāhū o te Ture.

<https://www.justice.govt.nz/assets/Documents/Publications/Cycle-5-key-findings-report-v3.0-FIN.pdf>

Ministry of Justice. (2023c). *Restorative Justice Review: Findings Report*

https://www.justice.govt.nz/assets/Documents/Publications/Ministry-of-Justice-Restorative-Justice-review-report_FINAL.pdf

Ministry of Women. (2021). *Manatū wāhine ministry for women*. Retrieved 21/02/2022 from

<https://women.govt.nz/about/our-work>

Ministry of Women's Affairs. (2009). *Restoring soul: Effective interventions for adult victim/survivors of sexual violence* (0478252471 9780478252477).

<https://women.govt.nz/sites/default/files/2022-04/restoring-soul-pdf-1.pdf>

Ministry of Women's Affairs. (2012). *Lightning does strike twice: Preventing sexual revictimisation*. Ministry of Women's Affairs.

https://women.govt.nz/sites/default/files/2021-10/Lightning%20does%20strike%20twice_2012%20report.pdf

Ministry of Women's Affairs. (2006). *CEDAW report: New Zealand's sixth report on its implementation of the United Nations convention on the elimination of all forms of discrimination against women*. https://women.govt.nz/sites/public_files/cedaw06.pdf

- Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health, 91*(5), 753-760. <https://www.icmec.org/wp-content/uploads/2015/10/CSA-and-Subsequent-Psychopathology-Results-for-the-National-Comorbidity-Survey-2001-Molnar.pdf>
- Monahan, J. (1981). *Predicting violent behavior: An assessment of clinical techniques*. Sage Publications. <https://doi.org/10.2307/2066734>
- Monroe, L. M., Kinney, L. M., Weist, M. D., Dafeamekpor, D. S., Dantzler, J., & Reynolds, M. W. (2005). The experience of sexual assault. Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence, 20*(7), 767-776. <https://doi.org/10.1177/08862605052771>
- Morris, A., Kingi, V., Poppelwell, E., Robertson, J., & Triggs, S. (2005). *New Zealand court-referred restorative justice pilot: Evaluation*. Ministry of Justice.
- Morris, A., & Maxwell, G. M. (2001). *Restorative justice for juveniles: Conferencing, mediation and circles*. Hart.
- Morris, A., Maxwell, G. M., & Robertson, J. P. (1993). Giving victims a voice: A New Zealand experiment. *Howard Journal of Criminal Justice, 32*(4), 301-321. <https://doi.org/10.1111/j.1468-2311.1993.tb00785.x>

Morris, A., Reilly, J., Berry, S., & Ransom, R. (2003). *New Zealand national survey of crime victims 2001*. ISBN 0-478-20180-X

Mossman, E., MacGibbon, L., Kingi, V., & Jordan, J. (2009). *Responding to sexual violence: Environmental scan of New Zealand agencies*. Ministry of Women's Affairs.
<https://women.govt.nz/sites/default/files/2022-04/environmental-scan.pdf>

Mulvey, E. P., & Iselin, A. M. R. (2008). Improving professional judgments of risk and amenability in juvenile justice *Future of Children, 18*(2), 35–57, *18*(2), 35-57.
<https://doi.org/10.1353/foc.0.0012>

Nada-Raja, S., & Skegg, K. (2011). Victimization, posttraumatic stress disorder symptomatology, and later nonsuicidal self-harm in a birth cohort. *Journal of Interpersonal Violence, 26*(18), 3667-3681.
<https://doi.org/10.1177/0886260511403757>

Nascimento, A. M., Andrade, J., & de Castro Rodrigues, A. (2022). The psychological impact of restorative justice practices on victims of crimes—A systematic review. *Trauma, Violence, & Abuse, 24*(3), 1929-1947.
<https://doi.org/10.1177/15248380221082085>

Nelson, E. C., Heath, A. C., Madden, P. A. F., Cooper, M. L., Dinwiddie, S. H., Bucholz, K. K., Glowinski, A., McLaughlin, T., Dunne, M. P., Statham, D. J., & Martin, N. G. (2002). Association between self-reported childhood sexual abuse and adverse

psychosocial outcomes: Results from a twin study. *Archives of General Psychiatry*, 59(2), 139-145. <https://doi.org/10.1001/archpsyc.59.2.139>.

New, C. (1998). Realism, deconstruction and the feminist standpoint. *Journal for the Theory of Social Behaviour*, 28(4), 349. <https://doi.org/10.1111/1468-5914.00080>

New York State Office of Children and Family Services. (2017). *Family assessment service plan guide*. <https://www.ocfs.ny.gov/ohrd/assets/docs/fasp/FASP-Ref-Guide-2017-0a-Cover.pdf>

New Zealand Guidelines Group and Ministry of Health. (2003). *The assessment and management of people at risk of suicide*. https://www.health.govt.nz/system/files/documents/publications/suicide_guideline.pdf

New Zealand Law Commission. (2015). *The justice response to victims of sexual violence: Criminal trials and alternative processes* (136). <https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC-R136-The-Justice-Response-to-Victims-of-Sexual-Violence.pdf>

New Zealand Police. (2016). *Restorative justice: Evidence brief*. New Zealand. <https://www.justice.govt.nz/assets/evidence-brief-restorative-justice.pdf>

Newton, A. S., Zou, B., Hamm, M. P., Curran, J., Gupta, S., Dumonceaux, C., & Lewis, M. (2010). Improving child protection in the emergency department: A systematic review

of professional interventions for health care providers. *Academic Emergency Medicine*, 17(2), 117-125. <https://doi.org/10.1111/j.1553-2712.2009.00640.x>

Note, N., Fornet-Betancout, R., Estermann, J., & Aerts, D. (2009). *Worldviews and cultures: Philosophical reflections from an intercultural perspective* (Vol. 10). Springer. <https://doi.org/10.1007/978-1-4020-5754-0>

O'Connell, T. (1998). *From Wagga Wagga to Minnesota* First North American Conference on Conferencing, Minneapolis, Minnesota. <https://www.iirp.edu/news/from-wagga-wagga-to-minnesota>

Oranga Tamariki Ministry for Children. (2014). *Safety and risk screen*. <https://practice.orangatamariki.govt.nz/our-work/practice-tools/other-practice-and-assessment-tools/safety-and-risk-screen/>

Orchowski, L. M., Nugent, N. R., Grocott, L., Bogen, K. W., Ilegbusi, A., & Amstadter, A. B. (2022). Barriers to reporting sexual violence: A qualitative analysis of #WhyIDidntReport. *Violence Against Women*, 28(14), 3530-3553. <https://doi.org/10.1177/10778012221092479>

Parsons, J., & Bergin, T. (2010). The impact of criminal justice involvement on victims' mental health. *Journal of Traumatic Stress*, 23(2), 182-188. <https://doi.org/10.1002/jts.20505>

- Patton, M. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Sage Publications.
- Peleg-Koriat, I., & Klar-Chalamish, C. (2020). The #MeToo movement and restorative justice: Exploring the views of the public. *Contemporary Justice Review: Issues in Criminal, Social, and Restorative Justice*, 23(3), 239-260.
<https://doi.org/10.1080/10282580.2020.1783257>
- Persson, S. (2022). *Rape myths: Understanding, assessing, and preventing*. Emerald Publishing Limited. <https://doi.org/10.1108/9781800711525>
- Petrak, J., Doyle, A.-M., Williams, L., Buchan, L., & Forster, G. (1997). The psychological impact of sexual assault: A study of female attenders of a sexual health psychology service. *Sexual & Marital Therapy*, 12(4), 339-345.
<https://doi.org/10.1080/02674659708408177>
- Pfander, S. M. (2020). Evaluating New Zealand's restorative promise: The impact of legislative design on the practice of restorative justice. *Kotuitui: New Zealand Journal of Social Sciences*, 15(1), 170-185. <https://doi.org/10.1080/1177083X.2019.1678492>
- Pitama, S. G., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand journal of psychology*, 36(3), 118-125. https://www.psychology.org.nz/journal-archive/Pitamaetal_NZJP36-3_pg118.pdf

- Pointer, L. (2019). Restorative practices in residence halls at Victoria University of Wellington, New Zealand. *Conflict Resolution Quarterly*, 36(3), 263-271.
<https://doi.org/10.1002/crq.21240>
- Polanyi, M. (1962). Tacit knowing: Its bearing on some problems of philosophy. *Reviews of Modern Physics*, 34(4), 601-616. <https://doi.org/10.1103/RevModPhys.34.601>
- Poulson, B. (2003). A third voice: A review of empirical research on the psychological outcomes of restorative justice. *Utah Law Review*, 1, 167-203.
- Pranis, K. (2002). Restorative values and confronting family violence. In J. Braithwaite & H. Strang (Eds.), *Restorative Justice and Family Violence*. Cambridge University Press.
- Pratt, J. (1996). Colonization, power and silence: A history of indigenous justice in New Zealand society. In B. Galaway & J. Hudson (Eds.), *Restorative justice: International perspectives*. Criminal Justice Press.
- Presley, S., & Day, S. X. (2019). Counseling dropout, retention, and ethnic/language match for Asian Americans. *Psychological Services*, 16(3), 491-497-497.
<https://doi.org/10.1037/ser0000223>

Proietti-Scifoni, G., & Daly, K. (2011). Gendered violence and restorative justice: The views of New Zealand opinion leaders. *Contemporary Justice Review*, 14(3), 269-290.

<https://doi.org/10.1080/10282580.2011.589666>

Project Restore NZ. (2005). *Project Restore NZ: Our model*

<https://www.projectrestore.nz/our-work/#model>

Quinn, M. (2019). *Justice and egalitarianism: Formal and substantive equality in some recent theories of justice*. Routledge. <https://doi.org/10.4324/9780429295027>

Quinsey, V. L., & Ambtman, R. (1979). Variables affecting psychiatrists' and teachers' assessments of the dangerousness of mentally ill offenders. *Journal of Consulting and Clinical Psychology*, 47(2), 353-362. <https://doi.org/10.1037//0022-006x.47.2.353>

Radio New Zealand. (2021, October 3). ACC to spend \$44.9 million on sexual violence prevention. *Radio New Zealand*. <https://www.rnz.co.nz/news/national/452805/acc-to-spend-44-point-9-million-on-sexual-violence-prevention>

Radio New Zealand. (2022, April 12). I was raped, then ruined by the systems that were supposed to help me *Radio New Zealand*. <https://www.rnz.co.nz/news/in-depth/465111/i-was-raped-then-ruined-by-the-systems-that-were-supposed-to-help-me>

- Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology & Psychotherapy: Theory, Research & Practice*, 76(1), 1. <https://doi.org/10.1348/14760830260569210>
- Redman, K. A. (2019). *"I wonder if we should even be doing it at all": An exploratory study of family violence restorative justice in cases of intimate partner violence* [Master of Applied Psychology - Community Psychology, The University of Waikato].
- Regehr, C. (1990). Parental responses to extrafamilial child sexual assault. *Child Abuse and Neglect*, 14(1), 113-120. [https://doi.org/10.1016/0145-2134\(90\)90086-9](https://doi.org/10.1016/0145-2134(90)90086-9)
- Reinharz, S., & Davidman, L. (1992). *Feminist methods in social research*. Oxford University Press USA.
- Restorative Justice Council. (2011). *Best practice guidance for restorative practice*. <https://restorativejustice.org.uk/sites/default/files/resources/files/Best%20practice%20guidance%20for%20restorative%20practice%202011.pdf>
- Reynolds, C. R., & Suzuki, L. A. (2012). Bias in psychological assessment: An empirical review and recommendations. In I. B. Weiner (Ed.), *Handbok of Psychology* (Second ed., Vol. 10). <https://doi.org/10.1002/9781118133880.hop210004>

Richards, K. (2022). *Desistance from sexual offending: The role of circles of support and accountability* (1st ed.). Routledge. <https://doi.org/10.4324/9781003125532>

Roche, D. (2001). The evolving definition of restorative justice. *Contemporary Justice Review*, 4(3/4), 341.

Roche, D. (2002). Restorative justice and the regulatory state in South African townships. *The British Journal of Criminology*, 42(3), 514-533.
<https://doi.org/10.1093/bjc/42.3.514>

Rodogno, R. (2008). Shame and guilt in restorative justice. *Psychology, Public Policy, and Law*, 14(2), 142-176. <https://doi.org/10.1037/a0013474>

Rollings, K. (2005). *Counting the costs of crime in Australia: A 2005 update*. Research and Public Policy Series. (Vol. 91) Australian Institute of Criminology.
<https://apo.org.au/sites/default/files/resource-files/2008-05/apo-nid3269.pdf>

Roper, T., & Thompson, A. (2006). *Estimating the costs of crime in New Zealand in 2003/2004*. <https://www.treasury.govt.nz/sites/default/files/2007-09/twp06-04.pdf>

Rossner, M., & Bruce, J. (2018). Trajectories and typologies of pre-sentence restorative justice rituals. *Australian and New Zealand journal of criminology*.
<https://doi.org/10.1177/00048658177492>

- Rothman, K., Roddy, M. K., Hatch, S. G., Doss, B. D., & Georgia Salivar, E. (2019). Sexual assault among women in college: Immediate and long-term associations with mental health, psychosocial functioning, and romantic relationships. *Journal of Interpersonal Violence*, 1–23. <https://doi.org/10.1177/0886260519870158>
- Ryan, T. G., & Ruddy, S. (2015). Restorative justice: A changing community response. *International Electronic Journal of Elementary Education*, 7(2), 253-262. <https://files.eric.ed.gov/fulltext/EJ1057888.pdf>
- Saulnier, A., & Sivasubramaniam, D. (2015). Effects of victim presence and coercion in restorative justice: An experimental paradigm. *Law & Human Behavior (American Psychological Association)*, 39(4), 378-387. <https://doi.org/10.1037/lhb0000130>
- Sayali, C. T., & Swati, R. D. (2020). A study to assess the effect of stressful life events on psychological distress levels of participants living in an urban area. *Journal of Family Medicine and Primary Care*, 9(6), 2730-2735. https://doi.org/10.4103/jfmpe.jfmpe_96_20
- Scarduzio, J., A., Wehlage, S., J., & Lueken, S. (2018). "It's like taking your man card away": Male victims' narratives of male-to-male sexual harassment. *Communication Quarterly*, 66(5), 481-500. <https://doi.org/10.1080/01463373.2018.1447978>
- Schaller, A., & Aebi, M. F. (2022). Domestic Violence: Criminal prosecution authorities management of violences committed by intimate (ex-) partners: The Neuchâtel perspective. Domestic violence victims' perception of recidivism risk: An empirical

longitudinal examination of its accuracy and its implications for crime prevention.

Annales Medico-Psychologiques, 180(3), 272-273-273.

<https://doi.org/10.1016/j.amp.2022.01.016>

Scheela, R. A. (2001). Sex offender treatment: Therapists' experiences and perceptions.

Issues in Mental Health Nursing, 22(8), 749-767.

<https://doi.org/10.1080/01612840152713009>

Scottish Executive. (2000). *Report of the committee on serious violent and sexual offenders*.

https://content.iriss.org.uk/throughcare/files/pdf/longterm/lt4_resource2.pdf?q=throughcare/files/pdf/longterm/lt4_resource2.pdf

Shapland, J., Atkinson, A., Atkinson, H., Dignan, J., Edwards, L., Hibbert, J., Howes, M.,

Johnstone, J., Robinson, G., & Sorsby, A. (2008). *Does restorative justice affect reconviction? The fourth report from the evaluation of three schemes* (Ministry of

Justice Research Series 10/08, Issue. http://www.kdm.org.il/wp-content/uploads/2015/01/Shapland_fourth_report_2008.pdf

Shepherd, S. M. (2016). Violence risk instruments may be culturally unsafe for use with

Indigenous patients. *Australasian Psychiatry*, 24(6), 565-567-567.

<https://doi.org/10.1177/1039856216665287>

Shepp, V., O'Callaghan, E., & Ullman, S. E. (2020). Interactions with offenders post-assault and their impacts on recovery: A qualitative study of sexual assault survivors and

support providers. *Journal of Aggression, Maltreatment & Trauma*, 29(6), 725-747.

<https://doi.org/10.1080/10926771.2019.1660443>

Sherman, L. W., & Strang, H. (2007). *Restorative justice: The evidence*. The Smith Institute.

https://www.iirp.edu/pdf/RJ_full_report.pdf

Sherman, L. W., Strang, H., Barnes, G. C., Braithwaite, J., Inkpen, N., & Teh, M.-M. (1999). *Experiments in restorative policing: A progress report on the Canberra reintegrative shaming experiments*. Australian Federal Police and Australian National University.

<https://www.aic.gov.au/sites/default/files/2020-09/CRG-4793-4-FinalReport.pdf>

Sherman, L. W., Strang, H., Barnes, G. C., Woods, D. J., Bennett, S., Inkpen, N., Newbury-Birch, D., Rossner, M., Angel, C., Mearns, M., & Slothower, M. (2015). Twelve experiments in restorative justice: The Jerry Lee program of randomized trials of restorative justice conferences. *Journal of Experimental Criminology*, 11(4), 501.

<https://doi.org/10.1007/s11292-015-9247-6>

Shin, S.-M., Chow, C., Camacho-Gonsalves, T., Levy, R. J., Allen, I. E., & Leff, H. S.

(2005). A meta-analytic review of racial-ethnic matching for African American and Caucasian American clients and clinicians. *Journal of Counseling Psychology*, 52(1),

45-56. <https://doi.org/10.1037/0022-0167.52.1.45>

Sittig, J. S., Post, E. D. M., Russel, I. M. B., van Dijk, I. A. G., Nieuwenhuis, E. E. S., & van de Putte, E. M. (2014). Evaluation of suspected child abuse at the ED; implementation

of American Academy of Pediatrics guidelines in the Netherlands. *American Journal of Emergency Medicine*, 32(1), 64-66. <https://doi.org/10.1016/j.ajem.2013.08.038>

Smith, D. E. (1997). Comment on Hekman's "Truth and method: Feminist standpoint theory revisited". *Signs*, 22(2), 392-398. <https://www.jstor.org/stable/3175279>

Smith, J. A., Larkin, M. H., & Flowers, P. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Smith, L. T. (2001). *Decolonizing methodologies: Research and indigenous peoples* (Third edition ed.). Zed Books. <https://doi.org/10.5040/9781350225282>

Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 National report*. <https://www.ojjdp.gov/ojstatbb/nr2006/downloads/nr2006.pdf>

Soanes, C., & Stevenson, A. (2005). *Oxford dictionary of English* (2nd ed.). Oxford University Press.

Spataro, J., Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *The British Journal of Psychiatry*, 184, 416-421. <http://dx.doi.org/10.1192/bjp.184.5.416>

- Spencer, C. M., Stith, S. M., & Cafferky, B. (2019). Risk markers for physical intimate partner violence victimization: A meta-analysis. *Aggression and Violent Behavior, 44*, 8-17. <https://doi.org/10.1016/j.avb.2018.10.009>
- Stallman, H. M. (2020). Health theory of coping. *Australian Psychologist, 55*(4), 295-306. <https://doi.org/10.1111/ap.12465>
- Stemple, L., & Meyer, I., H. (2014). The Sexual victimization of men in America: New data challenge old assumptions. *American Journal of Public Health, 104*(6), e19-e26. <https://doi.org/10.2105/AJPH.2014.301946>
- Strang, B. (2020, 20.5.21). Ninety-four percent of sexual assaults go unreported - survey. *Radio New Zealand*. <https://www.rnz.co.nz/news/national/417046/ninety-four-percent-of-sexual-assaults-go-unreported-survey>
- Strang, B. (2021). Risk of coercion in restorative justice highlighted by chief victims advisor. *Radio New Zealand*. <https://www.rnz.co.nz/news/national/448043/risk-of-coercion-in-restorative-justice-highlighted-by-chief-victims-advisor>
- Strang, H. (2001). Justice for victims of young offenders: The centrality of emotional harm and restoration. In A. Morris & G. Maxwell (Eds.), *Restorative justice for juveniles: conferencing, mediation and circles*. Hart.

- Strang, H., Sherman, L. W., Angel, C., M., Woods, D., J., Bennett, S., Newbury-Birch, D., & Inkpen, N. (2006). Victim evaluations of face-to-face restorative justice conferences: A quasi-experimental analysis. *Journal of Social Issues, 62*(2), 281-306.
<https://doi.org/10.1111/j.1540-4560.2006.00451.x>
- Strang, H., Sherman, L. W., Mayo-Wilson, E., Woods, D., & Ariel, B. (2013). Restorative justice conferencing (RJC) using face-to-face meetings of offenders and victims: Effects on offender recidivism and victim satisfaction. A systematic review. *Campbell Systematic Reviews, 9*(1), 1-59. <https://doi.org/10.4073/csr.2013.12>
- Stubbs-Richardson, M., Gilbreath, S., Paul, M., & Reid, A. (2023). It's a global #MeToo: a cross-national comparison of social change associated with the movement. *Feminist Media Studies, 1-20*. <https://doi.org/10.1080/14680777.2023.2231654>
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477-486. <https://doi.org/10.1002/j.1556-6676.1992.tb01642.x>
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*(4), 440-448. <https://doi.org/10.1037/0003-066X.53.4.440>
- Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548. <https://doi.org/10.1146/annurev.psych.60.110707.163651>

Suzuki, M., & Wood, W. R. (2017). Co-option, coercion and compromise: Challenges of restorative justice in Victoria, Australia. *Contemporary Justice Review*, 20(2), 274-292. <https://doi.org/10.1080/10282580.2017.1311194>

Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of Clinical Psychology*, 74(11), 1924-1937. <https://doi.org/10.1002/jclp.22680>

Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology*, 62(3), 337-350. <https://doi.org/10.1037/cou0000086>

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a qualitative research approach. *Journal of graduate medical education*, 7(4), 669-670. <https://doi.org/10.4300/JGME-D-15-00414.1>

Temple, J., Bowling, J., Mennicke, A., & Edwards, K. (2024). Social reactions to disclosure of sexual violence experienced by sexual and gender minority young adults: Comparisons of sexual and gender minority recipients versus cisgender/heterosexual recipients. *Journal of Interpersonal Violence*, 39(3/4), 477-498. <https://doi.org/10.1177/08862605231197786>

The Crimes Act 1961. (NZ).

<https://www.legislation.govt.nz/act/public/1961/0043/latest/DLM327382.html>

Tower, J. M. (2009). Striking a better balance between child safety and parental rights.

Advocates' Forum, The University of Chicago. <https://ssa.uchicago.edu/striking-better-balance-between-child-safety-and-parental-rights>

Triggs, S., Mossman, E., Jordan, J., & Kingi, V. (2009). *Responding to sexual violence:*

Attrition in the New Zealand criminal justice system (9780478252484 047825248X).

https://women.govt.nz/sites/public_files/responding%20to%20sexual%20violence%20attrition-pdf.pdf

Turner, J. H., & Stets, J. E. (2005). *The sociology of emotions.* Cambridge University Press.

<https://doi.org/10.1017/CBO9780511819612>

Tyson, J. (2023). Removing and replacing relationship education a step backwards in ending sexual violence, say experts. *New Zealand Herald.*

<https://www.nzherald.co.nz/kahu/removing-and-replacing-relationship-education-a-step-backward-in-ending-sexual-violence-experts/3ZHBWQZC2FGJRKEH4IE2C5XOLA/>

Umbreit, M. S., Bradshaw, W., & Coates, R. B. (1999). Victims of severe violence meet the offender: Restorative justice through dialogue. *International Review of Victimology,*

6(4), 321-343. <https://doi.org/10.1177/026975809900600405>

Umbreit, M. S., Coates, R. B., & Vos, B. (2004). Victim-offender mediation: Three decades of practice and research. *Conflict Resolution Quarterly*, 22(1/2), 279-303.

<https://doi.org/10.1002/crq.102>

Umbreit, M. S., & Vos, B. (2000). Homicide survivors meet the offender prior to execution: Restorative justice through dialogue. *Homicide Studies*, 4(1), 63-88.

<https://doi.org/10.1177/1088767900004001>

United Nations The Economic and Social Council. (2000). *Basic principles on the use of restorative justice programs in criminal matters*.

<https://www.un.org/en/ecosoc/docs/2002/resolution%202002-12.pdf>

Vaandering, D., & Reimer, K. (2019). Listening deeply to public perceptions of Restorative Justice: What can researchers and practitioners learn? *The International Journal of Restorative Justice*, 2(2), 186-208.

<https://doi.org/10.5553/IJRJ/258908912019002002002>

Vaithianathan, R., Maloney, T., Jiang, N., De Haan, I., Dale, C., Putnam-Hornstein, E., & Dare, T. (2012). *Vulnerable children: Can administrative data be used to identify children at risk of adverse outcomes?* <https://msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/vulnerable-children/auckland-university-can-administrative-data-be-used-to-identify-children-at-risk-of-adverse-outcome.pdf>

Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Van Stokkom, B. (2002). Moral emotions in restorative justice conferences: Managing shame, designing empathy. *Theoretical Criminology*, 6(3), 339-360.

<https://doi.org/10.1177/136248060200600306>

Wager, N. (2013). The experience and insight of survivors who have engaged in a restorative justice meeting with their assailant. *Temida*, 16(1), 11-32.

<https://doi.org/10.2298/TEM1301011W>

Wakeling, H. C., Webster, S. D., & Mann, R. E. (2005). Sexual offenders' treatment experience: A qualitative and quantitative investigation. *Journal of Sexual Aggression*, 11(2), 171-186. <https://doi.org/10.1080/13552600412331321323>

Wald, M. S., & Woolverton, M. (1990). Risk assessment: The emperor's new clothes? *Child Welfare*, 69(6), 483-512. <https://www.jstor.org/stable/45394134>

Wallis, P. (2014). *Understanding restorative justice: How empathy can close the gap created by crime*. Policy Press. <https://doi.org/10.2307/j.ctt1t89gbn>

Waters, H. R., Hyder, A. A., Rajkotia, Y., Basu, S., & Butchart, A. (2005). The costs of interpersonal violence - an international review. *Health Policy*, 73(3), 303-315.

<https://doi.org/10.1016/j.healthpol.2004.11.022>

Weekes, J. C. (2010). Race-matching in psychotherapy: Findings, inconsistencies, and future directions. *Graduate Student Journal of Psychology*, 58(4), 537–554.

https://www.tc.columbia.edu/media/centers-amp-labs/gsjp/gsjp-volume-pdfs/14422_Weekes.pdf

Weisz, A. N., Tolman, R. M., & Saunders, D. G. (2000). Assessing the risk of severe domestic violence: The importance of survivors' predictions. *Journal of Interpersonal Violence*, 15(1), 75-90. <https://doi.org/10.1177/088626000015001006>

Wemmers, J. (2002). Restorative justice for victims of crime: A victim-oriented approach to restorative justice. *International Review of Victimology*, 9(1), 43-59.

<https://doi.org/10.1177/026975800200900104>

Wemmers, J. (2013). Victims' experiences in the criminal justice system and their recovery from crime. *International Review of Victimology*, 19(3), 221-233.

<https://doi.org/10.1177/0269758013492755>

Wemmers, J., & Canuto, M. (2002). *Victims' experiences with, expectations and perceptions of restorative justice: A critical review of the literature.*

https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rr01_9/rr01_9.pdf

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist*, 62(6),

563-574. <https://doi.org/10.1037/0003-066X.62.6.563>

- Whitfield, H. W., Venable, R., & Broussard, S. (2010). Are client-counselor ethnic/racial matches associated with successful rehabilitation outcomes? *Rehabilitation Counseling Bulletin*, 53(2), 96-105-105. <https://doi.org/10.1177/0034355209338526>
- Wickramasekera, N., Wright, J., Elsey, H., Murray, J., & Tubeuf, S. (2015). Cost of crime: A systematic review. *Journal of Criminal Justice*, 43(3), 218-228. <https://doi.org/10.1016/j.jcrimjus.2015.04.009>
- Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. Open University Press.
- Woldgabreal, Y. (2023). Challenging bias in cross-cultural forensic psychology assessment and testing: A summary perspective. In G. C. Liell, L. F. Jones, & M. J. Fisher (Eds.), *Challenging bias in forensic psychological assessment and testing: Theoretical and practical approaches to working with diverse populations* (pp. 475–493). Routledge. <https://doi.org/10.4324/9781003230977>
- Woodman, J., Lecky, F., Hodes, D., Pitt, M., Taylor, B., & Gilbert, R. (2010). Screening injured children for physical abuse or neglect in emergency departments: A systematic review. *Child: Care, Health & Development*, 36(2), 153-164. <https://doi.org/10.1111/j.1365-2214.2009.01025.x>
- Woodyatt, L., & Wenzel, M. (2013). The psychological immune response in the face of transgressions: Pseudo self-forgiveness and threat to belonging. *Journal of*

Experimental Social Psychology, 49(6), 951-958.

<https://doi.org/10.1016/j.jesp.2013.05.016>

Yoon, D., Spehr, A., & Briken, P. (2011). Structured assessment of protective factors: A German pilot study in sex offenders. *Journal of Forensic Psychiatry & Psychology*, 22(6), 834-844. <https://doi.org/10.1080/14789949.2011.617831>

Young, R. (2001). Just cops doing “shameful” business?: Police-led restorative justice and the lessons of research. In A. Morris & G. Maxwell (Eds.), *Restorative justice for juveniles: conferencing, mediation and circles*. Hart.

Zaleski, K. L., Johnson, D. K., & Klein, J. T. (2016). Grounding Judith Herman’s Trauma Theory within Interpersonal Neuroscience and Evidence-Based Practice Modalities for Trauma Treatment. *Smith College Studies in Social Work (Taylor & Francis Ltd)*, 86(4), 377-393. <https://doi.org/10.1080/00377317.2016.1222110>

Zehr, H. (2005). *Changing lenses: A new focus for crime and justice* (3 ed.). Herald Press.

Zernova, M. (2016). Restorative justice in action. In *Restorative Justice: Ideals and realities*. Routledge. <https://doi.org/https://doi.org/10.4324/9781315264875>

Zoom Video Communications Inc. (2021a). *Best practices for securing your Zoom meetings*.

Retrieved 18.08.2021 from

<https://zoom.us/docs/doc/Securing%20Your%20Zoom%20Meetings.pdf>

Zoom Video Communications Inc. (2021b). *Security overview*. Retrieved 18.08.2021 from

<https://zoom.us/trust/security>

Appendix A: Professional Information Sheet

Risk and Readiness Prior to Sexual Violence Restorative Justice

Information Sheet

My name is Charlotte Bremer, and I am currently completing a Doctorate in Clinical Psychology at Massey University, supervised by Associate Professor Richard Fletcher and Associate Professor Matt Shepherd of the Massey University School of Psychology, and Associate Professor Shirley Jülich of the Massey University School of Social Work.

In my research I am investigating risk and readiness among people who engage in restorative justice following sexual violence (SVRJ), and how risk and readiness can be assessed. This research will develop recommended risk assessment guidelines which professionals could use to guide their risk assessments in this area, making the processes safer for all involved. Such guidelines could have wide-reaching impact as Aotearoa New Zealand is one of only a few countries offering SVRJ, and structured risk assessment guidelines are not yet available in this field. These guidelines may therefore support the use of SVRJ, allowing more people to experience the benefits of SVRJ in safe and considered ways.

What will participants be asked to do?

In this part of my research, I want to talk to individuals with relevant experience in the areas of Restorative Justice, sexual violence, and/or risk and readiness assessment. I am interested in hearing your experiences and perspectives around the current risk assessment processes being used (specifically pre-conference), what factors you deem to be most important in terms of participant risk in this area (physical and psychological), and how these processes can continue to be improved.

If you are interested in participating, we will arrange a time to meet for an interview, in person or online, based on your preference (and what is possible with COVID-19 restrictions). The interview will take approximately 60-90 minutes, and you are welcome to bring a support person along. The meeting will begin with introductions and a chance to ask any questions you may have prior to beginning the interview proper. Participants will receive a grocery voucher in partial reimbursement of time/travel.

The questions I will ask in the interview are outlined in the 'Interview Question Schedule' below. As this interview will discuss your experiences related to SVRJ, it is possible that this could bring up distressing memories. Your comfort will be the top priority throughout, and

interviews can be stopped or paused at any time. You will be encouraged to reach out to the supportive and therapeutic relationships in your life to debrief and discuss anything that arises from our conversation. Some options of support services you may wish to reach out to are provided on a separate sheet.

How are participant's identities and information protected?

Anyone who participates in this research will be assured that their data will be de-identified. This means that names will be changed, and no information that could identify you will be included in my thesis. The exception to this is an acknowledgment of your experience and knowledge in the fields of sexual violence, restorative justice, and/or risk assessment, however further details of this will not be disclosed. Transcripts will only be accessible to myself (Charlotte) and the main research supervisor (Associate Professor Richard Fletcher). Confidentiality is assured on the basis that I will not provide any information you give me to anyone else without your consent.

