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CAREGIVER SUPPORT FOLLOWING THE DISCLOSURE OF CHILD SEXUAL ABUSE

Annik Salome van Toledo

Abstract

Children who have been sexually abused generally have better outcomes if they receive support from their caregivers. However, in the literature to date there has been little focus on the needs of the caregivers supporting their child and the ways these can be addressed. In New Zealand, the Accident Compensation Corporation (ACC) introduced a pilot programme in 2006 that aimed to support caregivers in their parenting following the disclosure of child sexual abuse (CSA) by providing education about CSA, assisting in management of their children, and teaching them coping skills. This thesis presents the findings of a programme evaluation carried out on the Parenting Support Pilot Programme implemented by ACC.

This evaluation is the first large-scale study that has investigated an individual caregiver intervention that provides more than just psychoeducation. The programme was evaluated using an action research framework that included a needs assessment, process evaluation, outcome evaluation, and feedback given to ACC both during and at the completion of the pilot. Both qualitative and quantitative research methods were used, with an emphasis on interview data from consumers of the programme. The needs assessment was conducted on 60 paper files supplied by ACC and confirmed that support for caregivers is indicated following the disclosure of CSA. The process evaluation consisted of face-to-face semi-structured interviews with two ACC managers, two ACC peer reviewers, 11 ACC counsellors, and 10 caregivers. This evaluation produced recommendations to improve awareness and access to the programme, and identified the need for more sessions than prescribed for some caregivers. Despite some ongoing programme delivery issues, the impact evaluation, conducted via 57 telephone interviews with caregivers, showed that the programme was beneficial for most caregivers and their children. Specifically, the programme increased caregivers’ understanding of the impact of CSA on their child, improved caregivers’ ability to help their children, and helped them manage their own responses to the sexual abuse disclosure.
- This thesis is dedicated to my family -
Firstly, I would like to thank my participants for their time and willingness to contribute to this thesis. In particular, thanks must go to the caregivers who shared their stories during a particularly challenging time in their lives.

Over the course of this thesis, I have received help from many people who I would like to acknowledge here. Firstly, thank you to my supervisor Professor Fred Seymour for his support, motivation, and continued guidance throughout the course of this thesis. I also want to thank Dr Heather McDowell, my secondary supervisor, for her enthusiasm and support.

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I have learnt much from the staff and students at the University of Auckland, and particularly want to thank those in the Department of Psychology and Clinical Psychology Programme. Your support and help has meant a lot to me over these years. To my friends within the department, thank you for your continued advice, support, humour, and time.

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CHAPTER ONE: INTRODUCTION

Background

I have always had an interest in resiliency and how people recover from a variety of traumas including those related to wars, natural disasters, and different types of abuse. During my undergraduate studies this interest developed further, particularly in how trauma affects children and their families. Therefore when I began my training in clinical psychology I decided to combine these interests and investigate the effect of one type of trauma on children and their families.

In 2007 the Accident Compensation Corporation (ACC) in New Zealand (NZ) put out a request for proposals (RFP) to undertake an evaluation of their ‘Parenting Support Pilot Programme’, which had commenced in November 2006. The aim of this pilot was to provide parenting support to non-offending caregivers of children who had disclosed sexual abuse. Together with input from the other members of my research team consisting of Professor Fred Seymour, Dr Ian Lambie, Dr Heather McDowell, and Erana Cooper I wrote a proposal to conduct a process evaluation and impact evaluation on the pilot project in response to the to RFP put out by ACC. Following a formal assessment of this proposal, ACC contracted out the evaluation to our research team at the University of Auckland. This thesis arose from my role in the project which included designing interview schedules, collecting data, methods of analysis, and preparing four separate reports to ACC including a literature review, the process evaluation, the impact evaluation, and the final evaluation summary report. Therefore, this thesis investigated the Parenting Support Pilot Programme by using action research to evaluate and provide feedback on the current programme, with the aim of improving its efficiency and effectiveness.

Furthermore, this thesis aimed to add to the current literature about the usefulness of providing parenting support to caregivers following the disclosure of Child Sexual Abuse (CSA). To date, there is only limited literature available regarding the need for parenting interventions for
caregivers, despite research indicating that this may be important in the recovery from CSA. Additionally, this thesis considered how such support may best be provided in the NZ context, particularly given the unique diversity of ethnic backgrounds within the population.

The purpose of this chapter is to review the interventions available for caregivers of children who have disclosed sexual abuse. Summary background information is provided on the prevalence of child sexual abuse (CSA), the short- and long-term impacts of sexual abuse, factors that mediate these impacts, the legal responses to abuse disclosure, and the interventions available to CSA victims. The impact of a child’s disclosure on the non-offending caregiver and their related needs is also discussed in some detail. Finally, a review of specific interventions available to caregivers after such a disclosure is presented.

Prevalence of Child Sexual Abuse

Estimates of the proportion of CSA victims in the population is referred to as prevalence, while incidence studies estimate new cases occurring over a given period of time such as a year (Peters, Wyatt & Finkelhor, 1986). Prevalence estimates are generally more useful in CSA research due to the low reporting of abuse (Mullen, Martin, Anderson, Romans & Herbison, 1993; Russell, 1983).

Accurate prevalence rates are difficult to estimate due to discrepant CSA definitions, methodological issues in prevalence studies and issues around disclosure. Variations in definitions arise from differences in the upper age limit of victims employed, the type of abuse included (e.g., contact abuse only or contact and non-contact acts), and the criteria used to define a sexual experience as abusive (Haugaard, 2000; Lowe, Pavkov, Casanova & Wetchler, 2005; Wyatt & Peters, 1986a). Discrepancies in definition may have significant implications for conclusions reached. For example, narrow definitions may disregard the negative impacts for children that may follow non-contact sexual acts, whereas broader definitions may in turn distort and minimise the consequences of CSA due to the inclusion of acts for which there is less impact (Haugaard; Wyatt & Peters). Methodological issues such as where the sample is obtained from
and how the participants are questioned about abusive experiences may also affect reported prevalence rates (Wyatt & Peters, 1986b).

Despite these problems with definition, broad agreement reflected in several large prevalence studies is that at least one in four females and one in seven males have experienced some form of sexual abuse as children (Baker & Duncan, 1985; Briere & Elliott, 2003; Finkelhor & Dzuba-Leatherman, 1994; Finkelhor, Hotaling, Lewis & Smith, 1990; Finkelhor, Ormond, Turner & Hamsby, 2005; Kercher & McShane, 1984; McCrann, Lalor & Katabaro, 2006; Steel, Sanna, Hammond, Whipple & Cross, 2004; Wyatt, Loeb, Wolis & Carmona, 1999). Females reported higher prevalence rates in all the studies reviewed, irrespective of the ethnicity of the sample or the country where the study took place. A recent review by Pereda, Guilera, Forns, and Gomez-Benito (2009) showed that CSA prevalence rates appear to remain fairly constant over time.

Comparable prevalence rates have been found in NZ. In a large community survey, nearly one third of women reported having experienced at least one unwanted sexual experience before the age of 16, 70% for whom genital contact was involved, and 12% of the sample reporting intercourse (Mullen et al., 1993). In a longitudinal NZ study, 10.4% (3.4% of males and 17.3% of females) of 1265 survey participants disclosed at least one unwanted sexual experience before the age of 16 (Fergusson, Lynskey & Horwood, 1996). However, it is possible that the young age of the cohort at the time of questioning (18 years) led to underreporting of the prevalence rates, as reports of sexual abuse increased when asking the same participants three years later (Fergusson, Horwood & Woodward, 2000). The Adolescent Health Research Group (2003), which surveyed adolescents in high school, found similar rates to the study by Fergusson and colleagues with 14% of males and 26% of females reporting sexual abuse. A recent random household survey of NZ women found prevalence rates closer to that found by Mullen and colleagues with approximately one in four women reporting experiences of CSA, though their definition of CSA was broad and non-specific (Fanslow, Robinson, Crengle & Perese, 2007).

CSA is found to occur across ethnicities (Kercher & McShane, 1984; Putnam, 2003; Wyatt, 1985), socio-economic statuses (Alexander & Lupfer, 1987; Baker & Duncan, 1985; Fergusson, Lynskey & Horwood, 1996; Finkelhor, 1994; Putnam), parental education levels (Alexander & Lupfer), and urban/rural localities (Baker & Duncan; Mullen et al., 1993). A recent NZ study
indicated that Māori women report higher CSA rates than women of other ethnicities (Fanslow et al., 2007). There is increased risk of experiencing CSA if the victim is female (Dube & Hebert, 1988; Fergusson, Swain-Campbell & Hoorwood, 2002; Putnam; Ullman & Filipas, 2005), older (Finkelhor, Moore, Hamby & Straus, 1997), lacks confidence, or has low self-esteem (Elliot, Browne & Kilcoyne, 1995). Therefore, CSA is an issue that affects all of society, and it is important to consider the impact that such an event has on the individual both in the short-term and long-term.

Impact of Child Sexual Abuse on the Child

The consequences of CSA vary between individuals, from no apparent effects to debilitating psychological and behavioural effects (Putnam, 2003). Some individuals who at first report no adverse effects may report a deterioration in psychological wellbeing over time (Finkerlhor & Berliner, 1995; Gomes-Schwartz, Horowitz & Cardarelli, 1990; Mannarino, Cohen, Smith & Moore-Motily, 1991). The impacts of CSA on the individual have been found to be heterogeneous and comprise of a variety of both short-term and long-term effects. These effects have been described in reviews by Briere and Elliot (1994), Beitchman, Zucker, Hood, DaCosta, and Ackman (1991), Beitchman, Zucker, Hood, DaCosta, Ackman, and Cassacia (1992), Finkelhor (1990), Jumper (1995), Kendall-Tackett, Williams, and Finkelhor (1993), and Maniglio (2009).

Short-term effects
Children who have been sexually abused may experience a range of externalising and internalising effects during childhood. Internalising effects that children may experience include: anxiety, fearfulness, depression (Ackerman, Newton, McPherson, Jones & Dykman, 1998; Garnefski & Diekstra, 1997; Ligezinska, Firestone, Manion, McIntyre, Ensom & Wells, 1996; Swanston, Tebbutt, O’Toole & Oates, 1997), becoming withdrawn and avoidant (Deblinger, McLeer, Atkins, Ralphe & Foa, 1989), numbing of emotions (Deblinger et al.), decreased social efficacy, confidence and self-esteem (Ligezinska et al.), increased suicidality and suicidal ideation (Garnefski & Diekstra; Swanston et al.), loneliness (Garnefski & Diekstra), sleep disturbances including nightmares, flashbacks, experiences of detachment and derangement
Introduction

(Boney-McCoy & Finkelhor, 1995; Deblinger et al.). Externalising behaviours that have been reported include: sexualised behaviours, sexual dysfunction, and promiscuity in adolescence (Deblinger et al.), regressive behaviours, aggression, irrationality, running away, delinquency, cruelty, self-injurious behaviours, and somatic complaints (Swanston et al.). Such short-term effects have been linked to several Diagnostic and Statistical Manual IV (DSM-IV TR; American Psychological Association, 2000) diagnoses including: attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, conduct disorder, major depression, bipolar depression, dysthymia, separation anxiety, phobias, obsessive, compulsive, and avoidant personality disorders, and post-traumatic stress disorder (PTSD; Ackerman et al.; Boney-McCoy & Finkelhor; Deblinger et al.). Sexualised behaviour has been indicated as the effect most specific to exposure to CSA as the other short term effects described above are also common following physical abuse or neglect (American Psychological Association, 2001; Briere & Runtz, 1990; Deblinger et al.).

Long-term effects

In adulthood, individuals who were victims of CSA report experiencing a range of difficulties related to their victimisation including increased experiences of depression, panic attacks/anxiety, eating disorders, obsessions and compulsions, dissociation, avoidance, and PTSD (Brodsky, Oquendo, Ellis, Haas, Malone & Mann, 2001; Fergusson, Horwood & Lynskey, 1996; Fergusson et al., 2002; Goodwin, Fergusson & Horwood, 2005; Mulder, Beautrais, Joyce & Fergusson, 1998; Mullen, Martin, Anderson, Romans & Herbison, 1996; Neumann, Houskamp, Pollock & Briere, 1996). Additionally, some adults report feeling more impulsive, aggressive, and helpless, with some worrying about becoming perpetrators of abuse themselves (Brodsky et al.; Denov, 2004; Lisak, 1994). Victims of CSA may experience sexually related difficulties in adulthood including promiscuity, prostitution, sexual aggression, discomfort with sex, sexual dysfunction, sexual offending, and sexual revictimisation (Alexander & Lupfer, 1987; Denov; Fanslow et al., 2007; Fromouth, 1986; Neumann et al.; van Roode, Dickson, Herbison & Paul, 2009). Adults may also experience identity issues, with many individuals reporting lowered self-esteem or reduced self-concept (Alexander & Lupfer; Denov; Lisak; Mullen et al.; Neumann et al.). Furthermore, adult victims of CSA may have somatic complaints and thus increased medical utilisation (Arnow, Hart, Scott, Dea, O’Connell & Taylor, 1999; Neumann et al.), self-harm, think about or attempt suicide (Brodsky et al.; Fergusson, Horwood & Lynskey, 1996; Neumann
et al.), and abuse drugs and alcohol (Denov; Fergusson, Horwood & Lynskey; Mullen et al.; Singer, Petchers & Hussey, 1989). As a result these adults frequently report having greater problems with interpersonal relationships (Denov).

Despite such numerous and varying risks related to CSA, some individuals are resilient, with 40-50% of victims apparently not experiencing any negative effects (Finkelhor & Berliner, 1995; Kendall-Tackett et al., 1993). The degree to which CSA affects the individual victim is mediated by several factors related to characteristics of the child, the abuse event(s), the context in which abuse occurred, the level of attributions of responsibility, and level of support provided by caregivers.

Variables that Mediate the Impact of Child Sexual Abuse

There are several static and dynamic factors that may affect the impact of CSA on the individual. Understanding these factors may be important in identifying children who could be at greater risk of negative short-term and/or long-term effects as a result of the abuse, as well as being able to identify factors that may assist a child’s treatment and recovery.

**Characteristics of the individual**

Static factors linked to the victim that mediate the impact of CSA include gender, age when first abused, age when abuse finished, and age at disclosure (Back & Lips, 1998; Barker-Collo & Read, 2003; Fergusson, Lynskey & Horwood, 1996; Fergusson et al., 2002).

Although the effect of the age of onset for the abuse is inconclusive, some studies indicate greater impact of abuse with earlier onset (Back & Lips, 1998; Barker-Collo & Read, 2003). Despite it being suggested that the risk of victimisation increases with age (Finkelhor et al., 1997), Mullen and colleagues (1993) found that 65% of CSA victims were abused before their first menses, with abuse most likely to occur between the ages of eight to 12 (highest rates at 11 years old). More recently, Fanslow and colleagues (2007) identified the median age of abuse onset for females in NZ to be nine years old. Girls have generally been found to be victimised earlier than boys.
(Baker & Duncan, 1985). A large review has found that the effect of time since disclosure on individual outcomes is unclear (Kendall-Tackett et al., 1993).

It has been suggested that gender is associated with differential outcomes for CSA (Fergusson, Lynskey & Horwood, 1996; Fergusson et al., 2002). This may be accounted for by the fact that females report higher frequency and greater severity of abuse and more intrafamilial abuse, which may result in more distress and self-blame and the greater use of withdrawal and avoidance coping strategies than males (Dube & Hebert, 1988; Fergusson et al., 2002; Putnam, 2003; Romano & De Luca, 2001; Ullman & Filipas, 2005). Although women are more likely than men to disclose abuse (Briggs & Hawkins, 1995), men generally report greater PSTD symptomatology, which has been linked to delays in disclosure. Males report a greater range of effects and are more likely to be exposed to abuse involving physical contact than females (Baker & Duncan, 1985). Females tend to experience more internalising symptoms, while males experience a larger range of externalising symptoms (Baker & Duncan; Fergusson et al., 2002).

Perpetration
Along with individual victim characteristics, the relationship to the perpetrator is a significant predictor of psychological outcome in CSA victims. It is estimated that a high proportion of perpetrators are known to the victim (Baker & Duncan, 1985; Berliner & Conte, 1990; Finkelhor, 1994; Kendall-Tackett et al., 1993; Mullen et al., 1993). Perpetrators have been found to be diverse in age, socio-economic level, marital status, occupation, and ethnic group (Fergusson, Lynskey & Horwood, 1996; Murphy & Smith, 1997), although it has been suggested that perpetrators from higher income levels may be able to avoid detection more easily than other perpetrators (Briggs & Hawkins, 1995).

The majority of perpetrators are male (Anderson, Martin, Mullen, Romans & Herbison, 1993; Fergusson, Lynskey & Horwood, 1996; Finkelhor, 1990), although unique difficulties have been associated with female-perpetrated abuse as this type of abuse is more likely to be trivialised, resulting in inadequate care and support (Denov, 2004; Mullen et al., 1993). In one NZ study, female-perpetrated abuse has been found to account for approximately 2% of abuse incidences (Mullen et al.).
Closeness of the perpetrator to the victim is an important mediating variable, with intrafamilial abuse resulting in the worst short-term and long-term outcomes for CSA victims (Barker-Collo & Read, 2003; Coulburn-Faller, 1989; Fergusson, Horwood & Lynskey, 1996). The greater difficulties children experience after intrafamilial abuse has been related to higher levels of secrecy, coercion, and distortions of relationships, which are inherent in intrafamilial abuse (Baker & Duncan, 1985). Additionally, victims of intrafamilial abuse are more likely to experience a greater number of abuse events, longer duration of CSA occurrence, a greater time before disclosure, and are generally younger at the onset of abuse (Conte & Schuerman, 1987; Coulburn-Faller; Fergusson, Lynskey & Horwood, 1996; Fischer & McDonald, 1998).

The duration and severity of the abuse have also been identified as important mediators, with more violent or severe abuse being linked to greater impact of abuse (Baker & Duncan, 1985; Barker-Collo & Read, 2003; Fassler, Amodeo, Griffin, Clay & Ellis, 2005; Kellogg & Hoffmann, 1997; Kendall-Tackett et al., 1993; Steel et al., 2004). Additionally, greater impact of CSA has often been found when there has been gradual sexualisation of the relationship (referred to as ‘grooming’) so that children learn to attribute sexual behaviour to emotional closeness, perpetrators rationalise the abuse experiences, and coercion results in increased psychological control over the victim (Berliner & Conte, 1990).

Another factor that mediates the effect of CSA is the number of perpetrators, with multiple perpetrators being linked to more negative outcomes (Kellogg & Hoffmann, 1997; Steel et al., 2004). Repeat offending by perpetrators with multiple victims is not uncommon (Conte & Schuerman, 1987; Briere & Elliott, 1994).

**Context of abuse**

The wider family context related to abuse is also important to consider as a mediating variable. Studies indicate that negative family characteristics such as lack of cohesion, lack of adaptability, and high levels of conflict, mediate the incidence and long-term impacts of CSA more than the severity of the abuse itself, particularly in intrafamilial CSA (Alexander & Lupfer, 1987; Berliner & Conte, 1995; Fassler et al., 2005). Additionally, the quality of family relationships may affect both the risk for CSA and responses to disclosure, with higher incidences of abuse seen in families where there is parental separation or where children are exposed to high levels of marital
discord (Baker & Duncan, 1985; Boney-McCoy & Finkelhor, 1996; Fergusson, Lynskey & Horwood, 1996; Finkelhor et al., 1997; Sirles & Franke, 1989). Parental substance abuse also increases the incidence and repetition of CSA, as does negative parental mental health and the presence of other concomitant abuse or neglect in the home (Barker-Collo & Read, 2003; Fergusson, Lynskey & Horwood; Kellogg & Hoffmann, 1997; Mullen et al., 1993; Oates, Tebbutt, Swanston, Lynch & O’Toole, 1998; Putnam, 2003).

More CSA is reported in stepfamilies, though the higher overall incidence of incest in children living with both biological parents suggests that this aspect of family composition may not necessarily be protective (Fassler et al., 2005; Fergusson, Lynskey & Horwood, 1996). When prevalence rates are corrected for the number of victims living with biological fathers compared to stepfathers, it has been found that step-fathers are 10 times more likely to be perpetrators of CSA than biological fathers (Mullen et al., 1993). The quality and nature of peer and family relationships such as attachment styles and paternal overprotection can mediate long-term outcomes for CSA victims, with increased long-term problems for children from disorganised families (Barker-Collo & Read, 2003; Fergusson, Lynskey & Horwood; Lynskey & Fergusson, 1997).

Despite the significant impact that the context surrounding the abuse has on the risk for CSA and responses to disclosure, research controlling for contextual variables has found that such factors do not predict CSA risk and outcomes well (Fergusson, Lynskey & Horwood, 1996). This indicates that factors outside of the family context influence CSA occurrence and effects.

*Attributional style*

Several studies have indicated that the public may have different attitudes towards the culpability of victims depending on situational variables; victim variables, including age and gender; societal variables; and perpetrator variables (Back & Lips, 1998; Briere & Elliot, 1994; Jackson & Ferguson, 1983; Rogers & Davies, 2007). Blaming the victims and their non-offending caregivers is not uncommon, even among professionals, which may result in professionals being unsympathetic and unhelpful (Lerner & Miller, 1978; Muller, Caldwell & Hunter, 1993; Ford, Schindler & Medway, 2001). Males are more likely than females to attribute blame to the victims of abuse, and both males and females are more likely to attribute blame to victims who are
adolescents compared to children (Back & Lips; Briere & Elliot; Finkelhor, 1994; Rogers & Davies). Males are more likely than females to blame the victims if a victim is older, male, and the perpetrator is female (Rogers & Davies). Victim blaming attributions may be based on the opinion that they could have resisted the perpetrator and prevented the abuse and assumptions that older children are better able to defend themselves (Collings & Payne, 1991; Maynard & Wiederman, 1997). There are some limitations with such research, with attributions in part dependent on the types of questions asked, the language used pertaining to the sexual activity and/or abuse, and the source of respondents (e.g., community sample or university sample; Collings & Bodill, 2003; Jackson & Ferguson).

Although other peoples’ attributions of abuse may affect the support and stigma associated with CSA, the victim’s own cognitions or attributional style can mediate the negative long-term effects experienced as a result of victimisation (Barker-Collo, 2001; Barker-Collo & Read, 2003; Berliner & Conte, 1990; Wenninger & Ehlers, 1998). Forming attributions about CSA assists individuals in making sense of the abuse and allows some control over the environment and future for the victim and those around them (Lerner & Miller, 1978; Shaver, 1970). Not all children blame themselves (Hunter, Goodwin & Wilson, 1992), though they have been found more likely to do so if the abuse is intrafamilial (Barker-Collo). Attributional styles, together with coping strategies, can affect long-term outcomes for CSA victims over and above the impact of abuse-related variables such as closeness to the perpetrator, force used, age of onset, resistance, participation, and frequency (Steel et al., 2004). In general, CSA victims are more likely to attribute the occurrence of abuse and psychological problems to personal inadequacies than to others, in particular to the perpetrator (Briere & Elliot, 1994; Wenninger & Ehlers). Dysfunctional beliefs around safety, guilt, self-condemnation, self-esteem, intimacy or trust have been linked to negative long-term emotional and sexual problems in CSA victims (Elliott, 1999; Wenninger & Ehlers).

Experiences of disclosure
Disclosure of CSA events is usually significantly delayed (Finkelhor et al., 1990; Sorensen & Snow, 1991). A review by London, Bruck, Ceci, and Schuman (2005) concluded that there is a 33% disclosure rate during childhood; or more significantly, 67% of CSA victims do not tell anyone until adulthood, if at all. Disclosure of CSA can have a large impact on both the
individual who discloses, and those around them, although abuse may continue despite the disclosure (Berliner & Conte, 1995; Palmer et al., 1999). Anderson and colleagues (1993) found in their study that of those children who disclose that 37% disclose in the first year. Children may test the safety of disclosing abuse by beginning with a tentative disclosure, followed by increasingly direct disclosure, or retraction (Sorensen & Snow). Reasons for delays in disclosure of abuse may be due to concerns about upsetting people, fears that they might not be believed, embarrassment, guilt, protecting the perpetrator, and fearing or obeying the perpetrator (Hershkowitz, Lanes & Lamb, 2007). Less than half of initial disclosures are to parents (Anderson et al.; Mullen et al., 1993).

Retraction is relatively common. In a study conducted by Sorensen and Snow (1991) 22% of children retracted their allegations after the initial disclosure, though a more recent review by London et al. (2005) has indicated that this number may be much lower. Retraction has been found to be more common when CSA was intrafamilial and involved multiple incidences, or when disclosure was met with anger or disbelief (Berliner & Elliott, 1996; Herschkowitz et al., 2007). Tentative disclosures and retractions, together with the secrecy, helplessness, and coercion that occur as a result of CSA, contribute to the decreased credibility of victims (Summit, 1983). This has been referred to as the child sexual abuse accommodation syndrome (Summit). Disclosure is not affected by age or urban versus rural living, although factors such as privacy, support, and prompts may facilitate disclosure (Jensen, Gulbrandsen, Mossige, Reichelt & Tjersland, 2005; Mullen et al., 1993).

Responses to disclosure can include belief or disbelief, affective responses, and behavioural responses (ranging from removing the perpetrator from the household to allowing them continued access to the child; Alaggia, 2002). The response of others to disclosure has a very important impact on the outcomes of CSA for the child (Barker-Collo & Read, 2003; Berliner & Conte, 1995; Mullen et al., 1993). A child is more likely to experience negative outcomes when no action is taken against the perpetrator, with better outcomes related to supportive responses such as belief, acknowledgement, and action taken against the perpetrator (Palmer, Brown, Rae-Grant & Loughlin, 1999). Children report feeling more supported if they were believed when they first disclosed (Jinich & Litrownick, 1999).
Caregiver responses to the disclosure of abuse are fluid, changing over time, with the majority of mothers believing their child immediately, particularly in the case of extrafamilial abuse (Alaggia, 2002; Humphreys, 1992; Sirles & Franke, 1989). However, it may be difficult for some mothers to sustain this belief, particularly if they are themselves in a relationship with the perpetrator, and in the presence of their initial reactions which may include shock, shame and/or self-blame (Bolen & Lamb, 2004; Humphreys). Abuse characteristics such as increased age of the victim, the nature of the abuse (perpetrator closer to victim and more severe abuse), and the presence of the parent in the home during the abuse, are related to fewer disclosures being believed, as is the presence of domestic violence in the home (Sirles & Franke, 1989). Additionally, if a caregiver has been victimised in the past this may also affect how readily they believe their child (Hooper, 1992).

**Caregiver support**

The support children receive from their caregivers after disclosure is important, particularly when the child requires crisis support (Adams-Tucker, 1981; Barker-Collo & Read, 2003; Everson, Hunter, Runyon, Edelsohn & Coulter, 1989; Lipton, 1997; Plummer, 2006). The disclosure of CSA is usually a major crisis for a family, for which its members are unprepared (Humphreys, 1995; Lipton). It is during this time that children are most in need of support from their parents, which may be difficult because of the personal impact of disclosure (Everson et al.; Humphreys; Lipton). Lack of caregiver support has been linked to increased stress and trauma symptomatology in the child (Adamakos, Ryan & Ullman, 1986; Everson et al.; Feiring, Taska & Lewis, 1998; Lipton), and the overall level of support from caregivers is linked to better outcomes in children (Kendall-Tackett et al., 1993; Lovett, 1995; Newberger, Greym, Waternaux & Newberger, 1993). Caregiver support also plays an important role in assisting the child through investigation processes and treatment (Davies & Seymour, 1999a).

In summary, mediating variables, including victim characteristics, characteristics related to perpetration, the context of abuse, attributitional style, issues around disclosure and caregiver support all impact on the outcomes for children following CSA. Of particular relevance to the present research is caregiver support. To understand this, it is important to consider in more detail how disclosure of CSA impacts caregivers and other family members.
Therapeutic Interventions for Children

Following disclosure, children need to be assured that they will be supported and protected in the future by their non-offending caregivers, particularly in the case of intrafamilial CSA (Everson et al., 1989; Print & Dey, 1992). Furthermore, children may require additional support to work through issues around victimisation to reduce the negative impact of sexual abuse both in the short-term and long-term. Children generally report positive experiences of therapeutic interventions, with increased professional contact resulting in decreased distress (Berliner & Conte, 1995; Finkelhor & Berliner, 1995), although improvements coinciding with therapy could be mediated by the mere passage of time (Hetzel-Riggin, Brausch & Montgomery, 2007).

Individual interventions

Guidelines for treatment of child physical and sexual abuse developed for the USA Department of Justice (Saunders, Berliner & Hanson, 2004) outline several child-focussed therapies that are potentially useful to children including cognitive behavioural and dynamic play therapy, cognitive processing therapy (CPT), eye movement desensitisation and reprocessing (EMDR), resilient peer training intervention, therapeutic child development programme, trauma-focused cognitive behavioural therapy (TF-CBT), trauma-focussed integrative-eclectic therapy (TF-IET), and trauma-focused play therapy. Of these TF-CBT, which is an intervention based on learning and cognitive therapies, has the most evidence supporting its efficacy (Saunders et al.). This intervention has also been piloted successfully as a manualised intervention for multiply-abused children in NZ (Feather & Ronan, 2006). Further evidence for therapy effectiveness is provided in reviews by O’Donahue and Elliott (1992), Cohen, Berliner, and Mannarino (2000), Finkelhor and Berliner (1995), Jones and Ramchandani (1999), King, Tonge, Mullen, Myerson, Heyne, and Ollendick (1999), Mortimer, Evans, Jourdain, Cargill, and Woolley (2006), and Stevenson (1999). Finkelhor and Berliner (1995) suggest that important factors in the child’s context should be addressed as part of intervention. These factors include parental support, maternal help-seeking, family cohesion, and healthy conflict management within the family (Finkelhor & Berliner). Studies have indicated that individual and group interventions are equally useful in symptom reduction (Jones & Ramachandani, 1999), however a study by Nolan and colleagues (2002) found individual interventions were better able to reduce PTSD symptoms than group interventions. Although the duration and frequency of interventions fell within the scope of some
reviews, no conclusive evidence was found for optimal levels of these (Finkelhor & Berliner; Nurcombe, Wooding, Marrington, Bickman & Roberts, 2000).

A review by Finkelhor and Berliner (1995) indicated that there is evidence of spontaneous recovery in some children, with some studies showing equal improvements in both the treatment and non-treatment groups. However, this could be due to developmental aspects of recovery, differential parental support, or selection bias (Finkelhor & Berliner). They also indicated that there was less evidence for efficacious treatment for aggression and sexualised behaviours than other behaviour problems, while some children did not show any improvements with the interventions reviewed (Finkelhor & Berliner).