What will happen to the information given in the interview?

In person interviews will be audio-recorded, online interviews via Zoom will be video and audio recorded. After the interview, our conversation will be transcribed. A copy of your interview transcript can be made available to you. Please indicate on your consent form if you would like this to be emailed to you. The audio recordings and interview transcripts will be held in de-identified, password protected files on a password protected computer and used to prepare my Doctoral thesis. After my thesis is completed, I will provide anyone who has participated in my research with a summary of my findings. The full thesis will be available on the University website and can be shared with interested participants. In addition, my supervisors and I hope to prepare further publications from the research in order to reach a wider audience, these publications can also be shared with you. Finally, all information that has been stored, will be destroyed after five years.

Participant's Rights:

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *ask for the recorder to be turned off at any time during the interview;*
- *ask any questions about the study at any time during participation;*

- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *withdraw from the study within two weeks of the full interview;*
- *be given access to a summary of the project findings when it is concluded.*

What else do participants need to know?

All participants are welcome to ask any questions at any stage of the process. Participants can withdraw from the interview at any time. Participants can also withdraw from the research project up to two weeks after their interview has taken place. This means that any data analysis will not be disrupted at more crucial stages of the research process.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/65. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Who to contact for more information

If you would like to participate in this research, have any questions about the research, or would like to know more please contact me (Charlotte) directly, or one of my main supervisors via email:

Charlotte Bremer: Charlotte.Bremer.1@uni.massey.ac.nz (or charlottebremer235@gmail.com)

Associate Professor Richard Fletcher: R.B.Fletcher@massey.ac.nz

Associate Professor Matt Shepherd: M.Shepherd1@massey.ac.nz

Ngā mihi, Charlotte Bremer

Interview Question Schedule for SVRJ Professionals

The interview will be semi-structured. While in conversation, I will direct the dialogue to explore themes that are relevant to my research. The main questions that I wish to explore in the interview are presented below:

1: Demographic information and professional experience: I will first ask for some demographic information (including your gender and ethnic identity) and details about your relevant experience in the fields of restorative justice, sexual violence and/or risk assessment.

2: Current practices: “Tell me about how you believe risk should be assessed before SVRJ processes?” I will ask your thoughts about current risk assessment practices, how risk assessment should be approached and what you think should be considered. I will then use prompts to guide the conversation, some of which may include: What processes and/or factors should be included in risk assessments? What would you say is necessary for a comprehensive risk assessment prior to SVRJ? Should risk assessment processes change for different participants (victim-survivors, offenders)? Should potential risk of supporters to participants be assessed and how?

3: Risk Factors: “Tell me about the main risk factors you would look for?” I will ask for your perspective on risk factors; the things that increase the risk of a poor outcome for SVRJ. I will then use prompts to guide conversation, some of these may include: From your perspective what are the biggest risk factors to assess for before SVRJ? For victim-survivors, offenders, supporters? Tell me about risk factors which would lead you to think SVRJ is inappropriate? Tell me about risk factors that would cause you to put intervention/management strategies in place?

4: Protective Factors: “Tell me about protective factors you would look out for?” I will ask for your perspective on protective factors; the things that increase the chances of a good outcome for SVRJ. I will then use prompts to guide conversation, some of these may include: From your perspective what are the biggest protective factors to assess for before SVRJ? For victim-survivors, offenders, supporters? In your experience does intervening to enhance protective factors work well in SVRJ?

5: Cultural Considerations: “Tell me about what cultural factors need be considered when assessing risk prior to SVRJ?” I will ask about cultural considerations in risk assessment. I will then use prompts to guide conversation, some of these may include: How can we ensure SVRJ processes are culturally responsive and safe? Are there important cultural differences

in terms of factors that contribute to a positive or negative outcome being more likely? Do risk and protective factors change as a result of culture? Are there different considerations that need to be made when assessing risk for various cultures? How can we ensure risk assessment is culturally appropriate, respectful and relevant?

6: Risk factors from literature: In the literature several factors are commonly mentioned as contributing to risk and safety in this field, I will ask you about your perspective and experience as to how these impact on SVRJ and whether/how you would assess these.

- In your experience how important is it to have detailed information about the offending from participants, and how do/would you gather this?
- How important is it to understand a victim-survivor's internal narrative of events and how do/would you uncover this?
- How important is it to understand why a participant wants to do RJ, and how do/would you assess this?
- How important is it to ensure participants are choosing to participate free from coercion/pressure, and how do/would you assess this?
- How important is it to understand what a participant expects from the process and what they hope to get out of it? How would/do you assess this?

7: Coping mechanisms: "How important are coping mechanisms for participants to have available to them during conferences?" I will ask about coping mechanisms and their importance. I will then guide conversation with prompts, some of which may include: How do/would you assess a participant's available coping mechanisms? How do/would you ensure victim-survivors have sufficient coping mechanisms prior to a RJC?

8: Safety: "Tell me about how safe you think SVRJ processes currently are?" I will ask how safe you think current practices are. I will then use prompts to guide conversation, some of these may include: What outcomes do you usually see following the SVRJ? What would make these SVRJ processes safer for participants?

9: Applicability: "Do you think risk assessment guidelines would make the process safer?" I will ask about the potential effect of risk assessment guidelines. I will then use prompts to guide conversation, some of these may include: What kind of risk assessment guidelines would be readily applicable in your work? Do you think structured risk assessment guidelines might encourage more RJ providers to engage in SVRJCs? Would that be a good thing? Do

you think more RJ agencies should be supported to facilitate SVRJ processes? Why do you think SVRJ is not more common both in Aotearoa New Zealand and internationally?

10: Conclusion: “Do you have any concluding thoughts on how risk assessment prior to SVRJ processes could be improved?”

We will close the interview session in a way that feels appropriate to you, hoping to offer a sense of closure at the end of your participation. You will be encouraged to reach out to the supportive and therapeutic relationships in your life to debrief and discuss anything that arises from our conversation (some support service options available to you are provided).

Some support services available:

- **Need to Talk? 1737:** free call or text [1737](https://1737.org.nz) any time for support from trained counsellors; <https://1737.org.nz>
- **HELP:** Call 24/7 (Auckland): 09 623 1700, <https://www.helpauckland.org.nz>
- (Wellington): Call 04 801 6655 and press 0, <https://www.wellingtonhelp.org.nz/>
- **Safe to Talk** — sexual harm helpline. Call [0800 044 334](tel:0800044334), text [4334](tel:4334) or email support@safetotalk.nz, [Chat to counsellors online or find out more: https://www.safetotalk.nz](https://www.safetotalk.nz)
- **Victim Support:** 0800 650 654, <https://victimsinfo.govt.nz>
- **Lifeline:** [0800 543 354](tel:0800543354) (0800 LIFELINE) or free text [4357](tel:4357) (HELP), <https://www.lifeline.org.nz>
- **Tu Wahine Trust:** [09 838 8700](tel:098388700) – call for kaupapa Māori counselling, therapy, and support for survivors of sexual harm (mahi tukino) and violence within whānau.
- **Shakti New Zealand:** [0800 742 584](tel:0800742584) - call for culturally competent support services for women, children and families of Asian, African and Middle Eastern origin who have experienced domestic violence; <https://shaktiinternational.org/shakati-new-zealand/>
- **Family Services 211 Helpline:** [0800 211 211](tel:0800211211) - help finding community-based health and social support services near you; <https://www.familyservices.govt.nz/directory/>
- **Women's Refuge:** [0800 743 843](tel:0800743843) (0800 REFUGE) - connect to advocates in your area; <https://womensrefuge.org.nz/contact-us/find-your-local-refuge/>
- **Male Survivors Aotearoa New Zealand:** [0800 044 344](tel:0800044344) - peers and support groups for male survivors of sexual abuse and their significant others; <https://malesurvivor.nz>
- **Korowai Tumanako:** [022 474 7044](tel:0224747044) (text or call) - kaupapa Māori service for those with concerning or harmful sexual behaviour, <https://www.korowaitumanako.org>
- **Stop:** support for concerning or harmful sexual behaviour, <https://www.stop.org.nz>

Appendix B: Professional Consent Forms

Risk and Readiness Prior to Sexual Violence Restorative Justice

PARTICIPANT CONSENT FORM – IN PERSON

I have read and I understand the Information Sheet about this research project. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary. I also understand that I can stop the interview at any time, and I can withdraw my consent for the data from my interview to be used within a timeframe of two weeks after my interview.

1. I understand and accept that the interview will be audio recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.
3. I understand that my participation in this study is confidential and that no material which could identify me personally (with the exception of acknowledgement of my position as a SVRJ professional) will be used in any reports on this study.
4. I know who to contact if I have any questions about the study in general.
5. I wish to be emailed a copy of my interview transcript (please check one) Yes No
6. I wish to receive a copy of the summary of findings (please check one) Yes No
7. I wish to receive a copy of the completed full thesis (please check one) Yes No

Declaration by Participant:

I _____ hereby consent to take part in this study.
(full name)

Email: _____

Signature: _____ **Date:** _____

Risk and Readiness Prior to Sexual Violence Restorative Justice

PARTICIPANT CONSENT FORM – ONLINE

I have read and I understand the Information Sheet about this research project. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary. I also understand that I can stop the interview at any time, and I can withdraw my consent for the data from my interview to be used within a timeframe of two weeks after my interview.

1. I prefer to conduct the interview online via Zoom.
2. I understand and accept that the interview will be video and audio recorded.
3. I agree to participate in this study under the conditions set out in the Information Sheet
4. I understand that my participation in this study is confidential and that no material which could identify me personally (with the exception of acknowledgement of my position as a SVRJ professional) will be used in any reports on this study.
5. I know who to contact if I have any questions about the study in general.
6. I wish to be emailed a copy of my interview transcript (please check one) Yes No
7. I wish to receive a copy of the summary of findings (please check one) Yes No
8. I wish to receive a copy of the completed full thesis (please check one) Yes No

Declaration by Participant:

I _____ hereby consent to take part in this study.

(full name)

Email: _____

Signature: _____ **Date:** _____

Appendix C: Example SVRJ Risk Assessment Form

SVRJ Risk Assessment Guideline Recommendations

Assessment Factors	Evidence for/ against factors and risk management interventions implemented/ recommended
<p>Informed Consent</p> <p><i>Ensure participants are giving free and informed consent to engage in SVRJ</i></p>	
<p>Restorative motivations for engaging in SVRJ</p> <p><i>Victim-survivors: restorative justice needs (i.e., voice, accountability etc.)</i></p> <p><i>Perpetrator: primary motivation of wanting to take accountability</i></p>	
<p>Emotional Capacity</p> <p><i>Considering participant general wellbeing, mental health, and current adaptive and maladaptive coping skills</i></p> <p><i>Perpetrator: ability to express/demonstrate empathy for the victim-survivor</i></p> <p><i>Note: Consider if referral to external professional support is appropriate to help participants improve their emotional capacity</i></p>	
<p>Safe Support Systems</p>	

Social Support (family, friends; people who know about the SVRJ process and the harm that has occurred and can provide emotional support)

External Professional Support (access to and engagement with external professional support e.g., therapists, community organisations etc.)

Appropriate SVRJ Support people:

Supporters are able to manage their own emotionality within SVRJ process.

Consider relational dynamics that will be in the room and how these can be managed, particularly in the case of shared social networks

Culturally Competent Assessment

Consider cultural backgrounds and how these might affect the process. What can be done to ensure cultural needs are respected and met?

Consider own cultural limitations and whether cultural supervision would support this assessment?

Participant Alignment

Alignment between the victim-survivor's restorative needs and perpetrator's accountability taking; Is the victim-survivor likely to get what they need from this process, knowing the individuals involved?

Balance between honouring victim-survivors wishes and safety: Is there going to be undue risk in proceeding with a conference?

Consider alternative processes; is there a better way that justice needs could be met in this case?

Secondary Review Completed by:

Date:

Overall Recommendations and Decision:

Appendix D: Case Studies

ID:

Research Case Study

Reflections on research experience and clinical practice

Charlie Bremer

Massey University DClinPsych Candidate

Clinical Psychology Intern at Te Whare Manaakitanga

Special Treatment Unit for Violent Offending, Rimutaka Prison, Ara Poutama Department of
Corrections.

This case study represents the work of Charlie Bremer during their doctoral research and
clinical reflections as an Intern Psychologist in 2023

Candidate: Charlie Bremer

Date: 31 May 2023

Supervisor: Matt Shepherd

Date: 26th May 2023

Matt Shepherd

Abstract

Restorative justice following sexual violence (SVRJ) is a victim-centred justice approach which shows significant benefits for both victims (supporting recovery and healing), offenders (allowing insight, community reintegration, and reduced reoffending) and the wider community. SVRJ is not common practice internationally, mostly due to concerns of risks to victim-survivor safety, and Aotearoa New Zealand is one of only a few countries where such processes are available. Currently, risk in SVRJ is commonly assessed using unstructured professional judgment, which has been previously reported as unreliable. My doctoral research aims to develop risk assessment guideline recommendations through reflexive thematic analysis of interviews with professionals in the fields of restorative justice and sexual violence restorative justice risk assessment. It is hoped such guidelines will support more structured, transparent, and reliable assessment of risk within SVRJ and enable more people to access the benefits of SVRJ in safe and considered ways. The current case study includes a brief overview of my doctoral research, and a summary of the research to date. Following this I provide reflections on how my experience of this research has informed my developing practice as an Intern Psychologist working at Te Whare Manaakitanga Special Treatment Unit for Men with Violent Offending at Rimutaka prison.

Doctoral Thesis Overview

My doctoral research aims to develop risk assessment guideline recommendations based on the experiences and views of professionals in SVRJ, and people with relevant knowledge and experience in the areas of sexual violence, restorative justice, and risk assessment. Within this overview, I will provide a brief review of the relevant literature then outline the aims and methodology used within the research.

Literature Review

Sexual violence (SV) victimisation is relatively common in Aotearoa New Zealand and is associated with significant negative impacts which can have short- or long-term effects on individuals and wider society. In order to mitigate the impacts of victimisation, responses to SV are of high importance. Victim-survivors may choose to report the harm through the conventional criminal justice system; however, it is known that SV is the least commonly reported crime, and victim-survivors often experience dissatisfaction and secondary victimisation when using this response mechanism (Ministry of Justice, 2021). Further, the conventional criminal justice system routinely excludes victims from processes, has especially low rates of SV convictions, and limited empirical evidence suggests it is effective in reducing offending or in providing justice often referred to as the 'justice gap' (Daly, 2011).

Restorative Justice (RJ) is an alternative or adjunct to conventional processes, which views crime as an interpersonal offence and typically involves informal victim-centred processes in which victims, offenders and communities work collaboratively to repair harm and hold offenders accountable (Zehr, 2005). Aotearoa New Zealand is one of only a few countries where RJ is formally practiced and acknowledged within legislature, and among an even smaller group of countries practicing RJ following sexual violence (SVRJ) (Koss & Achilles, 2008).

High levels of victim preference for RJ and high levels of victim and offender satisfaction with RJ are reported in the international literature. RJ has been shown to reduce victim emotional distress and provide a greater sense of fairness and emotional restoration compared to conventional court processes. Furthermore, RJ has resulted in offenders having more insight into the impacts of their actions, greater remorse (and desire to make reparations), greater respect for the law, and improved functioning (Sherman et al., 2015). RJ is associated with small but significant reductions in reoffending compared to conventional justice processes, with larger effects noted for more serious crimes, particularly interpersonal offences (Morris et al., 2005). RJ provides a way to potentially better support victim-survivors gain justice and heal from trauma, while also supporting those who have caused harm, enabling accountability and supporting ongoing behavioural changes. Given its flexible nature, RJ can also provide more culturally appropriate responses to crime.

SVRJ is not common practice around the world, in great part due to concerns about the risk this approach may pose to victim-survivor safety. This protentional risk; however, needs to be evaluated against the potential benefits of RJ, particularly following SV. Critical analysis of justice responses suggests RJ is better grounded in psychological theory, better supports victim-survivors' mental health, and can better meet victim-survivor needs following SV (Daly, 2017). These processes also facilitate offender insight and responsibility taking, and the community involvement facilitates reintegration while supporting positive community-norm building (Pranis, 2002). SVRJ can be seen as an important process for providing justice and reducing both the harm, and the occurrence, of SV.

While empirical evidence consistently supports victim benefit, there are inherent risks, and a minority of individuals report negative RJ experiences. The potential risk of harm (particularly revictimisation) must be carefully considered. Concerns around risk in SVRJ include potential power dynamics or imbalances, manipulation, and coercion (Jülich et al., 2010).

Assessing risk comprehensively and sensitively is one way to mitigate and manage these concerns. There are three broad approaches to risk assessment. Unstructured professional judgement is where risk assessment is made through professional judgement alone. This can be flexible and efficient; however, it is highly susceptible to bias and subjectivity, lacks objective reliability and validity, and is considered the least accurate risk prediction method (Grove & Meehl, 1996; Hanson, 2009). Actuarial risk assessment involves the systematic use of statistics-based structured measures, enabling broad predictive risk statements. This method allows for transparent, replicable, and defensible assessment, reduces potential cognitive biases, and shows moderate to high reliability and moderate predictive validity (Hanson & Morton-Bourgon, 2009). However, significant disadvantages of this approach include the limited appropriate norm group comparisons, an overfocus on static risk factors, a limited ability for risk management, the questionable validity of applying statistical relationships determined from populations to individuals (without considering idiosyncratic differences), and professional over-reliance or incorrect use of measures. Structured professional judgement (SPJ) combines both unstructured and structured methodologies, using both evidence-based guidelines and professional judgement. This approach provides the reliability of structure while enabling more flexible, holistic, and individual-specific assessments. SPJ approaches show good inter-rater reliability and predictive validity and are commonly used to assess risk in a variety of settings (Allnutt et al., 2010).

Currently, no standardised approach to risk assessment in SVRJ is available, and professional judgement is instead commonly relied upon. Given the poor validity of unstructured approaches and high risk of revictimisation, the need for better ways to assess both victim-survivor and offender risk and readiness before SVRJ is apparent.

Study Rationale and Aim

My doctoral research aims to develop risk assessment guideline recommendations to support a structured professional judgement approach to risk assessment, enabling more reliable and valid assessment of risk in SVRJ. The research involves semi-structured interviews with SVRJ professionals and individuals with relevant knowledge/ experience in the fields of SV, RJ, and risk assessment. Interviews focus on current risk assessment practices, perspectives and experiences of risk and protective factors within SVRJ, and how these can be assessed. Reflexive thematic analysis is used to determine the areas of particular importance within SVRJ risk assessment, which will form risk assessment guideline recommendations. Only a limited number of published studies have investigated the perspectives and experiences of individuals who are knowledgeable about SVRJ (e.g., Curtis-Fawley & Daly, 2005), and few studies have included participant experiences within SVRJ. Developing guidelines based on the expertise and lived experiences of SVRJ professionals will help ensure that the guidelines capture the real-life risk factors and are based on assessment processes which have proven to be successful and practically implementable within this field.

Methodology

The current research takes a qualitative approach, using reflexive thematic analysis and a feminist standpoint approach to identify important aspects of SVRJ risk assessment, as guided by the knowledge of professionals in the fields of sexual violence, restorative justice, and risk assessment.

Ethics

The code of ethical conduct for research involving human participants, as described in the Massey code of ethics was consulted to identify potential ethical issues with the research project. Ethical issues identified were discussed with the co-supervisors of this research. The board of Project Restore have also been consulted throughout development of the research

and expressed their support. The research project was reviewed and given ethics approval by the Massey University Human Ethics Committee: Northern, Application NOR 21/65.

Participants

Participants were professionals with relevant knowledge and experience in the areas of sexual violence, restorative justice, and assessment of risk, as well as one SVRJ participant (victim-survivor) who had completed a SVRJ process. Participants were recruited through introductory emails in which research information, interview schedules and consent forms were provided and invitations to discuss the research and potential participation further with myself were made. A snowballing method was used in which potential participants were contacted based on recommendations from other research participants. In total 16 professionals were interviewed.

Demographic information consisting of gender and ethnic identity, and relevant professional experience was collected through the interviews. This is minimally presented in order to protect participants' identities. A total of 16 professional participants were interviewed, 10 self-identified as women, six as men. Ethnicity was reported as New Zealand European/ Pākehā or being of European descent by 13 participants, two participants were Māori, and one participant was of Asian descent.

Data Collection

All interviews began with an introduction (around 30 min) which was not recorded. The introduction focused on building rapport between the researcher and interviewee, in line with tikanga Māoriⁱ and whakawhanaungatangaⁱⁱ. Culturally appropriate openings and closings to the sessions were offered (e.g., karakiaⁱⁱⁱ, blessing, whakatauki^{iv}, grounding

ⁱ Correct procedures

ⁱⁱ Establishing relationships

ⁱⁱⁱ Incantation, ritual chant

^{iv} Proverb

exercises). The researcher offered some background information about themselves including aspects of their whakapapa^v, and self-disclosing their status as a victim-survivor, then provided space for the interviewee to also share some background information, hoping to facilitate rapport and trust, again in line with tikanga, and a feminist research approach (Reinharz & Davidman, 1992; Smith, 2001). Research objectives, rationale and process were discussed, and questions invited, before participants gave their informed consent to proceed. Interviews were conducted in person or online via Zoom, depending on participant preference.

Semi-Structured Interview Protocol

All participants were interviewed using a semi-structured interview schedule, developed by considering the broad area of risk assessment for SVRJ and factors of importance identified within the empirical literature, and participants were encouraged to speak freely and in-depth about their experiences and perspectives. This helped to ensure areas relevant to SVRJ risk assessment were discussed, and opinions on important matters in this area were gathered from participants in order to consider different perspectives on similar issues. All interviews were audio-recorded and then transcribed.

Data analysis

The data were analysed through reflexive thematic analysis, which is an iterative approach focused on finding, analysing, and reporting themes or patterns within research data while acknowledging the wider context within which research is conducted and the active role of the researcher (Braun & Clarke, 2006).

Subjectivity, Theoretical Position, and Researcher Reflexivity

^v Genealogy

The interpretative element of qualitative research inherently brings an element of subjectivity, and therefore a self-reflective practice is necessary to gain a fuller understanding of how raw data and developed interpretations relate to each other (Willig, 2012). A feminist standpoint is taken in this research, in which the authority of lived experience is central (Smith, 1997). Within this approach the researcher must be reflexive, considering their position of power and individual subjectivity which will influence analysis. My own experiences as a victim-survivor of SV and my identity as Pākehā are two important factors which affect the perspective with which I have approached this research and my experiences within society, and as such, are aspects I continue to reflect upon throughout the research process.

Data Analysis Process

Data analysis followed the process guidelines of TA outlined by Braun and Clarke (2006). A theoretical analytical approach to analysis was applied, in which the researcher's theoretical knowledge helped determine the importance of particular aspects of data and guide theme development. Researcher judgement (rather than strict prevalence rules) was used to identify themes, defined as patterned or meaningful responses within the data. NVivo software was used to assist the analysis process. Analysis began with the researcher becoming familiar with the data. Each interview was re-listened to, transcribed verbatim, and the transcript was actively read and re-read to ensure familiarisation. Initial insights and ideas for possible coding or patterns of meaning which may be of interest were recorded early on. Initial coding was 'open' using an exploratory process, looking for various codes or categories which could explain and fit the data, encompassing features of interest related to risk and risk assessment in SVRJ within the data. This inductive approach to analysis allowed for codes and eventually themes to come from the data itself and for the research data to highlight important areas or issues the researcher may not have predicted. Initial codes (succinct summary labels) were assigned throughout the data to encompass the features of

interest (factors related to risk and risk assessment for SVRJ). All transcripts were coded in a reiterative process, where codes were initially assigned, and then through the reading and re-reading process of the whole data set, new codes arose, and old codes transformed. Codes were supported by relevant extracts from the data, the contexts of which were also noted. Codes were then organised and collated into groups representing broader themes across the data, referred to as candidate themes and subthemes. Candidate themes represented a pattern of shared meaning underpinned by a central concept or idea; subthemes represented related but distinct patterns of meaning found within the overarching theme. Relationships between the various codes and candidate themes and subthemes were considered. A group of candidate themes and subthemes, supported by data extracts was developed. Candidate themes and subthemes were refined, ensuring each theme was internally cohesive and clearly distinct from other themes. Candidate themes, subthemes and coded data extracts were reworked to increase coherency of these patterns and ensure consistency between coded data extracts and the dataset as a whole. The researcher employed a reflexive, recursive process throughout, moving between the data set in its entirety, coded extracts of data, candidate themes and subthemes, and the written analysis being produced. The overall dataset and the validity of themes and subthemes relative to the data were reviewed, checking whether themes and subthemes truly represented the data, were answering the research questions, and telling a convincing story. Candidate themes or subthemes lacking supporting data were rejected or combined with other candidate themes and subthemes, some candidate themes or subthemes with diverse data were separated into multiple themes or subthemes (Braun & Clarke, 2006). The scope of each theme and the subthemes within it was described with a sentence or two, and concise informative names were developed for each. A table of themes and subthemes was constructed, with interview excerpts from the data supporting each identified theme and subtheme and providing context. This initial analysis is in the process of being reviewed by supervisors, and their feedback will likely lead to further revision and

refinement of themes and subthemes. Data analysis has been put on hold during my internship and will re-commence in 2024.

Clinical Psychology Internship

My clinical psychology internship based at Te Whare Manaakitanga Special Treatment Unit for Men with Violent Offending at Rimutaka Prison began in January 2023. Te Whare Manaakitanga provides men who are at high risk of violent re-offending with group therapy to address this risk, using principles of cognitive change (Bush & Bioldeau, 1993). It also functions as a therapeutic community, where the custody staff, therapy staff and men within the unit are encouraged to work together to support the men through their treatment journeys. This section discusses several reflections I made during my internship, and the way in which my experience of research informed and continues to influence my developing clinical psychology practice.

As indicated by my choice of research topic, I have a strong interest in supporting victim-survivors of sexual violence (and victims of other forms of trauma as well) in their healing journeys. Working within corrections has shown me an interesting side of this work. On the surface it appears that I am working more with people who have caused harm, helping them to understand the impacts of what they have done, understand their own beliefs, thoughts, feelings, and patterns of behaviour that led to their offending, with the aim of equipping them with the skills to prevent re-offending in the future. However, it would be unfair to not also acknowledge that all the clients I have worked with thus far within corrections have had their own experiences of victimisation and trauma. Such a realisation starts to break down the offender-victim binary, as it becomes clear that people who caused harm have often also been harmed themselves (Fitton et al., 2020). There is an overlap with the theories of restorative justice (RJ) here, in that research often finds that offenders who engage in RJ come to better understand the impacts of their actions as they hear their victim's

story, leading to reduced re-offending. Within treatment at Te Whare Manaakitanga, the men focus in on their own life stories and their pathway to offending, through which it is hoped they develop insight into their experiences and beliefs which have shaped their life. This insight, paired with the skills to challenge and reshape beliefs, and the development of skills to help manage emotions and make different choices than what they previously have, is hoped to reduce their risk of re-offending, and set them up for happier, healthier lives outside of the prison environment. The role of reflection as a means of accessing insight to enable different action, is a pattern across many forms of psychological intervention. I saw this within my research process, both for myself (as discussed below), and in my interactions with participants who were prompted through the interview to reflect on deeper aspects of their risk assessment and decision-making process, much of which had become semi-habitual for them, and often reported gaining insight into their own understandings and methods through this. Throughout the research interviews I found I often needed to prompt the interviewees to extrapolate, for example when they stated they assessed for motivation, I would ask exactly *how* they assessed motivation. This skill has been invaluable within the correctional setting, where clients' understandings and life experiences may be wildly different from the 'norm' or indeed from my own experiences. Clients within Te Whare Manaakitanga have often experienced significant trauma and instability within their lives, which to them has been normal. As such, if I do not question what a "good childhood" involved, I do not find out that the client means they were abused or neglected less than other children they knew, for example. I have had the importance of always asking "what do you mean by that?", requesting more concrete examples or elaboration, highlighted to me by similar examples several times. I think such questioning will vastly improve my clinical practice, as this can help me avoid assumptions and lessen the chances of missing significant aspects of client experiences. The process of thematic analysis has also enabled me to practice looking beneath the surface level, instead identifying and collating patterns of deeper meaning, which

I believe to have helped my formulation skills of identifying deeper underlying beliefs and rules for living that may be influencing client patterns of behaviour.

The role of colonisation within experiences of trauma, victimisation and harm became apparent through my internship work, as evidenced by the majority of men within Te Whare Manaakitanga being of Māori descent (with varying levels of connection to their culture). As a Pākehā person, I have had to reflect on how I work within this space. I believe I must tread lightly and in a well-considered way, acknowledging my own privilege and the boundaries of my cultural understanding. Many of the discussions I had with professionals in the SVRJ space included emphasis on the importance of cultural considerations within risk assessments and general work with clients, highlighting the different perspectives, world views and understanding that may be at play. An awareness that each person experiences and understands the world in a different way is something I make conscious effort to bring into my clinical practice. I have found I can do this by holding a stance of genuine curiosity, avoiding assumptions, ensuring there is space for different ways of being and understanding within sessions, and with the flexible use of models that may be more culturally appropriate for the person with whom I am working.

Prior to beginning my research interviews, I questioned whether the disclosure of my own victim-survivor status would be beneficial or not to my research process. This was a question I reflected carefully on, eventually deciding to disclose, as supported by the feminist research literature. I found that with the professionals I was talking to, for whom SV was highly normalised, it opened a space for them to also discuss or acknowledge their own experiences with SV and how that may have contributed to their professional interest in the SVRJ. Without my own demonstration of this, I am not sure such conversations would have arisen as commonly. I am also of the impression that being able to connect to the SVRJ participant through our shared experience of victimisation, helped her to feel more secure in her decision to participate in the research, building a sense of trust that her story would be

handled with care. The power of self-disclosure discovered within the research is in interesting contrast to my work within Te Whare Manaakitanga, where, given the correctional setting, there is a strong focus on keeping clear boundaries and being very conscious of what information is shared with clients. I acknowledge that within any clinical practice, self-disclosure should be used sparingly and only when it will be of benefit to the client (rather than simply disclosing for the therapist's sake), however the different extremes of my experience with research and correctional work have been interesting to navigate.

Considering what information is safe for me to share with correctional clients, has also raised interesting challenges for whakawhanaungatanga, as what I might normally share (e.g., where I grew up) is not something I feel comfortable sharing in this context. As such, I have had to rely on adapted ways of connecting, such as sharing my ancestry but not my place of birth and choosing three topics about my life that I might discuss with clients, while keeping the rest of my life private.

I found that in the process of researching the literature on SV, in particular the rates of occurrence, significant impacts of victimization, and the lack of appropriate support that victim-survivors commonly report, my own experiences of SV rose to the forefront of my mind again. At Te Whare Manaakitanga I was also exposed to stories of harm through direct work with clients and through the reviewing their offending histories. I noticed that this was having an effect on me and decided to engage in therapy to have some support in confronting and processing this experience. I engaged in eye movement desensitisation and reprocessing (EMDR) therapy to help process my SV-related trauma and found this to be an effective method for me. This has increased my own professional interest in EMDR, and I hope to pursue my own training in this methodology in the future. I continue to have an interest in working with trauma, and I believe my own experiences can help me to approach clients in a sensitive way. While we all experience trauma in our own ways, and no two experiences will be the same, the insights I have gained from my own process is invaluable, and I believe it to

be an asset rather than a hinderance to my clinical practice. This experience of resurfaced trauma and research reflection has also heightened my self-awareness and self-reflexivity skills, which supports my developing clinical skills. I understand that a key tenet of clinical practice is the ability to reflect on interactions and interventions with clients, to consider what went well and what did not go as well as hoped, and through that reflection, refine and improve our practice. Given the human aspects of this profession, reflecting on my own influence, my own transference reactions, my own experiences which shapes the lens through which I may see clients, is an invaluable skill and one I hope to continue to hone throughout my career.

References

- Allnutt, S., O'Driscoll, C., Ogloff, J. R. P., Daffern, M., & Adams, J. (2010). *Clinical risk assessment & management: A practical manual for mental health clinicians*. Justice Health.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Bush, J., & Bilodeau, B. (1993). *Options: A Cognitive Change Program*. National Institute of Corrections.
- Curtis-Fawley, S., & Daly, K. (2005). Gendered violence and restorative justice: The views of victim advocates. *Violence Against Women*, 11(5), 603-638. <https://doi.org/10.1177/1077801205274488>
- Daly, K. (2011). *Conventional and innovation responses to sexual violence*. Australian Institute of Family Studies Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies.
- Daly, K. (2017). Sexual violence and victims' justice interests. In E. Zinsstag & M. Keenan (Eds.), *Restorative responses to sexual violence: Legal, social, and therapeutic dimensions*. Routledge.
- Fitton, L., Yu, R. & Fazel, S. (2020) Childhood maltreatment and violent outcomes: A systematic review and meta-analysis of prospective studies. *Trauma, Violence, & Abuse*, 21(4), 754-768. <https://doi.org/10.1177/1524838018795269>
- Grove, W. M., & Meehl, P. E. (1996). Comparative efficiency of informal (subjective,

impressionistic) and formal (mechanical, algorithmic) prediction procedures: *The clinical-statistical controversy*. *Psychology, Public Policy, and Law*, 2(2), 293-323.

<https://doi.org/10.1037/1076-8971.2.2.293>

Hanson, R. K. (2009). The psychological assessment of risk for crime and violence.

Canadian psychology, 50(3), 172-182. <https://doi.org/10.1037/a0015726>

Hanson, R. K., & Morton-Bourgon, K. E. (2009). The accuracy of recidivism risk

assessments for sexual offenders: A meta-analysis of 118 prediction studies.

Psychological Assessment, 21(1), 1-21.

Jülich, S., Buttle, J., Cummins, C., & Freeborn, E. V. (2010). *Project Restore: An exploratory study of restorative justice*. Auckland University of Technology.

https://www.academia.edu/274691/Project_Restore_An_Exploratory_Study_of_Restorative_Justice_and_Sexual_Violence

Koss, M. P., & Achilles, M. (2008). *Restorative justice responses to sexual assault*. VAWnet:

The National Online Resource Centre on Violence Against Women.

http://vawnet.org/sites/default/files/materials/files/2016-09/AR_RestorativeJustice.pdf

Ministry of Justice. (2001). *New Zealand crime and victims survey. Key Findings, descriptive statistics. May 2021. Results drawn from Cycle 3 (2019/20) of the New Zealand crime*

and victims survey. Ministry of Justice, Tāhū o te Ture.

Morris, A., Kingi, V., Poppelwell, E., Robertson, J., & Triggs, S. (2005). *New Zealand court-*

referred restorative justice pilot: Evaluation. Ministry of Justice.

Pranis, K. (2002). Restorative values and confronting family violence. In J. Braithwaite & H.

Strang (Eds.), *Restorative Justice and Family Violence*. Cambridge University Press.

Reinharz, S., & Davidman, L. (1992). *Feminist methods in social research*. Oxford University Press USA.

Sherman, L. W., Strang, H., Barnes, G. C., Woods, D. J., Bennett, S., Inkpen, N., Newbury-

Birch, D., Rossner, M., Angel, C., Mearns, M., & Slothower, M. (2015). Twelve experiments in restorative justice: The Jerry Lee program of randomized trials of restorative justice conferences [Original Paper]. *Journal of Experimental Criminology*, 11(4), 501. <https://doi.org/10.1007/s11292-015-9247-6>

Smith, D. E. (1997). Comment on Hekman's "Truth and method: Feminist standpoint theory revisited". *Signs*, 22(2), 392-398.

Smith, L. T. (2001). *Decolonizing methodologies: Research and indigenous peoples* (Third edition ed.). Zed Books.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. Open University Press.

Zehr, H. (2005). *Changing lenses: A new focus for crime and justice* (3rd ed.). Herald Press.
(1990)

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Assessment Case Study One

The assessment of a 28-year-old incarcerated Māori man, to determine his treatment needs, goals and responsivity issues prior to beginning group therapy for reducing risk of violent reoffending.

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This case study represents the work of Charlie Bremer during their internship in 2023. Clinical supervision was received during the assessment for the individual within this case study. All names and identifiable information within the case study have been changed to protect the anonymity of the client.

Candidate: Charlie Bremer [Signature] Date: 8.11.23

Supervisor: Jaimee Kleinbichler [Signature] Date: 8.11.23

Abstract

This case study presents the risk and treatment needs assessment of a 28-year-old Māori man serving a life sentence of imprisonment for murder and entering into psychological treatment at the Special Treatment Unit for Violent Offending; Te Whare Manaakitanga, Rimutaka prison. The purpose of this assessment was to identify specific treatment needs related to his risk of violent reoffending, as well as potential responsivity issues that could interfere with his treatment and engagement in group therapy. A review of the literature relating to predicting and reducing the risk of violent reoffending is presented, followed by the findings of the assessment including relevant client background, formulation, treatment needs, and conclusions and finally, reflections on the case.

Assessing Risk and Treatment Needs Related to Future Violence

Risk assessment is an inherently uncertain process that involves predicting the likelihood of a future event. Assessing and managing risk is vital to reducing harm and so it should be conducted to the highest possible standard; in an evidence-based way (Allnutt et al., 2010; Hanson, 2009). This should involve a multi-modal and multi-perspective approach, considering and incorporating information from different sources and people (Allnutt et al., 2010). Empirical research into risk assessment has long shown that unstructured professional opinion, that is, judgements made without the use of guidelines, statistics, or formal approaches are the least accurate, valid, and reliable, and are prone to cognitive biases and error (Hanson, 2009). A more reliable approach to risk assessment is known as actuarial assessment, which involves the use of tools incorporating statistical models to predict the likelihood of future risk based on present variables (Allnutt et al., 2010). Individuals are assessed for the presence of risk factors with empirically supported statistical relations to the outcome of interest (e.g., violence), and from this information, a risk score is calculated indicating the individual's broad level of risk (Allnutt et al., 2010; Andrews et al., 2006). This approach can be limited by an inability to adapt to the idiosyncrasies of the individual involved due to the prefixed nature of actuarial assessment (Hart et al., 2016). However, the benefits of actuarial assessment, tend to outweigh such concerns, as actuarial approaches use consistent, systematic methods, reducing the chance of cognitive biases, and show moderate-high reliability and moderate predictive validity (Hanson & Harris, 2001). Further, actuarial assessment allows for transparent, replicable, and defensible risk assessment, which is particularly important in a correctional environment, where such assessments and outcome decisions can have significant impacts on people's lives and freedom (Allnutt et al., 2010; Bonta et al., 2001; Hart et al., 2016). Actuarial approaches are particularly useful to identify higher risk cases (as cut-off risk scores can be established), enabling targeted interventions to

be employed with individuals most in need and therefore facilitating sensible allocation of resources (Coohey et al., 2013; Mulvey & Iselin, 2008).

Ara Poutama psychologists operate under the Risk-Needs-Responsivity (RNR) model (Bonta & Andrews, 2017). The risk principle states that risk of further criminal behaviour can be predicted, and treatment interventions should match the risk level of the individual (e.g., high intensity treatment for high-risk offenders). The needs principle is that treatment should focus on the individual's dynamic (changeable) risk factors or criminogenic needs which are the factors that are most relevant for reducing reoffending. The responsivity principle declares that any interventions should be delivered in a way that suits the learning style of the individual, that is, treatment should be responsive to the individual's needs (Bonta & Andrews, 2017). Actuarial assessment enables the fulfilment of the RNR model, as those with the greatest level of risk and need can be more reliably identified.

The Violence Risk Scale (VRS) is an empirically developed actuarial risk assessment measure, which incorporates both static and dynamic variables to predict an individual's likelihood of future violent reoffending and facilitate violence reduction interventions (Wong & Gordon, 2006). The VRS consists of six static and 20 dynamic items. Each item is considered and assigned a rating of zero (not related to individual violence risk) to three (highly related to individual violence risk). Ratings are assigned by professionals considering a wide range of evidence including information from clinical and collateral interviews, and file review including consideration of case notes, incidents or misconducts, previous reports, and criminal conviction history. Ratings of two or three indicate the item is related to risk of reoffending and is therefore a treatment target for the individual. Dynamic items which are determined treatment targets are also rated in terms of the individual's stage of change (Prochaska & DiClemente, 1983), evaluating their treatment readiness and change in terms of awareness and behavioural skills implemented to manage that particular risk factor (Wong & Gordon, 2006). In international samples, VRS scores show moderate predictions of violent

recidivism. Predictive recidivism norms for VRS score bands are available, developed from a large Canadian sample of males who violently offended (Wong & Gordon, 2006). Research validating the VRS in Aotearoa New Zealand and developing relevant predictive recidivism norms is ongoing. However, the Canadian research is considered to support the use of the VRS for assessing risk and change related to violent offending in New Zealand, and the VRS is currently the standard measure used in Corrections for men who have violently offended.

VRS assessment has a place in ensuring treatment is targeted at those at greatest risk of reoffending in line with the RNR model, by providing a structure for more reliable and valid dynamic assessment of violent reoffending risk. Further, the VRS helps clinicians to identify factors most strongly linked to risk of reoffending for the individual, which can be used to guide the development of treatment goals and approaches. The initial VRS assessment acts as a baseline measure and a 'time two' VRS assessment after treatment enables change across treatment to be assessed, identifying any changes in the stages of change or recidivism risk, and highlighting areas of further need for the individual. This supports psychologists to consider further intervention that may benefit the individual (including additional programmes, support services, or individual psychological work), and communicate changes in recidivism risk and stages of change to support parole board decisions. Assessment as guided by the VRS is an important aspect of psychological work with those who have committed violent offences within the care of Ara Poutama, and more specifically at Te Whare Manaakitanga.

Case Study

Context: Te Whare Manaakitanga

Te Whare Manaakitanga (TWM) is a 30 bed Special Treatment Unit for men at high risk of violent re-offending in Rimutaka prison, which operates as a therapeutic community. The core group therapy at TWM spans around nine months and commences with groups of

10 men. When men first arrive at TWM, they undergo assessments to ensure their risk of violent offending is indeed high, to identify their specific violence related treatment needs, and any potential responsivity issues that could impair their engagement in group therapy.

Client referral

Matiu was recommended for the Special Treatment Unit for Violent Offending (STU:VO) programme at TWM. He was transferred to the unit several weeks ahead of the programme starting to allow him time to settle into the new environment. He was referred to the writer for pre-treatment assessment, to identify specific treatment needs, readiness for treatment, and potential responsivity issues. Matiu was noted to give informed consent to engage in the assessment and treatment planning process.

Client presentation

Matiu is a 28-year-old male of Māori descent. He initially presented as wary; however, after rapport was established, he was open and engaged well throughout the assessment. Matiu was noted to laugh and look away when discussing things that made him uncomfortable. There was no indication of any mood, perceptual or thought disorder. Risk of harm to self or others, as well as from others, was repeatedly assessed as low at the time of assessment.

Assessment Process

Assessment included a review of file information, clinical interviews with Matiu, and administration of psychometric measures. Matiu was assessed over three hours of clinical interview sessions, and two hours of psychometric assessments. Given Matiu's Māori culture, the hui process (Lacey et al., 2011) was used to guide sessions which included the use of karakia to open and close sessions. Psychometric assessment measures included the therapist-rated Violence Risk Scale (VRS) to assess dynamic factors specific to violent offending; a battery of self-report questionnaires to assess personality factors, offence-supportive attitudes,

childhood trauma, and emotion management (discussed in more detail below); and the Wechsler Abbreviated Scale of Intelligence – Second Edition (WASI-II) to identify potential responsivity issues related to cognitive function.

The information collected during assessment, including the psychometric results, was used to identify Matiu's areas of treatment needs, readiness for treatment, and responsivity issues in line with the RNR model. This will also be used as a basis to assess change over the course of psychological treatment. It is important to note that some of the psychometric measures used as standard procedure within TWM are not validated in a New Zealand context, or more specifically with a Māori population. In light of this, interpretations should be carefully considered, and the possibility of cultural bias kept in mind. The limitations of these psychometric measures highlight again the importance of multi-modal assessment, incorporating information from as many sources as possible, including from Matiu, from case notes over his time with Corrections, and from observations of therapy and custody staff in the unit.

Relevant Background Information

Matiu reported being the seventh child of 15 siblings. He described an early childhood characterised by exposure to violence, substance use, crime, and heavy familial involvement in a prominent New Zealand gang. Matiu reported receiving harsh physical discipline as a youth; however, downplayed this saying he had a “cool” childhood, as they had go-karts, motorbikes, and PlayStations. Matiu was taken into the care of Child Youth and Family (now Oranga Tamariki) at age 10, after a sibling made a report to school. From this time, he frequently changed residences and caregivers. Matiu denied experiencing further abuse while under State care; however, stated he often ran away, wanting to return to his family and access to cannabis. Matiu reported that while his siblings eventually returned to his parents' home, he was “too naughty” to do so, as he would frequently get in trouble at school.

Matiu attended multiple schools, often for only a few weeks at a time. He stated that while he found it easy to make friends by attracting them with possessions (i.e., his “mini-chopper”), he believed he did not really fit in, as he did not think he was as academically successful as his peers. He infrequently attended classes and reported getting in trouble for ‘showing off’, distracting others, fighting with peers, and using cannabis, before being expelled from school at age 14.

From age 11 Matiu reported stealing from shops to gain approval from peers, and later stealing cars. Matiu first received convictions at 14 years old for burglary and animal cruelty. Matiu stated that due to familial involvement in the gang he started prospecting at 15 years of age. He reported receiving his first gang facial tattoo at 16, and his patch at 17. Matiu reported a disconnection from his Māori culture, stating the gang was all he knew.

Matiu reported a history of polysubstance use, which started with daily cannabis use at age seven, and alcohol use at age eight. Prior to his incarceration at age 18, he reported ongoing daily cannabis use, use of methamphetamine about once a week, and alcohol consumption of approximately 25 standard drinks twice per week.

Matiu reported several short-term intimate relationships and reported being physically violent towards one partner. He has a stepdaughter, and a 10-year-old daughter from an earlier relationship. Matiu reported he currently has a partner, whom he has been with for the last year. This relationship has occurred solely during his incarceration. She is reportedly a gang associate, and despite noting that they have arguments on the phone, Matiu stated they are emotionally close because they talk about their feelings.

Matiu reported having had several “heavy knocks” to his head; however, denied any loss of consciousness or subsequent effects. Matiu reported past symptoms of post-traumatic stress relating to a violent incident; however, reported his current mood as “mostly good”. He reported a stable diet and a tendency to engage in physical exercise six days a week.

Matiu has accrued a total of 17 convictions between the age of 14 and 28 years old. Four of these related to violence and weapon possession/use. His remaining convictions involved dishonesty (x5) property (x3), drugs and antisocial (x1), administrative (x2), and driving (x2) offences. While relatively limited in contrast to other men at a high risk of reoffending, his conviction history illustrates an early onset of antisocial and violent behaviour, with an increase in severity of offences noted. Matiu acknowledged some detected offending, primarily related to selling drugs and gang-related violence.

Index Offences

Prior to his index offences, Matiu stated he was living with and gang prospecting for his co-offender (a high-ranking gang member). At this time, Matiu stated he was “always high”, living an unstructured lifestyle and not working. He reported always having a gun on him, due to ongoing gang violence.

The Judge’s Sentencing Notes (JSN) described Matiu and his co-offender taking items from a house when the person they sought to provide them with methamphetamine was not home. When the man they had sought (a gang member of another chapter) later learnt this, he demanded they return. Matiu and his co-offender drove back armed with a pistol and shot at a bread van in their way. They returned to find the man and a few associates armed with various weapons including a bat, a samurai sword, and a machete. An altercation arose, and Matiu fired several shots, causing the others to retreat. He and his co-offender returned to their car, the other men pursued them, attacking both of them and the car. Matiu fired a shot out the car window, hitting the victim, who later died.

Matiu’s description of events were mostly in line with the JSN. Matiu reported some remorse for what had happened but said it could easily have been him who lost his life; and therefore, felt somewhat justified in his actions.

Current Circumstances

Whilst incarcerated, Matiu has accrued 73 misconducts predominantly for abusive behaviour, fighting (related to gang issues), and possession of contraband (i.e., tattooing equipment, substances), and numerous negative case notes primarily related to abusive behaviour or communication towards staff. Matiu also has a significant number of positive file notes, which document a positive attitude, good work ethic, and the completion of a carpentry course. Matiu has held several jobs, mostly cleaning and in the laundry; however, he has also lost jobs due to his behavioural misconducts.

Psychometric Assessment

Violence Risk Scale (VRS)

Nineteen out of 20 dynamic risk factors related to violence were assessed as present on the VRS, and considered treatment needs for Matiu. Of the items assessed, he was considered to be in the precontemplative stage of change; meaning he was unaware of the problematic nature or unmotivated to address the following six factors: Criminal Personality, Criminal Peers, Substance Abuse, Stability of Relationships with Significant Others, Community Support, Cognitive Distortions. He was considered to be in the contemplative stage of change; or, aware of the problematic nature and motivated to address these 10 factors: Violent lifestyle, Criminal Attitudes, Work Ethic, Interpersonal Aggression, Emotional Control, Violence During Institutionalisation, Insight into Violence, Weapon Use, Release to High-Risk Situations, Violence Cycle. Matiu was considered to be in the preparation stage of change; or, aware of the problematic nature and showing initial signs of behaviour change on two factors: Impulsivity, Compliance with Community Supervision. The final factor related to his current security level, which is low medium. Matiu's score on the static risk factors was 17, on dynamic factors he scored 52, and his total VRS score was 69, putting him in the high-risk group (VRS >50) for violent recidivism. His stages of change were assessed as being primarily in contemplation and preparation; meaning he was showing

some awareness, motivation, and early stages of behavioural change on most identified risk factors and treatment targets; indicating good readiness for treatment.

Further Psychometric Assessment

Several further psychometric measures were used to inform his formulation, identify potential responsivity issues which could interfere with his ability to fully engage in group treatment, and act as a baseline against which change can be measured at the end of treatment. These measures included the Childhood Trauma Questionnaire (CTQ), the Criminal Attitudes towards Violence Scale (CAVS), State-Trait-Anger Inventory (STAXI-II) and the Million Clinical Multiaxial Inventory (MCMI-IV), which are discussed below.

CTQ: Matiu's responses on the Childhood Trauma Questionnaire (CTQ) indicated that in his childhood he experienced "moderate" physical abuse; however, his responses also suggested he likely engaged in some minimisation or denial.

CAVS: Responses on the CAVS indicated that Matiu strongly endorses the use of violence to maintain respect or honour for himself or his gang, prove his loyalty, release anger, or sort out differences. He also strongly endorsed carrying weapons in rough neighbourhoods.

STAXI-II: Matiu's responses suggested that he frequently experiences intense angry feelings which he either suppresses, expresses in aggressive behaviour, or both.

MCMI-IV: Matiu's responses on the MCMI-IV indicated a low level of disclosure. Despite this, his scores were interpretable and were noted to be elevated on the Antisocial, Turbulent and Schizoid clinical personality pattern scales, as well as the Drug Use clinical syndrome. Matiu's responses on personality measures were similar to individuals who may come across as unreliable and tend to make their own rules. People with similar profiles may appear forceful, strong-willed and be likely to lash out at perceived attacks or when things don't go their way. They typically have poor understandings of and relationships with others, often

preferring to do things on their own. They may see themselves as more powerful than they really are, and not accept their own vulnerability or need for help.

WASI: No significant concerns were noted in terms of Matiu's cognitive functioning; all indexes were within the average range.

Responsivity Issues

Responsivity issues are challenges or barriers that may get in the way of a person's ability to engage well in the treatment programme. It is normal for someone to enter TWM with a number of responsivity issues. However, in order to get the most out of treatment, these should be addressed early on.

Potential responsivity issues for Matiu included a tendency to engage in minimisation or attempts to paint things in a positive light. Given this tendency, Matiu was encouraged to become more open about his past experiences and uncomfortable thoughts or emotions in order to get the most out of therapy. Matiu also reported issues with getting "bored", which he thought could be an issue both within group therapy and the wider compound, as he may engage in unhelpful behaviours such as distracting others or rule breaking. Matiu identified strategies, such as getting more involved in activities or discussions as a way to mitigate this concern. He was also encouraged to discuss issues of boredom with his therapists if these did arise.

Tentative Formulation

The following provides an initial tentative formulation of what led to Matiu's offending behaviour. Matiu experienced an unstable childhood characterised by abuse, emotional neglect and normalisation of violence, substance use, antisocial beliefs, and gang culture. This also included time in state care and frequent changes in caregivers. Matiu likely developed an insecure avoidant attachment style, unsure of whether or not his caregivers would respond positively towards him and learned to fend for himself from an early age. With limited exposure

to prosocial role modelling or opportunities to learn adaptive interpersonal communication and emotion regulation skills, Matiu adopted the use of violence to resolve issues, gain respect, express anger, and prove his worth to others. To deal with uncomfortable emotions, Matiu turned to substance use. When he saw his other siblings returning to his parents' home after time in state care, he was told he was 'too naughty' to be accepted back. This likely solidified his sense that the world was unfair, and he had to survive on his own, and reinforced his beliefs about his own status as an outsider in society. In response to this, Matiu gravitated further towards antisocial peers, immersed himself in the gang, and rejected pro-social society. When distressing experiences, thoughts and emotions arose for Matiu, he tended to suppress these through cognitive avoidance techniques such as minimisation and denial, and continued substance use, as he lacked adaptive emotional regulation skills. These strategies served Matiu in the short term; however, have resulted in significant harm to himself and his community, continued aggression to prove worthiness, a lack of more adaptive emotional regulation and communication skills, and a loss of close relationships and prosocial community supports.

Treatment Goals and Personal Strengths

From the information gathered within this assessment, several treatment goals were set for Matiu. These treatment goals align with the items identified as treatment needs for Matiu on the VRS, ensuring that treatment is aimed at addressing factors related to his risk of reoffending. Goals that Matiu reported during the assessment interviews included: learning strategies and skills to manage conflict without using violence, learning, and practicing more impulse control strategies, and building up community supports and skills to facilitate reconnection with the outside world. Other goals that were identified as useful for Matiu to work on included:

- Learning skills to recognise and regulate emotions, including anger, in healthy ways

- Developing greater insight into problematic thinking styles, personality traits, and past cycles of violence, including those related to substance use
- Increased insight and awareness of the impacts and potential risks of antisocial cognitions, behaviour, and peer groups
- Increased insight into the quality and stability of his relationships, learning skills to improve interpersonal communication and conflict resolution, and building prosocial relationships
- Developing a comprehensive plan to manage future high risk situations without the use of violence

Matiu is considered to have a number of personal strengths that may assist him to achieve these goals. In particular, he has discussed his motivation to engage in treatment, and his hope to be able to focus on his family going forward. Matiu has reported seeing change in others and stated he has positive expectations of the treatment programme for himself. Matiu has been observed to be engaging in the therapeutic community through kapa haka and morning karakia.

Summary

Through the current assessment Matiu was identified as being at high risk of future violent offending. Several treatment targets that inform Matiu's risk of violence were highlighted to be addressed. It was noted that while Matiu was unaware of several of his risk factors, he was aware of the problematic nature of twelve of these and showing behavioural change in two of the factors, indicating good treatment readiness. Further, Matiu expressed his desire to engage in treatment and learn strategies other than violence to resolve conflict and support him towards his goals of one day being granted parole and a chance to live a life outside of prison.

Reflections

Working with Matiu, I was struck by the similarities in our age, yet our extreme differences in life experiences. I particularly found the fact that he had been in the justice system since age 14, and in prison on a life sentence since the age of 18, hard to come to terms with. Matiu has never lived an adult life outside of the criminal justice system, and hearing his life story, one wonders what chance he really had to live a prosocial life. The fact that Matiu had contact with both social services (CYFS) and the criminal justice system (youth court) at a young age, is also interesting to reflect on, and perhaps speaks to failures within these systems, as these interactions arguably should have functioned as opportunities to support this young man onto an alternative path. While these interactions were never guaranteed to change his overall trajectory, they were opportunities to get support systems in place. Reflecting on my own place within this system has been an interesting and challenging aspect of my internship year, as I have witnessed the efforts people within the system (e.g., my colleagues within the therapy and custody teams) go to support the men at TWM, but also the systemic challenges that the Department of Corrections faces (e.g., staffing issues) which can lead to particularly challenging situations and sometimes significant negative impacts for the men (e.g., no in-person visits).

Another factor that was interesting in my work with Matiu was his self-reported disconnection from his Māori culture. When questioned about his cultural identity, Matiu reported that he was Māori, and knew the iwi he affiliated to, however he also stated he “didn’t grow up Māori”, and that gang culture was all he ever knew. However, Matiu displayed a desire to connect with his culture and learn more about Te Ao Māori when given the opportunity. I found that following tikanga, including the use of the hui process was important in building rapport and trust between us. When I initially offered karakia, Matiu almost shrugged his shoulders, reporting that he did not know any. I offered to say one for us, and for the remaining sessions I brought in karakia which we then read together. The use of karakia at the start of sessions appeared to ease Matiu’s nerves and facilitate connection and

discussion between us. Matiu was also noted to join the unit kapa haka group, one of only a few new entrants who chose to engage. This was reflected upon as a strength for him heading into treatment, in terms of putting himself out there and trying new things. My reflection on this experience is that the use of the hui process can be helpful even in instances where clients initially report less connection with Te Ao Māori. Furthermore, taking a curious and humble approach, can support someone on their journey of rediscovery and reconnection to culture.

In working with Matiu I have also gained some insight into the difficulties of people who are entirely immersed in gangs. Matiu, could not see an option of distancing himself from his gang, when leaving would mean cutting ties with his whole family and a way of life that was all he had ever known. However, staying in the gang and remaining an active member is likely to increase his risk of future violence, which may result in him remaining in, or returning to, prison. Further, Matiu has gang tattoos on his face, something he refers to as his 'foul mask'. It is interesting to consider the function of this, as I believe it to be at least two-fold, while Matiu may initially have thought of it as something to intimidate others and display his loyalty to his gang, I think there is also a function of hiding from the world, attempting to protect himself from rejection by pushing society away first. These tattoos represent another barrier to distancing himself from the gang in the future. Matiu has however, expressed some interest in laser tattoo removal, and so this may be something he pursues in the future.

In line with best practice, I requested consent from Matiu to speak with collateral sources, ideally hoping to speak with his partner or mother, with both of whom he reported good relationships. Matiu was initially unsure about this, and we discussed it on multiple occasions. I wanted to ensure he did not feel pressured to consent to this, while also ensuring he had the opportunity for me, as his assessor, to gain a broader perspective of who he is and have some contact with his support system outside of prison. Matiu fluctuated between

wanting and not wanting me to talk with his support people. Ultimately, he chose not to provide me with their contact details. In reading back the report, Matiu queried why it said he had not consented to interview of his support people, and he clarified that actually “they didn’t want to talk to you”. While many factors could contribute to their not wanting to speak with me, I believe it is likely that Matiu’s supporters refused, at least in part, due to their own anti-authority and antisocial beliefs, which appear deeply engrained in Matiu’s life and social circles. If they had chosen to speak with me, I wonder how that conversation would have gone. I hypothesised they might feel somewhat hostile towards me, as someone working within the criminal justice system, and I can imagine my own apprehension that would creep up as I prepared for the conversation. Before Matiu confirmed he did not want me to contact his support people, I considered how I would engage in a conversation where it was likely both parties were coming with many preconceived notions of the other, and some level of anxiety, in such a way that I could still quickly build trust and rapport and gather relevant information for the assessment. I reflected that focusing on the common goal of supporting Matiu to live a life outside of prison would likely be a helpful way to align myself with his supporters and begin the conversation.

Matiu showed genuine curiosity about what the report would say, asking multiple times during the writing process about when it would be ready and if it would be “good or bad”. I was aware that Matiu may have been drawing similarities between this experience of the report and assessment, and his time at school. I tried to reassure him and explain that the report would be neither good nor bad, but rather, would help us understand how he got here and what he needed to work on to help him reduce the likelihood that he would use violence in the future. As we read through the report it was noted that Matiu did find certain aspects somewhat confronting. He was mostly quiet as we read out loud. He stopped to question the MCMI-IV interpretation, asking if that was about him or someone else. When clarified that his responses on the questionnaires had resulted in this interpretation, and asked if any of fit

with him, he did acknowledge that it could be valid. At the end of the report, I asked Matiu for any further questions or reflections he had. Matiu stated “this (the report) makes me sound like I’m a violent person”. This was an interesting moment, and not too uncommon in this area, where as a therapist I have to balance the client’s feelings and positive self-perception with challenging their distorted thinking and acknowledging that yes, they have used violence and are at high risk of using violence again. Matiu although initially sounding somewhat hurt, appeared to understand that while he had done violent things, we believed that he was here to change, and if he worked on the aspects outlined in the report, he could indeed reduce his risk of using violence in the future. He attended to the VRS items, and the goals outlined and was eager to have his own copy of the report (which was provided to him), so he could re-read and consider these treatment goals. Matiu has recently begun his treatment for violent offending and appears to be engaging and participating well in his group.

References

- Allnutt, S., O'Driscoll, C., Ogloff, J. R. P., Daffern, M., & Adams, J. (2010). *Clinical risk assessment & management: A practical manual for mental health clinicians*. Justice Health.
- Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, 52(1), 7-27.
<http://dx.doi.org/10.1177/0011128705281756>
- Bonta, J., & Andrews, D. A. (2017). *The psychology of criminal conduct* (Sixth ed.). Routledge, Taylor & Francis Group.
- Bonta, J., Bogue, B., Crowley, M., & Motiuk, L. (2001). Implementing offender classification systems: Lessons learned. In G. A. Bernfeld, D. P. Farrington, & A. W. Leschied (Eds.), *Offender rehabilitation in practice*. <https://epdf.tips/offender-rehabilitation-in-practice-implementing-and-evaluating-effective-progra83a8687975b616d4dc1caac70e6404c092562.html>
- Coohey, C., Johnson, K., Renner, L. M. & Easton, S. D. (2013). Actuarial risk assessment in child protective services: Construction methodology and performance criteria. *Children and Youth Services Review*, 35(1), 151-161.
<https://doi.org/10.1016/j.chilyouth.2012.09.020>
- Hanson, R. K. (2009). The psychological assessment of risk for crime and violence. *Canadian psychology*, 50(3), 172-182. <https://doi.org/10.1037/a0015726>
- Hanson, R. K. & Harris, A. (2011). The Sex Offender Need Assessment Rating (SONAR): Method for measuring change in risk levels 2000-1. Corrections Research, Department of the Solicitor General of Canada
- Hart, S. D., Douglas, S. K., & Guy, L. S. (2016). The structured professional judgement approach to violence risk assessment: Origins, nature, and advances. In L. Craig & M. Rettenberger (Eds.), *The Wiley handbook on the theories, assessment, treatment of*

sexual offending: Volume II. Assessment. Wiley.

<https://doi.org/10.1002/9781118574003.wattso030>

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: a framework to enhance the doctor-patient relationship with Māori. *The New Zealand medical journal*, 124(1347), 72-78

Mulvey, E. P., & Iselin, A. M. R. (2008). Improving professional judgements of risk and amenability in juvenile justice. *Future of Children*, 18(2), 35-57.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.

Wong, S. C. P., & Gordon, A. (2006). The validity and reliability of the Violence Risk Scale: A treatment-friendly violence risk assessment tool. *Psychology, Public Policy, and Law*, 12(3), 279-309. <https://doi.org/10.1037/1076-8971.12.3.279>

Assessment Case Study Two

The Assessment of a Nine-Year-Old Boy Referred for Assessment of Possible
Attention Deficit/ Hyperactivity Disorder

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This case study represents the work of Charlie Bremer during their internship in 2023. Clinical supervision was received during the assessment and therapy for the individual within this case study. All names and identifiable information within the case study have been changed to protect the anonymity of the client.

Candidate: Charlie Bremer [REDACTED] Date: 06/11/23

Supervisor: Dr Louise Edwards [REDACTED] Date: 06 November 2023

Abstract

This case study presents the assessment of a nine-year-old Pākehā boy, Sidney, referred for clinical assessment due to a query of attention deficit/hyperactivity disorder (ADHD). The assessment involved a clinical interview with Sidney's mother, a clinical interview with Sidney, a school observation and discussion with his teacher, and administration and interpretation of psychometric measures, including the SNAP IV-26, Conners-3, and the Strengths and Difficulties Questionnaire. A brief literature review of ADHD and the differential consideration of "giftedness" is presented, followed by the assessment protocol, relevant background information including current functioning and developmental history, psychological assessment information, diagnostic considerations, tentative formulation, summary, and recommendations. The final section of this case study provides a discussion of the assessment and personal reflections.

ADHD Presentation and Assessment, and Consideration of "Giftedness"

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR (American Psychiatric Association, 2022)), neurodevelopmental disorders emerge during the developmental period and are characterised by developmental deficits resulting in functional impairments. ADHD is an early onset neurodevelopmental disorder involving difficulties with inattention, hyperactivity, and impulsivity (See Appendix A for full diagnostic criteria) (American Psychiatric Association, 2022; Biederman & Faraone, 2002). Distinctions can be made between three categories of ADHD: inattentive type, hyperactivity and impulsivity type, or combined type. To meet diagnostic criteria for ADHD children must have at least six symptoms from either, or both, of the categories of inattention or hyperactivity and impulsivity, present before the age of 12, enduring for over six months, and with a significant negative impact on development and/ or functioning (American Psychiatric Association, 2022). Children with ADHD may be seen by parents and teachers as distractable, unable to stay on task or listen, accident-prone, impulsive, interruptive, and always on the move. Later in life, the impacts of ADHD may result in higher risk of poor self-esteem, poor peer relationships, and substance abuse (Biederman & Faraone, 2002).