Overall, reviews conclude that cognitive behavioural therapy (CBT) is the most efficacious intervention, supporting the guidelines developed for the USA Department of Justice (Cohen et al., 2000; Jones & Ramachandani, 1999; King et al., 1999; Stevenson, 1999). Cognitive behavioural therapy generally resulted in stable treatment effects and was favoured by caregivers, being particularly helpful with anxiety and depression, but less so in regards to PTSD (Saywitz, Mannarino, Berliner & Cohen, 2000). When children received CBT it was found that their caregivers experienced reduced stress, anxiety, and depression over the course of their child’s treatment (King et al.; Stevenson).

*Family/parent-child interventions*

The guidelines for treatment of child physical and sexual abuse developed for the USA Department of Justice also indicate several interventions for the whole family, for the parents alone, and for the parents and victimised child together. These include attachment therapy, attachment-trauma therapy, behavioural parent training, family focused therapy, child centred treatment, family resolution therapy (FRT), integrative family perseveration services, intensive family perseveration services, multisystemic therapy (MST), parent-child interaction therapy (PCIT), and Parents United (child sexual abuse treatment programme; Saunders et al., 2004). Most of these were recommended as acceptable treatments, but currently have little research supporting them (Saunders et al.).
A recent review by Corcoran (2004) of interventions involving non-offending parents describes a number of studies where interventions that focused on the child and included the active involvement of the non-offending parent. Notable amongst these studies were CBT interventions with parental involvement by Cohen and Mannarimo (1996a; 1996b; 1997; 1998a; 1998b; 2000), Deblinger, Lippmann, and Steer (1996), Deblinger, McLeer and Henry (1990), Deblinger, Stauffer and Steer (2001), Deblinger, Steer and Lippmann (1999), King and colleagues (2000), and Stauffer and Deblinger (1996).

Responses to CSA Disclosure in New Zealand

Caregiver response is not only important for providing psychological support for their child, but also to prevent further abuse and provide access to external social services. Before considering caregiver response in further detail, the social services involved in the care of those affected by CSA in NZ are described. After a child discloses sexual abuse, the family typically comes into contact with various agencies during the investigation and prosecution processes. Although there are local variations in the relevant services in NZ, there are similarities across all CSA investigations, which will be discussed below.

Initial investigation

In NZ, when CSA is suspected, notifications may be made to Child, Youth, and Family Services (CYFS) or the Police. Following such a notification a social worker is assigned to conduct an investigation, which will include a risk and needs assessment of the child. These efforts are coordinated with Police, who will decide whether to pursue a prosecution of the alleged perpetrator. The social worker generally becomes the main point of contact for the family of the child following the notification. If there has been a clear disclosure of abuse, an evidential video interview (EVI) may be carried out with the child for the purposes of promoting the care and protection of the child, and for potential use in criminal proceedings. Evidential video interviews are a joint operation between CYFS and police, and are conducted by specialists working under strict guidelines and monitoring. If indicated by the EVI, the social worker may also refer the child for a medical examination, which is recommended in all cases of alleged contact sexual abuse in the guidelines developed by Doctors for Sexual Abuse Care (DSAC; DSAC 2006). If
there is no clear disclosure of sexual abuse but there is reason for concern that such an event may have happened, social workers are able to refer children for a ‘diagnostic interview’, which is carried out by a specialist psychological branch of CYFS. This process is more common with very young children and may also support access to care and protection and/or could lead to support services for the family.

**Counselling**
The social worker or others involved with the investigation may also advise the child and their family of counselling services. Counselling may be provided through ACC or CYFS depending on the circumstances of the case (e.g., the perpetrator no longer has access to the child, or the allegation was found to be invalid). If and when the safety of the child has been assured, the EVI and medical examination has been completed, and counselling has been discussed, the case is usually closed by the social worker and CYFS involvement ceases.

**Criminal investigation**
Following notification from CYFS and provision of the EVI, police will begin their criminal investigations, which includes interviews with significant others, and ultimately the decision of whether to prosecute the alleged perpetrator (Davies, 1999). If there is a decision to prosecute, the case will go through pre-trial hearings for the court to assess whether there is sufficient evidence for the case to proceed. If there is sufficient evidence, the case will go to a trial if the alleged perpetrator maintains innocence, or will proceed immediately to sentencing if there is a guilty plea. Alleged perpetrators often enter a late guilty plea, therefore the case may go through a combination of trial preparation and sentencing (Davies).

**Impact of Child Sexual Abuse on Caregivers**

In the following sections, the impact of CSA disclosure on the non-offending caregiver is discussed along with their subsequent needs and ways these needs are met through a range of interventions. A range of impacts of CSA on the caregiver has been documented in the literature. Caregivers often experience a loss of social support networks, financial losses, and psychological
and emotional effects. Caregivers have described the disclosure of CSA as a major life crisis, with most caregivers admitting to being ill prepared to deal with the effects (Humphreys, 1995).

**Emotional impact**

Caregivers have reported experiencing strong emotional reactions as a result of disclosure, such as anger, despair, disbelief, ambivalence towards their child and/or the perpetrator, guilt around their parenting role, and concerns about the investigation and legal processes (Hill, 2001; Humphreys, 1995; Regher, 1990). Those caregivers whose children are involved in criminal trials experience more distress related to both the trial itself and added general life stresses than those that are not involved (Burgess, Hartman, Kelley, Grant & Gray, 1990). It has been found that fathers generally experience more distress than mothers, having greater intrusive and avoidant PTSD symptoms (Burgess et al.). In general, caregivers tend to experience more anxiety than closure as a result of their child testifying (Burgess et al.). Anxiety related to trials is generally due to fears about the child being frightened, discounted and pressured to speak. Some parents also have concerns around the reaction of the community to their child (Burgess et al.). Additionally, caregivers usually experience the fear of having their children removed from their care (Hill). Emotional and psychological effects are inflated when the abuser is the partner of the caregiver (Hill; Humphreys).

Caregivers can experience the effects of their child’s victimisation for several years following disclosure, with studies showing increased rates of maternal depression (Hill, 2001; Schuetze & Eiden, 2005; Wagner, 1991). It is considered important to respond to such emotional and psychological effects experienced by caregivers as it has been found that parental stress and feelings of competence mediate the outcomes of CSA for the child (Schuetze & Eiden).

**Impact on the availability of personal support**

Caregivers are frequently cut off from social and familial support networks following CSA disclosure, with biological caregivers experiencing more distress than non-relative caregivers (Lipton, 1997). Additionally, biological caregivers of CSA victims often experience loss of economic stability, particularly if the partner was the perpetrator of abuse (Carter, 1999; Lipton; Plummer & Eastin, 2007). Support from within the family is particularly difficult if the
perpetrator is a member of the same family, particularly when the perpetrator denies the abuse (Lipton; Plummer & Eastin).

Some caregivers have also described stress arising from a lack of support from some professionals, including being accused of promoting false allegations, receiving criticism about their parenting, experiencing lack of sensitivity about their concerns, and being denied access to social services (Davies & Seymour, 1999a; Henry, 1997; Hill, 2001; Plummer & Eastin, 2007). As a result, some caregivers state that they would not have involved authorities in the disclosure process if they had been able to predict the reaction they would receive (Plummer & Eastin).

Mother-blaming may contribute to the limits in support experienced by some caregivers. Mother-blaming arises from professionals, experts and/or lay-people making assumptions that mothers have an innate parenting instinct, and that by being primarily responsible for the child’s growth, development, behaviour, and safety they are responsible for outcomes for their children (Carter, 1999; Hooper, 1992; Sommerfeld, 1989; Wattenberg, 1985). Due to this belief, mothers may be accused of collusion and failure to protect their child if they plead ignorance to the knowledge of abuse occurring (Gavey, Florence, Pezaro & Tan, 1990). They may be labelled as failed mothers, failed wives, and failed individuals. Some of the earlier literature even suggested that children were abused due to some sexual inadequacy of their mothers (Gavey et al.; Print & Dey, 1992; Wattenberg).

In summary, caregivers may themselves experience emotional and psychological effects, loss of social support networks or financial losses following disclosure by their child of CSA. Additionally they may experience unhelpful attitudes from others making it more difficult for them to seek help for themselves and their child.

Needs of the Caregivers

The importance of caregivers in assisting children following the disclosure of CSA and the significant impact such disclosure may have on the caregivers indicates the importance of considering the needs of caregivers when working with their child.
Need for information and support

As described above, following disclosure, caregivers are typically at first in a state of crisis experiencing shock and disbelief, while having to ensure the safety of their child and family (Carter, 1999; Humphreys, 1995). Caregivers often require assistance in increasing their ability to cope and to work through feelings of denial, guilt, anger, self-pity, resentment, and fear as well as needing help to keep their child safe (Print & Dey, 1992). Furthermore, caregivers may need help in working through feelings of jealousy, betrayal, and powerlessness (Print & Dey).

This is usually a completely novel situation for caregivers, thus they are unaware of agencies to access for assistance. In a study of over 100 caregivers in NZ, Davies and Seymour (1999a) found that caregivers expressed frustration at being poorly informed of the investigation and legal processes, particularly those related to court, delays in the investigation processes, and lack of interagency communication. Furthermore, caregivers expressed difficulties in knowing how to discuss the abuse with their child and were often told not to discuss the abuse with the child in case this affected the evidence for legal proceedings (Davies & Seymour).

The need for external support and information is highlighted as a result of the impact of CSA disclosure on intimate relationships. Caregivers often report decreases in social, familial, and even partner support due to secrecy surrounding CSA, worries around friends being unable to cope, feelings of isolation, and being selective about telling people (Humphreys, 1995; Lewthwaite, 2000). Such a decrease of support is more apparent when the perpetrator of the abuse is the partner of the caregiver, although increases in marital discord and sexual difficulties are also seen when neither caregiver is the perpetrator (Humphreys). This marital conflict can in turn negatively affect the outcomes for the child (Humphreys). Due to the lack of support, caregivers may be reliant on professionals such as counsellors to help address their attributions for the abuse and relationship problems with their partner (Humphreys).

Although caregivers experience a major crisis following CSA disclosure, most are aware that they need to provide support to their child in the aftermath of disclosure (Humphreys, 1995). To be able to actively participate in assisting their child, caregivers are in need of information on the impact of CSA on their child, how to best assist the child, how to manage their child’s behaviour, as well as how they can access support for themselves to deal with their own emotions (Davies &
Seymour, 1999a, 1999b; Hooper, 1992; Humphreys). Additionally, information about the investigation and court processes were named as important by caregivers in the study by Davies and Seymour (1999a). Caregivers frequently indicated that they are not given adequate information (Hooper; Humphreys), and even when they are provided with some information, caregivers frequently expressed a lack of understanding of the information provided (Davies & Seymour, 1999a).

Need for support with their own victimisation
Caregivers may also have been themselves victimised in the past. Parents of children who were sexually abused are more likely than parents of non-abused children to have been themselves abused as children (Davies & Seymour, 1999a; Goodwin, McCarthy & DiVasto, 1981; Hooper, 1992; Oates et al., 1998). However, the same rates of intrafamilial CSA were found in families where caregivers had their own history of victimisation and in families where there was no history of victimisation, indicating that these caregivers were not more likely to choose perpetrators as partners (Oates et al.). Furthermore, CSA victims experienced the same emotional, behavioural, or psychological effects irrespective of whether their caregiver was previously victimised, indicating that a caregiver’s own victimisation was not related to their child’s outcome (Oates et al.). Despite this, such caregivers frequently report extreme emotional distress, requiring help to deal with their own victimisation (Davies & Seymour; Oates et al.).

Need for parenting assistance
Caregivers may also experience difficulties in their parenting abilities after disclosure, for which they require support. As discussed above, there are frequently changes in children’s behaviour following CSA including, but not limited to, anger, regression, sleeping disturbances, insecurity, and sexualised behaviours (Kendall-Tackett et al., 1993). Caregivers may find it particularly challenging to know how to respond to these behaviours (Barth, Yeaton & Winterfelt, 1994). When CSA has not been definitively determined, caregivers may be particularly unclear on how to parent (Plummer & Eastin, 2007).

In summary, the needs and outcomes of the non-offending caregivers are inseparable to those of their child. Davies and Seymour (1999a; 1999b) recommend that professionals involve caregivers as much as possible in the processes following disclosure, keeping them informed and assisting
them in accessing support, education, and counselling as required. Additionally, victimisation issues would be important to consider when looking at supporting caregivers following their child’s disclosure of CSA due to the increased distress they often experience, though this may not have direct consequences on the long-term outcomes of the child. Therefore, the issues that caregivers are faced with may include how to initially deal with disclosure, how to access information, how to deal with their own victimisation issues, and how to parent in this novel situation. Caregivers can be supported in meeting these needs in a variety of ways, with specific interventions needing to be tailored to the needs of the individual caregiver.

Interventions for Caregivers

Although the importance of support for non-offending caregivers of children who have been sexually abused has been indicated in the research as discussed above, there is currently very little information about interventions for caregivers. There are however some reports in the literature of interventions for caregivers which are aimed at providing information, emotional support, parenting advice, and help with their own relationship and victimisation issues (refer to Table 1; Barth et al., 1994; Deblinger, et al., 2001; Forbes, Duffy, Mok & Lemvig, 2003; Hewitt & Barnard, 1986; Hill, 2001; Jinich & Litrownik, 1999; Lewthwaite, 2000; Meiklejohn 2003; Ostis, 2002; Winton, 1990). These interventions provide information through a variety of media as well as utilising support groups, psychoeducational groups, and individual interventions. Most of the research has used qualitative methods to obtain information about the effectiveness of different interventions.

Provision of information
The mere provision of appropriate information may be beneficial for caregivers and their child in the time after CSA disclosure, either in isolation or to provide reinforcement of concepts provided during other interventions (Davies & Seymour, 1999a; 1999b; Humphreys, 1995; Jinich & Litrownik, 1999; Mara & Winton, 1990; Meikeljohn, 2003; Miller & Dwyer, 1997; Olo-Whaanga, 2000; Winton, 1990). Non-offending caregivers often report being unsure of how to respond to their child after disclosure of sexual abuse, both in regards to knowing what types of
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<td>Hewitt &amp; Barnard (1986)</td>
<td>Australia</td>
<td>Support</td>
<td>Support (married to perpetrator)</td>
<td>Group</td>
<td>Sexual Assault Clinic</td>
</tr>
<tr>
<td>Hewitt &amp; Barnard (1986)</td>
<td>Australia</td>
<td>Support</td>
<td>Support (married to perpetrator)</td>
<td>Group</td>
<td>Sexual Assault Clinic</td>
</tr>
<tr>
<td>Hill (2001)</td>
<td>UK</td>
<td>Support</td>
<td>Support</td>
<td>Group</td>
<td>Community sample</td>
</tr>
<tr>
<td>Jinich &amp; Litrownik (1999)</td>
<td>USA</td>
<td>Informational (video and pamphlet)</td>
<td>Teaching (supportive parenting)</td>
<td>Individual</td>
<td>Centre for Child Protection</td>
</tr>
<tr>
<td>Ostis (2002)</td>
<td>USA</td>
<td>Psycho-educational and support</td>
<td>Support, self-mastery and support to child</td>
<td>Group</td>
<td>Sexual Abuse Treatment Program (SATP)</td>
</tr>
<tr>
<td>Winton (1990)</td>
<td>USA</td>
<td>Psycho-educational and support</td>
<td>Education and emotional processing</td>
<td>Group</td>
<td>Hospital-based child abuse unit</td>
</tr>
<tr>
<td>Authors</td>
<td>Facilitators</td>
<td>Sample Size</td>
<td>Duration</td>
<td>Session Length</td>
<td>Frequency</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------</td>
<td>----------------------</td>
<td>----------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Barth et al. (1994)</td>
<td>Two clinicians</td>
<td>15 (all females)</td>
<td>11</td>
<td>Not specified</td>
<td>Not specified</td>
</tr>
<tr>
<td>Deblinger et al. (2001)</td>
<td>Therapists</td>
<td>44 (21 CBT; all females)</td>
<td>11</td>
<td>105 mins</td>
<td>Weekly</td>
</tr>
<tr>
<td>Hewitt &amp; Barnard (1986)</td>
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<td>3 (all females)</td>
<td>10</td>
<td>90 mins</td>
<td>Weekly</td>
</tr>
<tr>
<td>Hewitt &amp; Barnard (1986)</td>
<td>Two social workers</td>
<td>9 (all females)</td>
<td>Open-ended</td>
<td>90 mins</td>
<td>Fortnightly Post-disclosure to post-court</td>
</tr>
<tr>
<td>Hill (2001)</td>
<td>Mothers</td>
<td>11 (all females)</td>
<td>Open-ended</td>
<td>Not specified</td>
<td>Fortnightly Anytime</td>
</tr>
<tr>
<td>Jinich &amp; Litrownik (1999)</td>
<td>Researcher</td>
<td>64 (all females)</td>
<td>1 session</td>
<td>22 mins</td>
<td>Once</td>
</tr>
<tr>
<td>Lewthwaite (2000)</td>
<td>Two clinicians</td>
<td>9 (all females)</td>
<td>10</td>
<td>120 mins</td>
<td>Weekly</td>
</tr>
<tr>
<td>Meiklejohn (2003)</td>
<td>Researcher</td>
<td>23 (19 females, 4 males)</td>
<td>1 session</td>
<td>30 mins</td>
<td>Once</td>
</tr>
<tr>
<td>Ostis (2002)</td>
<td>Two therapists</td>
<td>31 (25 females, 6 males)</td>
<td>16 Sessions</td>
<td>90 mins</td>
<td>Weekly</td>
</tr>
<tr>
<td>Winton (1990)</td>
<td>Male/female co-therapists</td>
<td>27 (21 females, 6 males)</td>
<td>120 mins sessions</td>
<td>13 weekly</td>
<td>Not specified</td>
</tr>
</tbody>
</table>
new behaviours and emotions their child may display as a result of the abuse, and how to deal with these (Davies & Seymour, 1999a; Humphreys, 1995; Miller & Dwyer, 1997). Lewthwaite’s participants requested specific information around the investigation process, including how to support their child if they are required to go to court, what happens at depositions (pre-trial) hearings, the differences in outcomes of a perpetrator pleading guilty or not guilty and explanations of the differences between family and criminal courts. These issues are important as studies have indicated that repeat interviewing of children, whether prior to or during court proceedings, is related to increased levels of distress (Conte & Berliner, 1995; Henry, 1997). Caregivers have also indicated that it would be useful for them to receive information on the dynamics of abuse and disclosure, how to be more supportive to their child, the investigation process, long-term consequences of CSA on their child, and the implications of disclosure on wider family processes (Davies & Seymour, 1999a; Forbes et al., 2003; Jinich & Litrownik; Lewthwaite, 2000; Miller & Dwyer). Therefore, if caregivers can be better informed about these processes they may be able to provide more support to their child.

The medium the information is provided in is also an important consideration. Evidence suggests that caregivers have a preference for written and visual material over exclusively verbal information (Humphreys, 1995; Lewthwaite, 2000; Meiklejohn, 2003; Miller & Dwyer, 1997). Jinich and Litrownik (1999) demonstrated that mothers who were provided with an educational pamphlet and video retained more information and demonstrated more supportive behaviours towards their children during the evidential video interview stage of investigation than those who did not receive information. Mothers provided with information through useful media also showed more confidence in their knowledge about the investigation process, resulting in lower stress levels and feeling better able to support their child (Jinich & Litrownik).

Support groups
Several exploratory studies have indicated that peer support was important for caregivers coping with the disclosure of CSA (Adamakos et al., 1986; Alaggia, 2002; Hewitt & Barnard, 1986; Hill, 2001; Humphreys, 1995). As noted earlier, caregivers report decreases in social support after their child’s disclosure of sexual abuse, particularly in relation to intrafamilial abuse, giving a variety of reasons for this such as stigma around CSA, feeling overwhelmed or out of control, being unsure about what their friends’ understanding of CSA is or whether they would be able to
deal issues around the abuse, as well as issues related to the guilt that often accompanies CSA disclosures (Carter, 1999; Hewitt & Barnard; Hill).

Support groups have been suggested as a useful way to increase the support networks of non-offending caregivers, though individual work with caregivers may also assist them to increase social networks in the community in discussing how they can talk to others (Carter, 1999; Humphreys, 1995). In developing support groups for caregivers, cultural considerations must be taken into account due to increased stigmatisation in some communities, which would make such groups difficult (Abney & Priest, 1995; Comas-Diaz, 1995). In addition to helping re-build vital social networks, support groups may provide relief from finding others with similar experiences, aid individuals in coping with their own stresses, provide support around child rearing, help to normalise their child’s behaviour, and may even reduce depression in mothers of CSA victims (Hewitt & Barnard, 1986; Hill, 2001; Print & Dey, 1992; Winton, 1990).

In small short-term and long-term support groups common themes around loneliness, loss, anger, sexualy, economic problems, relationships with children, trying to understand incest, and issues around dealing with agencies were identified (Hewitt & Barnard, 1986). Caregivers reported that they benefited vicariously though other caregivers’ disclosures and appreciated the non-judgemental environment of these groups, which enabled them to express their own emotions safely (Hewitt & Barnard; Hill, 2001). In general, caregivers reported satisfaction with support groups, feeling able to give and receive support irrespective of how soon they joined the group after disclosure with mutual help sometimes extending beyond the sessions themselves (Barth et al., 1994; Hewitt & Barnard; Print & Dey, 1992). Caregivers in small support groups reported increases in self-esteem and improved trauma processing as a result of group participation, while the groups also appeared to indirectly help their children’s recovery by making the caregivers more confident in discussing difficult topics and dealing with the challenging behaviours their children presented with (Hewitt & Barnard; Hill).

Although such support groups have been found to be beneficial, several studies have indicated that support groups would be best carried out in conjunction with wider family interventions (Miller & Dwyer, 1997; Print & Dey, 1992).
Psychoeducational groups

Psychoeducational groups combine group support with provision of information. Most of the research in this area has been restricted to mothers (Barth et al., 1994; Lewthwaite, 2000), although some studies also include small numbers of fathers (Ostis, 2002; Winton, 1990). Non-offending caregivers frequently report being unsure of how to respond to their child after disclosure of sexual abuse, both in regards to knowing what types of new behaviours and emotions their child may display as a result of the abuse, and how to deal with them (Davies & Seymour, 1999a; Humphreys, 1995; Miller & Dwyer, 1997). As a result, many parental interventions include information for caregivers about victim’s responses to abuse as well as practical advice on how to deal with these behaviours and emotions (Adamakos et al., 1986; Barth et al.; Deblinger et al., 2001; Hewitt & Barnard, 1986; Hill, 2001; Ostis; Winton). Psychoeducational groups therefore typically include efforts to increase caregiver confidence and self-efficacy, improve dysfunctional behaviours of their children, provide a place for parents to understand and deal with their own emotions, and provide the caregivers with a wider support network (Barth et al.; Lewthwaite; Winton). These aspects of caregiver interventions may be tackled explicitly (Barth et al.; Deblinger et al.) or may come up spontaneously during group discussions (Adamakos et al.; Hewitt & Barnard; Hill; Ostis; Winton).

Participants usually reported that the content of psychoeducational groups was relevant, while the supportive group structure and setting provided opportunities for empowerment, practical help, and increased understandings (Barth et al., 1994; Winton, 1990). In some small studies, caregivers suggested that they would like professionals such as social workers, police, and lawyers to be present to help them understand their role as the caregiver in the investigation process (Lewthwaite, 2000; Mara & Winton, 1990). Caregivers also suggested having presentations from community agencies to provide caregivers with information about the services that are available to them out in the community (Lewthwaite).

Outcomes include general satisfaction with psychoeducational groups, with caregivers enjoying the supportive group environment while at the same time gaining useful skills (Winton, 1990). In several studies caregivers also reported increased wellbeing, confidence and understanding about child behaviour management, and feeling better able to care for the child in their care (Barth et al., 1994; Lewthwaite, 2000; Winton). Additionally, caregivers reported improved coping and
stress management and greater ability to deal with professionals as a result of the interventions though Winton found that actual stress levels did not change. There are some conflicting reports about the usefulness of psychoeducational groups in decreasing problem behaviours in children, with some reporting a decline in problem behaviours (Winton) and others failing to find any change (Barth et al.).

Group cohesion, both in supportive and psychoeducational groups, was generally formed quickly, which was usually attributed to the shared experience of its members (Barth et al., 1994; Hewitt & Barnard, 1986; Hill, 2001; Lewthwaite, 2000; Print & Dey, 1992). In general, caregivers appreciated not being pressured to speak in the groups because this helped them to feel in control. Nevertheless, some participants felt it was important that everyone contribute to the group process (Hill; Winton, 1990). Both types of groups were more useful to caregivers if they were in place long-term, though some studies suggest that the attendance of such extended support groups is not easy to maintain (Barth et al.; Hewitt & Barnard; Hill).

**Interventions for individual caregivers**

As suggested earlier, non-offending caregivers may require counselling separate from their children in order to help with their own healing processes (Carter, 1999). Therapeutic interventions have also been advised for caregivers who experience difficulties with their child’s behaviour, have unrealistic expectations for their child, lack involvement in their child’s therapy, or are themselves in need of more intense treatment or support (Mara & Winton, 1990). Thus, it has been suggested that individual interventions with caregivers should include components that foster recognition of their role in child protection, enable them to acknowledge and deal with a range of emotions, understand normal behavioural development in children, as well as assisting to support their child through continued trauma processing (Mara & Winton). Individual therapy to address the caregiver’s own healing processes may be particularly important if the caregiver has their own victimisation issues (Davies & Seymour, 1999a; 1999b; Manion, MyIntyre, Firestone, Ligezinska, Ensom & Wells, 1996, Newberger et al., 1993).

**Cultural considerations**

Cultural diversity must also be considered when reviewing the efficacy of different caregiver interventions. NZ being a multi-cultural society, it is important to consider the importance of
parental interventions within different cultural groups. Research on CSA conducted with several minority groups has suggested that these populations may experience greater stigmatisation from their community or family which results in greater psychological distress, particularly if the community values interdependence (Abney & Priest, 1995; Bernard, 1999; Comas-Diaz, 1995). This is often coupled with poorer access to mental health services, which may limit the availability of appropriate support. Within NZ, the importance of having Māori available to work for and with Māori, and the importance of taking a more holistic approach when working with people of this ethnic background have been highlighted (Harcourt, 2000; Durie, 2004). Thus, it is important to consider barriers to service access and how to make interventions most appropriate for specific ethnic groups.

In summary, there is evidence that providing interventions for caregivers has a positive effect on the functioning of the child in their care, indicating the importance of providing targeted assistance for caregivers. Some parents expressed the desire for such interventions to be provided earlier than they had experienced. Additionally, the importance of making interventions available to non-offending fathers and couples was also raised.

Research Considerations

Limitations of current research
Although interventions for caregivers of children who disclose sexual abuse are available, adequate research in this area is minimal as indicated in the previous section. Most studies have small sample sizes, cultural homogeneity, lack control groups, and suffer from selection bias (Deblinger et al., 2001; Forbes et al., 2003; Ostis, 2002; Winton, 1990). The lack of control groups is a problem, as children may spontaneously recover from the negative impacts of CSA without the need for caregiver interventions (Hetzel-Riggin et al., 2007; Winton). Without a control group the effects of the intervention cannot be separated from maturation processes or spontaneous recovery. Additionally, much of the research fails to control for the fact that children often receive separate interventions alongside the caregiver intervention that is being evaluated (Forbes et al.; Winton). While the need for randomised controlled trials is thus apparent (Forbes
et al.), this is difficult due to ethical concerns about withholding interventions and the sensitive nature of research in this area (Winton).

Another issue with research into caregiver interventions is that the duration of interventions required to provide benefits both to the caregivers and their children has not been investigated (Ostis, 2002; Winton, 1990). Additionally, assessing the long-term effects by lengthened follow-up periods would provide further support of intervention effectiveness (Deblinger et al., 2001; Jinich & Litrownik, 1999; Ostis; Winton). In the research described above, only the study by Jinich and Litrownik indicated the timeliness of intervention which was in the very acute phase following disclosure (evidential interview stage). Other research merely stated that the time post-disclosure ranged from soon after disclosure until much later (Hewitt & Barnard, 1986; Hill, 2001; Lewthwaite, 2000), while the rest of the studies did not provide any information on this. This could have implications for deciding which treatment aspects would be useful at different times post-disclosure (Ostis).

Aspects of interventions requested by caregivers and clinicians
Caregivers and clinicians alike have indicated the importance of including educational, supportive and therapeutic components in interventions, with some suggesting the usefulness of home visits to assist learning of behavioural management techniques (Barth et al., 1994; Lewthwaite, 2000; Ostis, 2002). Educational components may be particularly pertinent in preventing recurrence of intrafamilial abuse (Ostis). In one NZ study, caregivers requested information about the investigation and court processes, what to expect in terms of the impact of CSA, education around behavioural management, and more information about community services available to caregivers and their children. (Lewthwaite). The importance of involving paternal non-offending caregivers has also been highlighted (Humphreys, 1995; Lewthwaite).

Caregivers and intervention providers both indicate that cost may be a barrier to access therefore the provision of childcare, reimbursement of travelling costs, and other incentives for participation (such as receiving educational credit for attendance) would increase consistent attendance at intervention sessions (Barth et al., 1994).
Conclusion

There are strong indications for the need to provide interventions for non-offending caregivers of sexually abused children, particularly given what is presently known about the impact of CSA disclosure on caregivers and the value of caregiver support in assisting the caregiver and their children’s recovery from such events. The appropriate targets for such caregiver interventions include provision of information, support, assistance in the care and management of their children, and responses to caregivers’ own reaction to the disclosure of CSA by their child. Interventions may be provided in a group setting or individually, with the aims of increasing knowledge about the impact of CSA on the child and family, the needs of the child and the investigation process; providing practical support for the care and management of the child; and providing caregivers with a space to process their own reactions to the disclosure of CSA in the family, which may be particularly salient if they themselves have a history of victimisation. The literature indicates that by more adequately addressing the needs of the caregiver after their child discloses CSA, the outcomes for the child may be improved.

There is no available information about how frequently and extensively such interventions are available to non-offending caregivers after CSA disclosure. However, in a sample of over 100 mothers interviewed by Davies (1999) only a few had received services specifically targeted for parents. There are also very few available descriptions of intervention programmes provided for caregivers, which is surprising given the clear need for such interventions indicated in this review. The programmes that have been described and evaluated are generally small-scale descriptive studies employing qualitative methods without control groups. Additionally, different intervention goals are often mixed in studies, making an evaluation of effectiveness difficult.
CHAPTER TWO: PROGRAMME DESCRIPTION

The programme under investigation is the Parenting Support Pilot Programme, which was developed by the Accident Compensation Corporation (ACC) in New Zealand (NZ). ACC is an accident insurance scheme that includes provisions for claims of mental injury as a result of sexual abuse. These are referred to as “sensitive claims” and are managed within a specialised unit within ACC (Jenner & Pittams, 2007). The Parenting Support Pilot Programme broadly aims to assist non-offending caregivers in supporting their children with a sensitive claim.