ADHD is a common disorder, with some research indicating it is the third most common mental health disorder worldwide, behind depression and anxiety disorders (Bélanger et al., 2018). Epidemiological data in the United States, reports ADHD as the most commonly diagnosed mental health disorder in youth, with prevalence rates having increased across recent years (Center for Disease Control and Prevention, 2010). International prevalence rates of ADHD are reported to be between 5-8%, and in Australia between 6-10% (May et al., 2023). In the latest New Zealand Health Survey, the prevalence of ADHD diagnoses for people aged 2-14-years-old was reported as 2.4% (Whāraurau, 2021). ADHD is considered under-recognised in girls and women, primarily because girls tend to present with inattentive type ADHD, which may be less disruptive and noticeable (National Institute for Health and Care Excellence, 2018). ADHD commonly co-occurs with a range of disorders,

including learning, conduct, mood, anxiety, and autism spectrum disorders (Biederman & Faraone, 2002; May et al., 2023; McGough, 2014). Further, ADHD is associated with a greater lifetime risk of developing co-occurring disorders, particularly mood, anxiety, and substance use disorders (McGough, 2014).

Differential diagnosis is important to ensure accurate diagnoses are made, in line with ethical responsibilities (New Zealand Psychologist Board, 2002). This can be particularly important with ADHD diagnosis due to potentially significant secondary gains of diagnosis including access to psychostimulant medication (which can be misused or diverted) or educational accommodations (e.g., extra time on exams), and, somewhat conversely, due to the significant stigma that can be associated with ADHD (Harrison et al., 2007, Mueller et al., 2012). One important consideration (among others) when assessing for possible ADHD in young people, is that of “giftedness”. While there is not a unified definition of “giftedness”, this typically refers to people with high intelligence, creativity or “gift” in another skill or construct, in comparison to their peers (Carman, 2013; Sternberg et al., 2011). “Gifted” young people are thought to have exceptional perception which can lead to intensified emotional, psychomotor, intellectual, sensory, or imaginal experiences, sometimes expressed as ‘meltdowns’, hyperactivity, or perfectionism (Sampson, 2013). It is acknowledged that there can be an overlap between behaviours related to “giftedness” and those commonly associated with ADHD, including high energy levels, difficulties with attention and impulsivity, and emotional intensity. There are a number of ways that these behaviours can be understood among “gifted” children, for example, as being due to asynchronous development, possible situational boredom, or overexcitabilities (i.e., exceptional perception) (American Psychiatric Association, 2022; Mullet & Rinn, 2015; Rinn & Reynolds, 2012; Webb, 2000). It is acknowledged that it can be particularly difficult to distinguish between “gifted” children with ADHD or without ADHD, due to these overlaps (Mullet & Rinn, 2015).

ADHD has long been a somewhat controversial diagnosis, and the diagnostic criteria of ADHD has significantly changed over time (Mallett et al., 2014). Empirical evidence supports several aetiological factors in ADHD including genetic links, biological contributions including preterm delivery or birth complications and exposure to toxins, psychosocial adversity, and neurobiological differences (Biederman & Faraone, 2002). However, there are varying perceptions on etiological and physiological aspects of the disorder, and debates around the validity of current operational definitions of ADHD, given its wide heterogeneity and common comorbidities (McGough, 2014). Despite such controversies, ADHD is acknowledged to have significant impacts on individuals and society in terms of financial costs, stress to individuals and family systems, negative impacts on self-esteem, and functional impairments (Biederman & Faraone, 2002). People with ADHD may also be more likely to suffer from accidental injuries and more likely to engage in risky behaviour, which could result in harm to themselves and/or others (McGough, 2014).

In accordance with the United Kingdom based National Institute for Health and Care Excellence (NICE) guidelines and recently developed evidence-based clinical practice guidelines for ADHD in Australia, a thorough assessment is essential for a diagnosis of ADHD (May et al., 2023; National Institute for Health and Care Excellence, 2018). Assessment of potential ADHD should involve full clinical and psychosocial assessments, including assessment of the individual's symptoms and strengths across various aspects of their life, as well as considerations of the individuals developmental, medical, and mental health history, and observations from more than one other person within more than one setting to confirm presence of symptoms and functional difficulties across settings. Evidence-based assessment of ADHD should therefore be multi-informant and multi-method, incorporating the use of validated assessment measures (May et al., 2023; National Institute for Health and Care Excellence, 2018).

Case Study

Client Name: Sidney Smith

Date of Birth: 7/3/2014

Reason for referral: Sidney is a nine-year-old boy of New Zealand and Australian-European descent, referred to the Massey Psychology Clinic in September 2023, through CAMHS ADHD assessment service. The referral was made by Sidney's parents Lisa and Joe for assessment of potential ADHD due to long-standing difficulties with getting to sleep at night, distractibility, transitioning between tasks, and sustaining attention when not 'interested' in the topic.

Assessment protocol and information sources

- Behavioural Information Questionnaire and Developmental Questionnaire from Capital & Coast District Health Board completed by Lisa in March 2023
- Initial assessment interview around concerns and developmental history with Lisa on 29/9/2023
- Conners third edition (Conners-3) parent, teacher, and self-report forms: completed by Sidney, each of his parents (Lisa and Joe), and Ms Parker, his teacher
- Strengths and Difficulties Questionnaire completed by Lisa
- Assessment interview with Sidney on 6/9/2023
- School Observation and interview with Ms Parker on 17/10/2023 completed by Julia Ryan, Intern Psychologist

Current Functioning

Presenting Problems

Lisa described Sidney as having difficulty focusing in class, being easily distracted, and struggling to 'switch off his brain' when it was time to go to sleep at night. These difficulties were reported to impact on Sidney's ability to keep up in maths and to focus long

enough to complete writing tasks in English at school. It was noted that Sidney is able to easily focus with an “unbelievable attention to detail” when in a quiet environment or interested in a task/subject and could persevere with such tasks for hours. Sidney was also reported to struggle with transitions between tasks when he was doing a task he enjoyed. At home, Sidney was described as sometimes talking nonstop, not letting others speak, and struggling to stay in his seat during dinner. Lisa stated Sidney would not retain more than a couple of verbal instructions and would return for reminders of what he needed to do if he was unsure. In terms of his emotional regulation, Lisa reported that Sidney tended to be “100% either way”; either super happy and bouncing off the walls, or really upset.

Lisa indicated she hoped Sidney might receive an ADHD diagnosis in order to access funding for prescribed Melatonin to support Sidney’s sleep. She also reported wanting strategies to help Sidney focus at school, and to help him to more easily transition between tasks at home.

Safety

Risk to self, risk from others, and risk to others were all assessed. No concerns around risk were reported or identified during the assessment process.

Family

Sidney currently lives on a lifestyle block in the Wellington region with his mother Lisa, father Joe, and younger sister Imogen who is six years old. The children were both born in Australia, and the family relocated to New Zealand in March 2020, just prior to the Covid-19 lockdowns. The family enjoy being active outdoors, particularly going mountain biking. Sidney currently attends XX school and is in Year Five. No family or caregiver difficulties were currently reported. The family reported having close relationships and enjoying spending time together. One area of conflict that was reported involved getting Sidney to stop screen time at the end of his allocated time.

Sleep

Sidney is reported to struggle with getting to sleep at night. A few months ago, Sidney was started on prescription Melatonin (5mg per night) to support his sleep, which Lisa reported has been “life changing”. With Melatonin, Sidney has been able to sleep at least an hour before he normally would. Lisa reported Sidney gets a total of ten hours sleep, and has not had difficulties with bedtime resistance, excessive daytime sleepiness, awakening during the night, or snoring.

Exercise

Lisa reported that Sidney plays running games or soccer at school during the breaks and on free afternoons runs or rides his mountain bike. During the weekends, he attends swimming or goes mountain biking, tramping, running, or walking in the forest.

Diet

Lisa reported that the family eat a nutritious diet. Lisa reported Sidney was “really sensitive” to artificial colours in food, particularly red food colouring. Lisa reported that such foods seemed to result in Sidney losing all focus, experiencing extreme bursts of energy including fast nonstop talking, and give him headaches and nausea.

Academic Functioning

Lisa reported Sidney has achieved well academically despite his schooling being disrupted by COVID-19 lockdowns. Lisa reported this year was the first uninterrupted school year with the same teacher for Sidney. Lisa stated Sidney’s teacher informed her he would often get distracted, particularly when the class was noisy, and he was described as a ‘fidgeter’, constantly clicking his pen. Overall, Sidney was described as “an incredibly bright boy”, who is doing well at school, engaging with ‘MindPlus’ (a program for academically “gifted” children), and has a strong interest in science. However, when he is not interested in

a subject (e.g., mathematics, where he doesn't see 'the point'), he doesn't focus and is easily distracted by external stimuli (e.g., someone outside the window, talking with friends). In English, Sidney requires repetitive prompts from his teacher to stay on task. While he is performing well in most subjects, Lisa reported concerns that Sidney is now performing at an average to low-average level in mathematics, which given his overall ability, is below expected performance for him.

Social Functioning

Sidney was described as having a good close group of friends at school, and generally getting along well with his teachers and peers. He gets on well with his sister, and they often play together for hours. Lisa reported that Sidney displayed good empathy for others and was "really good" at describing emotions.

Current Coping Strategies

Lisa reported that she has been managing Sidney's difficulties through the use of structure and routine. This included having rules around what tasks need to be completed prior to accessing rewards such as screen time, and making adjustments to schedules such as having after-school activities at the start of the week rather than later when she notices Sidney will be more tired. Lisa also reported that giving Sidney ownership and options was helpful in getting him on to task. At school, Sidney's teachers have used the reward of being allowed to access resources to construct a "car" (the e-pro challenge 8), to incentivise Sidney to engage in his schoolwork, and remind him of this when he gets distracted to help bring his attention back to the immediate task.

Sidney's Report

Sidney reported that things were "good" for him in terms of his family, school, and peer life. Sidney reported difficulties getting to sleep prior to his use of Melatonin. He stated

he would sometimes be checking the time while he waited to sleep, and would think about the next day, or think of things he wanted to remember to say to friends. He stated that this would keep him awake, and he would often forget the ideas anyway. He did not report worries or anxious thoughts.

At school, Sidney stated that he had noticed he only really focuses on things that he likes, and that he can “never focus on maths” and only sometimes on writing. Sidney stated that when he’s not focusing, he is usually chatting with friends, watching the clock, or thinking about the “next fun thing coming up”. Sidney reported that at times when he was doing something he liked (particularly at home) and was told to do something else, he would hear, but ignore the request once (because he didn’t want to stop) before he would then comply. He stated he could follow one instruction at a time well, but if many instructions were given, he noticed he could get distracted and off-task; however, he stated he would still remember the other instructions and complete them later. He stated he believed that it was harder for him to focus than it is for his friends. Sidney reported that this did not really cause many problems for him; however, he stated that because he gets distracted, sometimes he doesn’t get all his work done, or it can take him a little longer to learn than his peers. Sidney stated that he found it helpful when the teacher reminded him to focus during class, and that the reward system currently in place (i.e., focus during class in order to have time building the e-pro challenge 8) was also beneficial. At home, Sidney reported he could play Lego for two to four hours at a time and would mostly make his own creations but also enjoyed following instructions.

Developmental history

Pregnancy and early development

Sidney was born at full term (40 weeks, 2-3 days overdue) with no birth complications. Lisa reported both she and Joe were “healthy” during and after the pregnancy,

and no substance use was reported. Lisa stated that from birth Sidney appeared to require very little sleep.

Motor skills and sensory development

Sidney met all motor developmental milestones at the expected times. Sidney was described as a “sensory seeker” as a young child, meaning he loved movement, for example enjoying crashing into things. Lisa also reported he would struggle in loud crowds when they lived in Australia, often “shutting down” which she attributed to being “overwhelmed” or sensory over-stimulation.

Language and Comprehension

Sidney had “advanced” language development, speaking in complete sentences, and using developmentally advanced vocabulary at two years old. As a young baby, Lisa reported that Sidney was known as “the little engineer” as he would ‘tinker’ with mechanisms from as early as eight months old.

Emotional Development

Managing Sidney’s “big emotions” during the ages of three to five-and-a-half-years-old was particularly difficult, and he would frequently have “meltdowns” which Lisa reported appeared amplified in comparison to other children his age.

Social Development

Sidney was described as being moderately social. Lisa stated that as a young child he used to be slow to warm up to new people but was now very social and outgoing. She reported he always had friends and got along well with his peers and his younger sister.

Medical/Mental Health history

Sidney occasionally experiences mild asthma and uses an asthma inhaler as required. Sidney has had his hearing and eyesight tested, and both were found to be very good. Lisa reported no significant injuries in his history.

Family Health History

Lisa stated no members of her family had received a formal diagnosis of ADHD; however, she believes both herself and her sister may have ADHD as they have always been talkative and full of energy. Lisa reported she had experienced postnatal depression following the birth of her daughter, which lasted for approximately two months, and stated her sister experienced both depression and anxiety. No health concerns were reported on Sidney's paternal side.

Prior Psychological Assessment

Sidney has not previously engaged with psychologists.

Psychological Assessment

Presentation and observations

Sidney presented as a polite and friendly nine-year-old boy. He was open to talking and opted to conduct the interview session without his parents. He answered all questions in a thoughtful manner and appeared attentive to detail. At times it was noted that his attention drifted; however, for the most part he maintained attention and continued the flow of the conversation. Sidney remained seated for the hour-long interview, fidgeting only a little in his seat throughout.

School observation

Sidney was observed in his classroom on the 17 October 2023, by Julia Ryan (Intern Psychologist). Sidney was observed to initially present as attentive; however, in mathematics class he sat at the back of the class with three other students and switched between whispering and completing the assigned task. Of note, Sidney was not disruptive or speaking in a loud voice, but he and his friends appeared more consistently off task than the other students. While Sidney focused on the task for brief periods of time, he tended to look around the classroom (e.g., at what the other students were doing) and appeared distracted. He did not interrupt the teacher, call out any answers or appear fidgety. Sidney was redirected by the teacher a few times, and ultimately, he chose to separate himself from his friends, where he was able to complete the required task.

Interview with Classroom Teacher

Sidney's teacher (Ms Parker) described him as easily distracted and said he had difficulties paying attention in class. She said he has one very close friend, and they constantly talk and distract each other. She did not describe him as impulsive, or fidgety, and said he does not yell out in class. She stated it can take him "ages" to complete work due to his becoming distracted, but that academically, he has the capacity to complete the tasks. She described him as "creative, gifted, and talented".

Psychometric assessment results

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief behavioural screening questionnaire consisting of 25 questions assessing the following areas: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. Lisa completed the SDQ on 6/10/2023. Her scores on the questionnaire indicate no internalising problems (i.e., neither emotional nor peer problems), and good prosocial tendencies; however, problems with hyperactivity are indicated to be in the 'high' range and conduct

problems in the ‘close to average’ range. The impact of these difficulties was reported to be within the ‘slightly raised’ band. Qualitatively, these difficulties were reported as interfering with Sidney’s everyday life ‘only a little’ at home, and ‘quite a lot’ in terms of classroom learning.

Canadian ADHD Resource Alliance: CAADRA SNAP-IV 26 Teacher and Parent Rating Scale

The SNAP-IV 26 is a questionnaire which consists of questions drawn from the criteria for ADHD and Oppositional Defiant Disorder (which can commonly co-occur with ADHD) within the DSM-IV. This was used as another screening measure, to screen for the possibility of ADHD. The SNAP-IV 26 was completed by Sidney’s teacher (Ms Parker) and his mother (Lisa) on the 8th of March 2023. Ratings indicated mild difficulties (e.g., “just a little bit”) with inattention reported by both Sidney’s teacher and Lisa, and mild difficulties with hyperactivity reported by Lisa.

Conners’ Rating Scales – 3

The Conners’ Rating Scales are questionnaires designed to support assessment and diagnosis of ADHD and commonly comorbid problems in youth aged six to 18 years of age (Conners, 2008). The use of the Conners supports multi-informant assessment including consideration of client presentation, symptomology, and impairment across contexts, as well as the client’s own internal experience of difficulties (Izzo et al., 2019). Related problems assessed with the Conners-3 include executive function, aggression, and learning difficulties as well as interpersonal problems with peers or familial relationships (Kao & Thomas, 2010).

Both of Sidney’s parents and his teacher completed the Conners-3 questionnaire in May 2023. Sidney completed the self-report version in October 2023. Unfortunately, Sidney omitted answers to over 10% of the items, therefore, results from his responses may not be

valid, and cannot be reliably interpreted. Sidney’s responses are presented here where it is considered they may be helpful to the overall assessment.

No response style bias was indicated in either parent or teacher responses. Responses have been converted into T-scores, which is a standardised way of scoring that enables comparisons to what is typical for Sidney’s age and gender. All T-scores have a mean of 50 and a standard deviation of 10 (see Figure 1 below). A score of 50 therefore represents the exact average score for the age and gender group, and the average range is within one standard deviation of the mean (i.e., between T Score 40 and 59). A T-score between 1.5 – 2 standard deviations above the mean (i.e., T Score 65 – 70) usually indicates significant concerns. A T-score greater than 2 standard deviations above the mean (i.e., T Score >70) is very likely to indicate an area of significant concern. Tables 1 and 2 below show respondents T-scores.

Table 1

T-score results for each of the Conners 3 Content scales.

Content Scale	Respondent			
	Joe	Lisa	Teacher	Sidney
Inattention	57	61	72	-
Hyperactivity/Impulsivity	65	69	56	68
Learning Problems	45	42	54	53
Executive Functioning	45	65	72	-
Defiance/Aggression	55	55	44	43
Peer Relations	44	44	43	-

Note: elevated scores are in bold font

Table 2

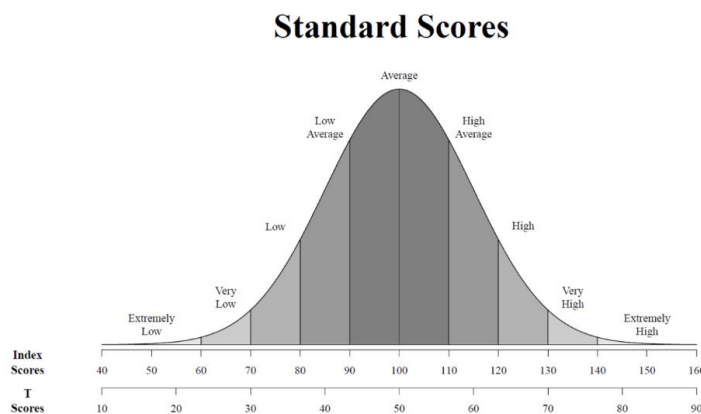
T-score results for the DSM-5 Symptom scales.

Symptom Scale	Respondent			
	Joe	Lisa	Teacher	Sidney
ADHD inattentive type	59	63	62	50
ADHD hyperactive/ impulsive type	61	65	56	65
Conduct Disorder	44	44	45	44
ODD	50	59	44	55

Note: elevated scores are in bold font

Figure 1

T Scores on a Normal Curve



Reported Impairment

Sidney’s problems were thought to seriously affect his functioning academically: “occasionally” by Joe, “often” by Sidney’s teacher (Ms Parker), and “very frequently” by Lisa. Sidney’s problems seriously affect his functioning at home only “occasionally” according to both his parents. Qualitatively, Lisa and Ms Parker’s responses suggest that a clinical classification of ADHD is strongly indicated (Lisa = 87%, Teacher = 91%), whereas Joe’s responses indicate ADHD is possible, however the score is borderline (56%).

DSM-5 Total Symptom Counts

Table 3 presents the number of ADHD symptoms reported by each respondent.

Table 3

Total DSM-5 symptom counts reported

ADHD Type	Respondent			
	Joe	Lisa	Teacher	Sidney
Inattentive	1	2	4	1
Hyperactive/Impulsive	3	5	3	4

It is important to note that the diagnostic criteria of ADHD require six or more symptoms within either or both (but not across) categories of ADHD inattentive type or ADHD hyperactive/impulsive type. Therefore, no reporters indicated sufficient symptoms were present to support a diagnosis of ADHD.

Diagnostic Impressions and Tentative Formulation

Information across the current assessment indicates Sidney does at times have difficulty maintaining his focus and can be easily distracted, particularly at school during topics he is less interested in. Sidney’s difficulties with distraction are thought to be causing some level of impairment for him quite often at school, and occasionally at home. Sidney is reported to be able to focus remarkably well, playing Lego (including following complex instructions to build different structures), reading his books for hours on end, writing pages on a topic of his choosing at home and playing well with his sister for extended periods of time. Sidney reported that at times he would hear and understand instructions (e.g., to transition tasks) but would choose to initially ignore these. Sidney is noted to be detail oriented, rarely making careless mistakes, and able to focus well on topics he is interested in. He is not described as forgetful, disorganised, or likely to avoid tasks involving sustained mental effort. He is also noted to have a high level of energy which he tends to put towards outdoor physical activities. Sidney also is reported to have difficulties getting to sleep at night, for which Melatonin has been helpful.

Sidney is considered by both teachers and his parents to be academically “gifted”. It is not uncommon for “gifted” young people to have experiences that could present similarly to individuals with ADHD, including apparent difficulties with inattention or distraction, or high energy levels, impulsivity, or emotionality (American Psychiatric Association, 2022; Mullett & Rinn, 2015; Rinn & Reynolds, 2012; Webb, 2000). “Gifted” young people also commonly experience trouble getting to sleep, with some research indicating around 20% of gifted individuals show a reduced need for sleep from a very early age, shorter sleep duration, and may be at greater risk for developing sleep difficulties, as is reported with Sidney (Bastien et al., 2022; Geiger et al., 2010; Webb, 2000). “Gifted” children often have an ‘intense nature’, and this may be displayed in their pursuit of their topics of interest (Webb, 2000). Sidney appears to engage in ‘flow’ at times, which refers to period of intense concentration where an individual is absorbed in an enjoyable or interesting task (e.g., Lego), is less aware of unrelated external stimuli, and performance in the task improves (Ashinoff & Abu-Akel, 2021). *It is noted that a symptom of hyperfocus has often been associated with ADHD in the literature (but is not part of the DSM criteria); however, Sidney's experience appears to be more aligned with flow state (as described above), than hyperfocus as seen in ADHD (which typically involves individuals focusing on activities which are continuously reinforcing and “automatic” (i.e., do not require effortful attention) such as videogames or social media).*

Sidney’s tendency to become distracted at times (particularly when less interested in a topic), and to become particularly absorbed in tasks at other times may be a reflection of his “giftedness” and potentially also related to his self-concept. It is noted that in topics where Sidney reports not being as interested, in particular mathematics, his distractibility is greater. Sidney reported that even when he knows the answer in mathematics, he will not put his hand up to answer a question. He stated this is because he knows less about the subject as a whole and so doesn’t like to talk about it as much. Sidney is described by his teacher as having

capacity within mathematics and appears to make the decision not to engage, rather than primarily experiencing an inability to engage due to struggles with concentration and focus, or specific mathematics-related learning difficulties (although this is considered important to explore further). Sidney's relative hesitancy to engage may be reflective of his perceived lack of ability/achievement in this subject, which likely conflicts with his identity of "being smart" (i.e., the "little engineer"). He may require a little extra support in order to build his confidence and interest in mathematics. Sidney's inattention could also be reflecting situational boredom when the academic environment is not providing him sufficient challenge or engagement, and changes to the environment could support Sidney's improved engagement.

"Gifted" difference comes with both special abilities and special sensitivities or vulnerabilities, and as such, there is a need for greater understanding, acceptance, and support from those around them (Sampson, 2013). For Sidney, some of these intense experiences may be seen within his high energy levels and fidgeting, his "big emotions", or his hesitancy or self-doubt about engaging in topics he is less sure about. While full neuropsychological testing was outside the scope of this report, it would likely be beneficial for Sidney and his family, to understand how Sidney learns best and what his relative strengths and weaknesses in the academic setting are. Sidney's reported difficulties were noted not to be affecting his relationships within the family or with peers.

Differential Diagnoses Considered

DSM-5 Diagnoses and Contraindications

ADHD

ADHD inattentive type:

- Sometimes easily distracted (other times "remarkable" attention)

- Sometimes seems not to listen (however stated he chooses to ignore)
- Reported “sometimes” loses/forgets things, but “not important things”, or makes mistakes (e.g., forgets capital letters in writing)
- Not described as forgetful, or avoiding tasks with sustained effort

ADHD hyperactive/Impulsive type:

- Fidgets and has high level of energy
- Sometimes talks excessively (at home, when interested in a topic)
- Doesn’t blurt out answers, interrupt others or have difficulty waiting his turn.
- Able to stay seated during school/ clinical interview, able to play quietly.

Does not meet diagnostic criteria for ADHD.

Specific Learning Disorder (Dyscalculia)

- Reported difficulties specific to mathematics.
- Described by teacher as “maths capable”, performance as expected for age (however; “average” performance may represent a relative weakness for Sidney).

Further assessment (and application of targeted interventions as indicated) recommended to rule this in/out.

Autism Spectrum Disorder

- Potential presence of fixed or restricted interests (e.g., Lego, engineering)
- Sensory overload in crowds leading to “shutting down”, enjoyment of movement/crashing as a young child may be indicative of hypersensitivity to sensory input or unusual interest in sensory aspects of environment.
- Strong indications of good social skills, reciprocal play and good relationships with peers, no observed deficits in social communication during clinical interview or school observation.

Does not meet diagnostic criteria for Autism Spectrum Disorder.

Insomnia

- Sidney reports difficulty getting to sleep; however, did not appear particularly concerned or distressed about this, therefore does not meet diagnostic criteria.

Other Diagnostic considerations

Anxiety or Mood disorders were also considered, however currently have been ruled out by both parents and Sidney reporting no concerns in these areas (e.g., no significant low mood/irritability, anhedonia, or worries).

Other Considerations

- Expected functioning for developmental age and stage; distractibility/ ability to concentrate and high energy may be comparable to peers and not represent a significant difference.
- Teacher style or the relationship between Sidney and his teacher could be impacting his ability to focus in mathematics class, as could the presence of particular peers (who are perhaps not in other classes with him). Could be more of a relational/situational issue.
- “Giftedness”: superior intellectual ability compared to his peers. Hypothesised as possible for Sidney due to teacher and parent reports of superior ability. Neuropsychological assessment required to explore this hypothesis further.

Summary and Concluding Statements

In conclusion, as supported by information gathered through clinical interviews, school observation and psychometric measures, Sidney does not appear to meet diagnostic

criteria for a diagnosis of ADHD at this time, and his presentation appears more consistent with “giftedness”. Sidney has many strengths which can be drawn upon to support the difficulties that he had been experiencing. These are described below, as are some suggestions for ways to support him in various areas of functioning.

Areas of Difficulty

The following areas of difficulty were noted for Sidney during the assessment. These include:

- Sustaining attention on tasks that he doesn't find as interesting, and getting easily distracted (e.g., talking to friends during class)
- Switching attention away from tasks once enjoying them
- Getting to sleep at night

Strengths

Sidney is described as intelligent, creative, knowledgeable, and ‘gifted’ with an ‘engineering mind’. He is doing well at school, enjoys reading both fiction and nonfiction books, and has a real interest in science and engineering. He is reported to have good friends and is a social and polite person. Sidney is described as curious, determined, funny, adventurous, and responsible. Sidney is a champion swimmer, a great mountain biker, and enjoys building with Lego, doing woodwork, SNAP circuits and practicing outdoor survival skills.

Recommendations for Further Assessment

In order to get a better understanding of Sidney's overall cognitive profile and find out more about where his particular cognitive strengths and difficulties lie, as well as how these can be best challenged and supported, a full neuropsychological assessment and an in-depth learning assessment (particularly related to mathematics) is recommended.

Recommendations Around How to Assist Sidney

At Home

It was noted during the assessment that there are some great strategies already in place that are supporting Sidney well. These include the use of clear structure and routines, single instructions where possible and multiple reminders. Some further strategies that may help Sidney include:

- Creating a rewards system at home for certain tasks that Sidney might struggle to get done. This should be somewhere visible, where Sidney can see points he earns towards a reward when he completes certain tasks or displays certain behaviours.
- Use of a visible family calendar or daily schedule. This will help encourage self-responsibility and communication, enabling Sidney to be more aware of his schedule. When there are important events coming up (or changes to routine), it might be helpful to schedule a time each week to check on upcoming plans together.
- At times when routines are changing, it may be helpful to have adapted routines/tasks written down in a visible place to provide Sidney a reminder which he can return to. This would also encourage Sidney's self-responsibility, as he can return to check tasks on the board, rather than asking for parental support each time.
- Prepare Sidney for upcoming transitions in advance and work through these together (e.g., end of screentime). This could include reviewing the daily schedule before he begins screentime, so he is aware of how long he has, reminding Sidney verbally or setting a visible timer to go off five minutes before the transition, one minute before the transition, and then again at the time of the transition, and collaboratively marking the transition together, (e.g., ticking the activity off on the schedule). Providing praise or reward for completing the transition will help reinforce this behaviour.

- Increased use of praise. Praising Sidney's behaviours that you would like to continue, and whenever possible, ignoring those that you want him to reduce, will help shape his behaviours. This might include more actively praising his stopping of activities when requested; for example, thanking him for starting to pack up, rewarding him when he has stopped. It is also recommended that when Sidney is not engaging in behaviours that are expected by parents, that they begin with validating Sidney's emotions around the situation. Emotional validation will assist Sidney in learning to manage his own difficult emotions.
- Maintaining family relationships: continuing to find special time to bond with Sidney where you're engaging in activities together that are enjoyable and just about being together. These kinds of regular activities facilitate a strong bond and can make it easier for children to speak with their parents at times when they might be struggling.

Sleep

Sidney reported that when he is going to sleep, he will sometimes be checking the time, and will often have thought of something he wants to tell his friends and be trying not to forget this. Here are some suggestions of what could support him getting to sleep easier:

- Helping Sidney have more time alone to wind down from the day before trying to sleep. This could include scheduled time to engage in a quiet and relaxing activity, such as reading or mindfulness (discussed more below). Establishing a structured bedtime routine that is adhered to nightly would likely be useful.
- When it is time to sleep, encourage Sidney to focus on relaxing and winding down, rather than specifically getting to sleep. Sleep is involuntary and the harder he tries to sleep, the harder it will be to sleep!
- To support Sidney settling his mind to sleep, starting a mindfulness, breathwork or meditation practice could be particularly beneficial. Such practices can also support

increased focus and emotional regulation, and they can be done throughout the day as well as at bedtime. There are many websites or apps that can be useful in guiding a mindfulness practice such as: <https://www.mindful.org/mindfulness-for-kids/>,

The 'Pause Breathe, Smile' programme could be contacted to teach mindfulness at Sidney's school : <https://pausebreathesmile.nz/>, or they have resources which could support a mindfulness practice at home: <https://pausebreathesmile.nz/free-resources/>

- It is recommended Sidney keep a notepad beside his bed so he can jot down the things he wants to tell his friends tomorrow, and then let those thoughts go. It will also be important to use this sparsely; remembering that it is OK to forget things sometimes, and it's important to go to bed at bedtime.
- Similarly, people can struggle to get to sleep more when they are checking the time frequently (which may also cause frustration as they notice they're not asleep). It is recommended that Sidney practice not checking the time when he is trying to sleep. Charging any screens/devices outside of the bedroom may support this also.
- Research indicates that including more Melatonin rich foods within a balanced diet, such as cherries, nuts, eggs, or fish can support better sleep (Borisenkov et al., 2023; Xiao et al., 2017). Tart Cherry Juice may be an alternative non-prescription sleep aid for Sidney that you might like to trial; this is available in both liquid and tablet form, and research indicates this can also increase melatonin levels and improve sleep duration and quality (Howatson et al., 2012).
- Synthetic food dyes have been shown to be associated with adverse neurobehavioural outcomes (e.g., hyperactivity) in children, and children vary in the level of sensitivity that they have to these (Miller et al., 2022). As you have been doing, continuing to limit Sidney's exposure to synthetic food dyes should help prevent excessive hyperactivity, as well as support better sleep onset for him.

- Further tips for supporting Sidney's sleep could be found here:

<https://www.kidshealth.org.nz/delayed-sleep?language=en>

At School

Sidney reported the following as having been helpful in supporting him to maintain focus at school: when the teacher reminds him to focus, when there is a reward system in place (e.g., if he attends for the class, he can build the e-pro challenge 8).

- It appears that Sidney can better focus in a quiet environment and tends to be distracted by talking with his friends in class. Sidney may benefit from choosing to sit further away from friends, particularly in classes he is finding more difficult to focus in. A seating plan where Sidney is not beside his closest friends may be helpful to support this. Sidney may also like to consider the use of earplugs or headphones during classes where he would benefit from a quieter environment and less external distraction. This could be prearranged with his teacher, and there are many inconspicuous earplugs available for this purpose.
- It may also be helpful to set up other reward systems, particularly in classes where Sidney typically struggles to maintain focus. These should be private, so he is not feeling singled out in front of his peers but could include the teacher noticing when he is focused and giving him points for this towards a reward that is meaningful for him.
- It may be that Sidney requires a little extra support in mathematics. It may be worth discussing this with his teacher, or at MindPlus, to see if any extra support is available for him, particularly around building his confidence around his own mathematical abilities. Extra encouragement from his parents and teacher to engage in mathematics, praise him for his efforts, and perhaps even highlighting the link between maths and science/ engineering could all support his engagement in this topic.

- Fidget toys could also be useful for Sidney, providing a quiet and nondisruptive way for him to fidget during class and supporting him to maintain attention on the topic at hand.

Reflections

As my internship has primarily been in Rimutaka Prison, prior to working with Sidney, I had very limited experience working with children. I've also had limited experience working with families, as there have been no in-person visits due to staffing issues within prisons. My contact with client whānau members over the year has been limited to one-off phone calls when clients consent to my gathering collateral information from whānau to inform assessment. I was glad to have the opportunity to work with a young person and their family and have some experience of managing the unique dynamics of this population. Assessing Sidney for ADHD was also interesting given my internship experience, where many of the men I have worked with do experience difficulties with inattention and/or hyperactivity/impulsivity which may have contributed to their offending and violence over their lives. I am aware that research indicates ADHD is associated with both criminality and recidivism and is likely under-diagnosed and under-treated within correctional settings (Baggio et al., 2022). It was interesting to note that I was quite anxious prior to my interviews with Sidney and his family, feeling I was in unknown territory working with a young person. Despite having experience working within a prison with men who have committed violent offences and are at high risk of violent reoffending; I was intimidated by a nine-year-old boy! I found that preparing myself well, talking through my approach with my supervisor and incorporating her suggestions helped me to ground myself appropriately and be fully present in my assessment interviews.

Even before meeting him, it was clear from his mother's description of Sidney that he was a highly intelligent young person, doing well in almost all areas of his life (e.g., socially, academically, emotionally). While the family and Sidney's teacher acknowledged some

difficulties for Sidney with distractibility at times, and high levels of energy, overall, Sidney appeared to be doing well, and he himself reported very minor impacts of possible ADHD-like symptoms (e.g., he was “sometimes a bit slower” to finish schoolwork). Much of what Lisa initially presented about Sidney could be considered to be symptoms of ADHD; however, there were several factors that led to my decision not to diagnose Sidney with ADHD, as outlined above. To summarise the evidence supporting my decision: Sidney did not display sufficient symptoms of ADHD for a diagnosis, and the impact on functioning of reported symptoms was not sufficient to be considered “significant clinical impact”. While there were some concerns around him possibly not performing as expected in mathematics, this could not definitively be contributed to ADHD. The concept of ‘masking’ in ADHD, paired with Sidney’s high intelligence raised the possibility that we might see minimal symptoms and impact due to Sidney’s ability to cover these and achieve well despite experienced difficulties; however, Sidney did not report awareness of this or distress due to his experiences, nor significant discrepancies between his behaviour at school and home, which may have indicated a tendency to ‘mask’ at school and, exhausted, experience increased difficulties at home. Researching into “giftedness”, it became apparent that the symptoms described by the family could well be understood within this framework; rather than pathologising his behaviour.

Despite being comfortable with the decision I have made around diagnosis in this case, it has been challenging in that this is a somewhat borderline presentation, with information that both supports and discounts a possible ADHD diagnosis. I have engaged in a lot of reflection, consideration of the data, research, and discussion with my supervisor in order to develop my understanding and explanation of this client and his presentation and come to my decision not to diagnose. There is, however, a certain element of uncertainty, which I believe can often be the case in working with people. People are not “clear-cut”, diagnoses can present in quite a range of different ways, and things can change given

different contexts or over time. This is part of what I love about psychology, but it is also an ongoing challenge to sit with uncertainty; and then further, to explain and normalise this to the people with whom I work.

It was interesting to learn that Lisa's primary reason for seeking diagnosis of ADHD was to access funding for Melatonin, which was reported as having been "lifechanging" for Sidney's sleep over the past few months, but which was financially costly for the family. I felt some pressure of not wanting to let them down; however, this was outweighed by my ethical duty to use diagnosis correctly, and the fact that there were many interventions I was able to recommend and discuss with the family that would hopefully be supportive above and beyond their desired Melatonin prescription. I noticed apprehension prior to feeding back Sidney's report to the family, unsure of how they would respond to not receiving the diagnosis they had hoped for. Unfortunately, it was not possible to feedback Sidney's report prior to submission of this case study.

I have settled my own nerves around it however, by planning well, and approaching it as an opportunity to celebrate all the wonderful things about Sidney with his family and provide them with some recommendations that will help Sidney overcome the difficulties described. To do this, I have written a "parent report" outlining the assessment process, information found, diagnostic impressions, summary, and recommendations, which we will read together. I have also written Sidney his own brief one page report, highlighting his strengths and recommending some strategies that could be helpful for his sleep and difficulties attending in class (see Appendix B). I hope that our feedback session will be one where, despite not receiving the diagnosis they may have hoped for, the family can be proud of Sidney, and learn some ways to help support him to thrive.

References

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders: DSM-5-TR* (Fifth edition, text revision). American Psychiatric Association Publishing.
- Ashinoff, B. K., & Abu-Akel, A. (2021). Hyperfocus: the forgotten frontier of attention. *Psychological Research*, 85(1), 1-19. <https://doi.org/10.1007/s00426-019-01245-8>
- Baggio, S., Heller, P., Wollff, H., Gétaz, L., Perroud, N., Buadze, A., Schleifer, R., & Liebreuz, M. (2022). Attention deficit hyperactivity disorder as a neglected psychiatric disease in prison: Call for identification and treatment. *Forensic Science International: Mind and Law*, 3. <https://doi.org/10.1016/j.fsimpl.2022.100071>
- Bastien, L., Théoret, R., Gagnon, K., Chicoine, M., & Godbout, R. (2022). Sleep characteristics and socio-emotional functioning of gifted children. *Behavioural Sleep Medicine*, 20(5), 598-609. <https://doi.org/10.1080/15402002.2021.1971984>
- Bélangier, S. A., Andrews, D., Gray, C., & Korczak, D. (2018). ADHD in children and youth: Part 1- Etiology, diagnosis, and comorbidity. *Paediatrics and Child Health (Canada)*, 23(7), 447-453. <https://doi.org/10.1093/pch/pxy109>
- Biederman, J., & Faraone, S. V. (2002). Current concepts on the neurobiology of Attention-Deficit/Hyperactivity Disorder. *Journal of Attention Disorders*, 6(1_suppl)7-16. <https://doi.org/10.1177/070674370200601s03>
- Borisenkov, M. F., Popov, S. V., Smirnov, V. V., Martinson, E. A., Solovieva, S. V., Danilova, L. A., & Gubin, D. G. (2023). The association between Melatonin-containing foods consumption and students' sleep-wake rhythm, psychoemotional, and anthropometric characteristics: A semi-qualitative analysis and hypothetical application. *Nutrients*, 15(5). <https://doi.org/10.3390/nu15153302>
- Carman, C. A. (2013). Comparing apples and oranges: Fifteen years of definitions of giftedness in research. *Journal of Advanced Academics*, 24(1), 52-70.

<https://doi.org/10.1177/1932202X12472602>

Centre for Disease Control and Prevention. (2010). Increasing prevalence of parent-reported Attention-deficit/hyperactivity disorder among children- United States, 2003 and 2007. *Morbidity and Mortality Weekly Report*, 59(44), 1439-1443.

Conners, C. K. (2008). *Conners 3rd edition: Manual*. Toronto, Ontario, Canada: Multi-Health Systems.

Geiger, A., Achermann, P., & Jenni, O. G. (2010). Association between sleep duration and intelligence scores in healthy children. *Developmental Psychology*, 46(4), 949-954.

<https://doi.org/10.1037/a0019679>

Howatson, G., Bell, P., Tallent, J., Middleton, B., McSidney, M., & Ellis, J. (2012). Effect of tart cherry juice (*Prunus cerasus*) on melatonin levels and enhanced sleep quality. *European Journal of Nutrition*, 51(8), 909-916.

Izzo, V. A., Donati, M. A., & Primi, C. (2019). Assessing ADHD through the multi-informant approach: The contribution of the Conners' 3 Scale. *Journal of Attention Disorders*, 23(6), 641-650. <https://doi.org/10.1177/1087054718815581>

Kao, G. S., & Thomas, H. M. (2010). Review of Conners 3rd edition. *Journal of Psychoeducational Assessment*, 28(6), 598-602.

<https://doi.org/10.1177/0734282909360011>

Mallett, C. A., Natarajan, A., & Hoy, J. (2014). Attention Deficit/Hyperactivity Disorder: A DSM timeline review. *International Journal of Mental Health*, 43(4), 36-60.

<https://doi.org/10.1080/00207411.2015.1009310>

May, T., Birch, E., Chaves, K., Cranswick, N., Culnane, E., Delaney, J., Derrick, M., Eapen, V., Edlington, C., Efron, D., Ewais, T., Garner, I., Gathercole, M., Jagadheesan, K., Jobson, L., Kramer, J., Mack, M., Misso, M., Murrup-Stewart, C., & Savage, E. (2023). The Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder. *Australian & New Zealand Journal of Psychiatry*, 57(8), 1101-

1116. <https://doi.org/10.1177/00048674231166329>

McGough, J. (2014). *ADHD*. Oxford University Press.

Miller, M. D., Steinmaus, C., Golub, M. S., Castorina, R., Thilakartne, R., Bradman, A., &

Marty, M. A. (2022). Potential impacts of synthetic food dyes on activity and attention in children: a review of the human and animal evidence. *Environmental Health*, 21(1). <https://doi.org/10.1186/s12940-022-00849-9>

Mullet, D. R., & Rinn, A. N. (2015). Giftedness and ADHD: Identification, Misdiagnosis, and Dual Diagnosis. *Roeper Review*, 37(4), 195-207.

<https://doi.org/10.1080/02783193.2015.1077910>

National Institute for Health and Care Excellence. (2018). *Attention deficit hyperactivity disorder: diagnosis and management*.

<https://www.nice.org.uk/guidance/ng87/resources/attention-deficit-hyperactivity-disorder-diagnosis-and-management-pdf-1837699732933>

New Zealand Psychologist Board. (2012). Code of Ethics.

<https://www.nzccp.co.nz/assets/Uploads/Code-of-Ethics-English.pdf>

Rinn, A. N., & Reynolds, M. J. (2012). Overexcitabilities and ADHD in the Gifted: An Examination. *Roeper Review*, 34(1), 38-45.

<https://doi.org/10.1080/02783193.2012.627551>

Sampson, C. (2013). Social and emotional issues of gifted young children. *APEX: The New Zealand Journal of Gifted Education*, 18(1).

Sternberg, R. J., Grigorenko, E. L., & Jarvin, L. (2011). *Explorations in giftedness*. Cambridge University Press.

Webb, J. T. (2000). *Mis-diagnosis and dual diagnosis of gifted children: Gifted and LD, ADHD, OCD, Oppositional Defiant Disorder*.

Whāraurau. (2021). *2020: Stocktake of infant, Child and Adolescent Mental Health and*

Alcohol and Other Drug Services in New Zealand. Auckland: Whāraurau, The University of Auckland.

Xiao, M., Ya, L., Sha, L., Yue, Z., Ren-You, G., Dong-Ping, X., & Hua-Bin, L. (2017)

Dietary sources and bioactivities of Melatonin. *Nutrients*, 9(4), 367-367.

<https://doi.org/10.3390/nu9040367>

Appendix A

Attention Deficit/ Hyperactivity Disorder (ADHD) Diagnostic Criteria

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterised by (1) and/or (2):

1. Inattention: Six (or more) of the following symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

- a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
- b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
- e. Often has difficulty organising tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganised work; has poor time management; fails to meet deadlines).
- f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones)
- h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
- i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

- a. Often fidgets with or taps hands or feet or squirms in seat.
- b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).

- c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
- d. Often unable to play or engage in leisure activities quietly.
- e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- f. Often talks excessively.
- g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).
- h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
- i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

Specify whether:

314.01 {F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

314.00 {F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 {F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hy-

peractivity-impulsivity) is met and Criterion A 1 (inattention) is not met for the past 6 months.

Specify if:

In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past six months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

Moderate: Symptoms or functional impairment between "mild" and "severe" are present.

Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.



Appendix B PSYCHOLOGICAL REPORT

Sidney Smith (9 years)

Dear Sidney,

During your assessment I noted that you have many wonderful strengths.



You are described as intelligent, creative, knowledgeable, and ‘gifted’ with an ‘engineering mind’ by your parents and teacher. You are doing well at school, you enjoy reading, and you have a real interest in science and engineering. You were described as curious, determined, funny, adventurous, and responsible. I understand you are a polite and social person, and you have good relationships with your friends and family. Some of your interests include swimming, mountain biking, building with Lego, doing woodwork, SNAP circuits, and practicing outdoor survival skills.

I learnt it’s sometimes hard for you to get to sleep. Here are some ideas that might help:

- Giving yourself more time alone to wind down before sleep. This could be time doing a quiet relaxing activity, such as reading or mindfulness exercises (which you can do anytime!).
- Keeping a notepad beside your bed so you can jot down the important things you want to remember to tell your friends tomorrow. Then you can let those thoughts go.

I understood that sometimes when you are not so interested in a subject, like mathematics, it can be difficult for you to pay attention and focus. Here are some things that might help:

- Choosing to sit further away from friends who you’re likely to talk to, or maybe trying out using earplugs or headphones could help you when you really need to focus and get your work done.
- Having a quiet fidget toy so that you can keep your hands busy may also help you to focus on your work during class.
- Special testing to see if there are other things that would help you engage better with Maths could also be useful.

It was a pleasure to meet you Sidney, and I wish you all the best for your bright future!

Charlie Bremer, Intern Psychologist.



Student ID: [REDACTED]

Treatment Case Study One

The assessment and treatment of a 40-year-old incarcerated Pākehā man
experiencing symptoms of social anxiety

Charlie Bremer

Massey University DClinPsych Candidate

Clinical Psychology Intern at Te Whare Manaakitanga

Special Treatment Unit for Violent Offending, Rimutaka Prison, Ara Poutama Department of
Corrections.

This case study represents the work of Charlie Bremer during their internship in 2023.
Clinical supervision was received during the assessment and treatment for the individual
within this case study. All names and identifiable information within the case study have
been changed to protect the anonymity of the client.

Candidate: Charlie Bremer [REDACTED] Date... 8.11.23

Supervisor: Jaimee Kleinbichler [REDACTED] Date... 8.11.23

Abstract

People who experience social anxiety struggle with a fear of being humiliated or judged within social or performance situations. The current case study details the assessment and treatment of a 40-year-old pākehā man (Jeff) currently in prison-based group therapy for violent offending, whose experiences of social anxiety were impacting on his ability to participate fully within the group and therapeutic community. The treatment predominantly followed a cognitive behavioural therapy approach, and involved psychoeducation, cognitive restructuring, and exposure work. Symptoms of social anxiety were monitored across sessions and found to improve over the course of treatment. Jeff reported finding the treatment beneficial and was observed to both take on more leadership roles within the community and engage more in his therapy group. A literature review of social anxiety disorder is presented, followed by Jeff's background information, initial formulation, session summaries, treatment progress, and finally discussion and reflections.

Social Anxiety

Social anxieties can be considered to exist along a continuum ranging from a complete lack of social anxiety, up to an extreme and disordered level of social anxiety (DiBartolo & Hofmann, 2014). While some degree of social anxiety can be adaptive, too much worry and focus on others' perceptions impacts negatively on life. Social Anxiety Disorder (SAD; previously Social Phobia) involves persistent fear or anxiety around performance within social or performance settings, disproportional to any actual threat, and negatively impacting on one's life (American Psychiatric Association, 2013; Koyuncu et al., 2019). People with SAD may experience fear related to things such as meeting new people, speaking in front of groups, or being observed in public. While such fears are common, people with SAD experience excessive concern and worry before, during, and after such experiences, and this causes them significant distress (NICE, 2013). SAD can result in significant negative impacts on all areas of life, including academic achievement, work, and social relationships (Barlow, 2014). People with SAD may avoid social or performance situations, to an extent where their quality of life suffers, and may engage in 'safety behaviours' to reduce their anxiety which can be ultimately unhelpful (NICE, 2013).

SAD is a particularly common disorder. The lifetime prevalence estimates of SAD found in the World Mental Health Survey were 1.3% for 30-day prevalence, 2.4% for 12-month prevalence and 4.0% for lifetime prevalence across countries, with higher income countries found to have higher prevalence rates of SAD than low/low-middle income countries (Stein et al., 2017). However, other lifetime prevalence estimates of social anxiety interfering with peoples' lives stretch to 12% of the total population, with predictions that this number is increasing (Barlow, 2014; NICE, 2013). The age of onset for SAD is quite early, with a median age of onset at 13 years old (NICE, 2013; Stein et al., 2017). Typically, SAD has a chronic course. Only around 50% of individuals who would meet criteria for SAD seek treatment, and generally this occurs 15-20 years after the onset of social anxiety symptoms.

SAD has significant rates of comorbidity with other mental health conditions, in particular depressive disorders (19%), substance-use disorder (17%), generalised anxiety disorder (5%), panic disorder (6%), and post-traumatic stress disorder (3%) (NICE, 2013). The high rates of comorbidity can lead to more significant symptoms and impacts of social anxiety as well as greater therapeutic challenges (Koyuncu et al., 2019).

Diagnosis and Differential Diagnosis

In accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), certain criteria must be met for a diagnosis of SAD (see Appendix A). It is important to note that a certain degree of anxiety in social situations is considered normative and adaptive, and concerns around social performance are known to increase in adolescence or in conjunction with other life transitions. Clinicians must consider normative shyness when assessing for SAD and recognise that the anxiety is disordered when the individual is experiencing significant distress or impairment (Sadock et al., 2014).

Common differential diagnoses for adult SAD include: generalised anxiety disorder (anxiety covers a broader range of concerns), agoraphobia (avoidance of social situations due to the difficulty of escape), panic disorder (primary concern is the occurrence of panic attacks), specific phobias (fears not usually around negative evaluation in social settings), major depressive disorder (fears related to negative perception of self), or other medical conditions (embarrassment related to symptoms of condition).

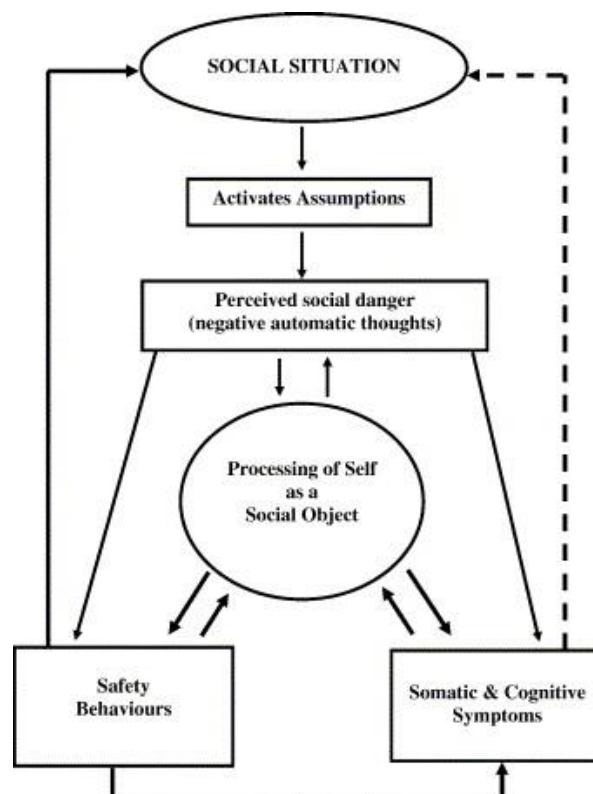
Aetiology and Models of SAD

Aetiology of SAD can be understood through the diathesis-stress model. Conditions including temperament, genetics, attachment style, caregiver parenting style and behaviours learnt through modelling can lead to a greater predisposition towards social anxiety. SAD can then be triggered by environmental stressors or stressful events in an individual's life (e.g., bullying, or perceived social rejection) (Sadock et al., 2014). Clark and Wells' (1995) cognitive model of social anxiety (see figure 1), posits that people with SAD hold underlying

performance-related beliefs which are activated by social situations. These beliefs may include excessively high standards (e.g., ‘I must always appear composed’), unhelpful consequential beliefs (e.g., ‘If people notice my anxiety, they’ll think I’m stupid’) or unhelpful unconditional beliefs (e.g., ‘I’m incompetent’). These beliefs result in unhelpful automatic thoughts, alerting the individual to perceived social danger. This triggers somatic and cognitive anxiety symptoms, increased self-monitoring, and the performance of safety behaviours (e.g., not making eye contact). These factors further increase experiences of anxiety and impair social behaviour, affirming unhelpful beliefs and reinforcing the idea that the social situation is dangerous (Clark & Wells, 1995).

Figure 1

Model of Social Phobia (Clark & Wells, 1995).



Assessment and Treatment of SAD

The National Institute for Health and Care Excellence (NICE) guidelines for assessment and treatment of SAD recommend clinical interview corroborated by the use of validated psychometric measures, including the Social Phobia Inventory (SPIN) or the Liebowitz Social Anxiety Scale (LSAS). Interventions should be conducted by competent practitioners, guided by treatment manuals, and incorporate ongoing assessments to monitor progress and efficacy (NICE, 2013). Individual Cognitive Behavioural Therapy (CBT) adapted for SAD should be offered as a first line treatment (NICE, 2013). As the client in this case was experiencing symptoms of SAD, his treatment plan was based on CBT for SAD, using the ‘Treatments that Work’ protocols, in alignment with the NICE guidelines (Hope et al., 2019).

Case Study

Context: Te Whare Manaakitanga

Te Whare Manaakitanga is a special treatment unit for men at high risk of violent re-offending in Rimutaka prison. Te Whare Manaakitanga (TWM) operates as a therapeutic community. All the men in the unit are there to engage in group therapy or are graduates who continue to support men newer to the unit. Men who display inappropriate or rule-breaking behaviour are generally exited from the unit. Therapy and custody staff are expected to interact with the men in supportive ways, role-modelling appropriate positive pro-social relationships. New men are welcomed in “community welcomes” with powhiri (welcome) and whakawhanaungatanga (establishing relationships) processes, involving each man standing up to welcome the new person and introduce himself in front of the community.

The core group therapy at TWM spans around nine months and is conducted in groups of up to 10 men. The treatment involves an initial stage of building group bonds, becoming more familiar with emotions and thoughts, learning emotional regulation skills (e.g., time outs, ‘coolers’, mindfulness), and learning the CBT model. In the first phase members write and present their life stories to the group and are supported to identify the

factors that had impacted on their life including emotions, thoughts, rules for living and core beliefs. In the second phase members map out their offending pathways, identifying what led to their offending behaviour. In the third and final phase they construct safety plans in which they identify future situations which will be high risk for reoffending, and strategies to reduce their risk of reoffending. While at TWM, the men also receive support from a Kaupapa Māori practitioner for Māori cultural advice and support, and a reintegration coordinator who helps organise their plans for release. Men are encouraged to take on more leadership roles as they progress through therapy which could include greater involvement in weekly community meetings, community events or welcoming ceremonies for guests or new men.

Client referral

Jeff is a 40-year-old pākehā man, completing group therapy for violent offending at Te Whare Manaakitanga. He was referred to me for treatment of his social anxiety, which was noted to be interfering with his progress and participation in group therapy and in the therapeutic community. Further, anxiety had played a significant part in his offending, and was therefore also an important treatment target for helping to reduce his risk of future reoffending.

Client presentation

Jeff presented as appropriately dressed in tidy prison clothes and well-groomed during sessions. It was noted he initially wore large sweaters even on warmer days, which was later identified as a safety behaviour of trying to hide sweatiness and observed to change during the course of treatment. Jeff made good eye contact, engaged in spontaneous conversation, and used humour appropriately. He was noted to sometimes fidget, however appeared engaged in our work and maintained concentration throughout our sessions.

Jeff reported a generally good mood, and his affect was observed to be appropriately aligned to the topics discussed. Jeff was oriented to time, place, and day. No mood, perceptual or thought disorder appeared to be currently present.

Client Risk

Jeff denied any thoughts of self-harm or suicidal ideation. He did not report any thoughts or plans to harm others, nor any sense of being at imminent risk of harm from others. Risk at the time of assessment and treatment was repeatedly assessed as low.

Client Presenting Complaints:

Jeff reported having experienced anxiety throughout his life, in particular surrounding his social performance (e.g., talking to new people), and stated this had been particularly bad in the past year or so. Recently, since settling in and becoming familiar with the people in TWM, he felt his anxiety had become more manageable. He noticed; however, that he still experienced a lot of anxiety when it came time to speak at community welcomes or meetings, and his anxiety and rumination after social interactions got in the way of him engaging as much as he would have liked to in social events within the therapeutic community. Jeff also reported high levels of self-criticism and judgement of self and others, which he believed impacted on his mood and behaviour. Jeff recognised that he would be leaving TWM after his group treatment graduation, moving to a self-care unit and likely facing the parole board, and he wanted to prepare himself for that (and life outside of prison) as best he could.

Relevant Background Information:

Jeff discussed aspects of his development and what he came to understand as having contributed to his social anxiety throughout our sessions together. A full psychological assessment had been completed on 11/10/22 by a clinical psychologist to determine Jeff's

treatment needs related to his violent offending. This report and Jeff's self-report have informed the information presented in the following section.

Childhood

Jeff grew up in a major city in Aotearoa New Zealand with two siblings. He was raised by both his parents until the age of seven when they divorced. Jeff described his father as "distant". Jeff reported that his mother had always been anxious with particular concerns about keeping up social appearances, and that she struggled to set boundaries for her children. Jeff stated he had "always" been anxious and avoidant. He reported feeling hard done by as a youth, because his family were "not rich", and he felt he didn't fit in with many of his peers. Jeff recalled looking up to his older brother who was often in trouble with the law.

Adolescence

As a young adolescent, Jeff began using substances including alcohol, cannabis and occasionally methamphetamine to manage his anxious feelings and connect socially with others. He found social connection among a few peers who also used substances and stole cars. Jeff used violence to support and prove his loyalty to these peers. At this time, Jeff reported feeling as if he could do whatever he liked, as he seldom experienced negative consequences. Jeff's mother married a man who was often intoxicated on alcohol and used violence against the family. Jeff felt unsafe living in the home and moved out at age 15. Jeff had an unstable lifestyle at this time, using and selling drugs and sleeping where he could (e.g., on couches or in cars). Jeff reported always having a small circle of friends and limited experiences of intimate relationships due to his anxiety holding him back.

Academic and Work History

Jeff reported leaving high school without formal qualifications around age 15. He had several jobs in the community but was often dismissed due to poor attendance. He was part way through a mechanics apprenticeship at the time of his index offending.

Offending history

Prior to his index offences, Jeff had accumulated 20 convictions related to non-compliance, dishonesty, and drink driving between the ages of 18 - 24. Jeff's index offending resulted in six convictions for violence and a life imprisonment sentence with 18.5 years non-parole. Jeff's index offending occurred when he joined a friend in fighting a group of strangers while under the influence of alcohol, cannabis, and methamphetamine. They were subsequently chased by witnesses and Jeff's response to this, which he describes as driven by fear, panic, rage, and a sense of needing to protect his friend regardless of what happened, resulted in injuries and deaths. His index offending is not outlined in detail for privacy reasons. Jeff has spent 16 years in prison. During this time, he has had seven misconducts, two of which involved violence, and the rest involved contraband. Jeff acknowledged having engaged in undetected violence within prison, and reported the purpose of this was to prevent his own victimisation.

Prior Treatment

Since 2019, Jeff has engaged in treatment including the Medium Intensity Rehabilitation Programme (MIRP) in 2019, and the Drug Treatment Programme (DTP) in 2022. Jeff specifically requested to attend the Special Treatment Unit: Violent Offending (STU:VO), believing that further psychological treatment would be beneficial for him. An assessment was undertaken, and he was found to be suitable for the STU:VO programme.

Circumstances at time of Referral

Jeff had been residing at the Special Treatment Unit: Violent Offending; Te Whare Manaakitanga for six months at the time of his referral and had completed two out of three phases of the group therapy programme. This, paired with his prior engagement in therapy, meant he had been exposed to many of the therapeutic concepts and skills used in Cognitive Behavioural Therapy.

Initial Case formulation

Jeff was likely predisposed to experience social anxiety through an anxious temperament, genetic predisposition, and caregiver modelling of social anxiety. Jeff's mother was both highly concerned about others' social perceptions of her and her family, and covertly critical of others. Through this, Jeff learnt to not let others see any of his 'faults' (including fears or emotions) and to expect harsh judgment from others. Jeff experienced social rejection through his childhood and adolescence, leading him to construct an understanding of himself as an outsider. With a lack of parental boundaries, he turned towards antisocial adolescent peers and learnt to use substances to manage his anxiety rather than more healthy coping strategies. Jeff's adverse life experiences, including exposure to violence, social rejection and substance use likely lead to beliefs such as 'The world is dangerous', 'Others are harsh critics', 'Others can't be trusted' and 'I don't fit in socially'. Jeff's experiences within the prison environment may have served to reinforce some of these beliefs, including a lack of trust in others, expectations of harsh criticism, and the importance of not showing 'weakness' (i.e., not letting others perceive his anxiety) so as not to be taken advantage of.

Regarding his social anxiety, Jeff's high and harsh standards for himself would become activated in social situations where he perceived possible judgement of others. Jeff would become overly aware of himself in the situation, increasing his awareness of internal cues of anxiety and engaging in safety behaviours such as speaking gruffly or wearing large

sweaters. These behaviours negatively impacted on his social performance, reinforcing his fears of a poor performance and negative evaluation. Jeff's experience of social anxiety included fears that others will see him as weak if they notice his anxiety and this will prompt a desire in him to 'prove' himself through using violence.

Jeff has many personal factors that were identified as strengths that would help him achieve his goals including his engagement in earlier treatment, his open and curious approach to therapy, and several strong relationships with prosocial support people. Further, despite his anxiety, Jeff was noted to be pushing himself to engage in group therapy and in the community, which he noticed had also been helping him in gaining a sense of control over his anxiety.

Diagnostic considerations

Jeff showed clear symptoms of social anxiety disorder, and this was aligned to his referral reasons. He denied having experienced panic attacks, and while he did experience some generalised worry, this was not causing him significant distress, unlike his concerns related to social performance.

Methods

Measures:

Liebowitz Social Anxiety Scale (LSAS)

The LSAS involves rating of both frequency of avoidance and intensity of fear/anxiety related to situations which would commonly invoke anxiety or avoidance among people experiencing social anxiety (Liebowitz, 1987).

Social Phobia Inventory (SPIN)

SPIN was developed to assess spectrums of fear, avoidance, and physiological symptoms of social anxiety disorder. SPIN shows good test-retest reliability, internal

consistency, and convergent and divergent validity, and is validated for use with Caucasian men. A score of over 19 is considered to indicate possible social anxiety (Connor et al., 2000).

Subjective Units of Distress (SUDs)

SUDs were used throughout therapy to gain ratings of anxiety prior to, during, and after exposures which were pertinent and relevant to Jeff. Jeff would rate his SUDs on a scale of 0 (no anxiety) to 10 (the most anxiety), anchored by Jeff's own experiences of anxiety.

Goals rating

Throughout treatment Jeff rated his satisfaction with his progress towards his goals on a scale of 0-10, where 0 was not at all satisfied and 10 was totally satisfied.

Assessment and Treatment protocol

Jeff attended an initial meeting prior to deciding to engage in treatment. We then had one clinical assessment session, followed by eight treatment sessions. Treatment sessions were 60 minutes and were initially held close to weekly (as the prison unit schedule allowed), then spaced out to fortnightly towards the end of treatment. Jeff completed the LSAS and SPIN at the start, middle and end of treatment, and goals progress was rated around the middle and at the end. The treatment plan followed a CBT approach. Earlier sessions focused on psychoeducation, collaborative formulation, and cognitive restructuring; later sessions on exposure and ongoing cognitive restructuring, and finally relapse prevention. Session content is described in more detail below.