The Programme

In 2006, ACC was allocated funding by the NZ government to develop the Parenting Support Pilot Programme for caregivers of children with sensitive claims. Originally it was designed to commence in October 2006 for a duration of two years, but due to some delays it started in November 2006 and was extended until June 2009 (Hill, 2006).

Programme Development

Prior to the current pilot programme, ACC commissioned Raranga Whatumanawa, The Weaving of Heart Patterns: Developing Practice Guidelines: Sexual Abuse and Mental Injury (Hill, 2006). These guidelines have now been published (ACC, 2008). The guidelines include the recommendation that caregivers receive their own support to complement their child’s counselling, and cites international research indicating that involvement of caregivers improves the efficacy of children’s counselling (Hill; ACC).

Before the current programme was introduced, caregivers had not been provided individual parenting support through ACC. The Parenting Support Pilot Programme that was developed by ACC recognised the importance of parenting and parental attitudes in rehabilitating child
claimants (Jenner & Pittams, 2007). The aim of the programme was to give parenting support to non-offending caregivers who were responsible for children with a sensitive claim so that the caregivers in turn could provide a more supportive environment to assist their children in recovery following sexual abuse (Hill, 2006; Jenner & Pittams). By assisting caregivers, it was hoped that there would be downstream effects to reduce problems resurfacing in the child claimant’s adulthood (Hill).

Because this programme was developed as a pilot, there was an additional aim of collecting data to investigate the effectiveness of the intervention, delivery, and monitoring processes (Hill, 2006). This information was to be utilised to inform future policy decisions (Hill).

**Programme Description**

The pilot consisted of an initial assessment session, followed by a maximum of five parenting support sessions (Hill, 2006). ACC identified three main aims of these sessions: improving caregiver self-management and coping, providing caregivers with help to manage their child’s behaviour, and providing caregivers with education about sexual abuse and its effects (Hill). These sessions were not for personal counselling or therapy for the caregivers, but rather they would be provided with information about appropriate service options by counsellors if required (Jenner & Pittams, 2007).

The programme was available to non-offending caregivers of a child for whom ACC had accepted a claim for mental injury suffered as a result of sexual abuse (Hill, 2006). The programme was offered to the permanent caregivers of the child, and generally was only offered once per child, although if the child changed caregiver during the pilot period a decision for more sessions could be made on a case-by-case basis as decided by ACC (ACC, 2006c). In the cases where there were shared custody arrangements between caregivers there were still only five sessions available, therefore the sessions needed to be split between caregivers if they are unable to attend together (ACC, 2006b). If caregivers wanted anyone else to attend their sessions, such as extended family members, this was at the counsellor’s discretion and discussed fully during the Needs Assessment process (ACC, 2006a). Although funding was provided by ACC for these Parenting Support Sessions, some counsellors charged caregivers a co-payment to make up the difference between the cost of their services and what ACC paid them.
The counselling sessions within the Parenting Support Pilot Programme were provided by counsellors registered with ACC who had indicated an interest in working with children, had provided ACC-funded counselling to children in the last 36 months, and were able to use goal focused models for these sessions (Hill, 2006; Jenner & Pittams, 2007). Counsellors meeting the eligibility criteria were notified of the pilot and given an information sheet (Appendix A2), and those who wished to contract with ACC to provide the Parenting Support service were offered a contract (Hill).

Within ACC, the programme was managed within the Sensitive Claims Unit (SCU) with the development of operational guidelines and staff training resources (Hill, 2006). The contracting of counsellors was managed by ACC Health Procurement by Letter of Agreement (Hill).

Pathway Through the Programme

During the operation of the pilot from 2006 to 2009, there were several processes caregivers had to engage in to receive notification of and then access to the Parenting Support Pilot Programme as outlined in Figure 1. Each step is individually discussed below.

Figure 1

*Diagram of caregivers’ pathway through the programme*
**Programme Description**

**Step 1: ACC45 form**

If an individual was mentally injured as a result of sexual abuse, they needed to see a doctor or an ACC registered counsellor as soon as possible who would help them fill out the ACC45 claim form (Appendix A3) and send it to ACC on their behalf (ACC, 2009). ACC accepted claims when there was evidence of mental injury resulting from sexual abuse that required treatment (ACC).

After the claim form was received by ACC, ACC would pay for the claimant to have up to four initial sessions with an ACC registered counsellor to help assess whether the claim would be accepted (ACC, 2009). Sometimes supplementary assessments by psychologists or psychiatrists were required by ACC to provide additional recommendations (ACC).

**Step 2: Cover determination**

Treatment of the child for injury resulting from sexual abuse was not covered until the assessment was completed and the claim was accepted by ACC (ACC, 2009). Following the assessment, the ACC registered counsellor provided a report to ACC including goals for future counselling if required (ACC). This, together with any reports provided by psychologists of psychiatrists was considered by the SCU, and claims would be accepted if ACC were satisfied that the mental injury was caused directly by the sexual abuse (ACC).

ACC had 60 days to make a cover decision on the claim from the date it was first registered. If cover was determined, ACC informed the caregiver of the child claimant in writing, and informed them of how many sessions the child had been allocated (ACC, 2009). At the conclusion of these allocated sessions, the counsellor wrote a report about progress made by the claimant, and further sessions were allocated if indicated (ACC). For these sessions there was assistance from ACC for travel costs (ACC).

**Step 3: Contacting caregivers**

During the Parenting Support Pilot Programme Period (November 2006 to June 2009) once a child had received cover determination for their claim, their caregivers could gain access to the parenting programme. They were sent information on the pilot (Appendix A1) and the Consent and Response form (Appendix A4).
If caregivers were interested in receiving the Parenting Support Pilot Programme, they were required to return the response and consent form to ACC. Once ACC received this, the initial Needs Assessment session for the caregiver was approved. Caregivers were provided with a list of ACC-registered counsellors able to provide the programme in their area to contact.

**Step 4: Needs Assessment**

Upon programme commencement, caregivers were required to complete a Needs Assessment form (Appendix A5) developed in collaboration between ACC Research Services and experts outside of ACC who had specialised knowledge about the recovery from child sexual abuse (Hill, 2006). This tool was used to establish goals for the sessions for caregivers to focus on in their five counselling sessions (Hill). Before the caregivers could commence the five counselling sessions, the Needs Assessment had to be peer reviewed and approved by ACC.

**Step 5: Peer Review Process**

Peer reviews were conducted on the Needs Assessment reports, which were evaluated, and comments were provided to counsellors with recommendations made when required (Du Plessis, 2007). The review provided counsellors with information and support when developing the treatment plan with claimants, and provided ACC with recommendations about the clinical appropriateness of the proposed treatment plan (Du Plessis). Counsellors had to wait for the peer review process to be completed before commencing the Parenting Support sessions.

**Step 6: Counselling Sessions**

Once the Needs Assessments were peer reviewed and accepted by ACC, caregivers were able to commence their five parenting support sessions. In these sessions, the goals identified in the Needs Assessment were worked through, and others as they came up. Sessions were to be completed within a three-month period (Hill, 2006). There was no financial support provided to caregivers in the programme for travel, childcare, home help, or loss of earnings (ACC, 2006b).

**Step 7: Achievement Summary**

In the final session, caregivers completed an Achievement Summary form (Appendix A6) with their counsellors. This recorded the progress that caregivers made on their goals during the
sessions, and was utilised to provide before-after comparisons for programme participants (ACC, 2006a; Hill, 2006).

**Step 8: Evaluation**

Once the Achievement Summary was received by ACC, all the paper information was sent on to the evaluation team including the ACC45 form, Response and Consent form, the Needs Assessment form, Peer Review report, and Achievement Summary. Caregivers who agreed to being contacted were contacted by myself, as outlined in the following sections.

**Evaluation Development**

To evaluate the Parenting Support Pilot Programme, ACC contracted out the evaluation to the University of Auckland (apart from the Formative Evaluation component). ACC had a formal process that required the development of a Request for Proposal (RFP) and a formal assessment of the resulting proposals (Jenner & Pittams, 2007). Due to the sensitive nature of the evaluation, the evaluation needed to be as un-intrusive as possible, and proposals were assessed taking this into consideration (Jenner & Pittams).

The aim of the evaluation of the pilot was to provide feedback to ACC on the efficiency and effectiveness of the programme, and provide advice and recommendations as to whether the pilot should be continued in the future (ACC, 2006c). The RFP suggested the use of a mixed-methods approach to the evaluation to gain the broadest understanding of the programme. The suggested format included the use of interviews with initial designers and manager, key providers and caregivers, telephone surveys, and analysis of Needs Assessment forms, goals, and Achievement Summary forms (ACC).

Based on these recommendations in the RFP, the evaluators developed the methodology as outlined in the next chapter, including both qualitative and quantitative approaches to programme evaluation.
Formative Evaluation

ACC conducted their own formative evaluation in June 2007, which focussed on collecting data on programme operations. This was to provide feedback to staff about the programme components that were working well and which were not, so that modifications to the programme could occur in early stages. In particular, the evaluation focussed on uptake and constraints to uptake.

Qualitative and quantitative data methods were utilised to obtain perspectives on the programme from ACC staff, counsellors and caregivers. This consisted of an examination of the spreadsheet of potential claims, the Needs Assessment and Achievement Summary forms, numbers of eligible counsellors, a log of telephone calls; and interviews conducted with ACC staff, counsellors and one caregiver (Jenner, 2007).

The evaluation revealed that the uptake rate at the time of evaluation was 4.9% based on the 31 Needs Assessment forms received from all 631 eligible caregivers. Not all of the 31 completed the Parenting Support sessions (Jenner, 2007). The evaluation concluded the low uptake and failure to complete sessions was not a reflection of poorly developed intervention, but rather low awareness of the programme’s existence and its capacity to be useful (Jenner). Additionally, several administrative issues may have slowed the momentum of the pilot (Jenner). To offset these issues, ACC recommended some short-term and long-term solutions in their report as well as ideas on reducing administrators’ time commitments related to the programme thus maintaining the momentum of the pilot during this time (Jenner).

The report also indicated that some caregivers were confused about their access to the programme and lacked awareness that their child needed their claim accepted before they could gain entry to the Parenting Support Pilot Programme (Jenner, 2007). It was suggested that caregivers and counsellors should be made more aware of the entry requirements, and that if required, caregivers would be notified by ACC once the claim had been accepted, rather than wait until the child began the cover determination process (Jenner).
Caregivers and counsellors indicated that the number of sessions was not enough to create significant change, suggesting ten sessions as a more appropriate number (Jenner, 2007). There was also awareness that caregivers may need access to the programme at later stages, such as when their child enters puberty or adolescence (Jenner). Counsellors also indicated that it would be useful to have an initial introductory session before completion of the Needs Assessment forms to assist in engagement (Jenner). Counsellors also suggested some improvements to the Needs Assessment and Achievement Summary forms in their interviews (Jenner).

Additionally, caregivers indicated that their children were having school difficulties as a result of the sexual abuse, but that they were unaware of the ACC teacher aide hours (Jenner, 2007). It was suggested that participating counsellors better guide caregivers in accessing these services (Jenner).
To evaluate the Parenting Support Pilot Programme developed by the ACC, both qualitative and quantitative research methods were employed within an action research framework (Chen, 1990; Coghan & Brannick, 2005; Kagan, Burton & Siddiquee, 2008; Seymour & Davies, 2002; Winter & Munn-Giddings, 2001), to provide a comprehensive programme evaluation consisting of a needs assessment, process evaluation, and impact evaluation.

**Action Research**

Evaluation of current practice is an integral part of action research, which studies people and their experiences within evolving processes, such as would occur in a pilot programme (Winter & Munn-Giddings, 2001). Action research is a collaborative process between researchers and participants, requiring flexibility to gain understanding and make change to produce increased wellbeing for participants (Chen, 1990; Coghan & Brannick, 2005; Kagan et al., 2008; Seymour & Davies, 2002). Because of this flexibility, action research allows a more practical understanding of individuals’ experiences within community or organisational settings, and has the ability to investigate whether both intended and unintended changes in the programme result in different outcomes (Fischer, 2006; Kagan et al.; Winter & Munn-Giddings). As the evaluation of the Parenting Support Pilot Programme progressed there was contact with ACC via telephone, e-mail, and face-to-face, which meant that adjustments were made to the programme on the basis of systematic data collection.

Outlined below are some of the theoretical and methodological aspects considered in the Parenting Support Pilot Programme.
Programme Evaluation

Programme evaluations conducted within an action research framework are flexible, allowing for change to occur in the programme both while it is being evaluated and as a result of the evaluation (Patton, 1997). The purpose of programme evaluation is to improve the quality of programmes and provide a basis for more useful decisions regarding such programmes (Patton). Patton defines programme evaluation to be:

“The systematic collection of information about activities, characteristics, and outcomes of programs to make judgements about the programme, improve programme effectiveness, and/or inform decisions about future programming.” (p. 23)

In the initial stages of planning an evaluation, decisions need to be made about what theoretical and methodological framework will be most appropriate, and the specific aims and focuses of the evaluation. To make the evaluation most useful, these decisions must be made in partnership between the evaluator and the end users of the programme, with collaborative discussions shaping the research (Gregory, 2002; Patton 1997; Weiss, 1998). Patton refers to this as utilisation-focused programme evaluation, where the research focuses on important but poorly understood aspects of a programme and as such has certain intended uses. However, evaluators must also be aware that certain biases may occur when gathering information from programme stakeholders, and thus the researchers must be clear about who the evaluation is intended for. Therefore, depending on the requirements of the end-user, programme evaluations can serve a range of functions and may focus on aspects of a programme such as participant needs, programme processes, and programme outcomes, which are the focus of the evaluation of this pilot (Patton). Thus, in the development of the Parenting Support Pilot Programme evaluation discussions were held with ACC to put together the most useful assessment of programme efficiency and usefulness, and a decision was made to gather information from a range of sources including programme developers, providers, and users. Furthermore, together with ACC, an attempt was made to minimise the amount of extra input required by caregivers as part of the evaluation, while ensuring that the information gathered would be most useful to inform future programme development.
Needs Assessment

Needs assessments focus on what programme participants need and how those needs can best be met (Patton, 1997). This type of evaluation usually occurs before the programme is implemented to identify the level of need, the goals of the future programme, and to consider how these needs would best be met (Patton; Posavac & Carey, 2007). Evaluators need to work closely with potential programme participants and key informants to identify current unmet needs, the current available resources, and the capacity of the community to support the implementation of a programme (Posavac & Carey, 2007). If a needs assessment is not properly conducted then the programme may not be as efficient or effective, and resources may be wasted (Posavac & Carey).

Prior to implementing the Parenting Support Pilot Programme, there was no systematic assessment of need to inform initial programme development. However, individual Needs Assessment forms were completed by caregivers prior to their own individual sessions that informed the work that they would do with their counsellors as part of the programme. Therefore these Needs Assessment forms were analysed to gain an understanding of the needs in general for caregivers accessing the programme and to help inform future programme development to best address these needs.

Process Evaluation

Process evaluations focus on how the programme outcomes are achieved, rather than the outcomes themselves (Patton, 1997). This type of evaluation seeks to understand the day-to-day processes, including what is working well and what is not, answers questions about how the programme operates, the extent to what the programme has been taken up, how participants experience the programme, and how well the programme is working as expected (Patton; Posavac & Carey, 2007). Process evaluations are crucial in the development of programmes to inform programme decisions, provide a record of programme development, and by learning how the programme actually operates, assisting in future expansion (Patton; Posavac & Carey).

Patton (1997) suggests that evaluations of process should be descriptive and inductive, looking to understand how the strengths and weaknesses impact the programme and being open to unexpected outcomes within the programme processes. For a comprehensive process evaluation, a variety of sources must be utilised to gain a range of experiences (Patton; Seale, 1999). This
may include interviews both with people using, and not using, the programme (Posavac & Carey, 2007). Therefore, semi-structured interviews were conducted and analysed with programme developers, providers, users of the programme, and non-users of the programme to gain a comprehensive understanding of the processes within the Parenting Support Pilot Programme.

**Impact Evaluation**

Impact evaluations are useful in the evaluation of programmes as they investigate the direct and indirect impact the programme has on participants and their wider communities (Chen, 1990; Patton, 1997). Therefore, there is a focus not only on those individuals who are expected to benefit from the programme, but also on the systems surrounding them (Patton).

To evaluate the impact of a programme it is important to consider the intended outcomes of the programme as well as to investigate unexpected effects (Chen, 1990; Patton, 1997; Posavac & Carey, 2007). Intended or expected outcomes must be clearly defined and measured with a high level of validity and reliability, for which quantitative research methods are most useful (Patton). Additionally, qualitative measures are important to investigate unintended impacts, and the impacts of the programme on the systems around the programme participants. Accordingly, this impact evaluation utilised both quantitative and qualitative research methods to provide the most comprehensive understanding of the direct and indirect effects the programme had on participants and their communities.

**Sensitive Research**

There may be cultural or situational variation in what types of research are considered sensitive, however research into aspects of the self that are normally kept private are generally considered sensitive (Renzetti & Lee, 1993). Hence, research that is conducted on someone’s deeply personal experience, or is related to a fear of being identified or stigmatised might be considered particularly sensitive (Renzetti & Lee). Additionally, research should be sensitive to participants from disadvantaged groups in society and should be aimed to empower them (Posavac & Carey, 2007; Renzetti & Lee, 1993; Sands, Bourjolly & Roer-Strier, 2007). As the topic of child sexual abuse (CSA) would be considered sensitive by most people and may occur in a range of cultures,
decisions were made before evaluation commencement about the most appropriate way to gather information, with respect for the sensitive information held by participants.

In New Zealand, considering Māori participation in programmes is particularly important due to their status as *tangata whenua* and the signing of *Te Tiriti o Waitangi* (The Treaty of Waitangi), which provides an agreement between Māori and the Crown that outlines the rights and obligations of both parties (Barnes & Whariki, 2009; Health Research Council of New Zealand (HRC), 2008). Therefore, evaluators need to respect the principles of partnership, protection, and participation outlined in the Treaty when evaluating programmes that involve Māori people (Kingi & Durie, 2000; HRC; Thomas 2002). Due to this, early on in the development of evaluations it is important to have community consultation to develop the best way to evaluate the cultural appropriateness of the programme (Thomas). With sensitive topics, it may be important to gain information from a variety of sources in a variety of ways, though the most useful data is usually gathered via qualitative methods (Renzetti & Lee, 1993; Sands et al., 2007; Thomas). Careful consideration still needs to be given to the type and order of questions that may be asked in the evaluation, particularly when conducting research over the phone as non-verbal feedback is lost (Sands et al.; Thomas).

Once the evaluation has been designed, it may still be difficult to access potential participants, probably requiring the participants to initially be approached by someone they know rather than by the evaluators (Sands et al., 2007). Some flexibility or choice may also be required regarding whether participants are interviewed over the telephone or face-to-face (Sands et al.). For participants in sensitive research, it is vital that they are fully informed about the purpose of the evaluation and that they have the right to decline participation, ask questions, or turn the tape-recorder off without fear for negative consequences (Renzetti & Lee, 1993; Sands et al., 2007). Additionally, it is vital to maintain the privacy and confidentiality of these participants, while at the same time gathering enough information for the evaluation to be useful (Posavac & Carey, 2007; Renzetti & Lee). Evaluators need to be more reflective in sensitive research than in other areas, consider the social context within which the research is conducted, and be empathetic and non-judgemental towards the participant and their needs (Posavac & Carey, 2007; Sands et al.).
There are also additional methodological considerations that must be taken into account when conducting programme evaluations to ensure that they remain useful and have high ethical standards (Posavac & Carey, 2007). Despite being employed by one programme stakeholder, evaluators should ensure that they represent and serve all programme stakeholders to provide the most comprehensive and useful programme evaluation (Posavac & Carey). Furthermore, scientific integrity must be upheld by describing procedures in such a way that the evaluation can be understood, replicated, and evaluated by others (Posavac & Carey).

These methodological aspects of the research were carefully considered before commencing the process evaluation, particularly due to the sensitive nature of this research. Additionally, it was decided that all participating parents would be asked for feedback on the evaluation processes to ensure this was occurring in the most appropriate way.

Methodological Considerations

In programme evaluation it is important to adopt methodological flexibility, acknowledging that different evaluation questions require different approaches. Therefore, consideration needs to be given to what approaches are needed to make the evaluation most useful to the end user (Kagan et al., 2008; Mason, 2006; Parker, 2004; Patton, 1997). Given the requirements of this programme evaluation, it was decided that a mixture of qualitative and quantitative methods would be utilised. The use of qualitative research provides rich and detailed data, which captures variations in the individual experiences of participants (Patton; Sapsford & Jupp 2006), while quantitative methods allow for descriptions and sometimes predictions of the characteristics found amongst the sample population (Brannen, 1992; Mason; Mitchell, 2004).

Mixed Methods

Mixed-method or multi-method research approaches are becoming increasingly more common, particularly in evaluation research (Bryman, 2006; Kelle, 2006; Tashakkori & Teddie, 2003). The advantage of this is that the evaluator is able to triangulate the data, thereby gaining a more complete picture of the programme, and drawing on the strengths of both qualitative and quantitative approaches (Brannen, 1992; Brewer & Hunter, 2006; Bryman; Kelle; Mason, 2006;
Morse, Niehaus, Wolfe & Wilkins, 2006; Posavac & Carey, 2007). However, when using this approach the evaluator needs to ensure that there is not too much data redundancy and that each approach provides insight into different aspects of the programme (Brannen, 1992; Bryman, 2006). Mixed-method approaches that include the combination of qualitative and quantitative research methods may also access multiple sources of information such as programme participants, providers, or key stakeholders (Brannen, 1992; Bryman, 2006; Posavac & Carey, 2007). Mixing methods can occur at a variety of stages, including at question formulation, data collection, analysis, or interpretation (Brannen; Bryman).

When mixed-methods approaches are used, consideration must be given to the relative importance given to the qualitative and quantitative components - both in terms of the data and the methods by which they are analysed (Brannen, 1992; Bryman, 2006; Morse et al., 2006). Additionally, the evaluator needs to consider whether the qualitative and quantitative data is collected sequentially or simultaneously (Brannen; Bryman; Kelle, 2006; Morse et al.). Sequential design allows for learning and design development from one stage to another, while simultaneous allows investigation of methodological artefacts which may be particularly important in sensitive research (Kelle). Researchers must ensure that the methods combine to produce comprehensive knowledge of the programme (Brewer & Hunter, 2006).

The core component of the current research was qualitative, as this form of data can help the evaluators understand unique aspects of programme setting and provides an opportunity for the evaluator to tailor the questions to suit the individual respondent, probe further in areas of interest, and check interpretations (Posavac & Carey, 2007; Sapsford & Jupp, 2006; Seale, 1999). Additionally, qualitative methods are able to look at systems and interdependencies within the data due to its holistic approach, being able to understand changes within the programme as they occur, which is particularly important early in programme development (Patton, 1997). In this way, the evaluator trades potential measurement precision to increase the utility of findings for the end user (Patton; Sapsford & Jupp). By immersing themselves and becoming intimately familiar with programme, the evaluator can develop more reasonable recommendations which are then more likely to be utilised at the end of the evaluation (Patton; Posavac & Carey). In this research, a qualitative approach was augmented by simultaneous quantitative data gathering to
Methodology

provide more objective and generalisable results, and to enable further exploration and validation of the findings in the qualitative data (Patton; Posavac & Carey; Sapsford & Jupp; Seale).

Epistemology

Different methodological approaches tend to employ varying epistemological perspectives on a continuum between subjective (relativist) and objective (realist) epistemologies (Coghan & Brannick, 2005; Creswell, 2003). Qualitative and quantitative methods tend to employ different theoretical perspectives on how aspects of reality are observed, and therefore answer different types of evaluation questions (Brannen, 1992). Action research accepts both theoretical perspectives, sitting within a critical realist paradigm (Coghan & Brannick). Throughout action research, the programme changes and evolves and the researcher is immersed in the research setting, therefore the data gathered occurs in a particular context for the individual participant in the programme at a certain time and thus is interpreted in a subjective way (Coghan & Brannick). Concurrently, the data gathered is considered to be the true external reality experienced by the participants and thus can also be viewed from an objective approach (Coghan & Brannick).

Programme Evaluation Development

The design of this evaluation was developed in collaboration with ACC to maximise the utility of evaluation outcomes. Additionally, discussions were held with a Māori consultant and Māori research team member to ensure the suitability of the intended research procedures across cultures in accordance with the Treaty of Waitangi.

Ethical approval was obtained for the evaluation from the Health and Disabilities Multiregional Ethics Committee and the ACC Ethics Committee.

The evaluation of the Parenting Support Pilot Programme was conducted in three stages:

1) Needs Assessment
2) Process Evaluation
3) Impact Evaluation
The process and impact evaluations were required by ACC with the intention of assessing the efficiency and effectiveness of the pilot programme. Following the process evaluation there was a face-to-face meeting with ACC to provide feedback, and they amended the programme delivery in response to that information. Initially it was proposed to include just the process and impact evaluations, but as the research evolved, it became clear that to gain a deeper understanding of the data in its appropriate context, a needs assessment section would also be required. Some participants were involved in both the process evaluation interviews and impact evaluation interviews due to low service uptake at the commencement of the evaluation.

Participants

Needs Assessment Respondents
In total, 60 Needs Assessment forms were completed which represented 59 families and 62 children. Out of the 60 completed Needs Assessment forms, eight (13.3%) were completed by both parents, 42 (70.0%) just by mothers, five (8.3%) just by fathers, four (6.7%) by an extended family member, and for two forms this information was missing. Out of the responding caregivers, 36 (60%) identified as New Zealand European, 16 (26.7%) as Māori, eight (13.3%) as other European, six (10.0%) as Pacific Islander, one (1.7%) as Asian, one (1.7%) as other, and for two caregivers this information was not available (this totals to more than 100% due to some caregivers identifying with more than one ethnicity).

Of the 62 child claimants represented in the Needs Assessment forms, 7 (11.3%) were male and 55 (88.7%) were female with an average age of 9.6 years (SD = 4.03 years). Of these, 39 (62.9%) were identified as New Zealand European, 19 (30.6%) as Māori, eight (12.9%) as Pacific Islander, three (4.8%) as Asian, seven (11.3%) as European, and two (3.2%) as other.

Achievement Summary Respondents
Achievement Summary forms were completed by 48 caregivers. Of these, three (6.3%) were completed by both parents, 37 (77.1%) just by mothers, four (8.3%) just by fathers, and four (8.3%) by an extended family member. Out of these 48 caregivers, 26 (54.2%) identified as New Zealand European, 12 (25.0%) as Māori, seven (14.6%) as other European, five (10.4%) as
Pacific Islander, one (2.1%) as Asian, one (2.1%) as other, and for two (4.2%) caregivers this information was missing.

*Process Evaluation Interviews*

Interviews were conducted with four groups of participants for the process evaluation: (1) ACC Managers, (2) ACC Peer Reviewers, (3) Counsellors, and (4) Parents.

**ACC Managers.** Two ACC Managers were invited to participate in the process evaluation. One was the Project Manager, while the other was a ‘Subject Matter Expert’ who had the greatest knowledge in the pilot project on how the project was interfacing with the sensitive claims unit. These participants were selected by ACC due to their specific programme related knowledge. Both had been involved since near the beginning of the pilot in November 2006 and were female. No additional demographic information was collected from these two participants.

**ACC Peer Reviewers.** Two Peer Reviewers were identified by ACC. Both had been involved with the Parenting Support Pilot Programme for approximately 11 months at the time of the interview. Both were registered Clinical Psychologists and female. No additional demographic information was collected from these two participants.

**ACC Counsellors.** Counsellors who were involved with the Parenting Support Pilot Programme were identified from the Needs Assessment files provided by ACC. Counsellors were selectively sampled based on their geographical location. They were contacted by telephone and invited to participate in the interviews. Only one counsellor declined participation because they were unavailable at the time the evaluator was in their city. Eleven Counsellors were interviewed in nine interviews (two interviews consisted of two Counsellors that worked in the same agency). Of the 11 Counsellors interviewed, three (27.3%) worked in Christchurch, three (27.3%) in Hamilton (two interviews), three (27.3%) in Auckland (two interviews), one (9.1%) in Wellington, and one (9.1%) in Tauranga. All 11 Counsellors were female, of which one identified as New Zealand Māori (9.1%) and the rest (90.9%) identified themselves as New Zealand European. These counsellors had worked with between one and five (mean = 1.6) caregivers through the Parenting Support Pilot Programme. Additional to the individual interviews, one group interview was conducted with a sexual abuse counselling group situated in
Christchurch identified by ACC as working closely alongside the pilot. This group consisted of six New Zealand European, female counsellors.

Caregivers. Caregivers who were involved with the Parenting Support Pilot Programme were identified from the paper files provided by ACC. They were initially contacted to take part in the impact evaluation, and at the conclusion of that interview were asked whether they would like to participate in the process evaluation. Nine interviews were conducted with 10 parents (one interview consisted of both parents of the child claimant) who had completed the Parenting Support Pilot Programme. Parents were selectively sampled based on geographic location and ethnic diversity, though where there were more potential participants than required, parents were randomly sampled. Of the 10 parents, five lived in the Auckland region, three lived in Canterbury, and two in Tauranga. Eight of the parents interviewed were female, of which one (12.5%) identified as being Pacific Islander, one (12.5%) as New Zealand Māori, one (12.5%) as other European, and five (62.5%) as New Zealand European. Seven (87.5%) of these female participants were the child claimant’s biological mothers, while one (12.5%) was the child’s stepmother. Two of the parents were male and both identified as New Zealand Māori. Both male participants were the child claimant’s biological fathers. Of the 10 parents, five were solo parents, while the other five were in two-parent families. The time between the lodgement of the ACC claim - which occurs as a result of the child visiting a health professional following disclosure of CSA - and the interviews ranged from approximately seven to 16 months (mean = 12.7 months).

Caregivers who declined participation in the Parenting Support Pilot Programme had the opportunity to comment on their reasons for declining support on their response and consent form. Twenty-nine such comments were made available to the evaluation team for analysis by ACC. Using such records can provide a unique insight that would not be available otherwise (Posavac & Carey, 1997).

Impact Evaluation Interviews
Caregivers who were involved with the Parenting Support Pilot Programme were identified from paper files provided by ACC. Of the 59 families involved in the pilot programme, 49 agreed to contact by the evaluation team on their ACC Response and Consent forms (Appendix A4). The evaluation team had originally aimed to recruit 50 research participants, but of the 59 families,
only 36 (61.0%) completed the initial impact evaluation interview. Thirty-two (88.9%) of these had completed the programme and four (11.1%) had not as based on their Achievement Summary forms. Five interviews were carried out with the four families who did not complete the programme as one family had two caregivers living apart. Therefore, in total, 37 interviews were conducted with caregivers as part of this impact evaluation. Follow-up Impact Evaluation interviews were conducted with 22 caregivers.

Out of the 37 caregivers that participated, six (16.2%) of the Needs Assessment forms were completed by both parents, 23 (62.2%) by mothers, three (8.1%) by fathers, and four (10.8%) by extended family members. Of these caregivers, 22 (62.9%) identified as New Zealand European, six (16.2%) as Māori, five (13.5%) as Pacific Islander, one (2.7%) as Asian, and six (16.2%) as other European. Of the 22 caregivers participating in the follow-up impact evaluation interviews five (22.7%) of the Needs Assessment forms were completed by both parents, 15 (68.2%) by mothers, one (4.5%) by a father, and one (4.5%) by an extended family member. Of these caregivers, 11 (50.0%) identified as New Zealand European, three (13.6%) as Māori, three (13.6%) as Pacific Islander, one (4.5%) as Asian, and three (13.6%) as other European. See Table 2 for the demographic data for the first and follow-up interviews.

Of the 23 (39.0%) caregivers who did not participate in the initial impact evaluation, 18 (78.3%) declined participation, and five (21.7%) were lost to follow-up. Of those declining participation in the evaluation, two (8.7%) of the Needs Assessment forms were completed by both parents, 19 (82.6%) by mothers, and two (8.7%) by fathers. Of these caregivers, 14 (60.9%) identified as New Zealand European, 10 (43.5%) as Māori, one (4.3%) as Pacific Islander, two (8.7%) as other European, and one (4.2%) as Other. Of the 10 caregivers that declined participation in the follow-up interviews, six declined participation and four were lost to follow up. Of these ten caregivers, four of the Needs Assessment forms were completed by mothers, one by a father, and three by an extended family member. Of these caregivers, nine identified as New Zealand European, two as Māori, one as Pacific Islander, and one as other European (some identified more than one ethnicity).
Table 2  
Relationship and ethnicities of caregivers who participated in the impact evaluation

<table>
<thead>
<tr>
<th>Relationship to Child on NA</th>
<th>First Interview</th>
<th>Follow-up Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (n=37)</td>
<td>Percentage</td>
</tr>
<tr>
<td>Both parents ¹</td>
<td>6</td>
<td>16.2</td>
</tr>
<tr>
<td>Mother</td>
<td>23</td>
<td>62.2</td>
</tr>
<tr>
<td>Father</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>Extended family</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity of Parent ²</th>
<th>First Interview</th>
<th>Follow-up Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand European</td>
<td>22</td>
<td>62.9</td>
</tr>
<tr>
<td>Māori</td>
<td>6</td>
<td>16.2</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>5</td>
<td>13.5</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Other European</td>
<td>6</td>
<td>16.2</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>5.4</td>
</tr>
</tbody>
</table>

¹ Considered both parents if primary caregiver was married, and partner attended.
² Percentages do not sum to one hundred because some caregivers identified multiple ethnicities.

Measures

Needs Assessment Forms
To assess the specific needs of the participants, a Needs Assessment form was developed by ACC and utilised in this research (Appendix A5). Needs Assessments were provided for 59 families, where three of these families had two children, thus representing a total of 62 child claimants. One of the 59 families had two participating caregivers, therefore there were 60 completed Needs Assessment forms.
Achievement Summary Forms

Achievement Summary forms were developed by ACC to gather information from participants in their final session about the effectiveness of the programme (Appendix A6). From the 59 participating caregivers, 48 completed all their sessions and provided an Achievement Summary form.

Process Evaluation Interviews

To gather information about the processes occurring within the Parenting Support Pilot Programme, semi-structured interview schedules were developed in collaboration with ACC. This ensured that a range of aspects related to programme processes were addressed in a standardised way, while enabling participants the freedom to talk (Posavac & Carey, 1997; Sapsford & Jupp, 2006). Additionally, it seemed unlikely that members of the target population would respond to a written survey given the sensitive nature of the topic (Renzetti & Lee, 1993). Different interview schedules were developed for ACC Managers, Peer Reviewers, Counsellors and parents to maximise the information gained from their different perspectives of the programme.

ACC Managers. There were six aspects covered in the Manager interviews (see Appendix B1) which included: (1) an outline of the current processes, (2) the efficiency of the programme, (3) what elements of the programme processes were working well and what areas could be improved, (4) the extent to which the programme had being taken up, (5) whether internal ACC processes were meeting the needs of the pilot research, and (6) how cultural needs were being addressed.

ACC Peer Reviewers. There were seven aspects covered in the interviews with the Peer Reviewers (see Appendix C1) which included: (1) an outline of the pilot processes, (2) the efficiency of the programme, (3) how the counsellors and parents were doing with filling out the Needs Assessment forms, (4) what elements of the programme processes were working well and which could be improved, (5) the extent to which the programme had been taken up by those eligible, (6) whether internal ACC processes were meeting the needs of the pilot, and (7) how cultural needs were being addressed.
ACC Counsellors. There were 10 aspects covered in the interviews with counsellors (see Appendix D1) which included: (1) how they were informed about the programme, (2) the efficiency of the programme, (3) access to further information on the programme, (4) what elements of the programme processes were working well and which could be improved, (5) the extent to which the programme was being taken up by those eligible, (6) how cultural needs were being met, (7) achievement of goals in the time given, (8) filling out the Needs Assessment forms, (9) the peer review process, and (10) confidence in implementing the programme and further training required.

Caregivers. There were eight aspects covered in the parent interviews (see Appendix E1) including: (1) how and when they were informed about the programme, (2) access to further information on the programme, (3) how they chose their counsellor, (4) how their cultural needs were met, (5) ACC paperwork including the Needs Assessment and Achievement Summary, (6) how sessions were run, (7) usefulness of the programme, and (8) what elements of the programme processes were working well and which could be improved.

Impact Evaluation Interviews
For gathering information about the impact of the Parenting Support Pilot Programme, telephone interviews with caregivers were utilised. This allowed access to most programme participants in a timely manner without the need for travel. Again, semi-structured interview schedules consisting of qualitative and quantitative questions were developed in collaboration with ACC. The interview format enabled caregivers to talk freely about a range of aspects related to programme outcomes, while ensuring important aspects were covered in a standardised way (Posavac & Carey, 1997; Sapsford & Jupp, 2006). Impact evaluations were carried out at two time points. The first round of telephone interviews were conducted when the completed files were received from ACC, while the second round was carried out as a follow-up 12 months after programme completion (as stated on the Achievement Summary forms). Four of the initial impact evaluation interviews were carried out face-to-face at the same time as the process evaluation interviews. Only one of the follow-up impact evaluation interviews was carried out face-to-face, at the request of the participant.
Initial Telephone Survey. There were nine aspects covered in the first round of impact evaluation interviews (see Appendix F1) including: (1) general impressions of the programme, (2) positive aspects of the programme, (3) goals worked on in the programme, (4) changes in their child, (5) changes in their management of their child, (6) changes noticed within the family, (7) sensitivity to cultural issues, (8) what changes they would like to see to the programme, and (9) what they felt about completing the evaluation. Additionally they were also asked 10 questions with answers registered on a five-point Likert scale covering similar issues.

Follow-up Telephone Survey. In the follow-up impact evaluation interviews similar areas were covered as in the initial impact evaluation interviews (see Appendix G1) including: (1) positive aspects of the programme, (2) changes in their child, (3) changes in their management of their child, (4) any additional help received outside the Parenting Support Pilot Programme, (5) changes noticed within the family, (6) what changes they would like to see to the programme, and (7) what they felt about completing the evaluation. Again they were asked the 10 questions registered on a five-point Likert scale covering similar issues.

Procedure

Needs Assessment (see Chapter Four)
ACC provided Needs Assessment together with the demographic data on the ACC45 forms, once participants completed the programme. The spontaneous responses on the open-ended questions in the Needs Assessment forms provided by ACC were entered into an Excel spreadsheet and responses to different questions formed the basis of deductive thematic analysis.

Process Evaluation (see Chapter Five)
There were different procedures for contacting participants dependent on their participant group. ACC Managers and Peer Reviewers associated with the Parenting Support Pilot Programme were identified by ACC and then invited to participate. The ACC Counsellors involved in the Parenting Support Pilot Programme were identified from completed Needs Assessment forms supplied by ACC. The counsellors were selectively sampled based on their geographic location to provide a range of perspectives from around the country including three main centres (Auckland,
Wellington, and Christchurch), and from two smaller centres accessible to Auckland (Hamilton and Tauranga). The counsellors in Auckland were assigned numbers and then randomly selected to reach the targeted number of interviews. Counsellors were telephoned and given a verbal summary of the purpose of the evaluation and proposed methodology and asked whether they were interested in participating. Additionally, ACC identified a counselling group utilising the Parenting Support Pilot Programme to interview its members and set this up for the evaluation team.

Caregivers were also identified from the paperwork held by ACC, on which they had consented to being contacted by the evaluation team. Parents were initially sent participant information sheets and consent forms for the impact evaluations, followed by telephone contact to see if they were interested in participation. Those parents who agreed to participate in the impact evaluation, and lived in Christchurch, Wellington, Tauranga, Hamilton or Auckland where informed about the process evaluation at the conclusion of their impact evaluation interviews and asked whether they were interested in participation.

All participants were provided with their relevant participant information sheet (see appendices B2, C2, D2, and E2) and a verbal explanation of the purpose of the study and proposed methodology. They were then all given the opportunity to ask questions, and if they consented to participation, were asked to sign a consent form (see appendices B3, C3, D3, and E3).

Process evaluation interviews were conducted over a four-month period. Of the two Managers, two Peer Reviewers, 11 counsellors, one group programme, and 13 caregivers approached, all but three parents consented to participation. Two of those who declined stated that they did not have time to participate, while the third parent did not supply a reason for why she did not want to participate. Interviews with ACC Managers and Peer Reviewers were conducted in ACC meeting rooms at a time of their convenience. All but two of the remaining interviews occurred in the participants’ homes or place of work, at their request, at a time that suited them. The remaining two interviews were conducted in quiet corners of restaurants. All of the process evaluation interviews were conducted by myself, with my supervisor, Professor Fred Seymour, also participating in interviews with ACC Managers and Peer Reviewers. With the participants’ permission, interviews were tape recorded in full for later analysis, although participants were
given the option to switch off the tape at any time if requested. Each participant was interviewed following the outline in the interview schedule (see appendices B1 to E1), while being encouraged to talk freely about topics that were important to him or her. Interviews took between 25 minutes to 1 hour 20 minutes.

*Impact Evaluation (see Chapter Six)*

Caregivers were identified from the paperwork held by ACC on which they had consented to contact by the evaluation team. Caregivers were initially sent a Cover Letter (see Appendix F2 and G2) with the Participant Information Sheet (see Appendix F3 and G3) and Consent Form (see Appendix F4 and G4), followed by telephone contact to see if they were interested in participation. A time was arranged at the caregiver’s convenience to conduct a telephone interview. All participants were provided with a verbal explanation of the purpose of the study and proposed methodology. They were then given the opportunity to ask questions, and if they consented to participation, their consent was audio-taped over the telephone.

The first impact evaluation interviews were conducted between February 2008 and September 2008. The time between the lodging of the ACC claim, which occurs as a result of the child visiting a health professional following disclosure of CSA, and the interviews ranged from approximately six to 19 months (mean = 11.5 months) for those who completed the programme and 11 to 22 months (mean = 15.6 months) for who did not. Of the 32 caregivers who completed the programme, time of interview from programme completion ranged from one to 10 months (mean = 5.3 months). The follow-up impact evaluation interviews were conducted between September 2008 and September 2009. For these interviews, the time between the lodging of the ACC claim and the interviews ranged from approximately 16 to 30 months (mean = 20.0 months) and the time of the follow-up interview from programme completion ranged from 11 to 18 months (mean = 13.9 months). Caregivers were rung up to a maximum of 23 times in an attempt to contact them for participation.

For both the initial and follow-up impact evaluation a Māori interviewer conducted interviews with Māori caregivers.
With the participants’ permission, interviews were audio-taped in full for later analysis, though participants were given the option to switch off the tape at any time. Each participant was interviewed following the outline in the interview schedule (see Appendix F1 and G1), while being encouraged to talk freely about topics that were important to him or her. The ten Likert scale questions were asked at the end of the interview. Five of the impact evaluation interviews were conducted face-to-face with participants as part of the process evaluation interviews, while one of the follow-up interviews was conducted face-to-face due to the participant requesting this. Interviews took between 15 minutes to 1 hour for the initial interviews and between 5 minutes to 1 hour for follow-up interviews.

Information for each caregiver was also gathered from the Achievement Summary forms provided by ACC following programme completion. For 11 participants no Achievement Summary forms were provided as they did not complete the programme. For these 11 participants it was clear that they would not be completing the programme when three months had elapsed without the receipt of an Achievement Summary form from the time of the completion of the Needs Assessment form, as this was the time limit set for sessions by ACC (see programme description in Chapter Two).

**Data Analysis**

*Qualitative analysis*

Qualitative information gathered from responses to open-ended questions on the paper files and from the semi-structured interviews formed the basis of qualitative thematic analysis. Thematic analysis is useful in this type of research as it provides a flexible inductive approach to the data, being open to the individual experiences of those involved in the Parenting Support Pilot Programme (Braun & Clarke, 2006; Sapsford & Jupp, 2006).

The thematic analysis utilised in this evaluation followed the procedures suggested by Braun and Clarke (2006) and Sapsford and Jupp (2006). Interview data was transcribed verbatim into Word documents and then were repeatedly read to identify semantic themes related to the processes and impacts of the pilot. Extensive coding of qualitative data in Word documents was followed by
sorting out and identifying preliminary themes, both around the specific research questions, and those that emerged out of the data but did not related directly to specific research questions (Braun & Clarke; Sapsford & Jupp). These themes were then discussed with the supervisor and as a result further refined and named, with sub-themes identified (Braun & Clarke). Extracts of interview data from a range of participants were cleaned by removing identifiers, redundant discourse markers and repetitions, and utilised to illustrate the themes and provide the context within which individual experiences occurred. Due to the small number of interview participants in the process and impact evaluations, assumptions about precise numerical representations of themes were not made, therefore qualitative labels such as few, some, many, most, and all were utilised. As the questions on the paper files were very constrained, themes were numerically reported.

Participant descriptions are shown next to quotes in the following chapters according to the codes listed in Table 3 below. Ethnicity was not included, as the low numbers in some groups may have enabled readers to identify individual participants.

Table 3

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Mother</td>
<td>C</td>
<td>Completed Programme</td>
</tr>
<tr>
<td>F</td>
<td>Father</td>
<td>IC</td>
<td>Incomplete Programme</td>
</tr>
<tr>
<td>EF</td>
<td>Extended Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quantitative analysis

Quantitative questions on paper files and Likert scale question responses were entered with demographic information from each participant into an SPSS v14.0 file for analysis. Along with descriptive information, independent samples t-tests, paired t-tests and repeated-measures analysis of variance (ANOVA) were carried out.
CHAPTER FOUR: NEEDS ASSESSMENT

This chapter investigates the needs identified by the caregivers in the Parenting Support Pilot Programme. This needs assessment is primarily based on the Needs Assessment forms developed by and gathered by ACC and supplemented by responses made on the Response and Consent form, the ACC45 form, and comments made during the interviews with caregivers. Spontaneously made comments in response to open-ended questions in the Needs Assessment forms were thematically analysed and are presented in the tables below. Caregivers frequently wrote about more than one theme in answers, therefore the number of responses recorded is often greater than the number of caregivers. Interview schedules with caregivers were not developed to assess need, but several caregivers spontaneously spoke about their needs during process evaluation and impact evaluation interviews. As questions did not specifically target needs, long term needs and needs relating to access to the programme were incorporated into the process evaluation chapter, while comments made by caregivers about needs that had been met by the programme were incorporated into the impact evaluation chapter.

Needs of the Children

Caregivers identified several needs for their children in relation to the emotional coping and support they need from their caregivers and school, and needs related to abuse characteristics such as contact with the perpetrator and the location of abuse occurrence.

Effects on the child

In the Needs Assessment form, caregivers were asked about the personality of the child before the abuse had occurred. The majority of children were described with words such as happy, bubbly, innocent, kind, outgoing, trusting, confident, friendly, well-adjusted, assertive, and compliant. Very few children were identified as non-compliant, shy, and/or lonely. However, this
contradicts the literature that indicates that children with low self-esteem or a lack of confidence may be at increased risk of experiencing CSA (Elliot et al., 1995). Therefore, it is possible that caregivers over-reported their children’s positive attributes prior to the disclosure of abuse due to this being in contrast to their children following disclosure.

Caregivers identified a whole range of ways in which their children had been affected by the sexual abuse in the question ‘How do you feel the sexual abuse has affected your child?’. These included changes in their emotions and behaviours as well as a range other changes (see Table 4). Some of these changes impacted the wider family in a negative way, as illustrated by one mother who said:

She was getting very angry and taking it out on her older sister and me. (M, IC)

Table 4

<table>
<thead>
<tr>
<th>How do you feel the sexual abuse has affected your child?</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional changes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry/irritable</td>
<td>29</td>
<td>46.8</td>
</tr>
<tr>
<td>Low confidence/self-conscious</td>
<td>17</td>
<td>27.4</td>
</tr>
<tr>
<td>Low mood</td>
<td>14</td>
<td>22.6</td>
</tr>
<tr>
<td>Anxious</td>
<td>13</td>
<td>21.0</td>
</tr>
<tr>
<td>Feel unsafe</td>
<td>13</td>
<td>21.0</td>
</tr>
<tr>
<td>Mood swings</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Confused</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Stressed</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Sensitive</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Guilt</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>
Table 4

How children were affected by the sexual abuse continued

<table>
<thead>
<tr>
<th>How do you feel the sexual abuse has affected your child?</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural changes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Problems</td>
<td>20</td>
<td>32.3</td>
</tr>
<tr>
<td>Withdrawn/Avoidant</td>
<td>18</td>
<td>29.0</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>11</td>
<td>17.7</td>
</tr>
<tr>
<td>Sexualised behaviours</td>
<td>11</td>
<td>17.7</td>
</tr>
<tr>
<td>Regression</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Clingy</td>
<td>6</td>
<td>9.7</td>
</tr>
<tr>
<td>Suicidal/self-harming</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Poor self-cares</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Controlling others</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Lack concentration/motivation</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Impulsivity/hyperactive</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Perfectionism</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Other behavioural problems</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Other changes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School problems</td>
<td>8</td>
<td>12.9</td>
</tr>
<tr>
<td>Personality change</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Interpersonal problems</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Somatic complaints</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Changed understanding of relationships</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Needs routine</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Caregivers offered some ideas as to what the children would need from them to recover from the effects of the abuse using the question ‘What kind of help does your child need from you now to deal with the sexual abuse?’ on the Needs Assessment form. The responses included emotional
support, practical support, and teaching their children skills (see Table 5). Three caregivers were not sure how they could best provide support as illustrated by the quotes from two mothers below:

The biggest thing ever, from the parent that thought she knew everything, not knowing what to do was like ‘oh my gosh’, you know. (M, C)

I had no skills or anything to deal with this situation and I’m here having to deal with this. Umm what happened to my daughter and I didn’t know how to deal with it. (M, C)

Table 5
Caregiver support needed to help child work through abuse effects

<table>
<thead>
<tr>
<th>What kind of help does your child need from you to deal with the sexual abuse?</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional support/love</td>
<td>53</td>
<td>85.5</td>
</tr>
<tr>
<td>Responding appropriately to behaviours</td>
<td>19</td>
<td>30.6</td>
</tr>
<tr>
<td>Patience</td>
<td>12</td>
<td>19.4</td>
</tr>
<tr>
<td>Reassurance/calmness</td>
<td>12</td>
<td>19.4</td>
</tr>
<tr>
<td>Practical support</td>
<td>11</td>
<td>17.7</td>
</tr>
<tr>
<td>Maintain a good relationship</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Provide understanding</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Consistency</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Provide safety</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Teach emotion management</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Provide stable family dynamics</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Improve own caregiver confidence</td>
<td>3</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Caregivers were asked how confident they were in providing this support to their children on the Needs Assessment Forms by answering the question ‘How confident are you that you can provide this?’ on a 5-point Likert Scale (1 = Not Confident, 5 = Very Confident). Caregivers scored from one to five (Mean = 3.42) on this item, indicating that caregivers felt not sure to confident that they would be able to provide this support. Additionally, they were asked about
their long-term confidence around this by answering the question ‘How confident are you that you will be able to manage the effects of the abuse on your child, over the longer term?’ on the same 5-point Likert Scale. Again caregiver’s responses ranged from one to five (Mean = 3.46) on this question, indicating caregivers felt some confidence to confident that they would be able to manage long-term effects of the abuse.

**Problems at school**

According to the Needs Assessment forms, 35 (56.5%) of the 62 child claimants had problems at school, while only 17 (27.4%) did not. Ten (16.1%) caregivers were unsure whether their child was experiencing problems at school. On the Needs Assessment forms, caregivers were asked ‘what kinds of problems is your child having?’ in relation to school, which is outlined in Table 6. The majority of the problems involved difficulties with social interactions, non-compliance, behavioural problems, and concentration or motivation. Other problems included academic performance, confidence, and emotional responses.

Table 6

*Problems experienced by children at school*

<table>
<thead>
<tr>
<th>What kinds of problems is your child having (at school)?</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate/negative social interactions</td>
<td>25</td>
<td>40.3</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>17</td>
<td>27.4</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>17</td>
<td>27.4</td>
</tr>
<tr>
<td>Low concentration/motivation</td>
<td>16</td>
<td>25.8</td>
</tr>
<tr>
<td>Academic difficulties</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Lack confidence</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Emotional problems</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Doesn’t attend school</td>
<td>3</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Some of the children were receiving help for the problems they were experiencing at school. Ten of the children received help through independent counselling, nine from school, two through ACC counsellors, and two were receiving educational remedial help. Three of the children were not attending school such as the child of the mother who said:
We got to a stage where we had to, enough was enough, I had to pull her out of school, it wasn’t going right. (M, C)

Abuse characteristics
Along with factors such as the impact on the caregiver from family conflict and loss of support, the literature indicates that the needs of children may vary according to certain abuse characteristics such as the proximity of the relationship to the perpetrator. Caregivers were asked about the relationship between the perpetrator and child in the Consent and Response forms in the question ‘relationship of alleged abuser to child?’. As Table 7 illustrates, of the 62 children represented, 31 (50.0%) of the perpetrators were in the child’s family, 18 (29.0%) were known to the child but outside the family, and only 10 (16.1%) of perpetrators were strangers to the child.

Table 7
The relationship of the alleged abuser to the child claimant

<table>
<thead>
<tr>
<th>Relationship to alleged abuser to child</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family acquaintance</td>
<td>18</td>
<td>29.0</td>
</tr>
<tr>
<td>Parental figure</td>
<td>15</td>
<td>24.2</td>
</tr>
<tr>
<td>Stranger</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Extended family member</td>
<td>9</td>
<td>14.5</td>
</tr>
<tr>
<td>Sibling</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Not answered</td>
<td>3</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Caregivers may experience increased parental stress associated with managing risk relating to the possibility of future abuse occurrences, and/or the effects that reminders of abuse may have on their children. The literature indicates that the outcomes for children may be worse if they are still in contact with the perpetrator following disclosure, which is more likely to occur if the perpetrator is within the family system. Because, such contact may have a major impact on the child and their caregivers, it was also investigated in the Needs Assessment forms. Of the 62 children represented in these forms, only 11 (17.7%) still had contact with the perpetrator while 50 (80.6%) did not (one did not respond to this question). Although there was no formal contact for some children, several caregivers indicated that the perpetrator was in their community so
there was still a possibility of future contact. Of these, one perpetrator was never found, seven of the perpetrators were still in their community, four had supervised access to the child, and for six children the perpetrator remained within the family (usually a sibling).

Additionally, the locality in which the abuse occurred is significantly associated with parental stress and the level of support or contact received from the community. This was one of the questions on the ACC45 form, which asked for the ‘accident scene’. For the majority of children, the abuse occurred in their own home, while for others it occurred at a place of recreation, at school, at the perpetrators home, or following an abduction (see Table 8).

Table 8

*Location of abuse occurrence for the claimants*

<table>
<thead>
<tr>
<th>Accident scene</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>37</td>
<td>59.7</td>
</tr>
<tr>
<td>Place of recreation (e.g., church, park)</td>
<td>6</td>
<td>9.7</td>
</tr>
<tr>
<td>Perpetrator’s home/abduction</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>School</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Not answered</td>
<td>6</td>
<td>9.7</td>
</tr>
</tbody>
</table>

**Needs of the caregivers**

Along with the needs of their children, caregivers identified several direct needs of their own. Mostly their needs related to how to best respond to their children’s difficulties, their own coping, and the support needed to work through these difficulties.

*Difficulties experienced by caregivers*

Caregivers experienced a range of difficulties with their children at the time of filling out the Needs Assessment form (see Table 9). When asked ‘what difficulties, if any, are you having with your child at home?’ only six caregivers said that they were not experiencing problems with their
child. Some of the difficulties experienced by caregivers were complex, and they struggled to know what to do in response as indicated in the quote below:

Do I keep talking to her about it to get it out in the open? Or do I not talk about it?
You know, I had so many questions. (M, C)

Table 9
Difficulties experienced by caregivers

<table>
<thead>
<tr>
<th>What difficulties, if any, are you having with your child at home?</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s behaviour</td>
<td>77</td>
<td>124.2(^1)</td>
</tr>
<tr>
<td>Child’s emotions</td>
<td>45</td>
<td>72.6</td>
</tr>
<tr>
<td>Knowing how to manage their child’s behaviour</td>
<td>14</td>
<td>22.6</td>
</tr>
<tr>
<td>Family conflict</td>
<td>6</td>
<td>9.7</td>
</tr>
<tr>
<td>School problems</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Their relationship with the child</td>
<td>2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

\(^1\) As several caregivers reported more than one child behaviour they found difficult the total added up to more than 100%.

When asked ‘what would you normally do to deal with these problems?’ most caregivers indicated that they already had some strategies in place as outlined in Table 10, although seven indicated that they did not. Some of these strategies were positive, while others appeared to be maladaptive.

Caregivers were asked to indicate how well they were managing their children’s behaviours on the Needs Assessment forms by answering the question ‘How well are you managing your child’s behaviour at the moment?’ on a 5-point Likert Scale (1 = not well, 5 = very well). Caregivers scored themselves between one and five (Mean = 3.13) on this question, indicating that most caregivers felt that they were managing their child’s behaviours Moderately well.
Table 10

*Strategies used by caregivers to deal with their child’s behaviour*

<table>
<thead>
<tr>
<th>What would you normally do to deal with these problems?</th>
<th>Number (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss with the child</td>
<td>22</td>
<td>35.5</td>
</tr>
<tr>
<td>Use reinforcement strategies</td>
<td>20</td>
<td>32.3</td>
</tr>
<tr>
<td>Use time out</td>
<td>12</td>
<td>19.4</td>
</tr>
<tr>
<td>Get angry with the child</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Give the child space</td>
<td>7</td>
<td>11.3</td>
</tr>
<tr>
<td>Ignore the behaviour</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Provide reassurance</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Mediate conflict in the family</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Educate/Model good behaviour</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Are softer on them</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Get help from others</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>Use structured routines</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

*Coping*

Some caregivers indicated that they were coping well with their child and the situation in the home, while others said that they were struggling. When asked *‘How are you coping since finding out about the sexual abuse?’*, some just said they were not coping well. The majority of caregivers responded that they were experiencing a variety of emotions, while others experienced physical symptoms such as changes in their sleep, appetite, and immune systems (see Table 11). The quote below illustrates some of the difficulties caregivers experienced in terms of their own emotional coping:

> Whatever your desires, your disappointment, your anger, you know, your anger that why did it happen? (M, C)

According to the literature, caregivers may find it particularly difficult to cope with their child’s disclosure of abuse if they themselves have been abused. In the interviews and on the Needs Assessment forms, a total of seven caregivers spontaneously disclosed their own historical abuse.
Table 11

*How caregivers were coping with the family situation at the time of the needs assessment*

<table>
<thead>
<tr>
<th>How are you coping since finding out about the sexual abuse?</th>
<th>Number (N = 60)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>74</td>
<td>123.3¹</td>
</tr>
<tr>
<td>Not well</td>
<td>19</td>
<td>31.7</td>
</tr>
<tr>
<td>Physical problems</td>
<td>13</td>
<td>21.7</td>
</tr>
<tr>
<td>Not knowing how to respond</td>
<td>13</td>
<td>21.7</td>
</tr>
<tr>
<td>Avoidant</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td>Well/with support</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Day by day</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Isolated</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Problem solving</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Variably</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Pushing through</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Caring/protective of child</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Struggling to believe</td>
<td>1</td>
<td>1.7</td>
</tr>
</tbody>
</table>

¹ As several caregivers reported more than one emotional difficulty the total added up to more than 100%.

This was the case for one mother who said:

> I was abused and raped as a child, so I was dealing with stuff myself and then when she brought it up it absolutely threw me to the ground. (M, C)

These caregivers may have unique needs in relation to being available to support their children following the disclosure of abuse.

**Support needed**

All but one caregiver indicated that they needed some help in being better able to support their child when asked ‘*What help do you need now to improve things for your child?’*. Some of these needs were the same as the aims of the programme, such as learning behavioural management strategies, coping strategies, and gaining education about abuse issues. Others needs that were not identified when the programme was first developed related to additional support caregivers...
required for themselves, having someone to listen, getting some respite from the difficulties they were experiencing, and having a safe space to reflect (see Table 12).

Table 12

<table>
<thead>
<tr>
<th>Help needed by caregivers to provide support to their child</th>
<th>Number (N = 60)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning to respond to child</td>
<td>28</td>
<td>46.7</td>
</tr>
<tr>
<td>Support for self</td>
<td>19</td>
<td>31.7</td>
</tr>
<tr>
<td>Information about abuse</td>
<td>17</td>
<td>28.3</td>
</tr>
<tr>
<td>Therapy for self</td>
<td>13</td>
<td>21.7</td>
</tr>
<tr>
<td>Coping strategies for themselves</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Practical help</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Having someone to listen</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Strategies to improve the relationship with child</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Guidance</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td>Respite</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Safe space to reflect</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Help from family</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Help with own emotions</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>Help putting difficulties into perspective</td>
<td>3</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Caregivers were asked ‘Who do you go to for support at the moment?’ In response to this, caregivers reported receiving support from a range of places such as from their parents, friends, doctor, family, and social workers (see Table 13). Eleven (18.3%) caregivers indicated receiving no support from anywhere.