Session Summaries

28.3.23 Initial meeting: Jeff was initially hesitant to work with me (following an offer from one of his group therapists) and took a few days before agreeing to an initial meeting. This initial session involved exploration of Jeff's experiences with anxiety, why treatment had been recommended, what it would involve and the rationale for this. During the

meeting Jeff opened up significantly about his anxiety and expressed strong motivation to engage in treatment.

3.4.23 Session one (assessment): Discussion of Jeff's physical and mental health history and current experiences (including mood, anxiety, substance use, and trauma), assessment of risk (to self and others and from others), social history and current relationships, and family mental and physical health history. Jeff reported anxiety including general worry, rumination, and concerns of evaluation in social situations. Jeff reported his anxiety had decreased since becoming more comfortable with the people at TWM, however, he was eager to work on his anxiety to help him cope in less familiar future situations. Jeff completed psychometric measures: SPIN and LSAS.

13.4.23 Session two: Functional analysis of a recent experience of social anxiety (reading out the community values at a welcome). Discussion of the CBT model (which Jeff was familiar with from group therapy) and the anxiety spiral. Explanation of the rationale of CBT treatment for SAD, including systematic graduated exposure, cognitive restructuring and between session work. Three goals were collaboratively set:

1. Hosting at the TWM 25th anniversary by being open and sharing his experiences with guests
2. Talking more openly with more people in the unit (currently talking to 10 people)
3. Practicing more assertive communication outside of the therapy room

Jeff was set between session work involving noticing and monitoring his physical sensations, thoughts and behaviours related to anxiety.

17.4.23 Session three: Discussion of the origins of social anxiety. Jeff identified familial anxiety, high expectations, strong beliefs about social perceptions, and harsh criticism of self and others. Jeff reported this to be a helpful and humbling exercise. A list of anxiety-provoking situations for Jeff which would help him progress towards his goals was

collaboratively developed. Jeff rated the level of anxiety each situation would cause using SUDs. An experiment exposure of facing potential conflict with his mother in an assertive way was set, which Jeff identified as manageable (SUDS 40). We also planned an experiment for Jeff's involvement in the upcoming 25th anniversary of TWM, gathering predictions and setting behavioural goals (including talking with guests, staying for the whole ceremony). Jeff was given a thought record to continue monitoring anxiety throughout the week.

2.5.23 Session four: Jeff reported his two between-session exposures (an assertive conversation with his mother and hosting guests at the TWM 25th anniversary) had gone well. Prior to the anniversary Jeff had thought he might find it tricky to keep the conversation going, but during the event he used the more helpful thought "they're probably just as nervous as me" and was able to communicate well. From this Jeff learnt: "talking with new people is not as bad as I think it is", "I can cope", and "I should just give it a go". We discussed the importance of cognition in social anxiety through the metaphor of the "amber coloured glasses". Jeff agreed to do a worksheet related to this for between session work.

8.5.23 Session five: Reviewed the "amber glasses" worksheet. Functional analysis of a recent anxiety provoking situation, involving a new position Jeff had taken on as the community meeting minute-taker (a leadership role). Jeff developed some more helpful thoughts. Jeff rated his satisfaction with progress towards his goals and set a new goal of becoming more comfortable as the minute-taker. We set an experiment to test his performance-related beliefs (i.e., "I looked stupid") involving asking 10 men in the community their perspectives on his performance and how they would feel in his position. Jeff agreed to record the answers objectively. Jeff reported SUDS of 45-50 related to this experiment, but that it felt manageable. Jeff completed the SPIN and LSAS.

15.5.23 Session six: We reviewed the results of Jeff's survey, from which he learnt even though some people thought he looked flustered, no one thought he looked stupid, and

80% of people reported they'd feel nervous doing Jeff's role. We reviewed the exposure ladder and set the next exposure experiment for Jeff to speak to two or three men he doesn't know well about topics outside of jail and the therapy course, including asking about their interests. Jeff agreed to conduct this experiment, as well as complete reflections and cognitive restructuring afterwards. Jeff requested resources on reducing self-criticism, a self-compassion workbook from the Centre for Clinical Interventions (CCI) was supplied (Saulsman et al., 2017).

22.5.23 Session seven: We reviewed Jeff's experiment and experiences over the week, including his reflections on having made conversation with a new man and started the self-compassion workbook. Completed exposures involving filming roleplays of starting a conversation with a stranger at a coffee shop, first with internally focused attention, then with externally focussed attention. Jeff noticed he felt much less anxious with an external focus of attention and the conversation flowed better. He also reflected that even though he felt really anxious (SUDs = 70), he didn't really look anxious from the outside. Set experiment to focus attention outwards during community meeting, make eye contact, use relaxed tone of voice, and ask for observations of his performance from other men.

6.6.23 Session eight: Reviewed experiences over past two weeks. Jeff reported attending outwards had significantly reduced his anxiety. As receiving praise in public was one of Jeff's highest rated anxiety provoking situations (and his TWM graduation ceremony was coming up), we discussed the importance and purpose of giving and receiving praise. We conducted a roleplay where a character responded to Jeff's praise in different ways, using an angry, dismissive, passive and then finally, an assertive style. Jeff noticed he often used an angry or dismissive style however this caused frustration and made him not want to talk to the person again. Jeff decided he would rather try an assertive style, and this was set as between session practice. Jeff also set a challenge of giving himself praise over the weeks and

noticing the impacts on his mood, thoughts, and ability to meet his standards. Jeff completed the SPIN, LSAS, and rated his progress towards his goals.

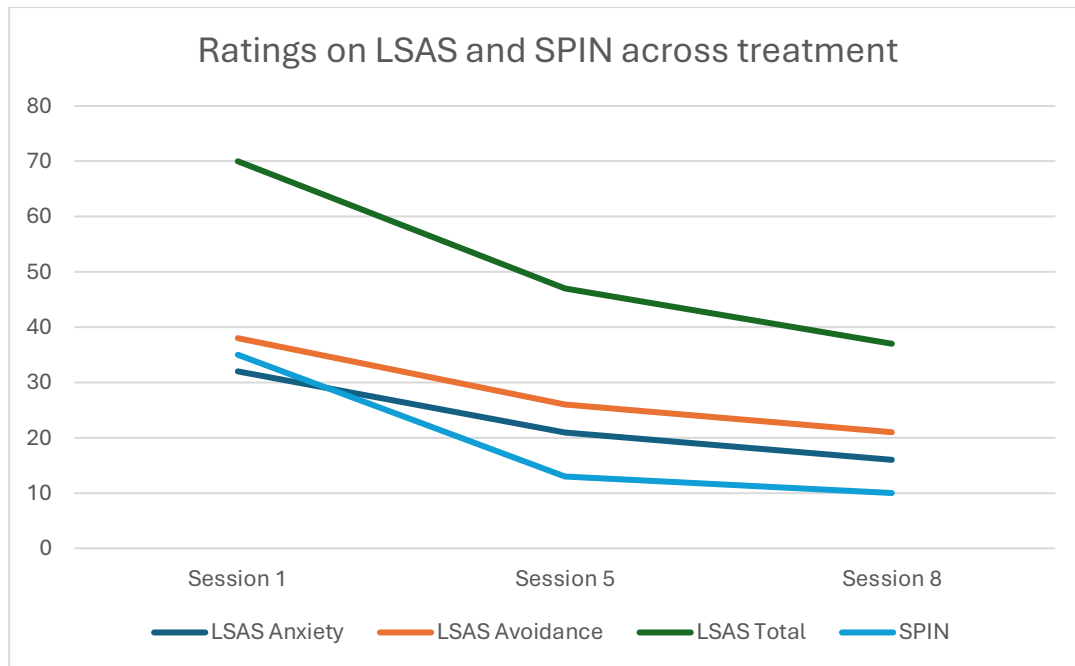
19.6.23 Session nine: Final session. Reviewed between session work of assertive responses to praise, and practicing giving praise to himself and others. Discussed Jeff's experience of a self-set experiment of talking in the community welcome to academic guests, where Jeff reported feeling proud of how he spoke, noticing others laughing but not minding, and learning that other men were inspired to also speak after watching him. We reviewed all the work we had done together summarised in a therapeutic letter (see appendix), reflected on Jeff's progress including examination of the graphs below, and constructed a relapse prevention plan which Jeff will continue to work on. Jeff set himself a task of reviewing the therapeutic letter and continuing with his self-praise.

Treatment Progress

As shown in Figure 1, treatment progress was observed in Jeff's responses to both the SPIN and LSAS (on both the anxiety and avoidance subscales), with all scores reducing across the course of treatment. Jeff's initial score of 35 on the SPIN was indicative of SAD, however by session five this had reduced to 13 (no longer indicative of SAD), and by the end of treatment was at 10. Jeff's total score on the LSAS was initially 70, which is indicative of marked social anxiety. By session five this had reduced to 47, and session 8 to 37, both of which indicate mild social anxiety. Jeff's scores on both of the LSAS subscales of anxiety and avoidance steadily decreased over treatment.

Figure 1

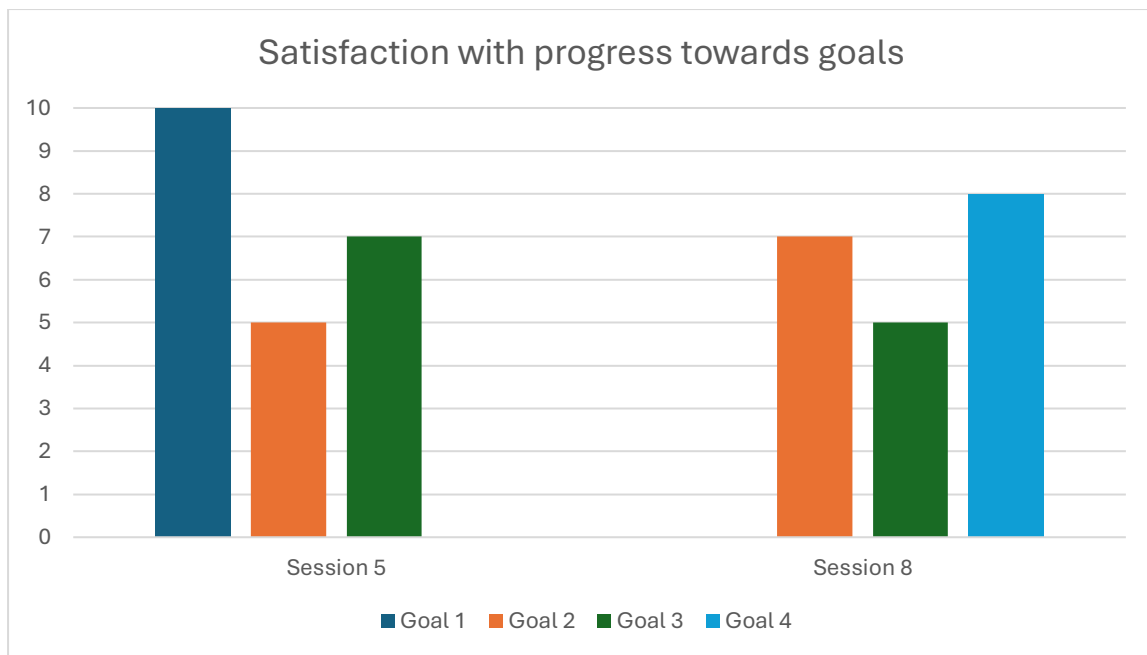
Jeff's ratings on the LSAS anxiety, LSAS avoidance, and SPIN across treatment sessions



Jeff's ratings of progress towards his goals indicated he was generally satisfied with this across the course of treatment, as shown in Figure 2. At the first rating, Jeff felt 100% satisfied with his progress towards his first goal (hosting guests at the TWM celebration), and so set another goal of becoming more comfortable as the community minute-taker (goal 4). Jeff showed steadily increasing satisfaction with his progress towards his second goal of talking more openly to more people. Jeff's third goal of increasing assertive communication was something he indicated a desire to continue working on.

Figure 2

Jeff's self-report ratings of satisfaction of progress towards goals



Note. As Goal 1 was achieved at session 4, Jeff set a replacement (Goal 4) as discussed above.

Self-reported and observed progress

Jeff reported he had greatly improved his understanding and management of his social anxiety through treatment. Jeff stated he felt he had vastly improved since beginning treatment and felt confident in his ability to manage anxiety going forward, particularly in light of his upcoming transfer to a unit focusing on rehabilitation and reintegration. He also stated he noticed a major change in the way he talks to himself, and that this has been particularly powerful for him. Jeff's behaviour reflected his progress, as he stated he would never have imagined himself taking on a leadership role like community minute-taker in the unit when he first arrived. Yet now, he was not only doing that, but also preparing himself for moving into the meeting host position which he believed he would potentially soon be offered. Jeff's group therapists reported his participation in group therapy vastly improved, including contributing (and even leading) group discussions and volunteering for roleplays, since engaging in the current individual treatment. Jeff appeared more at ease within the unit,

and was observed to join in on opportunities such as a competition to make a recreation of a movie photo, in which he dressed up as the lion from the Wizard of Oz.

Discussion and Reflections

Jeff has been my first client with whom I have had the opportunity to complete a full treatment protocol. I noticed my own experiences of anxiety related to this, including concerns of not being a practiced and knowledgeable practitioner and fears of my incompetence being noticed and negatively impacting on treatment. However, throughout the course of treatment I noticed my anxiety waning and confidence growing, almost in line with Jeff's own progress. I believe this was in part due to Jeff being a particularly motivated, reflective, and receptive client, who engaged well in discussions and treatment tasks.

There were some interesting moments for me, in coming to understand that some of Jeff's anxiety in performance situations related to a fear of violence. He expressed both fears that if he showed 'weakness' through his anxiety, he would become a target of violence, and equally, he feared that if he felt he were being made fun of (i.e., people laughed at him) then he himself would resort to violence to assert himself. These were concerns that I had no personal experience of and were initially somewhat surprising to me. I found myself having to be mindful of the context within which Jeff had spent the last 16 years of his life, and the fact that violence had been a very normalised aspect of his life. Jeff was of course addressing his beliefs around violence in his group therapy and had a desire to not use violence going forward, and so these were beliefs we could continue to challenge in our one on one work. However, the question 'what would be so bad about people laughing at you?' had a very different answer, and the conversation took a different turn, than what may have typically been expected in another context. It was interesting to notice my own reactions to this disclosure, and the shift in my perspective, as I came to gain further insight into Jeff's experiences and fears driving his anxiety.

I also had to manage some of my own ethical views and reactions with regards to some of Jeff's expressed concerns around the use of te reo Māori in TWM. At one stage in our work together, I raised the idea of Jeff participating in a unit event, as an opportunity for public speaking. To this, Jeff expressed concerns that the event would be in te reo Māori and frustration about the unit's strong Te Ao Māori focus, when "this isn't the Māori focus unit". In the moment, I noticed these comments getting my defences up, as I believe in the duty of tangata tiriti to learn and uplift Te Ao Māori worldviews, culture, language, and a more accurate depiction of our country's history. In session with Jeff, I gently pushed back, questioning his thoughts, asking if he could potentially participate in a way, he felt comfortable with. Jeff ultimately decided not to participate in this event. I took my feelings to supervision and came to the conclusion that these kinds of topics will continue to be a delicate balance for me between sharing alternate perspectives, validating clients' feelings without validating prejudiced views, and keeping in mind the focus of our therapeutic work, so as not to get too side-tracked or worse, damage our rapport.

I found that overall, I really enjoyed working with Jeff. While initially hesitant to engage, he quickly became enthusiastic about the progress he could make in improving his anxiety. He also reported enjoying the chance to talk and acknowledge some of the things he had been managing, much of which he did not feel was appropriate for him to bring to group therapy. Jeff reported understanding the origins of his social anxiety and learning that others also feel nervous speaking in public (i.e., he wasn't "messed up") were particularly helpful and reassuring for him. Jeff's improvements and this case study provide support for the efficacy of CBT in treating social anxiety for adult Pākehā males, in a correctional therapeutic community environment.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental Disorders* (Fifth ed.). American Psychiatric Association.
- Barlow, D. H. (2014). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (Fifth ed.). The Guildford Press.
- Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. R., Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social Phobia: diagnosis, assessment, and treatment*. The Guildford Press.
- Connor, K. M., Davidson, J. R. T., Churchill, L. E., Sherwood, A., Foa, E., & Weisler, R. H. (2000). Psychometric properties of the Social Phobia Inventory (SPIN): New self-rating scale. *The British Journal of Psychiatry*, *176*, 379-386.
- DiBartolo, P. M., & Hofmann, S. G. (2014). *Social anxiety: Clinical, developmental, and social perspectives* (Third ed.). Elsevier Science.
- Hope, D. A., Heimberg, R. G., & Turk, C. L. (2019). *Managing social anxiety: A cognitive-behavioural therapy approach: Therapist guide* (Third ed.). Oxford University Press.
- Koyuncu, A., Ince, E., Ertekin, E., & Tükel, R. (2019). Comorbidity in social anxiety disorder: diagnostic and therapeutic challenges. *Drugs in Context*, *8*, 1-13.
<https://doi.org/10.7573/dic.212573>
- Liebowitz, M. R. (1987). Social phobia. *Modern Problems of Pharmacopsychiatry* (22), 147-173.
- NICE (2013). *Social anxiety disorder: Recognition, assessment, and treatment*. Clinical

guideline [CG 159].

Sadock, B. J., Ruiz, P., & Sadock, V. A. (2014). *Kaplan & Sadock's synopsis of Psychiatry*

(Eleventh ed.). Wolters Kluwer.

Saulsman, L., Campbell, B., & Sng, A. (2017). *Building Self-Compassion: From Self-*

Criticism to Self-Kindness. Centre for Clinical Interventions.

Stein, D. J., Lim, C. C. W., Roest, A. M., de Jonge, P., Aguilar-Gaxiola, S., Al-Hamzawi, A.,

Alonso, J., Benjet, C., Bromet, E. J., Bruffaerts, R., de Girolamo, G., Florescu, S.,

Gureje, O., Haro, J. M., Harris, M. G., He, Y., Hinkov, H., Horiguchi, I., Hu, C.,

Karam, A., Karam, E. J., Lee, S., Lepine, J., Navarro-Mateu, F., Pennell, B., Piazza,

M., Posada-Villa, J., Ten Have, M., Torres, Y., Viana, M. C., Wojtyniak, B., Xavier,

M., Kessler, R. C., & Scott, K. M. (2017). The cross-national epidemiology of social

anxiety disorder: Data from the World Mental Health Survey Initiative. *BMC*

medicine, 15(1), 143. <https://doi.org/10.1186/s12916-017-0889-2>

Appendix A: Diagnosis of Social Anxiety Disorder:

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), the following criteria must be met for a diagnosis of SAD:

- A. Marked fear or anxiety about one or more social situations in which the individual feels under scrutiny by others. In children: must occur in peer settings and not just interactions with adults*
- B. The individual fears they will act in a way or show anxiety symptoms (e.g., blushing) that will be negatively evaluated. Worry about embarrassment or negative judgements*
- C. Social situations almost always provoke fear or anxiety. In children the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, not speaking*
- D. Situations are avoided or endured with intense fear/anxiety*
- E. The fear or anxiety is out of proportion to the actual threat posed*
- F. The fear/anxiety/avoidance is persistent, typically lasting 6+ months*
- G. Causes clinically significant distress or impairment*
- H. Not attributable to a substance or general medical condition*
- I. Not better explained by another mental disorder*
- J. If another medical condition is present, the fear, anxiety, or avoidance is unrelated or excessive*

Specify: performance only: restricted to speaking or performing in public

When the pattern of fear or anxiety is limited to speaking or performing in public, the specifier “performance only” is used.

Appendix B: Therapeutic Summary Letter

Over our sessions working together, we have...

- Explored and come to better understand your experiences of social anxiety
- Reviewed the CBT model and how this relates to anxiety
- Worked towards your goals including hosting at the TWM anniversary, becoming more comfortable as the community meeting minute taker, talking more openly with people in the unit and practicing more assertive communication outside of the therapy room.
- Took notice and monitored your physical sensations, thoughts and behaviours related to anxiety
- Discussed the origins of your social anxiety, including familial anxiety, high expectations, strong beliefs about social perceptions, and harsh criticism of self and others
- Discussed the ‘amber coloured glasses’ metaphor, the power of attending outwards rather than inwards, and how self-compassion may be more helpful than criticism
- Developed a list of anxiety-provoking situations and engaged in experiments exposing yourself to these situations and observing what happened. These experiments have included:
 - Facing potential conflict with family members in an assertive way
 - Hosting guests at the TWM anniversary
 - Asking for feedback on how you are perceived talking in the community
 - Talking to men you wouldn’t normally talk to
 - Roleplays focusing attention inwards vs. outwards, and then trying this at the community meeting too
 - Roleplays of receiving praise in different ways and the impacts of this

From all this you learnt the following (and more)...

- “I can cope”
- “I should just give it a go”
- “They’re probably just as nervous as me”

Student ID: [REDACTED]

Treatment Case Study Two

The use of Māori models for the assessment and treatment of a 47-year-old incarcerated Māori man.

Charlie Bremer

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Clinical Psychology Intern at Te Whare Manaakitanga

Special Treatment Unit for Violent Offending, Rimutaka Prison, Ara Poutama Department of Corrections.

This case study represents the work of Charlie Bremer during their internship in 2023. Clinical supervision was received during the assessment and treatment for the individual within this case study. All names and identifiable information within the case study have been changed to protect the anonymity of the client.

Candidate: Charlie Bremer [REDACTED] Date..... 8.11.23

Supervisor: Jaimee Kleinbichler [REDACTED] Date..... 8.11.23

Abstract

The current case study documents the use of the Hui process, the Mehihana model, Whai Tikanga, and culturally adapted Cognitive Behavioural Therapy (CBT) in the psychological assessment and treatment of a 47-year-old Māori man, Tama. Tama has been convicted of sexual offences and is coming to the end of his four-year prison sentence. He had previously declined engagement with psychological services, including individual and group treatment; however, this time decided to engage in individual treatment, involving a total of eight sessions within prison. From our initial meeting guided by the Hui process, Tama shared his strong connection to his Māori identity. The Meihana model was used throughout the assessment process to build his psychological formulation. Treatment predominantly followed a culturally adapted CBT approach, guided by the structure of group-based treatment for people who have committed sexual offences. Whai Tikanga values cards were incorporated to build motivation, engagement, and help Tama consider his journey forward outside of prison. A literature review of Māori mental health and relevant Māori models is presented, followed by Tama's background information, initial formulation, session summaries and my reflections on this case.

Culturally Appropriate Therapy for Māori: Why and How?

The impact of colonisation on Māori can be understood as historical trauma that has ongoing traumatic repercussions (Pihama et al., 2014). Māori are known to experience a significant burden of physical and mental health problems in Aotearoa New Zealand (Baxter, 2008; Oakley Brown et al., 2006). Psychologists working in Aotearoa must be culturally competent in their practice and have respect for the dignity of persons and peoples of all cultures (New Zealand Psychologist Board, 2002). In line with the Code of Ethics and Te Tiriti o Waitangi, psychologists have an obligation to provide culturally appropriate mental health care to Māori (New Zealand Psychologist Board, 2002; Te Tiriti o Waitangi February 6, 1840).

Significant over representation of indigenous people is seen in many places across the world (Australian Government, 2018; Bellrichard, 2020). Within Ara Poutama Aotearoa (Department of Corrections) Māori are vastly overrepresented, making up 52% of the prison population (as of December 31st, 2018), despite comprising only 15% of the total population of New Zealand (Ara Poutama Aotearoa Department of Corrections, 2019). Māori within prison have high and complex needs, including high rates of physical and mental health conditions. Māori also have higher rates of reconviction and reimprisonment following release from prison than non-Māori (Ara Poutama Aotearoa Department of Corrections, 2019). Correctional system overrepresentation and poor outcomes for Māori can at least partly be attributed to the ongoing impacts of historical trauma, colonisation, and institutional racism (Brittain, 2016; Pihama et al., 2014). Ara Poutama, and indeed psychologists working within this organisation, have a responsibility to work as effectively with Māori in their care to improve mental health, and increase the likelihood of clients being able to move forward into offence-free lifestyles (Ara Poutama Aotearoa Department of Corrections, 2019; Brittain, 2016).

Research in Aotearoa New Zealand has identified that effective psychological engagement with Māori involves the use of both western and Kaupapa Māori models of wellbeing (Te Pou o Te Whakaaro Nui, 2010, 2016). When working with Māori, tikanga Māori (protocols), consideration and involvement of the wider whānau (family group), emphasis on the importance of whakapapa (genealogy), and whakawhanaungatanga (the development of relationships) should be incorporated into practice as is appropriate for the individual (Te Pou o Te Whakaaro Nui, 2016). Further, psychologists should promote and support client understandings of their Māori culture and identity, as a means of enhancing psychological resilience (Muriwai et al., 2015). Psychologists must be consciously engaging with clients in culturally safe and appropriate ways, including their approaches to clinical interviews, assessment, treatment, and use of models and measures. The following section describes two Māori models which psychologists can use to support Māori client engagement; the Hui process and Meihana model, as well as an assessment measure of Māori wellbeing; Hua Oranga (Pitama et al., 2017).

The Hui Process

The Hui process provides a framework for clinicians to adapt the structure of clinical interactions to fit with principles of relationship building and engagement from a Te Ao Māori perspective (Lacey et al., 2011). This involves four components: mihimihi (initial greeting, introducing name and role, specific purpose of the session), whakawhanaungatanga (building of relationship and shared connections), kaupapa (attending to purpose of encounter) and poroporoaki / whakamutunga (clarifying the next steps for the client and closing the session).

Meihana Model

The Meihana model builds upon Sir Mason Durie's te whare tapa whā model of Māori wellbeing (Durie, 1994; Pitama et al., 2007). Central to the Meihana model is the

waka-hourua (double hulled canoe), in which the client and their whānau sit, paddling together towards the goal of hauora (wellbeing). The waka-hourua is made up of six dimensions to be explored with the client: the client- whānau relationships, tinana (physical wellbeing), hinengaro (mental and emotional wellbeing), wairua (spiritual wellbeing), taiao (physical environment), and ratonga hauora (previously iwi katoa; access to and previous engagement in quality healthcare). The waka hourua's trajectory is impacted by Ngā hau e whā (the four winds) and Ngā Roma Moana (the four ocean currents). Ngā hau e whā reflect societal influences including colonisation, racism, migration, and marginalisation, while Ngā Roma Moana reflect components from Te Ao Māori including āhua (personalised indicators), tikanga, whānau (relationships, roles, responsibilities) and whenua (genealogical or spiritual connection). The Meihana model assists clinicians to recognise the impact of being indigenous and being raised within a colonised community. This model encourages more comprehensive assessment and formulation for Māori clients (Pitama et al., 2017).

Hua Oranga

Hua Oranga is a culturally appropriate Māori assessment of wellbeing enabling a broad focus on wellbeing as guided by Te Whare Tapa Whā (Durie, 1994; McLachlan, 2022). The measure asks tangata whaiora (clients) to answer questions stating how strongly they agree with statements related to their wellbeing across four domains: taha tinana (physical wellbeing), taha wairua (spiritual wellbeing), taha whānau (social wellbeing), and taha hinengaro (mental wellbeing) (McLachlan, 2022).

Following on from initial engagement and assessment, culturally appropriate treatment approaches are important to ensure that treatment aligns well to the client's cultural perspectives, understandings, and needs. Two culturally appropriate treatment approaches developed for Māori are outlined below.

Culturally adapted CBT

Culturally adapted CBT involves the incorporation of culturally relevant examples, referral to Māori models of health (i.e. te whare tapa whā), use of karakia or whakataukī (encantations or proverbs) to open, close and even guide sessions, a greater degree of therapist self-disclosure, a deeper exploration of whakapapa (i.e. use of genograms), use of Māori language and metaphor and encouragement of whānau involvement in sessions and treatment objectives (Bennett et al., 2016). This approach has been demonstrated to be an effective treatment for Māori with major depression (Bennett et al., 2014).

Whai Tikanga

Whai Tikanga is a therapeutic approach using concepts of Acceptance and Commitment Therapy in a way that is culturally-adapted for Māori in terms of both content and process, including the use of Māori specific values (ngā Take Pū), use of whakataukī, incorporation of metaphor and use of Māori models of wellbeing (McLachlan et al., 2017). This approach enables exploration of cognitions, emotions and behaviours in a way that is culturally relevant for Māori and supports the process of re-enculturation for tangata whaiora (McLachlan et al., 2017).

Case Study

Client Referral

Tama was referred by prison services for a psychological assessment in 2021, at which time he was deemed eligible for the Adult Sexual Offending Treatment Programme (ASOTP). He was not motivated to engage in the ASOTP at that time and was subsequently referred for the Short Motivational Program (SMP) to increase his motivation for the ASOTP; however, he declined to engage in this as well. In May 2023, he was re-referred for psychological treatment. Given the short amount of time prior to his release, he became ineligible for the ASOTP and therefore individual treatment was recommended to address his risk of recidivism.

Client Presentation

Tama appeared apprehensive around the assessment process initially, however, was friendly and engaged well in conversation. Tama reported his Māori cultural identity to be of great importance to him. He presented as polite during interviews and was generally open to discussing the topics raised; however, he preferred not to go into detail about the abuse and trauma he experienced over his life. This was his first period of incarceration.

Client Risk

Tama denied any thoughts of self-harm or suicidal ideation. He did not report any thoughts or plans to harm others, nor any sense of being at imminent risk of harm from others. Risk at the time of assessment and treatment was repeatedly assessed as low.

Assessment Process

Assessment included three clinical interview sessions over three hours, using the Hui process, guided by the Meihana model, and incorporating Hua Oranga. The Hui process was used in order to support the building of rapport and to structure our sessions in a culturally appropriate way. The Meihana model was used to ensure that assessment was comprehensive and covered important aspects of experiences and understanding relevant to Māori, facilitating more comprehensive and relevant formulation. The measure of Hua Oranga was used to assess overall wellbeing in a culturally appropriate manner, gathering information on various aspects that are important in Māori wellbeing. Tama also presented me with a cultural report completed prior to his sentencing which outlined his experiences of trauma, and a letter of remorse he had written to his victims, for consideration in the current assessment. Findings from Tama's assessment as guided by the Meihana model are presented below.

Meihana Model Assessment

Waka Hourua

Client- whānau relationships

Tama reported growing up with his mother, father and five older siblings. He stated he experienced physical and psychological abuse from his father, who used substances heavily, and reported living in fear of him during this time. Tama reported getting married at age 23, being married for 18 years and having seven children prior to his marriage separation in 2016. This relationship appears to have been characterised by substance use, infidelity, and violence, for which Tama received convictions. Tama currently reported significant disconnection from his whānau, stating he had “pushed away” his parents, siblings, and his adult children due to his behaviour and substance use. He stated his sister was his biggest support, and she had remained in contact with him during his incarceration. Of note, several of Tama’s children have reconnected with him since his incarceration. Tama declined to have his whānau involved in the current assessment (e.g., provide collateral information via phone call).

Tinana (physical wellbeing)

Tama reported no significant health issues over his life other than his past substance use (discussed below) and being what he described as “overweight”. Tama reported good current physical wellbeing, stating he was healthier than he had been in years. Tama reported he had lost a significant amount of weight since being in prison and felt good having quit smoking cigarettes and the use of drugs and alcohol (discussed below). He reported he now enjoyed exercising and would continue this outside of prison, as well as sticking to a healthy diet.

Hinengaro (mental and emotional wellbeing)

Tama reported witnessing domestic violence, parental substance abuse and experiencing psychological and physical abuse in his childhood. At the age of 17, Tama was sexually assaulted at a gang party. Following the assault, Tama reported using substances to cope, smoking tobacco, and cannabis daily, and using alcohol two to three times a week. This

continued for 23 years. When his marriage dissolved in 2016, he reported his alcohol intake increasing to 62 standard drinks every afternoon and going to work (driving trucks) still intoxicated in the morning. In addition, he reported he began to use methamphetamine two or three times a week during this time. This level of consumption continued until his arrest in 2019. Tama's substance use caused financial issues, stress, loss of jobs, and homelessness. He reflected that his substance use had functioned to block thoughts of the abuse he had suffered, and later his relationship dissolution.

Tama currently reported experiencing a stable mood, showing affect appropriately aligned to the conversations, and a sense of hope for his future and upcoming release. No mood, perceptual or thought disorder appeared to be currently present. Tama had received a diagnosis of Post-Traumatic Stress Disorder in the past and reported still experiencing active symptoms, including avoidance and hypervigilance. He was attending sessions with an ACC therapist to address previous trauma. Tama denied having ever had active suicidal ideation. Risk of harm to self and others was assessed as low, as was risk of harm from others.

Wairua (spiritual wellbeing)

Tama reported his spiritual wellbeing as "fairly good", although this was a realm he wanted to develop by continuing to strengthen his connection to Te Ao Māori. He identified his spiritual wellbeing as being supported by his study and use of karakia, whakataukī, and tikanga Māori.

Taiao (physical environment)

As Tama was incarcerated at the time of referral, his physical environment was limited to the unit his cell was in and the laundry unit where he worked. Tama reported that this physical environment caused some stress for him, and he missed having connection with nature. It was also noted that the rooms in which we conducted our sessions caused some anxiety for Tama due to poor soundproofing. Understandably, Tama was hesitant to have

certain discussions for fear that other inmates would hear us. While this physical environment was not ideal, we made adjustments, such as talking quietly or moving away from the wall. With these adjustments, Tama felt able to continue engaging in the sessions.

Ratonga hauora (access to and previous engagement in quality healthcare)

Tama reported very limited engagement with physical and mental healthcare during his time in the community. He stated his whānau tended not to go to the doctor due to the high costs. When he was charged for his index offending in 2019, he had engaged in interviews to develop a cultural report for sentencing. This was the first time he acknowledged his own sexual victimisation. While not discussed in detail due to time constraints, Tama's limited earlier life experiences with health and wellbeing professionals may have contributed to his decision not to engage with psychological treatment earlier on in his prison sentence.

Ngā hau e whā: Colonisation, Racism, Migration and Marginalisation

Tama acknowledged significant impacts of colonisation on himself and his whānau, including disconnection from his Māori culture and language. While he reported growing up going to the marae with whānau, he also expressed his sense of disconnection at times stating, "I'm not *that* Māori" and showing disappointment in his lack of knowledge of te reo Māori. Tama discussed several disruptive cycles present within his whānau, which can be understood as having roots within the damage of colonisation to Māori including significant substance use and use of strict physical discipline and violence within the whānau. Tama did not recall his whānau having to migrate, however had his own experiences of this in moving away from Gisborne to the Wellington region. This, later paired with whānau disconnection left him feeling marginalised from his family, culture, and society. Tama briefly acknowledged his experiences of racism over his life in terms of having a sense society did not expect much from him because he was Māori.

**Ngā Roma Moana: Āhua (personalised indicators), Tikanga (Protocols),
Whānau, Whenua.**

Tama presented as a 47-year-old Māori man dressed in tidy prison clothes, with his long hair in a tidy ponytail or plaited back. He had several Māori tattoos visible on his forearms, including koru incorporating the names of his children. Tama reported following of tikanga to be important to him, and something he wanted to learn more about. Tama's general disconnection from his whānau, impacted on his sense of his own roles and responsibilities within his whānau, as did his current incarceration. Tama reported a great longing for reconnection with his whānau which would enable him to perform his roles again. He spoke about this particularly in terms of wanting to be able to be a father to his children and to care for his parents in their older age. Tama's ancestral whenua, the area he grew up in and where his whānau still live was in Gisborne. He reported having left the area following the sexual assault and had not returned in over 20 years. Part of this was due to his parents' elected disconnection from him. Tama stated that returning to his whenua and marae would be an important part of his reconnecting with his parents and wider whānau in the future.

Offending History and Index Offences

Tama's criminal history began in 1996 when he was 20 years old. He accrued a total of 14 convictions including sexual (x5), violence (x4), dishonesty (x2), administrative (x2), and driving (x1). Tama's offending began with dishonesty offences and progressed to violence within a few years. His sexual convictions occurred over a period of three and a half years and included rape and indecent assault of a 15-year-old girl and of two adult women, all known to him. These offences happened when the victims were asleep and/or intoxicated at the time. Tama's narrative of these offences aligned with the summary of facts. Leading up to these index offences, Tama reported experiencing a particularly low mood, being homeless, and engaging in heavy use of substances. He stated his focus at the time was blocking distressing

thoughts and emotions through increasing substance use, trying to make himself feel better in any way he could, and not caring about himself or the impacts of his actions on others.

Current Circumstances and Treatment Needs

Tama has not accrued any misconducts during his incarceration, and his polite and compliant behaviour has been documented, including in his employment within the prison laundry service. Tama engaged with a Department of Corrections Psychologist in August 2021 when he was assessed as being eligible for the ASOTP, due to being at high risk of sexual reoffending as determined by assessment with the Violence Risk Scale: Sexual Offending (VRS: SO) (Olver et al., 2007). Tama's VRS: SO was reviewed as part of the current assessment and determined to still be relevant. Eight out of 17 dynamic risk factors related to sexual offending were assessed as present on the VRS:SO and were considered treatment needs for Tama. Of the items assessed, he was considered aware of the problematic nature and motivated to address the following factors: Offence Planning, Emotional Control, Insight, Sexual Offending Cycle, Treatment Compliance, Deviant Sexual Preference. Tama was considered aware of the problematic nature and showing initial signs of behaviour change on the following factors: Interpersonal Aggression, Substance Use.

Hua Oranga

The Hua Oranga measure was used to identify treatment needs related to Tama's wellbeing in a culturally appropriate way and provided a baseline to assess change during psychological treatment. Tama's current responses on the Hua Oranga indicated fairly good overall hauora. He reported strong wellbeing in taha tinana (physical wellbeing). The domains of taha wairua (spiritual wellbeing), taha whānau (social wellbeing) and taha hinengaro (mental wellbeing) were indicated as areas to work on strengthening. Tama provided his lowest overall rating in relation to the health of his relationships with whānau and others.

Potential Responsivity Issues

Tama's potential responsivity issues (challenges that may impede engagement in treatment) include his reported desire to focus on treatment when he is out in the community, rather than treatment opportunities that are offered within prison, due to his belief this will enable him to have access to ongoing support outside of prison. While he agreed there was benefit to doing treatment leading up to his release, he may have been less motivated to fully engage and therefore benefit as much as he could, if he believed treatment outside to be more beneficial for him. Tama was encouraged to gain a solid foundation of skills during treatment within prison, upon which he could continue building in future treatment after release. Tama also appeared to contribute much of his harmful behaviour to the influence of substances. It was important for Tama to consider other factors that contributed to and resulted in his offending behaviours as we progressed through treatment, rather than attributing everything to substance use alone.

Tentative Case formulation

Tama was exposed to an unstable early childhood, characterised by heavy substance use and violence. This likely resulted in Tama developing an insecure attachment style, contributing to ongoing interpersonal relational difficulties, fear of abandonment and poor self-esteem. Tama lacked positive role-modelling of healthy emotion regulation and conflict resolution skills, and instead learned that emotional suppression, violence, and substance use were acceptable ways to manage and cope. Tama's experience of sexual assault as an adolescent left him with unresolved trauma. These experiences likely fostered and reinforced beliefs like: "Other people can't be trusted", "I am damaged and vulnerable", and "I'm entitled to only care about my needs because others won't look out for me". With a lack of more adaptive coping skills, a poor sense of self and low self-esteem, Tama turned to using substances, sex, and violence to avoid his distressing thoughts and emotions (including his symptoms of post-traumatic stress), and to gain a sense of power over others. Following his relationship separation, he relied more heavily on substance use to cope with his emotional

distress, which was compounded by the loss of his job and housing security and sought closeness and sex by targeting inappropriate and vulnerable women and girls, putting his own desires above the rights of others. These strategies may have allowed him to cope with his distress in the short term; however, have resulted in significant harm to himself and others in the long term, including a loss of close relationships with whānau, a continued lack of more appropriate skills to manage distressing thoughts and emotions, and creating victims of sexual/violent assault. Tama was considered to have a number of personal strengths that would assist him to achieve treatment goals. In particular, he demonstrated his ability to achieve academically and within the workplace during his time in prison, and showed an admirable work ethic, as recorded in case notes. Tama had also expressed significant motivation to make and maintain changes in his life going forward. Further, Tama had the support of several of his adult children and his sister, with intentions of connecting to his wider whānau and community after release.

Treatment Goals

Goals that Tama reported during the assessment interviews included:

- Learning strategies and skills to help remain alcohol and substance free in the community
- Developing insight into his triggers for distressing emotions, and learning skills to recognise and manage distressing emotions and stress in healthy ways
- Practicing skills (i.e. assertive communication) to support him in connecting with others and rebuilding relationships

Other goals that would be useful to work towards, as guided by the treatment targets identified in the VRS:SO included:

- Developing insight into the cycle and precipitating factors of past sexual offending

- Learning to identify and manage high risk situations, thoughts, and inappropriate arousal, through the use of relapse prevention strategies
- Developing his problem-solving skills, particularly related to managing frustration and difficult situations in more adaptive and flexible ways, rather than through violence or substance use
- Building self-compassion and strengthening his sense of identity/values to combat future lapses into not caring about himself and others

Treatment Protocol

Treatment predominantly followed a culturally adapted CBT approach, guided by the structure of group-based treatment for people who have committed sexual offences, and targeting factors identified as associated with Tama's risk of sexually reoffending. CBT was chosen as a treatment modality as research supports the efficacy of CBT treatment in reducing sexual reoffending (Hanson et al., 2002; Lösel & Schmucker, 2005; Schaffer et al., 2010). The CBT approach was adapted in line with Tama's Māori cultural identity to provide more meaningful and appropriate treatment, in accordance with the research, code of ethics and Ara Poutama goals of effective risk reduction treatment (Ara Poutama Aotearoa Department of Corrections, 2019; New Zealand Psychologist Board, 2002; Te Pou o Te Whakaaro Nui, 2010, 2016). Treatment session content is described in the following paragraphs, with a focus on the use and observed impacts of Māori models and approaches.

Session Summaries

All sessions began and ended with karakia, which were said together, selecting from a range of printed karakia (discussed further below).

Session one: Treatment began with discussion of the treatment plan. The 5-part CBT model, emotion wheel and thought record was introduced and examples worked through.

Taki (between session 'challenge') of completing thought diaries over the week was set.

Tama reported finding the CBT model helpful and was interested in applying this.

Session two: Reviewed taki. Tama reported becoming more aware of his thoughts and emotions over the week, and noticed he had identified more emotions and cognitions in his final diary entry for the week than he had in his earlier ones. Discussed consent and sexual assault. Brainstormed some thoughts that may have been present for Tama in the lead up to and during his offending. Introduced emotional regulation skill of mindfulness through the senses. Taki involved thought diaries, reflections on consent and ongoing mindfulness practice.

Session three: Reviewed taki in which we noticed Tama had recorded 'positive' emotions (e.g., 'happy') but 'negative' thoughts and behavioural urges (e.g., wanting to hit someone). This discrepancy was explored, and Tama was able to identify some more negatively valenced emotions which were also present (e.g., feeling 'gutted, stressed, pissed off'). The importance of all emotions and the messages they can have for us was discussed. Offence mapping process and rationale introduced. Taki set for Tama to complete three offence maps over the week. Following this discussion, it was noted Tama's emotions had shifted, and he was invited to notice how he was feeling. He identified that he was feeling anxious and noticed he had been fidgeting with his pen. We practiced the mindfulness five senses exercise, after which Tama reflected he felt less anxious. Tama was encouraged to use his mindfulness, affirmations, work-outs etc. to support him as he completed his offence maps over the week.

Session four: Following a death in custody, Tama postponed our session by a week. Tama talked through the thought diary he had completed regarding the death, and we discussed the impact it had had on him. Tama reported being most disturbed by the breaches of tikanga that occurred related to the body (e.g., dinner being served close by) which was

later resolved for him by kaiwhakamanawa volunteers (elders and spiritual leaders) performing karakia and cleansing the space. These experiences were explored in order to be responsive to Tama's needs, use the opportunity to notice the impacts they had on him, and practice relevant emotion regulation skills in the moment. We then reviewed Tama's offence maps, two of which he had completed over the week. Contributing feelings, thoughts and beliefs were identified and discussed. Some minimisations and justifications arose (e.g., "it took a year before the crime was reported", "I thought the victim was 16") and these were discussed and challenged. Tama agreed to continue with his thought diaries over the coming week and complete the offence map for the third offence.

Session Five: We reflected on the whakataukī: "titiro whakamuri, kokiri whakamua" (look back to move forwards). Initially, Tama stated he didn't know what the whakataukī meant, however as he reflected on the words and considered what they meant to him, he discussed the idea of learning from the past, and related this concept to the work he was doing with his offence maps; looking at his past to help him move towards his future. Tama presented his third offence map. The concept of Take Pū or values was introduced. Tama completed the Whai Tikanga Value Card Sort, considering the values he wanted to guide him over his next six months. The top five values Tama identified were: Manawanui (perseverance), Tika (making good decisions), Pono (being honest), Ako (learning and sharing), and Toiora (to be physically well and healthy). We discussed and reflected on the Take Pū: Tika. Tama agreed to a taki to complete further reflection on the remaining values over the week.

Session Six: We opened by discussing a whakataukī from one of Tama's top five values. Reviewed taki of values reflection. Discussed what goals and behaviours Tama could set and use to help him live in alignment with his guiding values. Completed the korurangi support people exercise. Began safety planning in terms of goals, motivation, and supporters. Tama was encouraged to continue this as a taki over the week. Discussed what activities

Tama could engage in to help balance his te whare tapa whā, and/or act as a replacement behaviour for drinking alcohol. Tama struggled with this, and so was encouraged to consider this over the week as well.

Session Seven: Reviewed taki; and provided Tama with whai tikanga pleasant events suggestions. Worked through first ‘initial warning signs’ and ‘high risk situations’ sections of Tama’s relapse prevention or “safety” plan. Taki set for Tama to complete remaining sections of his safety plan.

Session eight: Reviewed Tama’s completed safety plan and elaborated on some aspects. Tama reported he felt able to use this safety plan and refer to it in future. Tama completed the Hua Oranga and we compared his current wellbeing to his results when he initially completed this measure. Tama reported some improvement in taha whānau, indicating that he felt his relationships with whānau, and others had become healthier after treatment. We reflected collaboratively on what Tama could do to continue improving his wellbeing and balance his te whare tapa whā. We reviewed the skills covered over the course of therapy within a therapeutic letter (see Appendix). Tama was provided with a taki of reflecting on what he learned, liked, and disliked from our sessions so far. He was also provided further thought diaries to complete over the coming weeks and a self-esteem journal.

Follow Up

Tama reported a desire to continue with some follow-up sessions in the community after his release. These sessions will be used to ensure he feels able to use his safety plan and support him with his transition out of prison, as this is riskiest time period for reoffending. Further engagement in community programmes such as WellStop and Alcohol and Drug treatment programmes will be recommended.

Discussion and Reflections

Tama initially presented as reserved and somewhat unsure of himself within the therapy space, as he had previously declined to engage in any sort of psychological intervention. My observations of how his presentation changed over the course of our work together, as well as his choosing to engage in treatment at all, indicated to me how important the use of Māori therapeutic models and approaches were for this client. The use of the Hui process enabled connection to be established between us, and considering the Meihana model through the process of assessment enabled aspects of Tama's experiences to be explored in ways that may otherwise have been overlooked. Within the correctional environment there are some constraints to the usual process of whakawhanaugatanga within the Hui model. I tend not to share information about where I grew up or details about my family due to safety reasons, instead speaking more broadly about where my ancestors came from and acknowledging I grew up in the South Island (te wai pounamu) of Aotearoa. Even with these constraints, the Hui process gave structure to our session and enabled a sense of connection, highlighting to Tama that I was interested in understanding him and where he had come from. Tama reported a sense that we had a good working relationship, and even wanted to continue our work once he had been released to the community; a significant change from declining to engage with psychologists at all prior. I believe this was in great part due to the use of Māori models of engagement and my efforts to take a culturally sensitive and curious approach.

Receiving cultural supervision through engaging in discussions with supervisors, lecturers, and the Kaupapa Māori practitioner at TWM, as well as attending Kaupapa Māori learning days, was particularly important in terms of reflecting on how I approached assessment and treatment with Tama in a culturally appropriate way. One particular learning relating to this, was coming to notice how important the tata korero (little conversations) were for building relationship and rapport with Tama. These moments often came at the start or end of sessions, as we chatted about how his work in the laundry was going, or what book he had been reading. Reflecting back, I can see throughout our work together that this helped

us relate to each other as people and built a sense of being on the same team. This is something that can be particularly important within a correctional setting, where there can be difficulties associated with being in a position of authority and trying to build trust and connection with an incarcerated person, who may hold many anti-authority or anti-corrections beliefs.

There were many delicate subjects we discussed, including the great sense of whakamā that Tama held regarding his offences and his own past abuse, as well as the difficulties of his disconnection from his whānau. Tama showed real bravery in facing up to incredibly difficult conversations, which he initially showed a tendency to shy away from, preferring instead to think about the future and how things would be different now. The whakatauki ‘titiro whakamuri, kokiri whakamua’ (look back to move forwards) helped us to combat this tendency as we discussed and acknowledged how we needed to look back together to get a good understand of what had happened in his past (e.g., what thoughts, feelings, behaviours enabled his offending) in order to help him move forward in the way he wanted to. I also noticed that the use of karakia helped these difficult conversations, providing a way to release difficult emotions and to close the space in a spiritually safe way at the end of our session. Tama was noted to bring forward his printout of karakia as we approached the end of our session time and use this as an indication of when he was ready to close the session. Another interesting aspect of the karakia, was that we were learning these together. During the initial assessment sessions when I asked Tama about using karakia he would joke, stating “I still don’t know any karakia” and laughing. After I printed out and brought along a selection of karakia used to open or close hui, Tama began choosing karakia for us to say together. Each time, I would ask Tama which karakia he would like to use and asked if he would like to say them himself or both of us together. Initially, he would choose the same two karakia each time, however, as they became more familiar to him and he became more comfortable in the space, he ventured out and selected others, or asked me to

choose the karakia at times. There were parallels with this and our discussion of whakataukī through our work together. Given Tama's sense and experience of disconnection from his Māori culture, the incorporation of Te Ao Māori into the therapy space can be seen as important in terms of supporting his re-enculturation (McLachlan et al., 2017). For myself, this was also a valuable opportunity to continue learning and growing in my confidence to use karakia. In particular, my work with Tama highlighted the multiple ways in which the use of karakia is valuable for both my client and for myself as a clinician; including helping to ground us, to guide sessions, and to close off emotionally difficult conversations and help bring us back to the rest of the day.

Tama was the first person with whom I have done treatment focusing on reducing his risk of sexual reoffending. On reflection, I noticed having some preconceptions prior to meeting Tama, in light of his offending and his history of refusing to engage in treatment. Prior to meeting with Tama, I half-assumed he would again decline treatment. I also had some fears around how I would manage working with him; given that I was new to this field and had my own experiences of being a victim-survivor of sexual violence. These fears were discussed within ongoing supervision, and I found that having the reassurance of other experienced professionals and working guided by the processes supported by the empirical literature, helped me to manage these concerns and boost my confidence in my work. In terms of managing my own personal reactions to Tama and his offending behaviour, ensuring that I was taking time to reflect on what was going on for me and using my own mindfulness practices before, during and after our sessions was immensely important. In particular, I found challenging his distorted cognitions around sexual consent to be quite difficult (e.g., stating the underage victim had wanted to have sex with him). Grounding myself and slowing the session down to focus and question the validity of his statement and evidence against this (e.g., asking "at her age was she able to give consent?... Why not?") helped us to productively use these moments as a chance to reinforce learnings and challenge offence-supportive

distortions. I noticed within myself a real sense of relief as we had these important conversations and Tama reached more adaptive and prosocial conclusions. While these were not easy conversations to have, I am proud of being able to remain present and to gently challenge his problematic thinking in a way that allowed him to see things differently and will hopefully help to prevent further harm. The strength of our working relationship was important in helping us to have such conversations without leaving Tama feeling ashamed or judged, which likely would have resulted in him shutting down or disengaging from therapy. I noticed my understanding of him as a person outside of his offending, also helped to ground me in those moments.

A factor I had to be aware of within my work with Tama, was directing conversation and ensuring we were staying on track. Given that Tama's release was coming up, and paired with the fact he had some difficulties with his case manager postponing their meetings, leaving him unsure of his plans, he often wanted to discuss this within our sessions.

I found I needed to allow him a little space to hear his concerns, however I also needed to ensure we didn't get side-tracked and spend too much of our limited time discussing this. This was important to discuss in supervision, where I was advised to check case notes and progress of other professionals to confirm that there was indeed some progress happening for Tama's release plans. There was also a cultural and personal balance to be mindful of, in ensuring I could hear and validate the concerns that were top of mind for Tama and find a way to direct our conversation productively in a way that did not damage our rapport. A significant limitation of our work together was a heavily constrained timeline, with Tama's upcoming release and sentence end date, which made the need for this directiveness even greater.

One significant issue for Tama throughout our work together was his disconnection from Whānau. This was a source of great pain, but also great motivation for Tama, who

reported that rebuilding these connections was his main priority, and would help him remain substance free, as his children had said they “didn’t want to know him” if he went back to drinking. Considered through a Māori worldview, this disconnection from his parents can be understood as particularly difficult, as Tama had also been disconnected from his whenua, marae, and hapu, and had not felt able to return in quite some time. Tama drew hope and pride from the fact one he had regained contact with three of his children. In particular, one stepson had gone to great lengths to track him down inside of prison, which Tama stated meant he “must have done something right” as a parent. When Tama was released from prison, he was picked up by three of his children. At the time of treatment, visits were not happening within Rimutaka prison. Not being able to involve Tama’s whānau in treatment was a limitation of this work. In future instances I can imagine it being helpful to involve whānau, in particular in terms of discussing relapse prevention/ safety plans and what they can do to support their whānau member.

References

- Ara Poutama Aotearoa Department of Corrections. (2019). *Hōkai rangi: Ara Poutama Aotearoa strategy 2019-2024*. Ara Poutama Aotearoa Department of Corrections.
https://natlib-primo.hosted.exlibrisgroup.com/primo-explore/fulldisplay?docid=NLNZ_ALMA11372786620002836&context=L&vid=NLNZ&search_scope=NLNZ&tab=catalogue&lang=en_US
- Australian Government. (2018). Pathways to justice- Inquiry into the incarceration rate of Aboriginal and Torres Strait Islander peoples (ALRC Report 133). *Australian Law Reform Commission*.
- Baxter, J. (2008) *Māori mental health needs profile: A review of the evidence*. Te Rau Matatini. <http://teraumatatini.com/publications-and-resources>
- Bellrichard, C. (2020). Over-representation of Indigenous people in federal prisons reaches ‘disturbing’ historic high. *CBC News*.
- Bennett, S. T., Flett, R. A., & Babbage, D. R. (2014). Culturally adapted cognitive behaviour therapy for Māori with major depression. *Cognitive Behaviour Therapist*, 7.
<https://doi.org/10.1017/S1754470X14000233>
- Bennett, S. T., Flett, R. A., & Babbage, D. R. (2016). Considerations for culturally responsive Cognitive-Behavioural therapy for Māori with depression.
<https://doi.org/10.1017/prp.2016.5>
- Brittain, E. (2016) *Whai tikanga = In pursuit of justice: Māori interactions with the criminal justice system and experiences of institutional racism: A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Psychology at Massey University, New Zealand*.

- Durie, M. (1994). *Whaiora: Māori Health Development*. Oxford University Press.
- Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment: Official Journal of the Association for the Treatment of Sexual Abusers (ATSA)*, *14*(2), 169-194. <https://doi.org/10.1023/a:1014624315814>
- Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: a framework to enhance the doctor-patient relationship with Māori. *The New Zealand medical journal*, *124*(1347), 72-78.
- Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, *1*(1), 117-146-146. <https://doi.org/10.1007/s11292-004-6466-7>
- McLachlan, A. (2022). *Hua oranga: Whāngaihia te hua o oranga ki ō tatou whānau whānui, Ko te tikanga o te whakamahinga o Hua oranga*. Te Rau Ora.
- McLachlan, A. D., Wirihana, R., & Huriwai, T. (2017). Whai tikanga: The application of a culturally relevant value centred approach. *New Zealand journal of psychology*, *46*(3), 46-54.
- Muriwai, E. M., Houkamau, C. A., & Sibley, C. G. (2015). Culture as cure? The protective function of Māori cultural efficacy on psychological distress.
- New Zealand Psychologist Board. (2002). Code of Ethics. <https://www.nzccp.co.nz/assets/Uploads/Code-of-Ethics-English.pdf>
- Oakley Brown, M., Scott, K. M., & Wells, J. E. (2006). *Te rau hinengaro: the New Zealand*

mental health survey. Ministry of Health. <https://www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey>

- Olver, M. E., Wong, S. C. P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale-Sexual Offender version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19*(3), 318-329. <https://doi.org/10.1037/1040-3590.19.3.318>
- Pihama, L., Reynolds, P., Smith, C., Reid, J., Smith, L. T., & Te Nana, R. (2014). Positioning historical trauma theory within Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples, 10*(3), 248.
- Pitama, S. G., Bennett, S. T. M., Waitoki, W., Haitana, T. N., Valentine, H., Pahina, J., Taylor, J. E., Tassell-Matamua, N., Rowe, L., Beckert, L., Palmer, S. C., Huria, T. M., Lacey, C. J., & McLachlan, A. (2017). A proposed hauora Māori clinical guide for psychologists: Using the hui process and Meihana model in clinical assessment and formulation.
- Pitama, S. G., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand journal of psychology, 36*(3), 118-125. https://www.psychology.org.nz/journal-archive/Pitamaetal_NZJP36-3_pg118.pdf
- Schaffer, M., Jeglic, E. L., Moster, A., & Wnuk, D. (2010). Cognitive-Behavioral Therapy in the Treatment and Management of Sex Offenders. *Journal of Cognitive Psychotherapy, 24*(2), 92-103. <https://doi.org/10.1891/0889-8391.24.2.92>
- Te Pou o Te Whakaaro Nui. (2010). *He rongōā kei te kōrero = Talking therapies for Māori: Wise practice guide for mental health and addiction services*. Te Pou o Te Whakaaro

Nui. <https://www.tepou.co.nz/resources/talking-therapies-for-maori-he-rongoa-kei-te-korero/150>

Te Pou o te Whakaaro Nui. (2016). *Therapy: A guide to evidence-based talking therapies*. Te Pou o te Whakaaro Nui. <https://www.tepou.co.nz/resources/lets-get-talking-therapy/757>

Te Tiriti o Waitangi February 6 1840. <https://waitangitribunal.govt.nz/treaty-of-waitangi/english-version/>

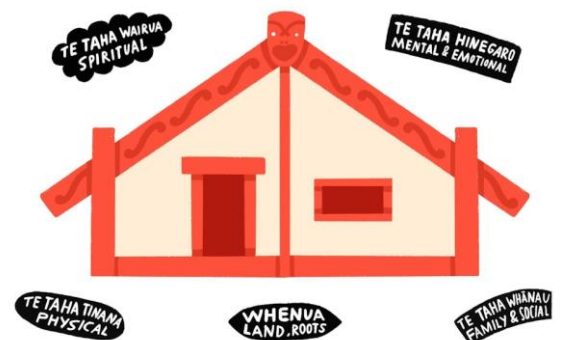
Appendix: Therapeutic Letter

Tama, over our sessions together, we have...

- Reflected on how thoughts, emotions, body sensations, and behaviours all impact on each other
- Increased your awareness of your thoughts, emotions, body sensations, and behaviours through thought diaries
- Increased your insight into and labels for emotions through the emotion wheel
- Discussed the importance of all emotions, including more 'negative' emotions, in helping you to understand what is going on for you
- Discussed consent within sexual interactions
- Identified thoughts, feelings, behaviours, and situations that led to offending behaviours for you in the past, by creating offence maps
- Identified and recorded warning signs and high-risk situations that can lead to offending for you
- Learned and practiced mindfulness exercises including 5-finger breathing, and 5 senses mindfulness
- Identified guiding values for you in your upcoming journey over the next six months, including the top five of:
 - Manawanui – Perseverance
 - Tika – Making good decisions
 - Pono – Being honest
 - Ako – Learning and sharing
 - Toiora – To be physically well and healthy



- Identified your support people are, and how you want them to support you
- Set goals for yourself, considering what you hope to achieve in the next year and in the next five years
- Identified pleasant activities you can do to enhance your wellbeing in all four areas of te whare tapa whā



ID: [REDACTED]

Treatment Case Study Three

The treatment of responsivity issues for a 63-year-old incarcerated man engaging in group treatment to reduce his risk of violent re-offending.

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This case study represents the work of Charlie Bremer during their internship in 2023. Clinical supervision was received during the assessment and treatment for the individual within this case study. All names and identifiable information within the case study have been changed to protect the anonymity of the client.

Candidate: Charlie Bremer [REDACTED] Date: 8.11.23

Supervisor: Jaimee Kleinbichler [REDACTED] Date: 8.11.23

Abstract

This case study details treatment addressing the responsivity issues of a 63-year-old Māori and Pākehā man with a history of trauma and chronic substance use, engaging in psychological group treatment to reduce his risk of violent reoffending. This man presented as eager to engage in treatment, however struggled with alertness, participation in group, anxiety, and cognitive difficulties (namely, working memory deficits and slower processing speed), in the early stages of group treatment. These responsivity issues were addressed in supplementary individual treatment sessions, which involved psychoeducation, behavioural experiments, cognitive challenging of negative core beliefs, and ongoing skills practice. The introduction provides an overview of the literature related to treatment responsivity issues for older adults with histories of trauma and chronic substance use. This is followed by the client's referral and background information, themes covered in individual treatment, observed progress, and reflections on the case.

Responsivity Issues for Older Adults with Histories of Trauma and Chronic Substance Use

Psychological treatment is a cognitively demanding process, involving learning, applying, and recalling new skills (Bush & Bilodeau, 1993). Psychological intervention at Ara Poutama Department of Corrections is guided by the Risk-Needs-Responsivity (RNR) model (Bonta & Andrews, 2017). The RNR model posits that interventions should match the level of reoffending risk the individual has (e.g., high intensity treatment for people at high risk of reoffending), should focus on the individual's dynamic (changeable) risk or need factors, and be responsive to the individual (Bonta & Andrews, 2017). The responsivity principle of the RNR model means that psychologists must take into consideration the factors that may impede a person's ability to engage well in psychological treatment; these factors are known as responsivity issues. Treatment interventions should be tailored to suit the individual's needs, so they can gain as much benefit as possible. Responsivity issues include a wide range of factors; however, some common issues seen in group psychological treatment within the corrections space may include entrenched anti-authority or antisocial beliefs, anxiety within groups, lack of motivation, and learning, reading, or memory difficulties.

Memory is a broad construct, which can be categorised in terms of how long and how much information is retained. Typically, three categories of memory are discussed. These include sensory memory (momentary retainment of information), short-term or working memory (where information is actively manipulated or worked with, and new information is lost if not rehearsed), and long-term memory (information stored in the longer term) (Larrabee, 2020). Working memory has a naturally limited capacity and is an important aspect of learning and encoding new information to be stored into long term memory (Forsberg et al., 2021). With healthy aging, a linear decline in both physical and mental ability is seen, including the performance of cognitive functions such as memory, attention, executive functioning, and language abilities (Larrabee, 2020). The greatest age-associated

cognitive declines in healthy adults are generally seen in terms of processing speed and working memory processes of encoding new information to be stored in the long-term memory (Larrabee, 2020). Research has also indicated that age and age-related hearing loss can affect cognitive function and result in poorer performance in working-memory based tasks (Zhao et al., 2022). This is hypothesised to be due to individuals with poorer hearing needing to put more cognitive resources towards hearing, and thereby reducing their remaining available cognitive resources to complete the required tasks (Zhao et al., 2022).

Early childhood adverse experiences have also been shown to be strongly associated with lower cognitive ability in childhood and adolescence, as well as poorer cognitive functioning in later adulthood, including reduced psychomotor speed and verbal fluency (Nilaweera et al., 2022; Richards & Wadsworth, 2004). In particular, early life stress or trauma is associated with poorer adult working memory in both clinical and nonclinical populations and is not mediated by the impacts of post-traumatic stress symptomology (Blanchette & Caparos, 2016; Goodman et al., 2019; Majer et al., 2010). It is also noted that the experience of childhood maltreatment is a known risk factor for problematic substance use later in life (Anda et al., 2006).

The effects of substance use over the lifetime are likely to impact on an individual's cognitive abilities. Given that adolescence is a time of significant neurodevelopment, early substance use can have long lasting effects on the brain. There is evidence to suggest that exposure to opioids in adolescence may increase the long-term rewarding effects of substances and increase long-term impulsive behaviours (Thorpe et al., 2020). Chronic substance use is known to have widespread impacts within the central nervous system, including neurodegenerative changes, loss of neurons, and changes in cerebral microvasculature (Büttner, 2011). There are a range of neuropathic changes thought to be associated with chronic heroin use in particular, including cerebral atrophy and demyelination of white matter (Büttner et al., 2000). Chronic heroin use can also inhibit neurogenesis, likely

contributing to both cognitive and memory deficits (Bayer et al., 2015). The predominant effects of chronic substance abuse include high rates of depressive disorders, memory loss and cognitive decline (Büttner, 2011). Stopping the use of substances following long-term use, may similarly have cognitive effects. Methadone maintenance is a common treatment for individuals with an opioid dependence and is typically a long-term treatment which involves daily administration to suppress symptoms of withdrawal (Tetrault & Fiellin, 2013). Individuals on methadone maintenance show impaired psychomotor and cognitive performance compared to both people with no history of substance abuse, and people who have historically, but no longer use opioids (Darke et al., 2012; Prosser et al., 2009). The level of methadone in the body, has a varying impact on cognitive functioning and psychomotor performance, with peak methadone levels being associated with worse performance in terms of sensory processing, psychomotor speed, divided attention and working memory (Rass et al., 2014). Higher doses of methadone also appear associated with poorer attention and working memory performance (Curran et al., 2001; Rass et al., 2014).