Additionally, 30 caregivers indicated that they were in contact with agencies outside of ACC when specifically asked ‘Are you or your child involved with any other agencies at the moment?’. Of the 62 children represented in the Needs Assessment forms, 30 (48.4%) of the caregivers indicated that they were involved with agencies outside ACC, while 29 (46.8%) were not (this information was missing for three caregivers). Caregivers indicated a range of agencies they were
involved with when asked ‘which agencies’, most commonly with Child, Youth, and Family and the Police (see Table 14).

Table 13
Places caregivers received support from

<table>
<thead>
<tr>
<th>Who do you get support from at the moment?</th>
<th>Number (N=60)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>30</td>
<td>50.0</td>
</tr>
<tr>
<td>Family/Partner</td>
<td>25</td>
<td>41.7</td>
</tr>
<tr>
<td>Counsellor/Psychologist</td>
<td>14</td>
<td>23.3</td>
</tr>
<tr>
<td>Parents</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>Doctor</td>
<td>6</td>
<td>10.0</td>
</tr>
<tr>
<td>Church</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>NGOs</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>School</td>
<td>1</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Table 14
The numbers of claimants involved with different agencies outside of ACC

<table>
<thead>
<tr>
<th>Which agencies (are you or your child involved with at the moment)?</th>
<th>Number (N = 30)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child, Youth, and Family (CYF)</td>
<td>16</td>
<td>53.3</td>
</tr>
<tr>
<td>Police</td>
<td>11</td>
<td>36.7</td>
</tr>
<tr>
<td>Non-governmental organizations</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td>Counselling</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Medical professional</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>Church</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Work and Income New Zealand (WINZ)</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Court</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Offender treatment programme</td>
<td>2</td>
<td>6.7</td>
</tr>
</tbody>
</table>
Needs of the family

As the context surrounding the child claimant is important, caregivers were asked about the effects of the abuse on the child’s siblings and extended family in the Needs Assessment forms. Additionally, caregivers spoke about the effects of the disclosure on their immediate family, as illustrated by the quotes below:

Your family takes a huge battering. There’s a lot of unanswered questions and what do you do now? (M, IC)

And I’m ending up with a husband who’s traumatised, you know. With the impact that can have on the couple life, you know. What it does is just utterly devastating. (M, IC)

My older daughter who was going haywire, she needed help as well. (M, IC)

**Effects on the siblings**

Of the Needs Assessment forms filled out, 41 (66.1%) indicated that the siblings of the victim knew about the abuse, 13 (21.0%) did not know about the abuse, and 7 (11.3%) children did not have any siblings (this information was missing for one child). According to the caregivers, the victims’ siblings were affected in a variety of ways after finding out about the disclosure when asked ‘How has finding out about the abuse affected other children in the family?’, though for two siblings there were no effects identified, and one sibling did not believe the disclosure (see Table 15).

**Relationships with extended family members**

All but six caregivers reported that their relationships with other family members were affected when asked ‘How has finding out about the sexual abuse affected relationships with other family members?’ This particularly seemed to occur when the abuse occurred within the family system. According to the caregivers, extended family members were affected by the disclosure in a variety of ways as outlined in Table 16.
Table 15

How the siblings were affected by disclosure of sexual abuse

<table>
<thead>
<tr>
<th>How has finding out about the abuse affected other children in the family?</th>
<th>Numbers (N = 62)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>42</td>
<td>67.7</td>
</tr>
<tr>
<td>Protective/supportive</td>
<td>10</td>
<td>16.1</td>
</tr>
<tr>
<td>Triggered their own victimisation</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Lacks understanding</td>
<td>5</td>
<td>8.1</td>
</tr>
<tr>
<td>Behaves negatively towards the victim</td>
<td>4</td>
<td>6.5</td>
</tr>
<tr>
<td>Adjusting to family dynamics</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Feels left out</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Doesn’t trust the victim</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Table 16

How the family members were affected by disclosure of sexual abuse

<table>
<thead>
<tr>
<th>How has finding out about the sexual abuse affected relationships with other family members?</th>
<th>Numbers (N = 60)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional difficulties</td>
<td>25</td>
<td>41.7</td>
</tr>
<tr>
<td>Isolated from family</td>
<td>23</td>
<td>38.3</td>
</tr>
<tr>
<td>Strained relationships</td>
<td>14</td>
<td>23.3</td>
</tr>
<tr>
<td>Reacted supportively</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Became avoidant of the victim</td>
<td>9</td>
<td>15.0</td>
</tr>
<tr>
<td>Strained marital relationship</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>Stronger relationships</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>Lack understanding</td>
<td>2</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Analysis of Goals

In the 60 individual Needs Assessment forms, caregivers identified a total of 197 goals. On average, caregivers identified 3.4 goals, with two identifying one goal, 10 identifying two goals,
19 identifying three goals, 17 identifying four goals, and 10 identifying five goals. The Needs Assessment forms provided prompts for four goals, and had a space to add any additional goals. In some instances caregivers combined more than one goal into each goal section. When this occurred the primary goal was used for analysis. Goals were ordered as indicated by the caregivers, or the order in which they were written if this was not specified.

There are three aims identified by ACC for the sessions within the Parenting Support Pilot Programme:

1) Parental self-management and coping
2) Managing their child’s behaviour
3) Education about sexual abuse and its effects

Along with goals in these three areas, caregivers identified several goals centred around supporting the child in their recovery more directly.

**Caregivers’ goals**

The 197 goals identified by caregivers are outlined in Table 17. Of these:

- 81 (41.1%) were in the area of parental self-management and coping including managing their own emotions, self-management, coping, confidence, interpersonal and family relationships and practical support.
- 76 (38.6%) were in the area of managing the child’s behaviour including direct behavioural management, managing the child’s emotions, and managing defiant behaviours and sexually inappropriate behaviours.
- 22 (11.2%) were in the area of education about sexual abuse and its effects.
- 18 (9.1%) were about supporting the child in their recovery more directly, including supporting the child’s coping, improving the parent-child relationship, and the child’s socialisation.
Table 17

Goals identified by caregivers on the Needs Assessment forms

<table>
<thead>
<tr>
<th>Parental management/coping</th>
<th>1st Goal</th>
<th>2nd Goal</th>
<th>3rd Goal</th>
<th>4th Goal</th>
<th>5th Goal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own emotions</td>
<td>(N=58)</td>
<td>(N=56)</td>
<td>(N=46)</td>
<td>(N=27)</td>
<td>(N=10)</td>
<td>(N=197)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Interpersonal/family relationships</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>10.3</td>
<td>10.7</td>
<td>15.2</td>
<td>14.8</td>
<td>20.0</td>
<td>12.7</td>
</tr>
<tr>
<td>Self-management</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>6.9</td>
<td>3.6</td>
<td>15.2</td>
<td>14.8</td>
<td>10.0</td>
<td>7.1</td>
</tr>
<tr>
<td>Practical support</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>0.0</td>
<td>1.8</td>
<td>8.7</td>
<td>3.7</td>
<td>10.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Coping</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>8.6</td>
<td>1.8</td>
<td>4.3</td>
<td>0.0</td>
<td>10.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Confidence</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>1.7</td>
<td>3.6</td>
<td>4.3</td>
<td>3.7</td>
<td>0.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Managing child's behaviour

| Behaviour Management                           | 11       | 14       | 5        | 2        | 0        | 32    |
|                                                | 19.0     | 25.0     | 10.9     | 7.4      | 0.0      | 16.2  |
| Child's emotions                               | 5        | 8        | 6        | 3        | 1        | 23    |
|                                                | 8.6      | 14.3     | 13.0     | 11.1     | 10.0     | 11.6  |
| Sexually inappropriate behaviour               | 6        | 2        | 4        | 1        | 0        | 13    |
|                                                | 10.3     | 3.6      | 8.8      | 3.7      | 0.0      | 6.6   |
| Compliance/School attendance                   | 1        | 3        | 4        | 0        | 0        | 8     |
|                                                | 1.7      | 5.3      | 8.7      | 0.0      | 0.0      | 4.1   |

Education about sexual abuse                    | 8        | 9        | 2        | 7        | 1        | 22    |
|                                                | 13.8     | 16.1     | 4.3      | 7.4      | 10.0     | 11.2  |

Supporting child

| Child's socialisation                          | 2        | 2        | 1        | 3        | 0        | 8     |
|                                                | 3.4      | 3.6      | 2.2      | 11.1     | 0.0      | 4.1   |
| Parent-Child relationship                      | 2        | 1        | 1        | 1        | 1        | 6     |
|                                                | 3.4      | 1.8      | 2.2      | 3.7      | 10.0     | 3.0   |
| Child's coping                                 | 3        | 1        | 0        | 0        | 0        | 4     |
|                                                | 5.2      | 1.8      | 0.0      | 0.0      | 0.0      | 2.0   |
**Additional goals identified**

On the Achievement Summary forms completed by caregivers at the end of the Parenting Support Pilot Programme, caregivers were asked to identify any additional goals they worked on during their sessions. Fourteen caregivers identified that they worked on additional goals in similar areas indicated by other caregivers in the Needs Assessment forms (see Table 18).

**Table 18**

*Additional goals identified in the Achievement Summary forms*

<table>
<thead>
<tr>
<th>How family affected</th>
<th>Numbers (N = 14)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental management/coping</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Managing child’s behaviour</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Education about sexual abuse</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Supporting the child</td>
<td>2</td>
<td>14.3</td>
</tr>
</tbody>
</table>

**Conclusions**

Overall, caregivers identified many specific needs that they had before the commencement of the Parenting Support Pilot Programme, including needs of their child, themselves, and their family. Several goals were identified in relation to these needs and the aims stipulated by the programme itself.

Caregivers identified that children needed support from them to overcome the difficulties experienced as a result of the CSA, which the literature also indicates (Kendall-Tackett et al., 1993; Lovett, 1995; Newberger et al., 1993), including emotional and behavioural difficulties. Additionally, caregivers identified that over half of the children were having difficulties at school, for which only some were receiving help. On the Needs Assessment forms, caregivers were asked about some abuse characteristics that may affect the needs required by the family, such as the relationship of the alleged perpetrator to child and the location of the abuse event (Barker & Duncan, 1985; Berliner & Conte, 1990; Finkelhor, 1994; Kendall-Tackett et al., 1993;
Mullen et al., 1993). As would be expected, the majority of the perpetrators were known to the child, which is associated with worse outcomes for children (Barker-Collo & Read, 2003; Coulburn-Faller, 1989; Fergusson et al., 1996), and the abuse most frequently occurred at the child’s home. These abuse characteristics are also likely to affect the needs of caregivers, such as if the caregivers knew the perpetrator and the abuse occurred in their home (Humphreys, 1995).

For the Parenting Support Pilot Programme to be useful it must address these caregiver needs and bring about positive changes in these areas, while keeping within the scope of the pilot programme. The next two chapters will discuss the extent to which the programme has addressed these needs.

Caregivers also identified a range of difficulties they were having with their children, such as problem behaviours, emotional difficulties, and knowing specific behaviour management strategies, which is consistent with previous literature (Barth et al., 1994). Most caregivers already had a range of strategies in place to work with these difficulties, most of them adaptive. Additionally, caregivers identified needs in terms of their own coping, as many of them were not coping well with the disclosure of the abuse and the subsequent family situation (Print & Dey, 1992). However, several caregivers were already receiving support from a range of places, most commonly their friends and family (55 caregivers), as well as from a range of agencies other than ACC.

Additionally, many caregivers identified that their immediate and extended family members had a range of needs following the disclosure of abuse. In particular, many of the child claimants had siblings who were aware of the abuse and were affected in a range of. Relationships with extended family members also changed, particularly if the abuse was intrafamilial.

The range of needs identified by caregivers were translated into goals during the needs assessment session, where caregivers identified a total of 197 goals. The majority of these goals fell into the main aims of the programme such as parental coping, managing their child’s behaviour, and education about the effects of sexual abuse. There were also additional goals identified concerning them supporting their child’s recovery more directly. Within parental coping, several personal needs were identified which were congruent with the literature, such as needing emotional support themselves (Print & Dey, 1992), particularly in cases where
caregivers had experienced their own victimisation (Davies & Seymour, 1999a; Oates et al., 1998) or had dealt with family conflict as a result of the abuse (Humphreys 1995). Due to the peer review process not being used systematically, it is not possible to identify which, if any, of the goals were changed as a result of this feedback process. Together with the addition of extra goals, this makes it difficult to evaluate which of the goals were met and makes further analysis difficult. In the next chapter, the processes of the programme will be identified and evaluated, while in the chapter following, the impact of the programme will be investigated.
CHAPTER FIVE: PROCESS EVALUATION

This chapter investigates the processes occurring within the Parenting Support Pilot Programme and is based on the thematic analysis of the process evaluation interviews conducted with ACC Managers, ACC Peer Reviewers, ACC counsellors, and caregivers. Additionally, consent and response forms from declining participants are analysed to identify reasons for declining support. Reasons given include: (1) already receiving other counselling, (2) already receiving other non-counselling support, (3), not believing that the support would be helpful, (4) struggling with access to the programme, (5) waiting for the child’s counselling to begin, and (6) the respondent was a claimant who did not want her caregivers to know about the sexual abuse.

Thematic Analysis of Interviews

Seven main themes, with several associated sub-themes, emerged during the interviews with participants and are presented in Table 19.

Poor information about the programme

Both caregivers and counsellors spoke about the importance of increasing awareness of the Parenting Support Pilot Programme. They identified a general lack of awareness about the programme, as well as specific aspects of the programme. Information was often unclear, and at times it was difficult to gain further clarification from ACC.
Table 19

*Themes and sub-themes identified in the data relating to processes*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor information about the programme</td>
<td>People don’t know</td>
</tr>
<tr>
<td></td>
<td>Information is not clear</td>
</tr>
<tr>
<td></td>
<td>It was hard to get more information</td>
</tr>
<tr>
<td>The programme was hard to access</td>
<td>Demands on time</td>
</tr>
<tr>
<td></td>
<td>Transport difficulties</td>
</tr>
<tr>
<td></td>
<td>Childcare difficulties</td>
</tr>
<tr>
<td></td>
<td>Cost barriers</td>
</tr>
<tr>
<td></td>
<td>Counsellor availability</td>
</tr>
<tr>
<td></td>
<td>When caregivers are separated</td>
</tr>
<tr>
<td></td>
<td>Caregivers not being eligible</td>
</tr>
<tr>
<td>Accessing the programme at the right time was</td>
<td>Not available soon enough</td>
</tr>
<tr>
<td>important</td>
<td>Slight delays are acceptable</td>
</tr>
<tr>
<td></td>
<td>Systemic problems within ACC</td>
</tr>
<tr>
<td>Developing goals was difficult</td>
<td>Needs Assessment forms were cumbersome</td>
</tr>
<tr>
<td></td>
<td>Goals change</td>
</tr>
<tr>
<td></td>
<td>Rapport needed first</td>
</tr>
<tr>
<td></td>
<td>Development of goals was difficult</td>
</tr>
<tr>
<td></td>
<td>Lack of clarity about the process of goal-setting</td>
</tr>
<tr>
<td>Not enough time to achieve goals</td>
<td>Adequacy of six sessions</td>
</tr>
<tr>
<td></td>
<td>Follow-up sessions are needed</td>
</tr>
<tr>
<td></td>
<td>Supplementary reading material would help</td>
</tr>
<tr>
<td></td>
<td>Need for information on related services</td>
</tr>
<tr>
<td>Counsellor characteristics are important</td>
<td>Caregivers need a good match with counsellors</td>
</tr>
<tr>
<td></td>
<td>Cultural considerations</td>
</tr>
<tr>
<td></td>
<td>Having the same counsellor as the child is beneficial</td>
</tr>
<tr>
<td></td>
<td>Counsellors need to be informed about the programme</td>
</tr>
<tr>
<td>Evaluation processes were sensitive to</td>
<td>Seeing the benefits of participation</td>
</tr>
<tr>
<td>caregivers’ needs</td>
<td>Transparent research methodology</td>
</tr>
<tr>
<td></td>
<td>Interviews conducted soon after the conclusion of counselling</td>
</tr>
</tbody>
</table>
People don’t know

There seemed to be a general lack of awareness about the programme, with most of the caregivers first being informed of the programme through contact with a counsellor rather than directly from ACC, though correspondence was usually received from ACC at some stage:

It was (the counsellor), she mentioned it first, and then funny enough I got all this paperwork after. (M)

Despite most caregivers first hearing of the programme from their counsellor, those that were informed directly by ACC found this helpful:

It was easy to me because it came to me rather than me having to look for it. I think it was a good in that when you’re a caregiver, you don’t know who to turn to or what to do next. (M)

One counsellor also spoke about caregivers receiving the information from ACC, but not knowing what the letter was about, and thus requiring support around this:

I often find that caregivers wait until you make appointments with them and then they say I got this form from ACC, what does it mean. They open it, but you know it hasn’t been looked at and often it has the consent form in it. So you go through it with them and fill it out. (Counsellor)

Added to this, two caregivers indicated that they would have preferred a more personal contact along with being sent the letter. The caregivers that spoke about this identified as Māori and Pacific Islander, which may indicate a cultural practice that should be considered when first approaching caregivers with information about the programme:

If ACC could possibly contact the caregivers and just say to them, ‘I’m sending out a list of counsellors, but just I guess making that first initial break, that, you know, that contact. (M)

Along with a lack of awareness amongst caregivers, participants also discussed the lack of awareness of the programme amongst some counsellors. The managers thought this may have
been due to the time it took getting the pilot off the ground, or possibly because counsellors receive so much ACC paperwork that they no longer read it all carefully.

For months it was ‘yes it’s coming, yes it’s coming, yes it’s coming’, now it’s here. And then that’s been it, haven’t kept that flow happening so I suspect that if we had said now it’s become legislation and we are going to do it, everyday people would be like ‘what, what?’ . (Manager)

Information is not clear
Some participants spoke about lacking awareness about certain aspects of the programme. One caregiver identified wanting more information about additional entitlements surrounding the programme such as monetary support:

I think that ACC should be up-front and talk to the people, talk to the victims, you know, the people that they’re helping about what their rights are, what’s available to them, to help them in a monetary, in a financial sense not just in the counsellor sense, but how are they going to get there if they can’t afford it. (M)

Additionally, one caregiver spoke about ringing a counsellor on the list provided by ACC who was unaware they were enrolled to provide the Parenting Support Pilot Programme. This indicated the need for more awareness amongst eligible ACC counsellors in general, as well as ensuring that the counsellor lists sent out to caregivers were accurate to avoid confusion:

When I started ringing there was one that said no they weren’t doing that. (M)

It was hard to get more information
Both caregivers and counsellors identified frustrations when trying to contact ACC for more information via the phone, both in terms of not being directly put through to the right people, and not receiving a response when they left a voice message:

I prefer direct dial, I hate going through the call centre and most counsellors do because usually you know what they can help you with and what they can’t help you with, but you have to go through the whole bloody story before you get put through. (Counsellor)
The programme was hard to access

Several factors were identified by programme participants that impacted on access to the programme including demands on time, transport, childcare, cost, counsellor availability, when caregivers are separated, and some caregivers not being eligible.

Demands on time

Time was identified as a constraint by many caregivers, related to time pressures in general, and needing to be flexible around work and school timetables:

It’s too many appointments, it was like my day sometimes I can’t relax because you’re always ‘I have to go from that one, to that one, to that one’. (M)

It was just because of work, you know we had to wait, like, we had to wait until I’d finished before we could go, I think a couple of times I knocked off early to go. (F)

However, this was made somewhat easier when the child and caregiver could be seen at the same time in the same agency:

I think at the start we’d take (our daughter) off to the counsellor, and then we’d see the other counsellor at the same time because they were in the same building. (F)

Transport difficulties

Many caregivers identified transport issues as potentially limiting access to counselling, and Managers acknowledged that this was not addressed within the pilot. Transport issues seemed particularly salient when there were several trips between home, work and counselling, with multiple trips adding up the mileage and petrol costs:

This pilot makes no account for transport or travelling and we already know we are light on counsellors in some areas. (Manager)

Childcare difficulties

Childcare was difficult for caregivers with young children for several reasons. Factors such as cost impacted, but in particular if there was an experience of CSA within the family system, caregivers were less likely to leave their child with strangers:
For someone to provide childcare, that would be really helpful. I mean that has been an ongoing issue. (Counsellor)

Instead, caregivers brought their children to counselling sessions so that they could look after them:

I took (my other daughter) to the counselling sessions with me, and the counsellor had toys and things to play with, and I’d take books and whatever, and (she) would often just sit down very quietly and just play quietly. (M)

Cost barriers
Programme stakeholders spoke about the cost related to accessing the programme as being a major issue, particularly as this also impacts on other areas of access such as transport and childcare. Although ACC provided the majority funding for the Parenting Support Pilot Programme sessions, some counsellors chose to charge an extra top-up fee called a ‘co-payment’. Evaluation participants all agreed that having to pay extra co-payments should not be utilised in this setting:

All of a sudden you have got the child in counselling and then the caregiver in counselling that could be up to another $140 a week to actually do the counselling. So on one hand you have to have a programme, but on the other you have to take into account if it’s actually accessible and affordable. So the funding of that program needs to be looked at quite carefully. (Peer Reviewers)

Counsellor availability
The shortage of counsellors affected programme access for caregivers in some regions. Even in centres where there were a range of counsellors that could potentially carry out the programme, they were often busy with waiting lists:

We do what we can, but there’s a shortage of counsellors across the country. So we can only do what we can do. (Manager)

She tried to get someone to see her and there was only one person who could in (her city) and she knew the person so she couldn’t access the program. So it could be that one of the problems is that there aren’t all that many people doing it. (Peer Reviewer)
Managers identified that the limited number of counsellors also impacted on their ability to provide caregivers with a culturally appropriate service:

I think we have about seven counsellors that are eligible who identify as Māori, and of the claimants, there is a percentage who are also Māori that won’t be a match there.
(Manager)

*When caregivers are separated*

Caregivers talked about the importance of the programme being available to both caregivers, particularly if the children spend time between homes or with different family members. Caregivers felt it would be important to include all caregivers if possible:

Counselling sessions should be open to both caregivers, taking into account the needs, taking into account that both caregivers are not always living together. (M)

I think it would be a waste of time if just one went. (F)

*Caregivers not being eligible*

As described earlier, when children first access ACC’s counselling services, they go through a process with a counsellor to determine whether there is a mental injury resulting from the incident that triggered the claim. This process is called cover determination. Caregivers are only able to access the Parenting Support Pilot Programme when their child’s claim has been accepted. Therefore, when children do not go through the cover determination process, caregivers are not able to get access to the Parenting Support Pilot Programme. Several caregivers indicated that there would still be a lot of issues that were raised for them, even if the child seemed to be coping well:

I mean we didn’t, we weren’t sure whether it was affecting her to start with, yet it is definitely affecting us, yet you couldn’t get it without her actually being assessed. (M)

Two other groups of caregivers were identified that would not be able to receive the Parenting Support Pilot Programme. These were caregivers of intellectually handicapped adults and caregivers of teenagers who signed their own consent forms:
One group that I can identify that the pilot has ignored are the teenagers. And the pilot has ignored them because if a teenager signs their own consent form the agreement was that we would not offer the pilot because we couldn’t provide any safety around it. We couldn’t contact caregivers. (Manager)

*Accessing the programme at the right time was important*

Most participants suggested that the programme was not available soon enough and that while slight delays were fine, the larger delays that happened due to systemic problems within ACC needed to be addressed.

*Not available soon enough*

Initially the Parenting Support Pilot Programme was developed to be an early intervention, which is when caregivers have indicated they would like to have support:

The pilot is supposed to be early intervention, however now we are saying you can’t have if for the next 6 weeks because it takes 6 to 8 weeks to get it (cover determination), so now you can’t get it in the first 8 weeks, which in my view is when they need it most. (Manager)

I believe right when it happens, that’s when you’re going through the most terrifying moment of your life, for you on a personal level as a caregiver, and your child. (M)

However, caregivers and counsellors had experienced many frustrations at the delay of support:

I mean I remember coming off the phone and saying to (my husband), for goodness sakes you know, what am I going to do? You can’t, I can’t wait another three weeks. (M)

Despite these delays and frustrations, many caregivers and their counsellors went ahead with the sessions despite approval being delayed:

We started to go ahead with them anyway, because by then the counsellor had seen (my daughter) for three times, and knew that I really needed help. (M)
I don’t hang around and wait to get the green light, you know when I’m already working with the child, why would I do that, that’s just silly. I’ve got to start, and fortunately I’m in an agency where I can. (Counsellor)

On the other hand, counselling was provided in a timely manner in the view of a smaller number of caregivers:

The whole process from ACC was very quick. (M)

It was actually quite soon, like into our second, maybe our third session of (my daughter’s) counselling. (M)

**Slight delays are acceptable**

Despite the majority of caregivers preferring parenting support soon after CSA disclosure, a few indicated a preference for having a slight delay in receiving support following disclosure as they had other considerations to make:

I remember thinking ‘I’m glad it wasn’t straight away because there’s too much’. I mean you’ve got to sort everything, clothes, tools, the house. I had to basically, because they walk out that day, and then you’ve got to pick up the pieces. (M)

**Systemic problems within ACC**

Some of the delays were occurring within ACC where there had been gaps between the Sensitive Claims Unit (SCU) and the pilot:

The delay has been around getting the administrator resource, getting the Needs Assessment to the Peer Reviewer. And there were periods where that took four to six weeks. And of course everyone assumes that it has gone to the Peer Reviewer but it hadn’t. (Manager)

Managers identified some of the gaps occurring between the SCU and the pilot to be due to a lack of understanding of the pilot and constraints on their time, indicating a need to clearly outline the requirements of the pilot, particularly as it evolves:

When you evolve a pilot you are making changes all the time. So you have got to have a good commitment of the service itself, and by that I mean the Sensitive Claims Unit, so
that means keeping them informed and they having an enthusiasm around that information. (Manager)

*Developing goals was difficult*

Caregivers developed goals together with the counsellors in the initial needs assessment session. The Needs Assessment form was found cumbersome by most participants, though some felt that this helped shape their goals. Many caregivers spoke about their struggle to identify goals to work on, while some counsellors experienced similar frustrations about being unsure of what ACC requirements were in regards to the programme.

*Needs Assessment forms were cumbersome*

The Needs Assessment form was initially developed to help inform the goals, but was experienced as being, repetitive, long and cumbersome by caregivers and counsellors:

> I think it needs to be revamped and made a lot more simple and made really really clear that this is for caregivers and not for children. So now you actually have to skew the forms in such a way that the goals are actually what ACC is expecting, which are caregiver focused. (Peer Reviewer)

The questions were really hard to answer and each one, like, repeated, and then they sent back that I’d answered them wrong. (M)

*Goals change*

Caregivers identified struggling to develop goals in the first session due to being unsure of what kinds of goals were expected, and also not knowing what to focus on due to the variable and emerging nature of their children’s behaviours:

> You don’t know, you’re hoping that they’re going to provide you some of the goals, to say ‘this is what you should be working for, and at the end of it you’re going to feel like this’. So I felt when we were doing it, I felt quite put on the spot of having to come up with some of the goals to justify why I needed the counselling. And I think that you don’t go in there with goals in mind. (M)
That was really hard, you had to come up with goals right there, right then, goals we were
going to achieve. We were like ‘how do you know?’ As you go along things evolve. (M)

One caregiver identified enjoying developing goals as this provided a sense of structure, despite
her going through a particularly difficult time herself:

That went kind of hard aye, because I wasn’t in a very good state of mind, I mean I was
going through depression at the time. It was actually good, to know that there were
actually goals that we (had). (M)

Counsellors also identified the importance of maintaining flexibility as needs change and goals
evolve:

I suppose the interesting thing is that although you may write something down that is very
child focused; in the actual session what you do is you work with whatever the caregiver
comes with. And so the things that she had written in the peer review, that maybe you
know is recommending this and that, I’d already done them. (Counsellor)

*Rapport needed first*

Caregivers and counsellors both identified positive benefits from knowing each other prior to
filling out the Needs Assessment form and developing goals. Some caregivers already knew the
counsellor through their child’s counselling, but those that did not found it difficult to start
straight with the Needs Assessment form:

The first session that I had with her, was that, just dealing with the paperwork, and I just
think it should’ve come about 2-3 sessions later. I think it should be ‘now that you’ve met
each other a couple of times, you’ve gotten to know each other on that level’, you know,
that you’ve had a free talk, without sitting there with the pressure of paperwork. (M)

*Development of goals was difficult*

Some counsellors seemed to struggle with making appropriate goals. Peer Reviewers spoke
about some of the goals provided being inappropriate given the framework of the Parenting
Support Pilot Programme:
People need to look at the fact that the child is the claimant. And the caregiver is in the caregiver pilot which is there to assist in managing the issues with the child so that the child gets over things more quickly. So it needs to be integrated (Peer Reviewer)

Peer Reviewers also identified difficulties for them in providing useful feedback to counsellors regarding their goals as these should be related to the children’s counselling. Peer Reviewers lacked consistent access to the child’s cover determination, which made it difficult for them to make connections between the child and caregiver’s counselling sessions:

It would seem to us that a cover report for the child is reviewed either at that time or before the needs assessment, because there has to be a sync between what has been done for the child and what is the child’s clinical representation and what’s being undertaken with the caregivers or caregivers. (Peer Reviewer)

Some participants suggested that to improve goal development, it may be useful to provide an outline of goals to counsellors and caregivers:

That’s one of the things we thought would be useful, a list of common goals that we would expect and then leave a little space for individual variations. You know, provide psychoeducation on this particular area. (Peer Reviewers)

*Lack of clarity about the process of goal setting*

Counsellors spoke about not having a clear outline of what was expected of them in regards to goal setting, and that sometimes the feedback from the Peer Reviewers was unhelpful:

The Peer Reviewer wrote back and told me basically that I had done it all wrong pretty much. I would hope that the comments that they were giving me would give me guidance and they would be giving me, they would simply support the work that I was doing. (Counsellor)

At the same time, the Peer Reviewers were being told to approve counselling sessions, even if the goals were somewhat inappropriate in order to encourage counsellor participation in the programme:
You might reject what they suggest but you still don’t have the teeth to say don’t do that or you can’t continue. (Peer Reviewers)

*Not enough time to achieve goals*

Caregivers and counsellors also spoke about the ability to complete the identified goals in the number of sessions provided. While some achieved their stated goals, many caregivers and counsellors felt that more counselling sessions would be needed, with the possibility of follow-up sessions and information on other supplementary support.