Slower processing speed may cause particular difficulties in group treatment where the pace of treatment may be less flexible due to the need to cater to the wider group. Individuals who need longer to process information may therefore not have enough time to fully understand new concepts introduced throughout therapy, resulting in less ability to fully participate and benefit from the treatment. Similarly, with poorer working memory, individuals may struggle to hold new information in mind and manipulate it as they learn and practice using new skills. As such, deficits in processing speed or working memory processes stemming from older age, hearing difficulties, exposure to trauma, chronic substance use and ongoing methadone maintenance therapy may pose significant responsibility issues for people engaging in psychological treatment, and such factors should therefore be responded to appropriately to mitigate potential detrimental impact.

Case Study

Context: Te Whare Manaakitanga

Te Whare Manaakitanga is a special treatment unit in Rimutaka prison for men who pose a high risk of violent re-offending. Te Whare Manaakitanga (TWM) operates as a therapeutic community, where the men engage in group therapy for around nine months in groups of up to 10 men. Over the course of treatment, the men first engage in psychoeducation around internal processes, which includes them learning about cognitions, emotions, adaptive emotion regulation skills (e.g., time outs, ‘coolers’, mindfulness), and the CBT model. They then engage in autobiographical work, writing and presenting their “life stories” and later their “offence maps” to the group, and are supported to identify the emotions, thoughts, behaviours, rules for living, and core beliefs that have impacted on them. In the final phase of group, they construct relapse prevention plans in preparation for future situations where there may be a high risk for reoffending, and record strategies to reduce this risk. While at TWM, the men receive support from a Kaupapa Māori practitioner for Māori cultural advice and support, and a reintegration coordinator who helps organise their plans for release.

Client referral

At the time of referral, Oliver had recently begun group treatment to address his high risk of violent reoffending. Given responsivity issues identified in his pre-treatment assessment and his observed presentation in group, Oliver had also begun individual sessions with one of his group therapists (described below). When it was identified that he would likely require longer term support, it was decided that another therapist should be involved in this due to the commitment required and pre-existing demands on his initial therapist, and Oliver was referred to the writer.

Client presentation

Oliver presented as a 63-year-old man of Māori and Pākeha descent. He appeared somewhat older than his chronological age, and when tired or overwhelmed would hunch over, hang his head, and cover himself with his arms. His presentation fluctuated within a single session from appearing lethargic and disinterested to highly animated, enthusiastic, and talkative. He would at times speak tangentially, and was observed to have memory difficulties, often struggling to recall information he had been repeatedly told, such as the group's chosen name or early content covered in sessions (e.g., concept of the 'stretch zone', or skill of taking time-out). Within group sessions, he was reported to often hunch over in his seat and close his eyes and was noted to provide sparse input into group discussions only when prompted.

Client Risk

Oliver was noted to have an extensive history of self-injury and suicide attempts. During our time working together, Oliver would occasionally raise thoughts of suicide, however when explored further, Oliver was able to see his expression of such thoughts as a signal of his distress, rather than indicative of current suicidal intent and Oliver reported no plan or intent to act on such thoughts. Oliver reported no thoughts or plans to hurt others and did not feel at risk of harm from others. Risk of harm to self, to others, and from others was monitored closely throughout treatment. Imminent risk throughout the time we were working together was repeatedly assessed as low, with the exception of an incident involving his medication, discussed in further detail below.

Relevant Background Information:

Oliver was assessed by psychologist T.D. (February 2023). The following background information is summarised from that assessment.

Childhood

Oliver experienced an unstable childhood, characterised by multiple forms of abuse and normalisation of substance use and violence. Oliver's mother died when he was nine-years-old. He reported moving and changing schools frequently, and at age 11 went to a state-run "Boy's home", where he experienced further abuse, bullying and racism.

Substance Use

Oliver began using substances at the age of 13, sniffing glue/petrol and taking pills (e.g., Valium), and progressed to intravenous heroin use at age 15. Oliver reported struggling with addiction throughout his life and is currently on methadone maintenance.

Mental Health

Oliver has a long history of difficulties with his mental health including generalised anxiety, low mood, and substance-induced psychosis (which lasted for approximately six years in his twenties). He has made multiple suicide attempts (most recently 15 years ago). Oliver did not report any current symptoms of psychosis, but reported anxiety and depression, particularly when in the community. Oliver also reported several symptoms typical of a trauma presentation, including flashbacks and difficulties differentiating between the past and present.

Employment

Oliver has received the sickness benefit for most of his adult life. He stated that he had historically financially supported himself by being a "criminal" (e.g., through burglary), or by exploiting the women he was dating.

Relationships and Children

Oliver reported that from adolescence onwards, he primarily associated with people who were involved in illegal or antisocial activities. Oliver described one significant intimate relationship with his current partner, whom he has been with for nineteen years. Oliver reported

having lost contact with most of his family as they live overseas or are deceased and noted two brothers and two nephews had died by suicide.

Offence History

Oliver has accrued a total of 180 convictions between the ages of 16 and 61 years old. Most of these are dishonesty-related offences (63%), followed by violence and property damage (14%) and drugs and antisocial type offending (12%), with the remaining (9%) considered “administrative” offences. Oliver’s primary pathway to violence was in pursuit of illicit substances while intoxicated. Oliver has spent most of his adult life in prison. He acknowledged that he found it “easier” to be incarcerated and has deliberately reoffended in order to return to prison, particularly when he has felt unable to manage his anxiety and mood in the community.

Index Offences

In the lead up to Oliver’s index offence, he reported significant stress due to the COVID-19 pandemic, escalating inter-familial conflict, and increasing use of substances. Oliver reported limited memory of the index offending, however; did not dispute the official version of events laid out in the Summary of Facts. Oliver recalled being heavily intoxicated on morphine when he received his daily dose of methadone. On his way home, he entered houses to steal drugs and money, encountered a person, and held a knife over them. Oliver stated that when he realised the person was a woman, he “sobered up”, dropped the knife, and ran away. When reflecting on the index offending, Oliver stated that it was “horrible, bad”, and must have been terrifying for the “poor lady”. However, he was also confused as to why she had not run away and stated the victim was “stupid for coming at a man with a knife”.

Current Circumstances

Throughout his current period of incarceration, Oliver has consistently displayed compliant behaviour and accrued no misconducts. Oliver's case notes report polite and respectful behaviour.

Psychometric Assessment

Weschler Adult Intelligence Scale, Fourth Edition (WAIS-IV)

The WAIS-IV involves a battery of tests designed to assess various domains of cognitive functioning. Oliver was assessed with four subtests of the WAIS-IV which comprise the indexes of Working Memory (digit span and arithmetic) and Processing speed (symbol search and coding), due to suspected difficulties in these areas. His responses indicated some difficulties in both indexes. In the index of Working Memory, where he received a composite score range of 72 – 85 (95% confidence interval), indicating a borderline to low average performance in comparison to normative performances of similar age peers. This suggests Oliver may have some difficulties taking information in, holding the information in immediate awareness, and performing mental operations on that information. Further, Oliver's score on the Processing Speed index was in the range of 75-91 (95% confidence interval), a borderline to average performance in comparison to performances of similar age peers. This indicates that Oliver may at times mentally process information at a slower rate than his peers, and therefore need more time to accurately understand information.

Millon Clinical Multiaxial Inventory – Fourth Edition (MCMI-IV)

The MCMI-IV is a self-report measure which can provide some insight into personality traits and psychopathology. Oliver's responses indicated high levels of disclosure, which is likely reflective of a tendency to self-disclose a high degree of psychological and interpersonal problems. Prominent personality/clinical patterns (indicated by a score of 85+) included the Antisocial clinical personality scale and the clinical syndromes of drug use, post-traumatic stress, and generalised anxiety. Prevalent patterns (with a score of 75+) were seen on the severe

personality pathology scales of Paranoid and Borderline, as well as the clinical personality patterns of Narcissistic, Melancholic, Negativistic, Masochistic, and Dependent, and the clinical syndrome of alcohol use.

This pattern of responses is similar to individuals who tend to be suspicious of others, lack trust, have black and white thinking patterns, and an overall pessimistic outlook. People with a similar profile tend to avoid close relationships, and instead focus on their own needs. They may tend to take advantage of others and may believe that they are special and more important than other people. Oliver's responses also indicated elevated levels of post-traumatic stress and generalised anxiety. People with similar scores in these areas tend to have experienced or witnessed traumatising event(s) which triggered feelings of fear or helplessness, and may experience physical tension and hypervigilance, and find it difficult to relax. This interpretation appeared congruent with Oliver's presentation.

Potential Responsivity Issues

Potential responsivity issues identified for Oliver included: social anxiety, his active trauma symptomology, hearing difficulties, side effects of his medication regime (particularly Methadone), his cognitive functioning (e.g., working memory difficulties and slower processing speed), tendencies towards being suspicious or pessimistic, and his poor self-esteem. Therapy staff were made aware of these issues prior to Oliver commencing treatment and these were accommodated for as best as possible during his time at TWM.

Initial Case Formulation

From the information outlined above, an initial formulation of the factors that contributed to Oliver's offending is presented below:

Oliver experienced an unstable childhood characterised by multiple forms of abuse and neglect. This instability, paired with the early loss of his mother, likely led to the development

of an insecure attachment style, contributing to ongoing interpersonal difficulties. These experiences likely fostered beliefs such as “I am bad”, “I cannot cope”, “The world is unsafe”, and “People are untrustworthy”. Experiencing a sense of rejection from his caregivers and peers, Oliver turned towards antisocial peers where he found greater acceptance. Without prosocial role-models, Oliver lacked opportunities to learn adaptive emotion regulation skills and instead turned to substances to manage his distress related to symptomology of complex post-traumatic stress. Over time, he became more heavily involved in substance use and criminal activity. He developed a sense of dependency on others and an entitlement to meet his needs in whatever way he could. Oliver resorted to the normalised violent behaviours he had learnt in childhood, reacting aggressively and violently towards property, others, or himself when distressed. In times where he felt particularly overwhelmed, he would purposefully seek time in prison. These strategies served Oliver in the short term; however, resulted in a lack of more adaptive skills to manage distress and led to him being triggered in situations that remind him of past trauma. This, in turn resulted in an ongoing sense of poor self-esteem, perceived inability to cope, continued aggression and mental distress, and a loss of close relationships over time. Oliver has a number of strengths and protective factors that will support him through treatment to reduce his risk of violence. In particular, he has demonstrated empathy for others, motivation for treatment and change, positive attitudes towards authority, and good engagement with professional care. Spirituality has also become an important aspect of Oliver’s daily life which he reports as something that has been helpful and motivating for him.

Treatment Protocol

Oliver had five individual sessions with one of his group therapists prior to his being referred to the writer. We engaged in weekly sessions (as possible), from 11 April 2023. Oliver’s individual treatment work was responsive to his changing needs as he progressed through group treatment. Treatment is ongoing and will likely continue until Oliver leaves the unit to engage in further reintegration work.

The five sessions Oliver engaged in with his first therapist involved distress tolerance related to experiences of social anxiety and setting up related behavioural experiments. Following a handover from Oliver's initial therapist, we continued with the work of enhancing distress tolerance, encouraging behavioural change within group therapy and the wider therapeutic community, and challenging unhelpful beliefs. As Oliver's distress and impairment related to anxiety subsided and he was better able to attend in group, we pivoted to having a greater focus on reinforcing the learnings within his group sessions and addressing concerns or barriers as they arose.

Treatment themes

The treatment completed with Oliver will be discussed as various themes, with examples and impacts of the work provided.

Challenging socially anxious cognitions and safety behaviours

Initially, we focused on continuing behavioural experiments targeting Oliver's social anxiety in the group and community. Experiments aimed to help him become more aware of his thoughts, feelings, and behaviour, and to help him engage better within group therapy. Initial experiments progressively challenged Oliver to sit upright, keep his eyes open, and contribute without being called on in the group therapy sessions. As Oliver tried this more, he noticed the other men enjoyed and encouraged his contributions, and he had an easier time following and recalling group content. Oliver's report of these changing behaviours within therapy were corroborated by his therapists', who were also able to inform me of behavioural lapses, which we addressed and worked through.

Much of Oliver's social anxiety related to fears that others perceived him as a "bad man" and thought poorly of him. These cognitions became particularly strong in situations where he would need to speak in front of groups. To challenge such thoughts, a survey experiment was constructed in which Oliver asked therapy staff about their opinions of him.

Oliver made predictions beforehand (e.g., “They will say I’m no good.”) and was instructed to objectively record responses. Oliver conducted interviews with five therapy staff. He reported finding it difficult to hear nice things about himself, but despite the survey being hard, he also found it was helpful. Oliver completed a reflection task on the survey responses, and in returning to his initial predictions, found they had not occurred. Oliver created alternative thoughts from the responses including "Others see me as a good man" "I am kind, brave, wise". Oliver kept the survey responses and found this a useful resource to return to in times of doubt (e.g., prior to doing a presentation to his group).

Oliver set himself a behavioural experiment as the unit’s 25th birthday celebration approached, to make an effort to stay for the duration of the event, and to welcome and have conversations with the visitors. Oliver stated he would typically avoid such events and think that he “couldn’t cope” but thought he could try to stay and recall his motivation to change if he felt overwhelmed. After the event, Oliver noted he had managed to meet all of his goals (engaging, staying, and socialising), learnt people were not there to judge him, and had enjoyed being there.

Reinforcing learnings and skills practice

Given Oliver’s difficulties with hearing, working memory, and slower information processing speed, he needed extra time and repetition to fully grasp and retain the concepts covered in the group therapy room. A primary focus of our sessions was practicing “CBT walk throughs”; an embodied practice of the CBT model involving laying out the CBT model on the ground and standing on each aspect while explaining out loud the associated experience (e.g., reporting thoughts while standing on the thoughts aspect). Each session, Oliver completed at least two CBT walk throughs. Oliver was initially guided through the practice; however, took on more independence with this as treatment progressed. Discussions around the various aspects of the model and reinforcing of learnings occurred through the use

of prompts, questions, or reminders. The use of the visible CBT model and embodied practice of standing on each aspect and reflecting on these one at a time, likely helped to reduce the working memory load, and improved Oliver's ability to engage with the CBT model. Oliver also completed thought diaries as between session work, which provided him further opportunities to practice. Some examples of CBT walk throughs Oliver completed included: feelings of anxiety in the lead up to group presentations (and re-visiting these following the presentation), his experience around his partner missing an important scheduled call, and Oliver stealing whiteboard pens from the therapy room (which he was initially unsure why he had done).

At various points through our work together, there were also elements covered in group therapy that Oliver reported having not fully understood. Our individual sessions provided a chance to revisit these topics, refine Oliver's understanding of them, and apply the concepts to his own life. Some of the concepts we covered in this way included Te Whare Tapa Whā (Durie, 1994), the DEAR MAN model of assertive communication (Linehan, 2015) and the concepts of Tika, Pono, and Aroha (doing what is right, honest, and caring). Throughout treatment, the use of therapeutic skills including grounding, mindfulness techniques, or slowing down to identify specific thoughts, emotions or behaviours was encouraged and modelled.

Challenging problematic thinking

Through the CBT walk throughs and our therapeutic discussions, Oliver's tendencies to think in a Black and White manner or catastrophise would often arise. Some examples of Oliver's black and white thinking included "If one thing goes wrong, I'm a failure", "If my family argues, I will have to go back to using substances, violence, and jail", "People never want to help me.". Throughout treatment, this thinking style was challenged, with prompts for Oliver to consider alternative perspectives or options and label his thinking style in the moment. As he progressed through treatment, Oliver became increasingly able to

spontaneously identify his unhelpful thinking styles and challenge them with more adaptive thoughts.

Providing space to further discuss current challenges

Individual treatment provided a space outside of group therapy for Oliver to further discuss current challenges in his life both inside and outside of prison. Initially, these were strongly related to his poor sense of self-esteem and anxiety, and later to issues maintaining change and planning for the next steps of his rehabilitation and reintegration. One example of a further challenge that arose within an individual session and posed possible imminent risk of harm, related to changes in his medication dispensation. In that session, Oliver presented as highly distressed and spoke in a coded and hesitant manner. Eventually, he informed me that the prison medical team had provided him a week's worth of sleeping pills, which he had taken inappropriately a few days ago (e.g., more than prescribed) and he was finding it difficult to stop abusing these further. We discussed Oliver's coping strategies and problem-solving options, and Oliver agreed to consider talking to the medical team about the manner in which his medications were provided. Oliver was also encouraged to talk to custody or therapy staff, particularly if he noticed being tempted to abuse the medication, which he agreed he could do. Oliver agreed that, as this was an important risk issue, it would be discussed with others. This was discussed with my supervisor and Oliver's therapists as well as the Manager of Psychological Services at TWM, who followed up with medical staff. Over the next few days, Oliver chose to approach medical staff himself, and told them he did not want to be on a week contract and would instead like to return to receiving his medication daily. Oliver reported feeling proud of himself for managing this difficult situation in the way that he did.

Therapeutic relationship

The therapeutic relationship itself was a particularly important aspect of our work together. Having experienced significant adversity in childhood and limited opportunities to observe or engage in healthy relationships over his lifetime, Oliver typically did not feel safe in relationships. The experience and practice of forming a secure relationship was an important aspect of Oliver's therapy, and provided him with ongoing and consistent support, healthy relationship modelling, and opportunities to practice his interpersonal skills. Within the safety of the therapeutic relationship, Oliver was able to identify and share difficult experiences, feelings, and behavioural patterns that he had been suppressing or unaware of for a long time. Another thing Oliver had struggled with over his life was endings or saying goodbye to people. He reported that he would usually get violent or use substances rather than say goodbye. My role as Oliver's individual therapist meant that during the difficult time of group ending, he still had some consistency in knowing our sessions would continue. During this time, Oliver discussed the fact that he appreciated the chance to meet and have "real talk" in our sessions, as he was missing the group sessions.

Treatment Progress

Observed and Self-reported Progress

Case notes recording Oliver's participation and engagement in group therapy, demonstrated a significant shift in his behaviour. Initially, Oliver was noted within each group session to slouch in his chair, hold his head in his hands, and frequently fall asleep. Early case notes document Oliver as mostly quiet and only contributing to the group discussion if repeatedly prompted. As treatment progressed, Oliver was described as actively engaged within the group, participating well, sharing his ideas, and demonstrating his understanding of the relevant topics and skills. In his treatment outcome report, Oliver's group therapists reported seeing significant shifts in his behaviour and participation within group. Oliver's therapists reported seeing him be better able to identify triggers and emotions

that were occurring for him, and while he would still experience intense emotions and tended to initially catastrophise, he was able to notice and understand his reactions, use skills of emotion regulation, and thought challenging to reduce the intensity of his emotions and move through his emotions more quickly.

His therapists also noted an increase in his openness and relationship building with other group members, as well as a decrease in his anxiety in both group sessions and the therapeutic community. Near the end of group sessions, Oliver was noted to spontaneously present a CBT walk through of a recent situation (where another man had taken his radio without asking). His therapist was so impressed, she asked if we had worked on the walk through together and I confirmed that Oliver had done it alone, demonstrating significant growth in his understanding and use of the CBT model, and his own self-confidence.

Oliver himself reported noticing changes in his understanding of group content and his confidence in his ability to apply the skills he had learnt. In our later sessions Oliver discussed how much he felt he had changed over his time at Te Whare Manaakitanga. He reflected that he now had a better understanding of his past behaviour and was growing in his confidence of his ability to cope. He acknowledged that at the start of therapy he had sometimes ‘nodded off’ when he felt overwhelmed, to avoid having to engage in difficult discussions, and stated he no longer used this safety behaviour. Oliver reported having stood up to offer support to new men in the unit, despite fears that he might not be good enough or might “mess up”, and in doing so, he noticed feeling “worthy and proud” of himself; something he had not felt before. He reported feeling amazed at how much he had learnt and changed, and that he was inspired to teach and use the therapeutic concepts with his wider whānau.

As his individual therapist, I was able to observe changes in Oliver over our time working together, corroborating those outlined above. I observed Oliver becoming more

confident in himself and in his social interactions with staff and men in the unit. I also noticed significant shifts in Oliver's thinking style, which initially had been negativistic, moving towards a more balanced outlook. While he could still gravitate towards a more pessimistic style, he would usually catch himself and use thought challenging to see another perspective. One challenge that Oliver often came back to was "I've got a chance here"; a reframing thought he would use, meaning in a difficult situation, he had an opportunity to practice his skills and try doing something different.

Risk of Reoffending Assessment

The therapist rated Violence Risk Scale (VRS) guides treatment in the STU: VO. Before treatment, 17 out of 20 dynamic risk factors specific to violence were identified as present for Oliver and formed his treatment targets. Initially, Oliver was assessed as lacking insight into the problematic nature of five items (*criminal attitudes, work ethic, weapon use, release to high-risk situations, stability of relationships with significant others*), had some insight but no behavioural change on five items (*violent lifestyle, substance abuse, community support, violence cycle, criminal peers*), and had shown initial behavioural change on six items (*violence during institutionalisation, mental disorder, insight into violence, impulsivity, emotional control, interpersonal aggression*). At the end of core group treatment, Oliver was assessed as having displayed insight into all of the identified risk factors. Oliver showed relevant behavioural change in 15 areas (*violent lifestyle, criminal attitudes, criminal peers, emotional control, work ethic, insight into violence, mental disorder, substance abuse, release to high-risk situations, stability of relationships, community support, violence cycle, impulsivity, and cognitive distortions*), with stable behavioural change in one area (*interpersonal aggression*). The only factor where behavioural change was not seen was his security classification, which remained at 'low'.

Further Plans for Treatment

Individual treatment is planned to continue until Oliver is released, likely to a residential rehabilitation provider. Skills practice and relapse prevention will be the major focuses, including revision and specific practice of his safety plan and relevant skills to manage possible high-risk situations that could arise. The ending of our working relationship will be closely processed and worked through, as this has been a high-risk situation for Oliver in the past and will therefore be a good opportunity to work through difficult emotions, practice saying healthy goodbyes, and again reinforce that he can cope.

Discussion and Reflections

Oliver has been a particularly interesting client to work with. Initially, his presentation from one week to the next could be dramatically different, let alone the changes evident within the course of a single therapy session. However, over the course of our work together he demonstrated a significant deepening in his insight and ability to regulate his emotions.

One of the first things we did in our work together was a survey of therapy staff, asking about their perspectives of Oliver, as discussed above. The impact that this exercise had on Oliver was huge. He would often return to the survey responses, or bring up the survey within our sessions to reflect on how meaningful it had been to him to hear people say positive things about him. Oliver often insisted that we should do something like that with all the men in the unit. Seeing the impact of this on him, has encouraged me to use similar interventions in the future with people who seem to have this deeply engrained sense of worthlessness or low self-esteem (where appropriate and possible). I think the benefit of this was that it helped Oliver see a view of himself other than the one he had developed having survived years of abuse. Interestingly, Oliver was in fact widely liked and supported within the unit by the men and staff alike. Given his comparatively older age, the men in the unit tended to see him as an elder and respected him as such. He had a good sense of humour and was generally caring, despite having a lot of unhelpful antisocial, substance and violence-related beliefs at the start

of treatment. When we first started working together, Oliver did not see any of his own strengths or positive character traits, and so, working alongside him, celebrating his successes, and helping him to see the positive sides of himself was a real joy.

The course of our work together initially started with a focus on his social anxiety, however; our focus shifted in consultation with his group therapists to ensure the individual work we were doing was enabling him to get the most out of his group work. This was an interesting challenge and learning for myself, in relation to the need for flexibility and responsiveness to the client and their changing circumstances. Much of the work that Oliver and I did together involved re-covering and practicing concepts and skills he had learnt in the group sessions. At times, I noticed feeling as if such work was perhaps not all that helpful, even doubting that I was making a difference for him. This was something I discussed with his therapists as well as reflected on myself. This reflection illuminated to me, just how much change Oliver really had made over our time working together, and how sometimes just a little extra support and time can help people get a lot more out of what they are learning. I reflected that building a consistent relationship and supporting Oliver's skills practice was valuable and helpful for him. I didn't need to be doing a full manualised and planned out intervention in order to be adequately using and developing my clinical skills and supporting my client well. From early case notes it was clear that Oliver required extra therapeutic support, and without this he may not have made it through the course due to his difficulties with engaging in group, retaining information and becoming overwhelmed by his emotions. Our work together helped him to become more aware of and then to change some of his behaviours, and ensured he was able to take in all the important learnings he was being offered.

Oliver also presented challenges in learning how to balance hearing and validating his story and concerns, while ensuring we were also using our limited time together productively. Oliver could at times speak almost continuously from one topic to the next, and I quickly

found that he had a tendency to spiral towards his past traumas if left to do this for too long. Initially when this would happen, he would become quite visibly distressed, however; over time he was better able to make the links between his current experiences and past trauma without feeling overwhelmed. An example of this occurred in a later session when Oliver was exploring his self-deprecating thoughts and circled down to an answer of “because my father always told me he hated me”. He went on to challenge this thought, acknowledging that his father had later apologised for the way he had treated him, and had expressed his love for him before he died. Watching Oliver be able to challenge his distress in real time and reach a more helpful adaptive conclusion in his thinking, provided some good evidence that Oliver really had grasped and was able to apply many of the skills he had been learning and practising over his treatment sessions.

There were also some learnings for me in keeping a good focus on what we were intending to cover in treatment, and not getting too drawn in to addressing Oliver’s trauma history. One reason why this would have been inappropriate, was that Oliver was not ready to unpack his traumatic experiences, and with the ongoing demands and learnings of the group therapy trying to do so would likely have been overwhelming for him. Further, the focus of our work within the correctional space was on reducing his risk of violent reoffending, and guided by the evidence base, this meant focusing on the factors empirically linked to violent reoffending. My work and the group therapy work did however help Oliver develop his skills for coping with his trauma and supported him to start rewriting his narrative of this, without having to directly address and do specifically focused trauma work.

Working with Oliver, I learnt to expect the unexpected. Generally, I like to have a clear plan of what I will cover in the session, and while flexible to the client’s needs, this structure provides me with a sense of knowing where I am going and what I am doing. With Oliver, however, his presentation and what he actually needed from the session was somewhat unpredictable, and he would present very differently from one day to the next. As

such, I learnt to come prepared, but be open to whatever Oliver might be bringing to the session. This approach worked well, and over time, I found I was more able to come with some ideas in mind, but handover to Oliver for him to decide what CBT walk throughs we would do or what topics we would discuss. I also found that the monitoring of countertransference reactions was important with Oliver, especially early in our work together. At that time, Oliver often experienced feelings of being overwhelmed and unable to cope, and I noticed that when this was happening, I would also start feeling lost within the session and unsure of what to do. Over time, I learnt to become more consciously aware of my own reactions in the moment and was able to notice what was occurring. This insight then enabled me to offer and implement grounding techniques, which helped us both to become more settled in the room. The practice of increasing my own awareness and using grounding skills myself both helped Oliver to become more aware of his own reactions and ground himself and provided a model of this in action for him to learn from.

References

- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174-186. <https://doi.org/10.1007/s00406-005-0624-4>
- Bayer, R., Franke, H., Ficker, C., Richter, M., Lessig, R., Büttner, A., & Weber, M. (2015). Alterations of neuronal precursor cells in stages of human adult neurogenesis in heroin addicts. *Drug & Alcohol Dependence*, *156*, 139-149. <https://doi.org/10.1016/j.drugalcdep.2015.09.005>
- Blanchette, I., & Caparos, S. (2016). Working memory function is linked to trauma exposure, independently of post-traumatic stress disorder symptoms. *Cognitive Neuropsychiatry*, *21*(6), 494-509. <https://doi.org/10.1080/13546805.2016.1236015>
- Bonta, J., & Andrews, D. A. (2017). *The psychology of criminal conduct* (Sixth ed.). Routledge, Taylor & Francis Group.
- Bush, J. M., & Bilodeau, B. (1993). *Options: A Cognitive Change Program*. National Institute of Corrections.
- Büttner, A. (2011). Review: The neuropathology of drug abuse. *Neuropathology & Applied Neurobiology*, *37*(2), 118-134. <https://doi.org/10.1111/j.1365-2990.2010.01131.x>
- Büttner, A., Mall, G., Penning, R., & Weis, S. (2000). The neuropathology of heroin abuse. *113*(1-3), 435-442.

- Curran, H. V., Kleckham, J., Bearn, J., Strang, J., & Wanigaratne, S. (2001). Effects of methadone on cognition, mood and craving in detoxifying opiate addicts: a dose-response study. *Psychopharmacology*, *154*(2), 153-160.
<https://doi.org/10.1007/s002130000628>
- Darke, S., McDonald, S., Kaye, S., & Torok, M. (2012). Comparative patterns of cognitive performance amongst opioid maintenance patients, abstinent opioid users and non-opioid users. *Drug and Alcohol Dependence*, *126*(3), 309-315.
<https://doi.org/10.1016/j.drugalcdep.2012.05.032>
- Durie, M. (1994). *Whaiora: Maori Health Development* Oxford University Press.
- Forsberg, A., Adams, E. J., & Cowan, N. (2021). The role of working memory in long-term learning: Implications for childhood development. In K. D. Federmeier (Ed.), *The psychology of learning and motivation*. (Vol. 74, pp. 1-45). Elsevier Academic Press.
<https://doi.org/10.1016/bs.plm.2021.02.001>
- Goodman, J. B., Freeman, E. E., & Chalmers, K. A. (2019). The relationship between early life stress and working memory in adulthood: A systematic review and meta-analysis. *Memory*, *27*(6), 868-880. <https://doi.org/10.1080/09658211.2018.1561897>
- Larrabee, G. J. (2020). Memory Changes in the Aging Brain. In K. M. Heilman & S. E. Nadeau (Eds.), *Cognitive changes and the aging brain*. Cambridge University Press.
- Linehan, M. (2015). *DBT® skills training manual* (Second edition ed.). The Guilford Press.
- Majer, M., Nater, U. M., Lin, J.-M. S., Capuron, L., & Reeves, W. C. (2010). Association of childhood trauma with cognitive function in healthy adults: A pilot study. *BMC Neurology*, *10*. <https://doi.org/10.1186/1471-2377-10-61>

Nilaweera, D., Freak-Poli, R., Gurvich, C., Ritchie, K., Chaudieu, I., Ancelin, M.-L., & Ryan,

J. (2022). The association between adverse childhood events and later-life cognitive function and dementia risk. *Journal of Affective Disorders*, 304, 128-132.

<https://doi.org/10.1016/j.jad.2022.02.062>

Prosser, J., London, E. D., & Galyner, I. I. (2009). Sustained attention in patients receiving

and abstinent following methadone maintenance treatment for opiate dependence:

Performance and neuroimaging results. *Drug and Alcohol Dependence*, 104(3), 228-

240. <https://doi.org/10.1016/j.drugalcdep.2009.04.022>

Rass, O., Kleykamp, B. A., Vandrey, R. G., Bigelow, G. E., Leoutsakos, J.-M., Stitzer, M. L.,

Strain, E. C., Copersino, M. L., & Mintzer, M. Z. (2014). Cognitive performance in

methadone maintenance patients: Effects of time relative to dosing and maintenance

dose level. *Experimental and Clinical Psychopharmacology*, 22(3), 248-256.

<https://doi.org/10.1037/a0035712>

Richards, M., & Wadsworth, M. E. J. (2004). Long term effects of early adversity on

cognitive function. *Archives of Disease in Childhood*, 89(10), 922-927.

Tetrault, J. M., & Fiellin, D. A. (2013). Current and Potential Pharmacological Treatment

Options for Maintenance Therapy in Opioid-Dependent Individuals. *Drugs*, 72(2),

217-228. <https://doi.org/10.2165/11597520-000000000-00000>

Thorpe, H. H. A., Hamidullah, S., Jenkins, B. W., & Khokhar, J. Y. (2020). Adolescent

neurodevelopment and substance use: Receptor expression and behavioural

consequences. *Pharmacology and Therapeutics*, 206.

<https://doi.org/10.1016/j.pharmthera.2019.107431>

Zhao, R., Hu, Y., Ni, G., & Bai, Y. (2022). *The influence of age-related hearing loss on*

working memory based on EEG analysis [Conference]. International Conference on
Complex Medical Engineering.