*Adequacy of six sessions*

Many evaluation participants felt that six sessions were too few, and acknowledged the need to maximise what they could achieve in a limited number of sessions:

- It’s a huge brief, six or so sessions to look at some of the things we are targeting and that’s our thought, especially for these kinds of things, that dollop of work, for some claimants, that’s the most important bit to get family sorted in terms of how they are dealing with this person. But it’s a small dollop and a dollop within a certain time frame. (Peer Reviewer)
- It’s so hard to put a number on these things, so it’s you know, some families are so much more complex than others. So I’d say probably a minimum of six, but it would be nice to have 10 without having to worry about it. (Counsellor)

A few caregivers felt that they should be entitled to the same number of sessions as their child. They felt that if their children were still experiencing enough issues to need counselling, then they as the caregiver would most likely need support to manage these difficulties too:

- I think that saying you’ve got five sessions as a caregiver, but your child can have 30 sessions, I think that is a negative. (M)

However, one counsellor did not believe that if more parenting sessions were provided all caregivers would use these:
I don’t think caregivers are going to want to come unless they really need to. So they will be the ones to say ‘look I think we are doing alright now’, and even if the child is continuing to come but they feel like they can manage themselves. People have busy lives you know, it’s not something they will want to be doing unless they really have a need for it. And it depends on how much support they’ve got outside. (Counsellor)

Several counsellors indicated that they went over the allocated number of sessions to ensure that caregivers were adequately supported:

I ended up doing way more than the number I was allocated. (Counsellor)

Caregivers from two-caregiver and divorced families identified the need for more sessions due to the different issues presented by each caregiver:

If both parents need it, they should get five sessions each. (F)

*Follow-up sessions are needed*
Caregivers also expressed a desire to have extra follow-up sessions to address further issues as they arose. They indicated that these would not need to be as frequent as the original allotment of six sessions, but that it would nice to have someone check in and provide support from time to time:

Because some caregivers will see the child’s counsellor at the end of each session to just check in, but you know that’s been discontinued, and this is long gone, so kind of having some long term support would be really important. (M)

Other caregivers spoke about wanting the option to have a further allotment of sessions available to them in the future, in case there were times that they would need caregiver support again:

If something’s happened to the child who’s very young, adolescence is probably where it’s more than likely to come out and that’s going to be very traumatic. You know, how do you cope with that? (M)
Supplementary reading material would help
Caregivers also expressed a desire to be provided with reading material such as pamphlets to supplement the counselling sessions:

It probably would’ve been helpful if there were brochures there. You know, like you can go into any kindergarten and they’ve got a wall of stages your children go through, or how to handle tantrums and things like that. I think that would all be very beneficial, if there were brochures there on how to cope with children with sexual abuse. Brochures on coping mechanisms and how do I understand our teenagers. (M)

The few caregivers who were provided with reading material expressed finding this useful for themselves, as well as being able to show this to other family members who were not attending sessions:

She gave me some written information, which was great. I could come home, and I could show this to (my husband) and even if he might not read it, he might look at it and go, ‘oh’, at least it’s in his head, he knows it’s not just all mumbo jumbo stuff, and then I can look back and review it. (M)

Need for information on related services
Several caregivers indicated interest in accessing supplementary services such as support groups, and telephone help lines:

I’d love a support group, (to) make you feel like you weren’t the only one out there. (M)

Somebody that you can call in the middle of the night, that there’s a counsellor 24 hours you know, like you know there’s a healthline. You know, someone at the end of the other line for reassurance that you can call and say, something’s happening, and I don’t know, I’m not understanding, so you know, help lines. (M)

Some caregivers also expressed a desire to be provided with the opportunity for their own personal counselling:

I’d like to see it included, not just how to deal with your children’s behaviour, but actually counselling for the caregivers, because they’re like a secondary victim as well, and you’ve
got a whole gauntlet of emotions to deal with as well. And kind of cope with that on top of your child’s behaviour. (M)

_Counsellor characteristics are important_

As counsellors were the ones providing the Parenting Support Pilot Programme to caregivers their competent involvement within the programme was very important. Participants spoke about the importance of having a good match with the counsellor irrespective of their culture of origin, how culture may affect the counselling, the abilities needed by the counsellors, and issues around caregivers having the same counsellor as the child - all of which may affect the perceived level of competence of counsellors.

_Caregivers need a good match with their counsellor_

Most participants felt that it was important for there to be a good match between the caregivers and their counsellor:

> I was so desparate to find help, I would’ve launched onto anything that would give me help. But in saying that, if somebody was horrible, and I didn’t feel comfortable with, I would’ve shut off and I wouldn’t have put (my daughter) in it either. (M)

> I think what it would always come down to be it working for that person. And if it is working for that person would it continue, because there’s no point in having a counsellor that the caregiver doesn’t get on with. (Manager)

Several caregivers also indicated that a personal match with the counsellor was more important than having specific cultural matching:

> Therapy is pretty non-cultural really, it’s just a place for someone to talk. (M)

> If you’re going to be stuck on your own culture, then personally I cant see how that’s going to help, because it can so easily be about yourself rather than the child. (M)
Counsellor competency is important

ACC Managers and Peer Reviewers indicated the need for clear competency guidelines around Counselling to ensure that a high standard of Counselling was provided:

I think there is a real need to have very clear competencies around identifying who can deliver this service because it is very clear that there are such significant skills required to provide the best service. (Manager)

I suppose when looking at other ACC contracts when you go to contract now you do have to give some, a lot of information now about your competencies in this area whether it would be a plain contract or another area, or a peer review contract. You have to give your experience in that particular area, so I would want to see a separate contract as opposed to a counsellor’s add on. (Peer Reviewer)

Cultural considerations

Despite some caregivers prioritising personal matching above cultural matching, several participants discussed the importance of considering cultural complexities that arise in this work:

When we went to the one in town, a Māori woman actually came in and spoke to us as well, the first time we went there. I think being a Māori family as well, (my wife) is not Māori but the kids are into it as well, it was good that that happened. (F)

The ACC Managers were aware of this need, and therefore identified that it would be important to consider Whanau counselling groups within the scope of the pilot:

Another problem is that there are Whanau counselling groups and we don’t engage with them. And given that these are the very groups we should be engaging with, we need to be able to identify what is their level of service and is it actually consistent with the goals of the pilot. (Manager)

Having the same counsellor as the child is beneficial

Participants differed in their opinions about the usefulness of having the same counsellor providing support for the child and the caregiver. A few caregivers identified that they preferred having the same counsellor as their child because that meant the counsellors got a fuller picture of what was going on for the family, without them having to repeat a lot of their story:
It meant that you didn’t have to tell your story again. Because it gets hard telling your story over and over again, so it meant that just talking to one person, and she knew us from having, you know, our contact with her, so it just built that relationship even more. (M)

Because our counsellor was dealing with both of us, she got the whole picture, not the half picture. (M)

Many caregivers also felt more comfortable having the same counsellor as their child as they had already established a relationship prior to the commencement of the Parenting Support Pilot Programme:

Because she knew the girls and she knew me, and we developed a relationship, and so there was a lot more trust, and I think that trust is so important. (M)

Where different counsellors were seeing the caregiver and the child, the Peer Reviewers indicated that it would be important to liaise between the two to ensure clinical safety. They also indicated the difficulty they experienced in not necessarily having access to the child claimant’s file, therefore being unable to check whether the goals for the child and the caregiver align:

There didn’t seem to be a liaison between the counsellors, and there needs to be between the counsellor for the caregiver and the counsellor for the child. So because the counsellor report didn’t come to the peer review, you theoretically can’t make any comments of the appropriateness of what is going on for the child’s goals and everything. And here they are reciprocated in the caregiver’s needs assessment, so there is a potential for slippage. Clinical slippage. (Peer Reviewers)

_Counsellors need to be informed about the programme_

For counsellors to provide the best service for caregivers, they must be educated in the pilot programme and more fully informed about what their involvement will entail:

It might have been better to talk to the counsellors a bit more. They certainly showed a lack of understanding at what the whole thing was about, in the beginning, and with the process as well, what am I supposed to do, what forms should I fill out, that sort of thing. (Manager)
Evaluation processes were sensitive to caregivers’ needs

To ensure that caregivers felt comfortable with the research methodology, they were asked for feedback on the evaluation, which was generally positive.

Seeing the benefits of participation
Although acknowledging that this was a sensitive topic several caregivers identified enjoying their participation:

I think it’s fine, I think it’s great, because it’s good to see that changes are being made. (M)

Yeah because I think it’s positive, the job that you’re doing as the questioner, is to try and assess, to try and make this programme available to the wider community, as a permanent fixture, and I think that can only be good. (M)

Transparent research methodology
Additionally, caregivers identified the importance of a transparent research methodology where they were fully informed and given the opportunity to decline participation:

People can still choose to say no, and you’ve definitely explained in there in all time, clearly, you know you clearly stated that, privacy, and there’s no pressure, and there hasn’t been any pressure, and you know your contact before, and this is no pressure today (M)

I felt that the way the questionnaire was done, the upfront, the openness of saying, also to people, the confidentiality situation, that is going to be a big issue for many people, and they are going to want to feel safe and secure, that information is not going to go out into the general public. (M)

Interviews need to be conducted soon after conclusion of counselling
One caregiver also spoke about the importance of not waiting too long to carry out evaluations of this nature as caregivers who had concluded counselling and court processes may be less likely to want to participate:
I do understand that once you got, it’s probably a good time to do it before it’s completely ended, just around that time, not too far past, because then I’d be like ‘I don’t even want to go there either, as part of the book I don’t want to open’. (M)

Declining Participants

Reasons for declining participation in the Parenting Support Pilot Programme was gathered from written comments made on the response and consent form. There were several reasons identified for declining participation by the 29 caregivers including: (1) already receiving other counselling, (2) already receiving other non-counselling support, (3), not believing that the support would be helpful, (4) struggling with access to the programme, (5) waiting for the child’s counselling to begin, and (6) the respondent was a claimant who did not want her caregivers to know about her sexual abuse.

Already receiving other counselling

Twelve caregivers stated that they were already receiving some form of counselling support and therefore did not need further support from the ACC Parenting Support Pilot Programme:

I am receiving counselling and am satisfied with the support and assistance I am receiving. I do however think that the pilot programme would otherwise be valuable to me and my child.

I attend all of my son's counselling session - so if I have any queries I will ask his counsellor.

Already receiving other non-counselling support

Another five caregivers stated that they were receiving other types of support, which was sufficient for them:

We have chosen to deal with the situation using alternative methods - naturopathic preparations of herbs, bach flower.

Have other support I feel is adequate through my church.

Have plenty of support from family and friends.
Not believing that the support would be helpful

Eight caregivers stated that they did not feel that counselling was needed or that it would be beneficial for them:

Will cause extra emotional, un-needed trauma. (Daughter) seems to be quite comfortable in life with events that have happened.

(She) is 3 years old. I doubt any sexual abuse occurred - we need to move on - concentrate on ways to prevent anything happening in the future.

I'm also not happy to be a guinea pig for these type of systems.

Struggling with access to the programme

Another four caregivers declined participation due to access issues involving work, transport, and cost:

(I) am a single caregiver this would involve time off work and reduction in wages

Transport mainly and the expense of getting there

Due to being self-employed it is a little harder to juggle time

Waiting for the child’s counselling to begin

One caregiver declined support as their child’s sessions had not begun:

Not interested in the support sessions at the moment. The child’s therapy hasn’t started yet.

Teenage claimant who did not want her caregivers to know about her sexual abuse

One response form was sent in by a counsellor on behalf of a teenager as the caregivers were unaware of the abuse:

(She) has chosen not to inform her caregivers of her previous abuse
Conclusions

The purpose of this process evaluation of the Parenting Support Pilot Programme was to identify both strengths and weaknesses within the ACC pilot that would provide a basis for recommendations to programme development.

Access. Overall, the majority of respondents found that awareness of the programme amongst counsellors, caregivers, and the potential referrers of the Parenting Support Pilot Programme was lacking. Additionally, barriers to accessing the programme were identified, including transport, time, cost, child care, and counsellor availability. Some of these access issues were also identified by caregivers as the reasons for declining participation in the programme. Therefore, if the uptake of the Parenting Support Pilot Programme was to be increased these access issues would need to be addressed.

Length of programme. Some participants questioned the ability of caregivers to develop and cover their goals within five sessions, however participants varied in their thoughts about whether this number was adequate. The majority of caregivers and counsellors agreed that there should be at least an option to apply for more sessions over a longer duration allowing for follow-up in the future if additional parenting issues arose.

Needs assessment and goal setting. Both counsellors and caregivers had difficulties with goal setting. They described goal setting as long, cumbersome, and repetitive. This process took up part of the first needs assessment session and both counsellors and caregivers indicated that it was difficult to make goals before rapport had been properly established. Therefore, it may be useful for caregivers to have preliminary session(s) with the counsellor before being required to complete the Needs Assessment form if they did not already know them. Participants also pointed out that goals changed while the caregivers were in the programme and therefore that there should be some flexibility in the goals that are set. Peer Reviewers also indicated that the goals were frequently poorly done (although this was improving) as a result of both counsellors and caregivers being unclear of how to set goals. This may be improved by providing more counsellor training and assistance, and giving caregivers and counsellors a list of possible goals.
to use. Providing such assistance could make goals more useful to caregivers and reduce the time the goal-setting takes in the initial session.

_Timeliness._ Another major area of concern for both programme providers and users was the timeliness of the Parenting Support Pilot Programme. The majority of stakeholders identified that support should be provided as soon as possible following disclosure, though some caregivers said that they needed some time first to deal with the initial impact and practical matters. Therefore, delays in processes were of concern to most evaluation participants. Some of these delays occurred within ACC, where difficulties communicating between the Sensitive Claims Unit and the pilot group resulted in delays in the pilot being informed of new claims, delays in the letter being sent out to caregivers, and delays in providing the Peer Reviewers with the Needs Assessment forms. These delays, in part, occurred because this was a pilot and therefore the processes were separated from regular processes within the Sensitive Claims Unit, thus creating extra work for employees who may not have had the training or time to do this work. Further delays occurred externally to ACC due to difficulties in caregivers getting access to counsellors, where limited numbers of counsellors in some areas meant that caregivers were placed on waiting lists. The majority of caregivers who declined support indicated that this was because they were already receiving support elsewhere, perhaps indicating that caregivers required, and sought, help immediately. In reducing delays, the support would be available to caregivers when they need it most, thereby maximising the potential impact of the programme.

_Counsellor-client relationship._ Many caregivers also discussed the importance of a good personal match with the counsellor, with a few identifying this as being more important than any other cultural considerations or specific counsellor competencies. Along with a good match, flexibility of the counsellor with respect to session times also assisted in addressing some of the access issues previously described.

_Training and supervision._ Some counsellors indicated that they would have liked more training or supervision, specifically in regards to the pilot, particularly when first beginning to provide the programme. Providing this training may also encourage more counsellors to participate in the Parenting Support Pilot Programme. Limited numbers of counsellors were
affecting access to the programme for some caregivers. Additionally, this training would increase counsellor competence, thereby improving the service for caregivers.

By employing qualitative methods, some ability generalisability may be lost. Nevertheless, given the developmental stage of the Parenting Support Pilot Programme, this is not as important as gaining rich in-depth data (Patton, 1997). Additionally, Renzetti and Lee (1993) indicate that qualitative methods may be more appropriate when researching sensitive topics. Caregivers were asked for feedback on the evaluation process during the interviews, which indicated that although caregivers acknowledged that this was a difficult area for them to discuss in interviews, they appreciated being provided with the opportunity to add to the programme evaluation. They could understand that other caregivers might not have wanted to participate in the evaluation processes due to the emotional content of their involvement in the programme, particularly if it had been a long time since they had completed their counselling. It must be acknowledged that these positive reports may have been biased by the researcher herself asking for this feedback.

As a result of these findings in the process evaluation a list of nine recommendations were provided to ACC with the aim of addressing process weaknesses whilst maintaining and utilising the processes in place that were working well (see Appendix H). These recommendations included making caregivers, counsellors and other potential referrers more aware of the Parenting Support Pilot Programme to increase uptake, improving access for caregivers by decreasing practical and financial barriers, and increasing the number of counsellors available to deliver the programme to ensure good geographical coverage. It was also recommended that counsellors’ knowledge about the programme be improved to expedite the process and improve utility of the programme. This could be supported by ACC changing their internal processes to improve the timeliness of the programme and the needs assessment and goal setting processes. Suggestions were also made about how to best contact the caregivers of teenagers in the programme when the teenager had signed the ACC45 form. To maximise the utility of the programme, it was recommended that caregivers be allowed additional sessions if required and be provided with supplementary information.

During the course of the process evaluation the research team met with the ACC programme developers to provide some early feedback. As a result of these earlier meetings and the changing
nature of the pilot, some recommendations were acted on spontaneously before the process evaluation was completed. These included changing the processes within ACC to improve timeliness of the programme. Following the completion of the process evaluation, the above recommendations were provided to ACC and followed up with a face-to-face meeting in Wellington with the ACC programme developers.
CHAPTER SIX: IMPACT EVALUATION

This chapter presents the impact evaluation of the Parenting Support Pilot Programme and is based on the thematic analysis of the impact evaluation interviews, follow-up impact evaluation interviews, interviews conducted with caregivers as part of the process analysis, and responses on open-ended questions on the Achievement Summary forms. The initial impact evaluation and process evaluation consists of the interviews conducted soon after the files were first received by ACC, and the follow-up impact evaluation consists of interviews conducted with caregivers 12 months after programme completion. The follow-up interviews were analysed separately from the initial impact evaluation interviews, but due to the similarity of themes between the two interviews, they were incorporated and differences are highlighted in the text.

Analysis on the Likert Scale Questions

Responses to Likert Scale Questions
The responses provided on the Likert scale questions are shown in Table 20 for the initial interviews, and in Table 21 for the follow-up interviews. In both the initial and follow-up impact evaluation interviews, participants scored relatively lower on the question ‘The programme helped to educate me about child sexual abuse’ compared to other questions, with approximately one third of respondents answering neutral or below on this question during both interviews. During the interviews some caregivers indicated that they were scoring this item lower as they already felt educated prior to the programme, for example, through personal experiences or additional reading.
### Table 20

*Responses on telephone quantitative questions for those that participated in the initial impact evaluation interviews*

<table>
<thead>
<tr>
<th>Likert Scale Questions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>I felt the “Parenting Support” Programme was worthwhile</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>5.4</td>
<td>1</td>
</tr>
<tr>
<td>I would recommend the “Parenting Support” Programme to other caregivers</td>
<td>1</td>
<td>2.8</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>The programme helped me to gain coping skills</td>
<td>1</td>
<td>2.8</td>
<td>1</td>
<td>2.8</td>
<td>4</td>
</tr>
<tr>
<td>The programme helped me to better manage my child’s behaviour</td>
<td>1</td>
<td>2.8</td>
<td>1</td>
<td>2.8</td>
<td>4</td>
</tr>
<tr>
<td>The programme helped to educate me about child sexual abuse</td>
<td>1</td>
<td>2.8</td>
<td>4</td>
<td>11.1</td>
<td>7</td>
</tr>
<tr>
<td>I feel confident in my ability to support my child’s recovery from the abuse over longer term</td>
<td>0</td>
<td>0.0</td>
<td>4</td>
<td>11.1</td>
<td>5</td>
</tr>
<tr>
<td>I feel the skills I gained through the programme have resulted in positive changes in my child</td>
<td>0</td>
<td>0.0</td>
<td>5</td>
<td>13.9</td>
<td>3</td>
</tr>
<tr>
<td>I felt the programme was appropriate to my culture</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
</tr>
<tr>
<td>I felt my rights were protected throughout the programme</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>5.6</td>
<td>0</td>
</tr>
<tr>
<td>I felt that the evaluation of the programme was done in an appropriate manner</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
</tbody>
</table>

NB. For the purposes of this table, when a response was halfway between two qualitative responses, the lower one was used.
<table>
<thead>
<tr>
<th>Likert Scale Questions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt the “Parenting Support” Programme was worthwhile</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>1 % 4.5</td>
<td>2 % 9.1</td>
<td>19 % 86.4</td>
</tr>
<tr>
<td>I would recommend the “Parenting Support” Programme to other caregivers</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>5 % 22.7</td>
<td>17 % 77.3</td>
</tr>
<tr>
<td>The programme helped me to gain coping skills</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>2 % 9.1</td>
<td>8 % 36.3</td>
<td>12 % 54.5</td>
</tr>
<tr>
<td>The programme helped me to better manage my child’s behaviour</td>
<td>0 % 0.0</td>
<td>1 % 4.5</td>
<td>1 % 4.5</td>
<td>11 % 50.0</td>
<td>9 % 40.9</td>
</tr>
<tr>
<td>The programme helped to educate me about child sexual abuse</td>
<td>1 % 4.5</td>
<td>2 % 9.1</td>
<td>3 % 13.6</td>
<td>6 % 27.3</td>
<td>10 % 45.5</td>
</tr>
<tr>
<td>I feel confident in my ability to support my child’s recovery from the abuse over longer term</td>
<td>0 % 0.0</td>
<td>2 % 9.1</td>
<td>2 % 9.1</td>
<td>5 % 22.7</td>
<td>13 % 59.1</td>
</tr>
<tr>
<td>I feel the skills I gained through the programme have resulted in positive changes in my child</td>
<td>0 % 0.0</td>
<td>4 % 18.2</td>
<td>1 % 4.5</td>
<td>5 % 22.7</td>
<td>12 % 54.5</td>
</tr>
<tr>
<td>I felt the programme was appropriate to my culture</td>
<td>0 % 0.0</td>
<td>2 % 9.1</td>
<td>1 % 4.5</td>
<td>7 % 31.8</td>
<td>12 % 54.5</td>
</tr>
<tr>
<td>I felt my rights were protected throughout the programme</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>2 % 9.1</td>
<td>4 % 18.2</td>
<td>16 % 72.7</td>
</tr>
<tr>
<td>I felt that the evaluation of the programme was done in an appropriate manner</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>0 % 0.0</td>
<td>6 % 27.3</td>
<td>16 % 72.7</td>
</tr>
</tbody>
</table>
To provide a basis of comparison between those that completed the programme and those that did not, Table 22 shows the mean responses to each of the questions for initial impact interviews and the follow-up interviews to draw comparisons. Additionally independent t-tests were conducted to investigate whether there were any statistical differences between groups. It was found that on the question ‘I felt the programme was appropriate to my culture’, that those who had completed the programme (Mean = 4.3, SD = .67) scored significantly higher than those that did not complete the programme (Mean = 3.5, SD = .50). Of the five caregivers who did not complete the programme, three (60.0%) identified as New Zealand European, one (20.0%) as Māori, one (20.0%) as Pacific Islander, and one (20.0%) as other European. No other significant differences were found between these groups (p > .05).

A one-way analysis of variance (ANOVA) was conducted to investigate whether there were any differences in the responses on the Likert scale questions between which caregiver had participated in the needs assessment (both parents, mother, father, or extended family) and their ethnicities (New Zealand European, Māori, Pacific Islander, Asian, or Other European). No significant differences were found between these groups for the initial impact evaluation interviews, and the numbers for comparison were too small for the follow-up interviews (p > .05).

Comparisons were made between responses on the Likert Scale questions in the initial and follow-up impact evaluation interviews using paired T-tests (see Table 23). There were significant decreases in several questions over time including: ‘The programme helped me to gain coping skills’, ‘The programme helped me to better manage my child’s behaviours’, ‘I feel the skills I gained through the programme have resulted in positive changes in my child’, and ‘I felt my rights were protected throughout the programme’. Over time there were significant increases in response to the questions: ‘The programme helped to educate me about child sexual abuse’, ‘I feel confident in my ability to support my child’s recovery from the abuse over longer term’, and ‘I felt the programme was appropriate to my culture’. However, due to the small number of participants that participated in both interviews, these results must be interpreted with caution.
Table 22

**Responses on telephone quantitative questions for those that participated**

<table>
<thead>
<tr>
<th>Likert Scale Questions</th>
<th>Initial Interview: Completed Programme (n=32)</th>
<th>Initial Interview: Incomplete Programme (n=5)</th>
<th>Initial Interview: Total (n=37)</th>
<th>Follow-up Interview (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt the “Parenting Support” Programme was worthwhile</td>
<td>4.72 (0.52)</td>
<td>3.80 (1.64)</td>
<td>4.59 (0.80)</td>
<td>4.81 (0.50)</td>
</tr>
<tr>
<td>I would recommend the “Parenting Support” Programme to other caregivers</td>
<td>4.61 (0.81)</td>
<td>4.50 (1.00)</td>
<td>4.60 (0.82)</td>
<td>477 (0.43)</td>
</tr>
<tr>
<td>The programme helped me to gain coping skills</td>
<td>4.47 (0.84)</td>
<td>4.25 (1.50)</td>
<td>4.44 (0.91)</td>
<td>4.48 (0.67)</td>
</tr>
<tr>
<td>The programme helped me to better manage my child’s behaviour</td>
<td>4.27 (0.90)</td>
<td>4.25 (1.50)</td>
<td>4.26 (0.95)</td>
<td>4.27 (0.77)</td>
</tr>
<tr>
<td>The programme helped to educate me about child sexual abuse</td>
<td>3.86 (1.07)</td>
<td>3.75 (1.5)</td>
<td>3.85 (1.10)</td>
<td>4.00 (1.20)</td>
</tr>
<tr>
<td>I feel confident in my ability to support my child’s recovery from the abuse over longer term</td>
<td>4.03 (0.93)</td>
<td>3.50 (1.29)</td>
<td>3.97 (0.97)</td>
<td>4.32 (0.99)</td>
</tr>
<tr>
<td>I feel the skills I gained through the programme have resulted in positive changes in my child</td>
<td>4.31 (1.09)</td>
<td>4.00 (1.41)</td>
<td>4.28 (1.11)</td>
<td>4.14 (1.15)</td>
</tr>
<tr>
<td>I felt the programme was appropriate to my culture</td>
<td>4.25 (0.67)</td>
<td>3.50 (0.50)</td>
<td>4.15 (0.70)</td>
<td>4.32 (0.95)</td>
</tr>
<tr>
<td>I felt my rights were protected throughout the programme</td>
<td>4.67 (0.59)</td>
<td>4.00 (1.41)</td>
<td>4.60 (0.73)</td>
<td>4.64 (0.66)</td>
</tr>
<tr>
<td>I felt that the evaluation of the programme was done in an appropriate manner</td>
<td>4.67 (0.53)</td>
<td>4.20 (0.45)</td>
<td>4.61 (0.54)</td>
<td>4.73 (0.46)</td>
</tr>
</tbody>
</table>
Table 23

Comparison of Likert Scale question responses at initial and follow-up impact evaluation interviews for the 22 caregivers that participated in both interviews

<table>
<thead>
<tr>
<th>Likert Scale Questions</th>
<th>Initial Interview</th>
<th>Follow-up Interview</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>p-value</td>
</tr>
<tr>
<td>I felt the “Parenting Support” Programme was worthwhile</td>
<td>4.82 (0.39)</td>
<td>4.82 (0.50)</td>
<td>.772</td>
</tr>
<tr>
<td>I would recommend the “Parenting Support” Programme to other caregivers</td>
<td>4.80 (0.45)</td>
<td>4.77 (0.43)</td>
<td>.284</td>
</tr>
<tr>
<td>The programme helped me to gain coping skills</td>
<td>4.55 (0.60)</td>
<td>4.48 (0.66)</td>
<td>.005*</td>
</tr>
<tr>
<td>The programme helped me to better manage my child’s behaviour</td>
<td>4.34 (0.68)</td>
<td>4.27 (0.77)</td>
<td>.001*</td>
</tr>
<tr>
<td>The programme helped to educate me about child sexual abuse</td>
<td>3.84 (0.99)</td>
<td>4.00 (1.20)</td>
<td>.004*</td>
</tr>
<tr>
<td>I feel confident in my ability to support my child’s recovery from the abuse over longer term</td>
<td>4.09 (1.02)</td>
<td>4.32 (0.99)</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>I feel the skills I gained through the programme have resulted in positive changes in my child</td>
<td>4.32 (1.04)</td>
<td>4.14 (1.17)</td>
<td>.004*</td>
</tr>
<tr>
<td>I felt the programme was appropriate to my culture</td>
<td>4.23 (0.69)</td>
<td>4.32 (0.95)</td>
<td>.027*</td>
</tr>
<tr>
<td>I felt my rights were protected throughout the programme</td>
<td>4.70 (0.63)</td>
<td>4.64 (0.66)</td>
<td>.001*</td>
</tr>
<tr>
<td>I felt that the evaluation of the programme was done in an appropriate manner</td>
<td>4.75 (0.43)</td>
<td>4.73 (0.46)</td>
<td>.095</td>
</tr>
</tbody>
</table>

*Significant differences at alpha = .05

In the follow-up impact evaluation interviews all participants were asked whether they had received any additional help outside of the ACC parenting support programme for themselves. Of the 22 respondents, only four had received support for themselves other than from the pilot programme. Two caregivers also received support outside the programme for their children.
Thematic Analysis of Interviews

Six main themes with several associated sub-themes emerged from both the initial and follow-up interviews with participants. These are presented in Table 24. No new themes emerged from the follow-up analysis, though the sub-theme of ‘caregivers felt more hopeful about the future’ from the initial impact evaluation was not present in the follow-up interviews.

The programme was beneficial

Many caregivers - at both the initial and follow-up impact evaluation - spoke about the programme being beneficial to them and their families. This was frequently in response to being asked what their general impressions of the programme were. Caregivers identified the positive impact the programme had for them, with some attributing this specifically to their counsellors. Caregivers liked that the programme recognised them as an important aspect of their child’s recovery, with their own needs being addressed alongside their child’s.

The programme was helpful

Many caregivers in both the initial and follow-up interviews spoke about the programme being helpful in assisting them through a particularly difficult time for their families.

Of these, some spoke about the positive impact that the programme had for them personally as caregivers:

  I can say that this programme is truly beneficial to parents or caregivers of children that have been abused. (M, C)

  It’s really important to have that support out there. Until you have actually been dumped in that situation you’ve just got no idea how horrible it is. (M, FU)

A few of the caregivers in the initial impact evaluation interviews linked this helpfulness to the counsellor specifically, rather than the programme more generally:
I really did benefit from it, you know, and I can’t praise the counsellor enough, she was tremendous, she really was. (EF, C)

Table 24

*Themes and sub-themes identified in the data relating to programme impacts*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The programme was helpful</td>
<td>The programme was helpful</td>
</tr>
<tr>
<td>The caregivers were recognised as an important part of the child’s system</td>
<td>The programme increased their understanding of their child</td>
</tr>
<tr>
<td>Caregivers felt more hopeful about the future¹</td>
<td>The programme increased awareness of the impact it has on themselves as caregivers</td>
</tr>
<tr>
<td>Caregivers were better educated about the effects of abuse</td>
<td>Caregivers received useful strategies to respond to their child</td>
</tr>
<tr>
<td>The programme increased awareness of the impact it has on themselves as caregivers</td>
<td>Caregivers learned how to better manage their child’s behaviour</td>
</tr>
<tr>
<td>Caregivers felt more confident in their parenting</td>
<td>The programme helped caregivers to better cope with emotions</td>
</tr>
<tr>
<td>The programme helped caregivers to express their feelings</td>
<td>The programme helped caregivers to separate their own emotions from the needs of their child</td>
</tr>
<tr>
<td>The caregivers received support as the parental figure</td>
<td>There were improvements in their child’s coping and behaviour</td>
</tr>
<tr>
<td>There were positive outcomes for children</td>
<td>Their child’s confidence increased</td>
</tr>
<tr>
<td>There was a beneficial impact on their other children</td>
<td>There were positive outcomes for children</td>
</tr>
<tr>
<td>Some children experienced ongoing difficulties</td>
<td>Problematic process issues had a negative impact for some caregivers</td>
</tr>
</tbody>
</table>

¹ This sub-theme was not present in follow-up interviews
Due to the positive impact of the programme, a few caregivers in both interviews spontaneously said that they would recommend the programme to other caregivers in similar situations:

I would recommend it, because it did, it helped me. (M, C)

I couldn’t recommend it any more … use whatever big words you can to support this programme. (M, FU)

*The caregivers were recognised as an important part of the child’s system*

One aspect of the programme caregivers really seemed to like was that they were being acknowledged as their child’s support person, with many of the participants speaking about this in the initial impact evaluation interviews, and a few in the follow-up interviews. In fact, this was frequently the response when asked what they liked best about the programme. They felt that this recognition opened up an avenue to get their own needs identified and met:

The fact that I had the choice to be recognised as a parent. (M, C)

I would like to see them make this a permanent programme not a pilot programme because I think that this would be very beneficial … to know that, yes, ACC is not only thinking of your child but also thinking of you as a parent and to recognise that you also have needs to get through and to cope and to help you support your child. (M, C)

Some caregivers felt that this recognition allowed them to talk about their concerns with someone who was concerned for them as an individual rather than just the parent of their child:

It was to have somebody that understood … to actually sit with somebody, through the parent pilot scheme, who understood, was awesome. Incredibly awesome. (M, C)

It was quite a relief that all of a sudden I was going to go and just be able to go and talk to somebody that was going to go and tell me something that’s quite useful. It just makes it clearer to be able to talk and get it reflected back. (EF, C)

In particular, some caregivers in both impact evaluation interviews said this was very important as often in these situations other avenues of support may not be available to them, or they may not feel comfortable speaking to their usual supports about some of their issues:
There isn’t really anybody unless you’ve got someone close to you that’s been through it, you can’t really ask anybody. You kind of need someone outside the situation too because it’s yeah, not easy. (M, C)

It’s good to have someone that is not too close to the situation or home to talk to because it can get very emotional, it’s just nice to know that it’s out there for you. (M, FU)

_Caregivers felt more hopeful about the future_

One caregiver in the initial impact evaluation spoke about how the abuse had made her lose hope for the future of her child. Through the programme she was able to see more hope again, and as a result her daughter also seemed more hopeful:

I've always encouraged all my children to get the best out of life, always, and I, for (my daughter) with what happened to her, I couldn’t see how she was going to be able to. And so being able to do the programme, it gave that back to me. (M, C)

Through the programme, that's exactly what I was able to give back to (my daughter). Really her future. Yeah, because otherwise she, as far as she was concerned, she didn't have one. (M, C)

_The programme increased caregiver awareness of how the abuse affected their family_

One of the important things the programme seemed to give to caregivers was an increased awareness of sexual abuse and how this affected their child, with many participants commenting on this in the initial and follow-up impact evaluation. This was one of the main areas the programme aimed to have an effect in, therefore specific questions were asked around this during the interviews. Some caregivers knew more than others about sexual abuse at the start of counselling, but in general caregivers seemed to gain an increased understanding of abuse and their child’s response to the abuse. Additionally, several caregivers gained an increased awareness of the impact that the abuse had on them as the person in the caregiver role.
Caregivers were better educated about the effects of abuse

Caregivers talked about the programme being a good place to obtain information about sexual abuse issues and how this related to their child. Many caregivers in the initial interviews and several in the follow-up interviews felt that they were better educated about the effects of abuse:

I was a pretty pig-headed parent. You know, I really, honestly thought I knew it all ... and there’s so much you can learn and understand from (the programme). (M, C)

I didn’t really know a lot about it so I guess that helped, knowing all the different things and ways to cope. (M, FU)

Several caregivers in the initial interviews also felt that this support helped to explain and normalise their children’s behaviour as a result of the abuse:

Another thing she went through was distinguishing normal behaviour for someone her age and behaviour that’s associated with the trauma. (M, C)

Just knowing that there was somebody there that you could talk to and would say to you that this is all perfectly normal and these are ways to cope with it. (M, C)

For several caregivers in the initial interviews it increased their understanding of how this could happen to their child and family. In one case this removed some of the blame they had placed on their child initially:

Because initially I blamed her for being so stupid. (M, C)

A few caregivers in both interviews had such a positive experience in the programme that they spoke about wanting to pass on their experience to other caregivers. They not only wanted to inform other caregivers about the existence of the programme, but they also spoke about sharing what they had learnt from the counsellor, and teaching other caregivers how to deal with children to help prevent sexual abuse occurring:

Now I know that that pilot scheme is out there ... you know it’s something that I can tell them about. It’s available there for them. (M, C)
Because when I first went I had a lot of guilt around it and so that’s not there anymore and I hope to maybe one day pass my experience on to another parent who been though it. (M, C)

*The programme increased their understanding of their child*

Along with general education about sexual abuse issues, several caregivers in the initial interview and a few in the follow-up interview spoke about gaining an increased understanding of their child as a result of the programme:

Able to see things from their point of view, the kids’ point of view and giving them their choices instead of making the decisions for them. (M, C)

I now understand her behaviours and her triggers better and so I know what she needs from me when those things happen. So it means that I can parent her to what she needs as opposed to what you might normally do as a parent. (M, FU)

As a result of being able to understand their child better, several caregivers in the initial interviews spoke about being able to make better sense of the behaviours and emotions exhibited by some children:

She was just very defensive and I got to see and understand her more through that .... I got to know her for her, not the quiet third daughter that, you know, gone off the rails terribly. I got to know and understand her through that. (M, C)

She had quite a traumatic time and was taking it out on her sister. And the programme helped me to identify that. (M, C)

*The programme increased awareness of the impact it has on themselves as caregivers*

Several caregivers in both interviews did not fully realise the extent of the impact that the abuse had on them until they entered the programme. Some of these spoke about not recognising a need for their own support at all until they spoke to the counsellor through the programme. Once they had entered the programme they realised how valuable it was:

You forget that you are too, as a parent, impacted. So you know, by whatever your desires, your disappointment, your anger, you know your anger that why did it happen?
And then also, you know, how could you have it happen? You know, the blame that you may put on yourself. (M, C)

It wasn't actually until I'd started the counselling that I realized jeez this had a huge impact on me, what my child is going through. (M, FU)

Caregivers learned to be more helpful to their child

Most of the caregivers in both the initial and follow-up impact evaluation interviews stated that they learnt a lot about responding to their child in more positive ways through the programme. The programme taught them new behavioural management strategies, reinforced some of their current strategies, and helped to reinstate strategies they had in place before the abuse occurred. Through this, several caregivers spoke about feeling more confident in their parenting.

Caregivers received useful strategies to respond to their child

For many caregivers in both the initial and follow-up interviews, the programme provided them with useful strategies to respond to their child. These caregivers spoke about having gained ways to identify and respond to their child’s emotional needs:

When you’ve had a child who’s been abused you want to protect them. And (the counsellor) sort of showing me how to do that, but also let her make her own decisions and make mistakes. (M, C)

It helped me know how to handle my daughter when the issues arose, what to say, what to do. (M, FU)

The programme also helped several of the caregivers in the initial interviews respond to their child in a more helpful way when they brought up abuse issues or asked difficult questions:

She equipped me and gave me strategies to deal with my daughter when she brought up the stuff, the sensitive claim. Especially because the person is a sibling, it made it harder. (M, C)
I’ve grown tremendously in a lot of areas. I suppose mainly it was knowing what the right thing to say, you know, and just being there with support and love, with also boundaries. (M, C)

Additionally, several caregivers in the initial interviews spoke about learning to give their children space to discuss abuse issues in their own time and way, and to be more supportive of them in doing this:

Just let her talk about it when she’s ready, don’t, don’t force it and don’t let other people instigate it. Has to come from her, just a few very important things like that. (M, C)

The difference was probably being more freed to talk about what happened, and then be sensitive to her, you know, requests when she wants to talk about it or not … so just being able to, just be there and not worry. (M, C)

Through being in the programme, several caregivers in the initial interviews identified interactions they had with their children that were less helpful. Several caregivers spoke about learning to modify these to be more supportive of their children, particularly in terms of behavioural strategies used and talking about the abuse:

It’s made me realize certain things shouldn’t be said or done. (M, IC)

You know, like I might playfully smack her on the bum, but after I kind of went, ‘oh, that kind of thing, she might’, you know? More aware of those things. (F, C)

Another positive outcome, which several of the caregivers in both interviews spoke about, was the improvement in the communication with their child as a result of the programme. This then led to a better relationship between the caregiver and child for some:

One of the positives that’s come out of it is that the communication between her and I has improved greatly. (M, C)

I think the biggest thing that I have learnt, that even if the message isn’t a nice one, to be honest and open with it. (M, FU)
Caregivers learned how to better manage their child’s behaviour

Most of the caregivers in the initial interviews and several in the follow-up interviews talked about the guidance they received through the programme in terms of how to deal with their children’s behaviour in an appropriate way. This was one of the main aims of the programme, therefore this was an expected outcome which was specifically asked about in the interviews:

Guiding me in what was best for the children and what I sort of needed to do, you know? (The counsellors) have been tremendous. (M, C)

It’s great being told you’re supposed to do this and that … when it’s important and you need to do that because you’re somebody’s lifeline, as it were, in terms of coping, then you do as suggested. (M, IC)

For several caregivers in the initial interviews, the programme also seemed to help them respond to their children’s requests and maintain boundaries in the home:

Instead of snapping at her and saying no you can’t do that, now I stop and think about things first before I say no. Now I stop and think what the consequences are for her. So yes in a way, so that’s helped me to be able to react in a more positive way to my daughter as a teenager. (M, C)

I’ve got more skills and I’ve got more ways of doing it, without getting angry and saying you can’t do this, you can’t do that … I’ve learnt how to say yes and how to say no, because before I felt sorry for her. (F, C)

A few of the caregivers in the initial interviews spoke about specific materials they were provided with to help them respond to their child. Having these tools to take away with them seemed to help them over time:

She (the counsellor) gave us a piece of paper we had to read and it was just like, ‘if you feel bad about anything just have a look at the paper’. And if anything happened, you can have a look to see what you should do then. (F, IC)

(My counsellor) pretty much answered most of my questions and she gave me a book to read. It was very horrible reading in stages, but good reading. It was very helpful. (M, C)
Caregivers also felt that some of their current behavioural management techniques were reinforced through the programme. Several caregivers in both interviews spoke about this helping them to regain their previous competency as a caregiver:

Not going off at her when she got upset, you know, just trying to help her along. I think that, I suppose any parent would do that, but it reinforced that with us. (F, IC)

The insurance of knowing that you are doing right … that I wasn’t going a bit silly or anything and that I was on the right track. (M, FU)

**Caregivers felt more confident in their parenting**

As a result of learning how to manage their child’s behaviours, caregivers felt more confident in their parenting. Many caregivers in both impact evaluation interviews spoke about their confidence increasing due to being part of the programme:

Probably a little more confident with handling that side of things. Knowing a little bit more, as I say, about what to do and probably more importantly what not to do. (M, C)

Having the authority and confidence in what I’m saying is actually a necessary thing and not wavering from it. (M, FU)

However, one caregiver in the initial interviews spoke about this confidence sometimes being intermittent depending on what family dynamics were occurring at different times:

Sometimes I do and sometimes I don’t. I don’t know whether it’s her personality, just recently she really stood up to me and my mum and I just felt like I crumbled. (M, IC)

**The programme helped caregivers to manage their own emotional response to the situation**

Most of the caregivers in the initial and follow-up impact evaluations talked about the difficulties of coping with strong emotions arising as a result of the sexual abuse. They felt that the programme helped them to cope with these, providing them with skills and giving them space to discuss their feelings in a safe and non-judgemental forum.
The programme helped caregivers to better cope with emotions

Caregivers felt that the programme helped them to explore, and come to terms with, some of the emotions they were experiencing as a result of their child’s abuse. Many caregivers talked about this in both the interviews. Some caregivers felt that being able to cope with their emotions better put them in a better position to then help their child:

I think it helps you understand better your emotions, what you’re going through and with the anger and the hopelessness and the helplessness and guilt … it helps you deal with those emotions to sort of climb out of the pit that you are in to try and see the light at the end of the tunnel. (M, C)

It allowed me to deal with my feelings and my emotional stuff. I think more than anything the benefit was being able to get through all that emotional stuff for myself. (M, FU)

A few of these caregivers in both interviews spoke about getting help with their emotions when they were unable to help their child, and needing to accept their own helplessness at times:

Those are the times when as a parent you can’t help them … it was helpful after those sessions to be able to talk to the counsellor about how you were feeling, going through that, and knowing that you were totally helpless at that time to help your daughter … those were terrible times. (M, C)

It helped me thinking that I can’t get it perfect, that I shouldn’t expect certain things, and that it’s ok to get it wrong sometimes. (EF, FU)

For a few of the caregivers in the initial evaluation, the process of going through and setting goals itself helped them to cope, as it gave them a sense of direction. Additionally, it helped some caregivers gain perspective on the difficulties experienced by their child:

I went to the first one and remember doing the expectations sort of thing and remember doing that and it was awesome, and then sort of setting up what I wanted to get out of it. (M, C)
I had to lower my expectations and goals of her behaviour, so that was one of the ones that we had to go and sort of just sat with. My counsellor just calmed me right down. (EF, C)

_The programme helped caregivers to express their feelings_

Many of the caregivers in both the initial and follow-up interviews spoke about how good it was having their own safe space to express their feelings, and getting their own support in order to be able to cope with the situation within their wider families:

> It let me bring out things that I needed to, to share with someone … I’m a proud parent and I didn’t want to show them that I was a failure to my children. (M, C)

> I think it’s just somewhere where we can go and talk about how we feel about it. About our own feelings. I mean we see our children suffer, but we suffer with them. And it’s just like an outlet, and finding ways of dealing and coping … so it sort of helps things. (M, C)

In particular, several caregivers in the initial interviews spoke about the importance of receiving understanding and help from counsellors in response to expressing their feelings:

> Finding another adult to talk to who could put me on track, because I couldn’t find anyone else who had been down that track. (M, C)

> It was good to talk to, to another adult about my feelings because, you know, and seek someone who could help me get through them. (M, C)

Some caregivers felt that they were better able to share their feelings with their immediate and extended family as a result of sharing feelings within therapy. Several caregivers in both interviews spoke about having better and more open communication between members of the immediate and extended family:

> Now I know that he knows I’m in tears for a reason, I’m really upset or I’m angry or I’m at the end of my tether for a reason and I need your help. You are the father, not just a label. (M, IC)
Going through something like that could cause a marriage to crumble, but she was able to point out our strengths and how we balance ourselves. It helped us communicate more and know how to communicate with each other. (M, FU)

The programme helped caregivers to separate their own emotions from the needs of their child

For a few caregivers in the initial interviews, receiving this support helped them to separate their own emotions from the needs of their child, allowing them to be more open and available to their children, responding to them in more helpful ways. This has resulted in positive outcomes for their children:

It allowed me just to know where I am with my own thoughts. And be able to get that out so then see clearly some actions that needed to be taken and, you know, how to approach a certain thing in the family. (M, C)

I don’t get emotional about practical things anymore and so it’s been quite helpful like that and she’s really responded to it as well … it has really helped to just take the tension out because I’m calmer. (EF, C)

Several caregivers disclosed that they themselves had been sexually abused as a child during the course of both the interviews. Over half of these felt that the programme had assisted them to separate out their own issues from those of their child, enabling them to be more emotionally available to them:

I talked a lot to my counsellor in regards to how I deal with situations, you know, because I was also sexually assaulted as a child, so I just focus on what’s best for her, and you know, and differentiate what’s her stuff and what’s mine. (M, C)

I was sexually abused and so therefore some of the things that I have experienced or been through, I am trying to impose on (my daughter). But it’s not her experience it’s mine and I don’t know whether what I see is real or if it’s my experience. (M, FU)

Being in the parenting support programme and having a positive experience with the counsellor prompted one caregiver in the initial impact evaluation to seek additional help for her own historical abuse:
In the end I ended up, I actually ended up staying with counselling and putting an ACC claim in myself. (M, C)

There were positive outcomes for children

Many caregivers in both the interviews identified positive changes in their children following completion of the parenting support programme. These changes were in their child’s emotional coping, behaviour, and confidence. A few caregivers also noticed positive effects in their other children as a result of the parenting programme.

There were improvements in their child’s coping and behaviour

Several caregivers in the initial interviews and many in the follow-up impact evaluation interviews noted positive changes in their children’s behaviour and coping as a result of the parenting programme:

Before we started I guess she has quite a lot of behavioural problems and patterns and dealing with anger and that. Since going she’s been a lot better. (M, C)

Her behaviour has got much better and, you know, it’s kind of being very caring and quite firm too about what’s acceptable and what’s not. (M, C)

She’s just blossomed. She’s better able to express the way she’s feeling. (M, FU)

A few of the caregivers in the initial impact evaluation also noticed that their children were calmer and somewhat less emotionally labile than before they attended the parenting programme:

She sort of opened up a bit more and wasn't as angry as before. (F, IC)

What I got out of counselling was for her not to internalise, and for her to be able to feel safe to come to me, and now, I can provide her safety, so that was a big, big thing. (M, C)

As a result of the caregivers being in counselling, several of them in the initial interviews felt that their children were better able to maintain personal boundaries than before they entered the parenting programme:
But now I have a lovely guy, he’s a neighbour of mine, and he is marvellous with the children. Fixes bikes for them and does all sorts of things and (my granddaughter) knows her boundaries now. (EF, C)

She won’t let boys touch her inappropriately. (M, C)

A few caregivers in the follow-up evaluation spoke about how their children had grown or strengthened as a result of their experiences and the support their received following the sexual abuse:

She’s come through this in a real positive way. (M, FU)

She’s realising that the way she feels is OK and she’s grown some strength from the whole thing and she’s become more of a leader. (M, FU).

Additionally, for a couple of the caregivers in the initial evaluation, their attendance at the parenting support sessions seemed to encourage their children to attend their own counselling. This then resulted in even bigger improvements in the children:

And there's no way I would've gotten her along to them … but actually having me there for the first, you know three of them sessions. (M, C)

It didn’t have them think that it was only them, like they were the only ones. Like ‘ok well mummy’s doing it too’. (M, C)

Their child’s confidence increased

Several of the caregivers in both interviews identified an increase in their child’s confidence due to the programme helping caregivers to be more open and responsive:

She is a lot more self confident and settled, learning a lot more at school. A lot of people have commented on how much she has grown. (M, FU)

She used to get a wee bit more homesick … but is a bit more confident now, confidence in everything else (too). (M, FU)
A few of the caregivers in both interviews felt that this increased confidence resulted in their children having more independence:

She’s just back to that freedom, that sense of independence and wanting to get out and experience the world and not feeling like she’s held back by anything and it’s so good, it’s so refreshing. (M, C)

Her being more confident and going away from here. So moving out from other places, like going to camp, going to stay with other people, you know. (EF, C)

Improvements were also seen at school for a few of the children in the initial impact evaluation, which also seems to have been due to this increased confidence and independence:

She had no friends, not a friend at school. Until this last term and she went to this little girl’s place for the day. And she was so excited she had a friend. (EF, C)

There was a beneficial impact on their other children

Several caregivers in the both the interviews spoke about positive effects for their other children through involving them in the counselling process or using the same skills learnt in the parenting session with their other children:

Also (how) to deal with the other children in the family, how to deal with them, like her older brother, her two brothers. (M, FU)

It was really good for (my other daughter) as well because they were fighting so much. When she came along, we actually let quite a lot out, and she was crying and really upset, and yeah it all came out, rather than her bottling it all up. (F, IC)

There were ongoing difficulties after programme completion

Many caregivers in the initial impact evaluation, and several in the follow-up evaluation talked about some of the ongoing or new difficulties that they experienced with their children following programme completion. The majority of these caregivers had seen some improvements in their children, but there were still some problematic behaviours left, or improvements were fluctuating. 
A smaller number of caregivers experienced no improvements, or the emergence of new problems over time. Difficulties with process issues such as long delays or other difficulties gaining access tended to exacerbate these ongoing problems. For other caregivers, problematic process issues lead to detrimental outcomes in themselves.

Some children experienced ongoing difficulties

Several caregivers in both interviews experienced some ongoing difficulties. However, among these were some caregivers who saw mostly improvements, despite a few small ongoing issues:

It just took a little while, but she has come such a long way. And it’s really good. Sometimes we go back to the same way. She does, she tries to push these boundaries, and I get a bit slack because I get tired because I’m a worker. And I get really tired and just can’t be bothered, but I push the boundaries back in there. I wouldn’t have been able to do this without them, the parenting programme. (M, C)

She (is) suicidal sometimes … it’s changed from what she was doing then to a bit different as she’s got older. (M, FU)

Several caregivers in the initial interviews experienced fluctuations in their children’s behaviours, with some improvements being transient:

We thought it was getting better and, you know, you’re just getting better and something else happens. And then you try and get that better and something else happens so it was up and down. (M, C)

We had all these ideas and it’ll all be great and we put them into action and it happens for two or three weeks and then what happens? It slowly goes back to normal. (M, IC)

A few caregivers in the initial impact evaluation talked about ongoing problems without identifying any improvements. Most of these caregivers were single parents or they had ongoing court cases:

I sort of wanted (my daughter) to open up a bit because she was getting very angry and taking it out on her older sister and me and stuff. So I was hoping that the counselling would settle that down, but it didn’t. (M, IC)
A few times I've gone ‘right, I'm moving ahead’, but the problem with cases like this is you can't move ahead, you're still stuck in the same trauma, there is no ending. (M, C)

For a couple of the caregivers in the initial impact evaluation, the child did not engage in counselling, which meant that changes were very difficult to make:

(The counsellor) was just wondering where it was going after a while, because we’d practically covered everything. With no cooperation from my daughter, it wasn’t worth it. (M, C)

A few caregivers in the initial interviews identified worsened behaviours in their children. This was generally identified as being due to the child’s maturation, or the development of old problematic behaviour into new forms:

For me, her behaviour is now a lot worse and I think that’s due to puberty. (M, C)

A year ago, she was, she would go off with strange men … that was a worry then. She's sort of stepped back from approaching men, but gone to teenage boys now. (M, C)

*Problematic process issues had a negative impact for some caregivers*

Several caregivers spoke about problematic process issues having a detrimental impact on themselves, or the outcomes for their child. A few caregivers experienced very long delays, which affected caregiver well-being. As caregivers could only gain access to the programme once their child’s claim had cover determination, some were initially told they were not allowed access to the programme due to delays in the start of their child’s own counselling. This was particularly bad for one caregiver in the initial impact evaluation who initially saw a counsellor to fill out a Needs Assessment form, but following many delays never gained access to the programme:

It was not implemented, so that had a negative effect in the sense that we were expecting to be able to have some support and we had none. So it even had a detrimental effect. (M, IC)
Impact Evaluation

**Thematic Analysis of Achievement Summary Forms**

Out of the 48 caregivers who completed the Achievement Summary form, 13 (27.1%) identified that they did not have all their goals addressed through the programme. An assessment of goals was not possible due to the peer review process having an impact on the final session goals for some caregivers and because not all caregivers specified the final list of goals they worked on in their Achievement Summary forms.

When asked whether caregivers had ongoing difficulties, 22 reported that there were no ongoing difficulties related to the abuse. At the completion of the programme, 26 had ongoing concerns for their children (see Table 25). Fifteen caregivers had no ongoing concerns for their child following programme completion, while 33 did (see Table 26). Seven caregivers did not express concern about their children’s recovery in the future, while 41 did (see Table 27).

**Table 25**

*The nature of difficulties experienced by caregivers who had ongoing problems at programme completion*

<table>
<thead>
<tr>
<th>What difficulties, if any, are you having at the moment with your child?</th>
<th>Number (N = 26)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s emotions</td>
<td>9</td>
<td>34.6</td>
</tr>
<tr>
<td>Child’s behaviours</td>
<td>8</td>
<td>30.8</td>
</tr>
<tr>
<td>Problems at school (e.g., schoolwork, behavioural issues)</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>Relationship difficulties between parent and child</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>Challenges with parenting</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>Other difficulties</td>
<td>5</td>
<td>19.2</td>
</tr>
</tbody>
</table>
Table 26

*Nature of concerns for child by caregivers who had concerns following programme completion*

<table>
<thead>
<tr>
<th>What are your biggest concerns today about your child?</th>
<th>Number (N = 33)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing behavioural problems</td>
<td>14</td>
<td>42.4</td>
</tr>
<tr>
<td>Parental inability to cope</td>
<td>6</td>
<td>18.2</td>
</tr>
<tr>
<td>Child’s emotional well-being</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Future impacts of abuse</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Learning affected</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Relationships with others (social and romantic)</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Family relationships</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>Other (e.g., court process, adaptation to moving)</td>
<td>3</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Table 27

*Nature of worries by concerned caregivers for their children in the future*

<table>
<thead>
<tr>
<th>What are your biggest concerns about your child’s recovery in the future?</th>
<th>Number (N = 41)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships (social and romantic)</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td>Revictimisation/retraumatisation</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Not recovering fully</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Problem behaviours (including risk)</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Continued low self-concept</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Related to adolescent development</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Difficulties parenting (e.g., boundary keeping)</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Sexual development affected</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Become an offender</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Other (including not specified)</td>
<td>5</td>
<td>12.2</td>
</tr>
</tbody>
</table>

Regardless of concerns about ongoing difficulties for their children, all but two caregivers were able to identify the assistance they would require to deal with the sexual abuse beyond programme completion (see Table 28).
Table 28

Kind of help needed by children from their caregivers following programme completion

<table>
<thead>
<tr>
<th>What kind of help does your child need from you now to deal with the sexual abuse?</th>
<th>Number (N = 46)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive parental regard and attention</td>
<td>33</td>
<td>71.7</td>
</tr>
<tr>
<td>Parental support</td>
<td>22</td>
<td>47.8</td>
</tr>
<tr>
<td>Good parenting strategies/structure</td>
<td>12</td>
<td>26.1</td>
</tr>
<tr>
<td>Open communication</td>
<td>12</td>
<td>26.1</td>
</tr>
<tr>
<td>Other support needed (e.g., friends, counselling, courses)</td>
<td>9</td>
<td>19.6</td>
</tr>
<tr>
<td>Time</td>
<td>8</td>
<td>17.4</td>
</tr>
<tr>
<td>Provide safety</td>
<td>5</td>
<td>10.9</td>
</tr>
<tr>
<td>Family stability</td>
<td>4</td>
<td>8.7</td>
</tr>
<tr>
<td>Other (e.g., increase knowledge and independence)</td>
<td>3</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Despite being aware of the support their children needed to deal with the sexual abuse beyond programme completion, some caregivers identified several problems with giving their children this support (see Table 29). Twenty-two caregivers identified that they had no problems providing their children with the help required.

Two caregivers noted a deterioration in their child while being involved in the programme on the Achievement Summary forms; another two noted little difference. The other 44 caregivers identified positive changes in their child and themselves at the completion of the programme. The changes identified are summarised in Table 30.
Table 29

*Problems for caregivers in providing their children with the help they needed*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental emotional response (including retraumatisation)</td>
<td>6</td>
<td>23.1</td>
</tr>
<tr>
<td>External stressors (e.g., financial, moving house, time)</td>
<td>5</td>
<td>19.2</td>
</tr>
<tr>
<td>Problematic family interactions (e.g., lack of communication, conflict)</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>Ongoing parenting difficulties</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>Parent needing ongoing support</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>Child’s behaviour hard to manage</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>Age appropriateness of help</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>Lack of respite</td>
<td>1</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Table 30

*Changes seen in child and family*

<table>
<thead>
<tr>
<th>Change in child and family</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s emotion regulation and self-concept improved</td>
<td>20</td>
<td>45.5</td>
</tr>
<tr>
<td>Change in parenting strategies</td>
<td>18</td>
<td>40.9</td>
</tr>
<tr>
<td>Improved family relationships (e.g., communication, trust)</td>
<td>16</td>
<td>36.4</td>
</tr>
<tr>
<td>Behaviours manageable</td>
<td>13</td>
<td>29.5</td>
</tr>
<tr>
<td>Improved parental coping</td>
<td>8</td>
<td>18.2</td>
</tr>
<tr>
<td>Improved parental understanding</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>Increased stability/security</td>
<td>4</td>
<td>9.1</td>
</tr>
<tr>
<td>Improvements at school</td>
<td>3</td>
<td>6.8</td>
</tr>
<tr>
<td>Better social relationships</td>
<td>2</td>
<td>4.5</td>
</tr>
<tr>
<td>Positive changes not specified</td>
<td>7</td>
<td>15.9</td>
</tr>
</tbody>
</table>
Conclusions

The purpose of the impact evaluation was to provide ACC with a comprehensive evaluation of the Parenting Support Pilot Programme. It was hoped that both direct and indirect impacts on programme participants would be identified.

In both the interviews and the Likert scale questions, caregivers generally reported that the programme was beneficial, especially in that it recognised them as an important part of the child’s support system. This resulted in many caregivers feeling more hopeful about the future and being likely to recommend the programme to other caregivers. The theme of caregivers being more hopeful about the future was not present at follow-up. The absence of this theme may have been due to hope having decreased over time or, more likely given the positive outcomes reported at follow-up, that many of them did not think about or worry about the future anymore. The programme seemed to have had a positive impact on caregivers in general which was supported by comments made on the Achievement Summary forms. Overall, only five of the caregivers in the initial impact evaluation interviews reported no improvements in their children, suggesting that the programme contributed to a positive impact for most participants. At follow-up, caregivers maintained that the programme was beneficial, particularly commenting on having learned to be more helpful to their child, and being better able to manage their own emotions.

The benefits of participation in the programme included an increased awareness of sexual abuse issues and how this had affected their child, themselves, and their families. Caregivers were educated by their counsellors, and had a safe place to ask questions about sexual abuse and the impact of abuse on their child. Some of these caregivers felt that the parenting support programme was the only forum for their questions to be answered. Additionally, caregivers gained insight into what their child may be experiencing following the abuse, which helped them to understand the behaviours and emotions exhibited by their children. Furthermore, there were a large number of caregivers who had not realised the extent of impact of the abuse on themselves, and felt that the programme had helped them to be more self-aware. Education about abuse issues was one of the specific aims of the programme.
Another aim of the programme was to provide caregivers with more positive ways of responding to their child, particularly in terms of behaviour management and their children’s emotions. In general, caregivers reported that they had learnt strategies to be more helpful to their children, learning to respond to both their emotions and behaviours in more positive and effective ways. Caregivers learned to allow children the space and opportunity to talk about the sexual abuse, and to be more effective when their children brought up abuse issues. As a result, several caregivers reported that they now had better communication with their children enabling them to develop a stronger relationship with them. Many caregivers also felt more empowered with improved behavioural management strategies and tools, while others had their current strategies reinforced. Knowing how to manage their child’s behaviours led to caregivers feeling more confident in their parenting and to more positive outcomes for the child.

Caregivers also spoke about receiving help in managing their own emotional response to their child’s sexual abuse. The programme seemed to provide a safe space for caregivers to express and explore their emotional reactions, allowing them to identify their feelings and work through them. Caregivers thought that the counsellors provided them with understanding and support, which was especially important for those caregivers who felt unable to access their usual support networks. As a result, caregivers were better able to separate their own emotional reactions from the needs of the child, particularly if they themselves had experienced sexual abuse in their past, thus helping them to be more focussed on their child’s recovery. Additionally, with the coping skills that the caregivers gained, some felt that they were better able to facilitate communication within their immediate and extended family. Although this was not a specified aim of the programme, it seems that caregivers did gain ways to better cope with their own emotions.

Along with impacts on the caregiver, several other positive outcomes were identified for the children as a result of the caregivers being engaged in the programme. Caregivers reported that children’s behaviour and coping improved, and some children were better able to maintain personal boundaries. This finding was supported by the responses in the Achievement Summary forms and has important implications for the safety of the child in terms of prevention of future abuse. Additionally, some children were found to be more likely to enter into their own counselling if the caregivers were also going to sessions. This is particularly important as some of
the caregivers attributed their children’s improvements to their children’s own counselling in addition to the parenting programme. Along with improved emotional and behavioural functioning, children’s confidence seemed to grow which generally lead to increased independence in the child and improvements at school. Furthermore, a few caregivers identified a positive impact on their other children. Overall, there were some positive impacts seen on family members beyond the programme participants themselves.

During the follow-up interviews caregivers mostly talked about having learnt coping skills for themselves and to be more helpful to their child. Most caregivers talked about positive outcomes for their children over time, with some children gaining strength and resilience as a result of receiving assistance following their victimisation. In general, caregivers participating in the follow-up interviews were positive about the programme though many wanted the programme to be longer and to have the availability of further sessions in the future if required.

Despite many of these positive outcomes for families, there were ongoing problems for some caregivers. Many of these problems were relatively minor; nevertheless, some caregivers experienced more substantial ongoing problems. Some caregivers identified that problems were ongoing due to their child’s maturation. For some caregivers it appeared that the outcome for their child was limited by the child’s non-participation in counselling. This was not raised as an issue in the follow-up interviews, but several caregivers commented that the child’s own counselling was important in improving outcomes for their children. Therefore, it may be that maximum impact is obtained from counselling when both the caregiver and child are attending.

Several ongoing problems were attributed to process issues, in particular delays in receiving support, initially being denied support, and for one caregiver, never receiving the support after completing the Needs Assessment form. These caregivers felt that these issues had had a detrimental impact on them, as they felt frustrated and unsupported during a particularly difficult time. Such delays in receiving support were also raised by caregivers in the process evaluation. It may be that this problem was specific to those caregivers entering the pilot early in its development. Some participants also identified problems associated with having a bad match
with their counsellor resulting in them feeling misunderstood and, in some cases, blamed for the abuse.

As noted above, caregivers’ responses to the Likert scale questions also indicated a positive impact of programme participation. Comparative analyses did not provide evidence for differences between ethnic groups or which caregiver had responded on the Needs Assessment form. However, on the question ‘I felt the programme was appropriate to my culture’, it was found that those who had completed the programme scored higher than those who had not. Therefore, cultural factors may have influenced whether some caregivers continued with counselling. However, the numbers for the comparison were very small (only five caregivers did not complete the programme) and as a result it is difficult to know whether this is a real difference.

Limitations to conclusions that can be drawn from this impact evaluation include that these caregivers may not be representative of the total population of programme participants. Of the total eligible for participation in this evaluation, 64 percent were interviewed in the initial interviews. We cannot know whether those who declined to be interviewed were those disenchanted with the programme, or conversely, that those who agreed to be interviewed volunteered just because they had positive experiences.

Another difficulty in evaluating the ‘initial’ impact of the programme was that there was a large range in time between caregivers finishing the programme and their being interviewed. As difficulties within families may resolve or worsen over time, these delays make it difficult to assess the specific effects of programme participation soon after completion. Caregivers in the follow-up interview spoke about changes that had occurred with time, therefore, in future evaluations it would be important to standardise the time between programme completion and when the caregivers were interviewed, as was the original intention in this evaluation.

Because only a small number of caregivers participated in both the initial and follow-up impact evaluation interviews, it is difficult to draw specific conclusions from the data gathered on the Likert scale questions. There were several significant changes over time, with satisfaction
improving in some areas, and declining in others. All differences that reached statistical significance were small, indicating that the overall programme effects were maintained long-term. In the follow-up interviews, caregivers generally raised mostly the same issues as they had in the initial interviews, particularly in regards to having gained coping skills, being more helpful to their child, and wanting more sessions available to them through the programme. This indicates that impressions of the programme remained reasonably consistent over time.

Overall, positive outcomes are seen for the caregiver and their child as a result of participation in the Parenting Support Pilot Programme. As a result of these positive findings it was recommended that the Parenting Support Pilot Programme continue as a permanent programme within ACC, though there were delays in feeding back the initial impact evaluation findings to ACC due to illness of ACC staff members and the consequent need to cancel meetings.
CHAPTER SEVEN: DISCUSSION

The majority of CSA research has focussed on the needs and recovery of the victim. Importantly, the literature provides evidence suggesting that caregiver support following disclosure of CSA is an important mediating factor in a child’s recovery. The disclosure of CSA has been found to have negative impacts on caregivers including a loss of social support networks, financial loss, and psychological and emotional effects (Carter, 1999; Hill, 2001; Humphreys, 1995; Lipton, 1997). For caregivers to be most effective at supporting their children following CSA, their needs must also be addressed, hence it is logical to provide support and psychoeducation to caregivers following CSA disclosure. These caregiver needs can be addressed through programmes targeted specifically to caregivers or other interventions following disclosure of CSA that have a family orientation.

The Parenting Support Programme piloted by ACC in NZ was developed to address these needs for caregivers. The aims of the programme included improving caregiver self-management and coping, and providing them with help managing their child’s behaviour and education about sexual abuse and its effects (Hill, 2006).

The purpose of this thesis was to evaluate the Parenting Support Pilot Programme, provide recommendations for future programme development, and consider the implications of these findings on the provision of caregiver support following disclosure of CSA. During the evaluation, paper files were collected for 60 caregivers and 80 interviews were conducted, providing the opportunity to obtain a wide range of opinions and advice about how the Parenting Support Pilot Programme was operating. Unfortunately, in 2009 the Parenting Support Pilot Programme was discontinued before the evaluation was completed and ACC could be provided with the overall evaluation findings. This coincided with a change in government and a commitment to decrease costs. Despite the pilot programme no longer operating, the evaluation provides an increased understanding of the needs of caregivers following the disclosure of CSA and how to best facilitate subsequent support for them.
Overall, this research reinforces the need for caregiver support following disclosure of CSA. This chapter will summarise the key findings in the programme evaluation and the relationship of this research to international literature. Clinical implications of the evaluation and more general implications for therapy with families following CSA disclosure are considered. Furthermore, these implications are discussed within the NZ context and the findings will provide suggestions for ways to improve support for caregivers of CSA victims and provide recommendations for future policy and practice.

Key Findings

The programme evaluation of the pilot programme confirmed that interventions for caregivers are indicated following their child being sexually abused. However, there may be a group of caregivers who were unable to access such support following CSA due to being unaware of the pilot programme, or being unable to access it.

The needs assessment identified that their children experienced emotional and behavioural changes as a result of their victimisation, which is consistent with the literature (Finkelhor, 1990; Briere & Elliot, 1994; Beitchman et al., 1991; Jumper, 1995; Kendall-Tackett et al., 1993). Caregivers identified ways to address some of the difficulties experienced by their children by providing emotional support, responding appropriately to behaviours, being patient and calm, and providing practical support. Despite this, many caregivers identified that it was difficult to know how to respond to their child’s behaviours and emotions. Furthermore, consistent with the literature, caregivers identified that they were not coping well with the disclosure of abuse themselves (Hill, 2001; Humphreys, 1995; Regher, 1990). Despite some already receiving support, many caregivers indicated that they required additional support to be able to improve outcomes for their children (Davies & Seymour 1999a; Print & Dey, 1992). Caregivers also identified that there were effects on siblings and the extended family.
The process evaluation identified how difficult it is to implement a national, state-funded programme and despite adjustments during the evaluation process, some problems with programme delivery remained. Caregivers and counsellors both acknowledged a lack of awareness about the programme among service providers, which delayed access to the programme in some instances and may have initially contributed to the poor uptake of the programme. Furthermore, some caregivers who were informed of the programme were denied access due to their child not accessing their own counselling. Others failed to gain access to the programme due to the length of time it took for the needs assessment process. These caregivers reported that the presence of a programme that was not available to them was more detrimental to their well-being and functioning compared to never being offered support in the first place. They also indicated that they had personally been affected by the CSA disclosure, despite this not being followed up further for the child. For other caregivers, delays in accessing the programme were common. Many spoke about the importance of having the programme available as soon as possible after disclosure, which is when caregivers are most likely to need assistance (Carter, 1999; Humphreys, 1995; Print & Dey, 1992). Through feedback processes to ACC during the process evaluation these delays were reduced by modifying internal processes within ACC. However, caregivers indicated a strong desire for support following CSA disclosure irrespective of whether the child goes on to get their own counselling, though this would require legislative changes in NZ.

Access to the programme for some caregivers was limited due to difficulties with transportation, finding childcare, lack of time, and lack of counsellor availability. Evaluation participants also identified a need for more parenting sessions than the allocated six sessions in order to adequately address their goals, with the possibility of accessing more sessions in the future. In particular, caregivers identified that they would like additional support when their children go through court proceedings, which caregivers in another NZ study also identified as an area where they lacked support (Davies & Seymour, 1999). Caregivers anticipated requiring extra parenting support when their children went through periods of transition such as reaching adolescence or commencing their first intimate relationship. Furthermore, they indicated that they would have liked access to additional support outside the scope of the programme, such as provision of
written material in the form of pamphlets, support groups, and access to personal development programmes.

Counsellor characteristics were raised as being one of the most important aspects related to positive impacts of the Parenting Support Pilot Programme by caregivers. Important characteristics included a good personal match with the counsellor, counsellor competency, flexibility of the counsellor around session times and the number of sessions, and assistance in addressing access issues (e.g., help with childcare or transport). Counsellors indicated that they would have liked more training and supervision specifically in regards to the pilot programme and some additional support in filling out the paperwork which both caregivers and counsellors found cumbersome and difficult.

Despite these process issues, when the programme reached caregivers they reported positive outcomes, even within the constraint of six sessions. Therefore, this research supports the need for caregiver interventions following the disclosure of CSA, which concurs with previous literature in this area. Overall, the programme aims were met by improving caregiver coping, providing help to manage their child’s behaviour, and providing education about sexual abuse and its effects.

Furthermore, caregivers reported that their participation in the programme had positive effects on their children. This was an expected outcome of the programme given that the literature has highlighted the role of caregiver support as a mediating factor in assisting recovery following CSA (Adams-Tucker, 1981; Barker-Collo & Read, 2003; Everson et al., 1989; Lipton 1997; Plummer, 2006). Only a small number of caregivers reported no improvements in their children overall, though some reported a small decrease in positive outcomes over time in the follow-up interviews, which indicates a need for ongoing access to assistance. However, it should be noted that these finding are based on caregiver report only, as more objective measures were not used due to ACC wishing to minimise the burden of participation on caregivers.

The findings in this evaluation are comparable to other studies undertaken or commissioned by ACC as outlined in the summary of rehabilitation outcomes for a range of ACC interventions.
available following injury (Cropp, 2009). Factors relating to positive outcomes for caregivers and their children in the pilot were similar to those contributing to positive rehabilitation outcomes such as good and timely communication between the service providers and caregivers (including programme awareness), timeliness of the intervention, and the interventions being tailored to individual caregiver needs. Similar barriers were also identified in the programme evaluation and the summary of rehabilitation outcomes, including lack of coordination between ACC and other agencies, poor communication between ACC and the caregivers, inadequate help to deal with their current psychological distress and lack of support from the caregiver’s wider context. As a result of the pilot programme evaluation, a series of recommendations were made to ACC to address these difficulties. Thus, the findings in this thesis can provide some general guidelines about how to best develop new programmes within ACC to maximise the positive outcomes for programme participants.

Recommendations Arising from Evaluation Findings

As noted above, towards the end of the impact evaluation ACC decided to end the pilot programme and not develop this into a full programme. This decision was made in a context of a changing financial climate and did not reflect on how well the Parenting Support Pilot Programme itself was operating. Despite the children’s individual counselling continuing, this evaluation reinforced the need for parental support in interventions targeting children, as this appears to contribute to the progress of the child and consequently may decrease overall treatment costs.

The evaluation of the pilot programme has enabled a thorough investigation into the process of the programme as well as the impact the programme can have on caregivers and their wider community. Within the action research framework of this evaluation, feedback was given to ACC at several points through face-to-face meetings and as a result several changes were made to the programme while it was operating. The main changes involved ACC improving its internal processes to improve the access to the programme by improving awareness of the Parenting Support Pilot Programme within the Sensitive Claims Unit and ensuring that caregivers were
informed of the programme. Other processes were altered within ACC to improve timeliness of the programme, including changes to ensure the documents were passed onto the peer review process more efficiently.

If this programme were to be re-established in the future, there are several components that should be considered to provide an ideal programme for caregivers of CSA victims. Awareness of any programme is vital in its uptake. To ensure that there is awareness of a programme for caregivers, all caregivers should be informed of the programme in writing and where possible, through personal contact following disclosure of CSA. Awareness of a programme among potential referrers such as child protection agencies, police, doctors, and school guidance counsellors should be improved through mail-outs and road-shows through the country. Counsellors who are able to provide the service should also be made more aware of the programme and provided with information, training and supervision to assist with understanding the processes within the programme and to improve counsellor competence. Within NZ, additional training may need to be provided to increase the numbers of available counsellors, both to have counsellors available from a range of ethnic backgrounds and to ensure a good geographical distribution of counsellors.

To improve the timeliness of caregiver support it would be best to provide assistance to them following CSA disclosure irrespective of whether their child accesses help. Access could be further improved for caregivers by providing transport to and from the sessions, providing full financial cover for the sessions, and providing assistance with childcare while caregivers attend sessions.

Caregivers have varying needs following disclosure of CSA which is related to the other support available to them outside the programme, the effects on their child, and their own resilience and emotional coping as a result of the disclosure. Additionally, caregivers should also be able to access support in the future if their children continue to experience ongoing difficulties related to the sexual abuse as this may bring additional challenges for them as parents. Therefore it is difficult to define an ideal number of sessions and more sessions should be available to caregivers if required. Retention of the material covered in parenting sessions may be improved by
providing written material in the form of pamphlets. More sessions may be required initially to build a relationship between the caregiver and their counsellor before setting goals for the sessions, particularly if there is a cultural difference between them. However, such a programme for caregivers has an individual focus, and therefore may be complemented by Whānau counselling, support group sessions, or personal development programmes.

If there is no reintroduction of the programme, there are several ways in which these evaluation findings may inform ongoing service delivery to ACC’s child-focused services. To provide some level of support for caregivers, the individual work with children could be supplemented by adding where possible, (1) time for caregivers associated with their child’s therapy in which information is given to parents by the child’s counsellor about their progress, and advice for how to manage particular issues; (2) providing caregivers with information on how they can access their own individual and/or family services now or in the future; and (3) providing caregivers with relevant educational materials such as pamphlets, DVDs, or other written materials.

**General Implications for Therapy with Families Following CSA Disclosure**

This evaluation supports the current literature that children need to be supported by their caregivers following the disclosure of CSA to improve outcomes (Adams-Tucker, 1981; Barker-Collo & Read, 2003; Everson et al., 1989; Lipton, 1997; Plummer, 2006). Consistent with the literature, caregivers in this evaluation identified that in general they did not cope well with the disclosure of CSA, and needed their own support to best help their children (Hill, 2001; Humphreys, 1995; Regher, 1990). Furthermore, it has been found that the wider family context impacts the outcomes for children following CSA disclosure (Alexander & Lupfer, 1987; Berliner & Conte, 1995; Fassler et al., 2005). Therefore the best outcomes may be achieved by using a complete family approach, which may include concurrent individual sessions for children and their caregivers. This was supported by comments made by caregivers in the evaluation of the pilot programme, where they indicated that there was also an impact of disclosure on other family members and that they felt they needed the same level of support as their children.
The Parenting Support Pilot Programme was not set up to provide a complete family approach, which was not possible because the funding structure within ACC meant caregivers and their children were identified as two individual consumers. However, some counsellors did try to use a family approach within the pilot programme when providing support for both the child and their caregivers. Where this occurred, caregivers reported that there were benefits from having the same counsellor for both themselves and their child as there was a matching between the work that was done in both sessions and there was no need to repeat information. In the international literature there is some support for providing caregiver support alongside support for the child, which generally improved adjustment following disclosure for both children and their caregivers (Cohen & Mannarino, 1996a; 1996b; 1997; 1998a; 1998b; 2000; Deblinger et al., 1996; Deblinger et al., 2001; Deblinger et al., 1999; King et al., 2000; Stauffer & Deblinger, 1996).

By making comparisons between the Parenting Support Pilot Programme and existing literature it is possible to draw some conclusions regarding useful elements of caregiver interventions following disclosure of CSA. Other caregiver interventions to date have either been in a group format with components such as psychoeducation, support, and behavioural management (Barth et al., 1994; Deblinger et al., 2001; Hewitt & Barnard, 1986; Hill, 2001; Lewthwaite, 2000; Ostis 2002; Winton, 1990), or individual caregiver psychoeducation using video tapes (Jinich & Litrownick, 1999; Meiklejohn, 2003). The Parenting Support Pilot Programme consisted of an individual caregiver intervention that used a combination of psychoeducation, support, and behavioural management. Like the current evaluation, most of the interventions did not have a control group (Forbes et al., 2003; Hewitt & Barnard; Hill; Lewthwaite; Ostis; Winton), and most used qualitative or a combination of qualitative and quantitative methods (Barth et al.; Hewitt & Barnard; Hill; Lewthwaite; Meiklejohn). Caregivers in the pilot programme reported gaining particular benefit from being able to get advice on how to best manage their children and being provided with support around their own coping in relation to the abuse disclosure, which is similar to what has been found in other caregiver interventions (Barth et al.; Deblinger et al.; Forbes et al.; Hewitt & Barnard; Hill; Lewthwaite; Ostis; Winton). Depending on the particular methodology employed, caregivers identified that they had gained understanding, reduced emotional distress, had an increase in their confidence, were better able to manage their children’s behaviours, and that their children’s behaviour changed as a result of participation in a
group (Barth et al.; Deblinger et al.; Forbes et al.; Hewitt & Barnard; Hill; Lewthwaite; Ostis; Winton), while those who received individual interventions identified that they had learnt how to better support their child (Jinich & Litrownick; Meiklejohn). Caregivers in the pilot programme identified that they gained understanding, noticed an increased confidence in their parenting, were able to cope better with their distress, were better able to manage their child’s behaviours, and some noticed behavioural and emotional changes in their child as a result. This indicates that in general, providing support for caregivers following the disclosure of CSA results in positive outcomes for caregivers and their children. Such support can be given on an individual basis such as the Parenting Support Pilot Programme from ACC, or in a group format.

Other research has indicated the utility of written and/or audio material for caregivers following disclosure of CSA (Jinich & Litrownik, 1999; Meiklejohn, 2003). Provision of such material was found to facilitate caregivers being more supportive to their child. While this was not incorporated in the pilot programme, several caregivers and counsellors said that it would have been useful to have access to such information. Therefore, caregivers could be provided with written and/or audio material to further assist them in supporting their child, particularly in the context of the parenting programme being discontinued.

Cultural Appropriateness of the Programme

In NZ, minority groups such as people identifying with Māori or Pacific Island cultures have proportionately worse health outcomes than those identifying as belonging to the European culture (Health Research Council of New Zealand, 2008). International research has also indicated that minority groups may experience greater psychological distress following CSA (Abney & Priest, 1995; Bernard, 1999; Comas-Diaz, 1995). For evaluations based in NZ, consideration of Māori participation in programmes and their evaluation is particularly important due to their status as tangata whenua and the signing of Te Tiriti o Waitangi (the Treaty of Waitangi; Barnes & Whariki, 2009; HRC, 2008).
During the evaluation of the pilot programme several caregivers made suggestions about how parenting support programmes may be made more culturally appropriate for both Māori and other minority participants. Caregivers suggested that the inclusion of more whānau in the counselling process and more time for engagement before completing any paperwork would be beneficial, which would require them having more sessions. Furthermore, some caregivers spoke about the importance of having a counsellor of the same ethnicity but also said that a good match with the counsellor assisted overcoming cultural barriers and resulted in the programme being useful for them irrespective of differences in culture between themselves and their counsellor. This suggests that ensuring that counsellors are available from a range of ethnic backgrounds and ensuring cultural competence amongst counsellors in general is important when working with caregivers from a variety of cultural backgrounds. Some caregivers also spoke about the difficulties in general about accepting help from outside the family, following an event such as CSA, where a counselling model was not widely used. To increase the likelihood that caregivers take up support programmes, the caregivers suggested it would be important to provide some personal contact (either face-to-face or over the telephone) in addition to the paperwork from ACC to help promote the programme and provide caregivers with a place to ask questions about this. Caregivers of all ethnicities said that they were more likely to pick up the programme following a personal contact. Despite cultural limitations identified in the pilot programme, caregivers from a range of cultural backgrounds reported positive impacts resulting from participation.

Strengths and Limitations of the Research

Although there has been some previous research about caregiver interventions following the disclosure of CSA, the majority of studies have focused on group formats or providing individual psychoeducation. This research evaluated an individual parenting support programme which provided assistance with managing children’s behaviours and assistance with parental coping alongside psychoeducation. Both qualitative and quantitative methods were used to conduct a systematic review across the country, which allowed for a wide range of issues to be explored, while at the same time allowing for some generalisations to be made across participants.
Caregivers in general reported that the programme evaluation was done appropriately and, as suggested in previous literature, some evaluation participants enjoyed providing their opinion about the programme (Sapsford & Jupp, 2006). It was important that caregivers were fully informed about what information was collected and for what purpose, for caregivers to be contacted at a time of their convenience, and seeing the benefits of participation, particularly because this was sensitive research (Renzetti & Lee, 1993). Some caregivers said that they would have liked to have been offered a choice of face-to-face or telephone interviews, and those caregivers who were seen face-to-face as part of the process evaluation said that this worked well for them. The evaluation also found that caregivers preferred to be interviewed soon after programme completion to help them remember the content of the sessions themselves and to prevent them having to revisit a difficult time for their family much later. However, several caregivers spoke about the usefulness for themselves of looking back to see how far they had come over this time period.

One limitation in this research was that problems in programme implementation affected numbers taking up the programme, which may have resulted in the sample not being representative of caregivers of CSA victims. Furthermore, it was difficult to have a control group as this would have withheld a potentially beneficial programme from caregivers and their children. Therefore, it was difficult to evaluate the effects of the programme independently from possible confounds.

The evaluation of the Parenting Support Pilot Programme could have been strengthened by the use of psychometrics for both the caregivers and their children to more objectively measure changes in parenting outcomes and their children’s behaviours. This had been considered early in evaluation development, but ACC concluded that asking caregivers to fill in extra psychometrics would place a burden on potential participants that was not required for the purposes of evaluating the pilot programme (see Jenner & Pittams, 2007).

Several questions producing quantitative data were included in the telephone surveys, which provided the ability to get some overall measures about the programme. However, it may have been useful to include some reverse-scaled items in the questionnaire, and to keep some of the
questions consistent with those on the Needs Assessment and Achievement Summary forms to provide more consistent comparisons over time. In focusing on qualitative methods, some ability to generalise from the data may have been lost; however this approach addressed the need to gather in-depth data on a new programme and may have been more appropriate for researching such a sensitive topic (Patton, 1997; Renzetti & Lee, 1993). Future research into parenting programmes could include more quantitative measures to strengthen the evaluation protocol and support conclusions made about the programme.

Another source of possible bias within this evaluation was the length of time between programme completion and the first impact evaluation interviews. As originally planned, there would have been up to 6 weeks between programme completion and the first interviews. However, delays in accessing paperwork from ACC meant that these initial interviews often occurred much after programme completion. As a result, it was difficult to assess the effect that the passage of time had on outcomes for caregivers and their children.

A further limitation, common to effectiveness research, was the lack of adherence to programme protocols by counsellors resulting in poor treatment integrity. Several caregivers spoke about receiving more than the allocated sessions, which they thought resulted in better outcomes for their family. Furthermore, because counsellor characteristics were identified as being important to programme impact, the fact that several caregivers had the same counsellor may have resulted in some outcomes being distorted. The child’s own counselling was another confound due to both the child’s and the caregiver’s interventions having contributed to positive outcomes for families.

Therefore, in future research, it would be important to improve treatment integrity and to control for possible confounds using statistical methods on larger sample sizes.

Future research

Due to there being very limited assessment of interventions for caregivers following disclosure of CSA it is important for more research to be done in this area. The evaluation of the Parenting Support Pilot Programme indicated that interventions for caregivers are necessary in optimising
recovery following CSA and therefore, continuing to offer such interventions for caregivers is important. Future research should aim to address the limitations in the current research by controlling for factors such as the number of sessions caregivers receive, several caregivers receiving support from the same source, the length of time between programme completion and its evaluation, and the amount of support the children themselves are receiving. Furthermore, it would be important to consider how a control group could be used, without potential participants missing out on a potentially useful programme. The inclusion of Māori models of research, or models of research developed for other minority groups, may also provide more culturally appropriate programme evaluations and recommendations. It would also be useful to undertake larger quantitative studies to further investigate the impact of parenting programmes and to allow for better generalisation to other caregivers.

Future research may consider how to implement a similar programme in a variety of settings without the reliance on ACC’s processes or the need for cover determination. Additionally, it may be useful for more research to be conducted with other forms of intervention such as those that the caregivers during this evaluation mentioned (access to support groups, development programmes, and additional psychoeducational reading material). These could be run in conjunction with individual counselling support and may further improve outcomes for caregivers and their families. Furthermore, how to best include the wider family support systems should be considered as caregivers from a range of ethnic background in this evaluation indicated that it would be useful to have access to counselling for all family members. This may particularly be important for those caregivers that identify as not being of European origin, and further investigation into the cultural appropriateness of these programmes should be conducted, with the possibility of alternative programmes being set up if required.

Conclusion

The results from this evaluation indicate both the need for, and effectiveness of, interventions for caregivers following disclosure of CSA in NZ. Programme participation was associated with improvements in the caregiver’s ability to manage their child’s behaviour, develop their own
coping skills, and gain increased awareness about the effects of CSA which were the aims of the programme outlined by ACC. Furthermore, caregivers noticed positive changes in their children, which were maintained for over 12 months following the conclusion of the Parenting Support Pilot Programme sessions. The evaluation also highlighted several important process issues to consider when developing a programme such as this in New Zealand including timeliness of support, duration of the intervention, and cultural considerations.

Although there has previously been some research about caregiver interventions following the disclosure of CSA, this is the first study of this size that has investigated individual caregiver interventions that provided more than just psychoeducation. The findings in this evaluation will allow improvements to be made to current programmes and enable other interventions to be developed to best meet the needs for caregivers of CSA victims so that they can support their children in their recovery.
APPENDIX A:
Documents Provided by ACC
Appendix A1: Information for Caregivers

Parenting Support Pilot Programme

Information for parents and carers

ACC is currently piloting the provision of parenting support for parents and carers of children with a mental injury resulting from sexual abuse. The information below tells you more about how this pilot works.

Giving you extra support
We know that child sexual abuse can be traumatic for parents and carers.

Often you have strong personal reactions and emotions that you find hard to deal with and there are changes in your child’s behaviour that have arisen following the abuse. Or you may simply be unsure what things you can do to help your child to recover.

The pilot we are conducting will help us see if the provision of parenting support can assist parents and carers to deal with issues such as these.

What sort of help can I get
An ACC registered counsellor will work with you to identify your needs and will help to identify goals to work towards over the next five sessions.

The Needs Assessment will involve talking to your counsellor about the issues or concerns you want to address and the goals you want to achieve during sessions. Your counsellor will record these and send the assessment to ACC. Once we’ve received it, we will let you know if we can approve the parenting support sessions for you.

Focus of parenting support sessions
The parenting support sessions offered will focus on how you as a parent or carer can cope with and assist your child’s recovery.

Although your counsellor will take into account the goals set for your child, these sessions are not meant as an extension of your child’s counselling. They are an opportunity for you to have ‘parent/adult only’ time, and if you wish, to discuss issues that may not be appropriate for your child to hear.

Evaluating the parenting support sessions
Because this service is part of a pilot, we will see if it works before deciding whether to include it in ACC’s normal range of services. As part of our evaluation of the service, we will:

- view the information you provide in your Needs Assessment, and
- ask you some questions during your final session about how helpful the parenting support sessions were (your counsellor will record your answers on an ‘Achievement Summary’ and send this to ACC).

You can get a copy of your Needs Assessment and Achievement Summary if you want to.

At the end of the pilot, we will contact you by phone to ask you some follow-up questions about the pilot. If you don’t want to receive this call, you can let us know at any time, by contacting Vanessa Kennedy, ACC, on freephone 0800 272 736.

How do I apply?
To apply for parenting support sessions, you must first fill out the enclosed ACC Response and Consent Form (ACC2476).

Once we’ve received this, we will contact you about arranging your initial session.

ACC Response and Consent Forms are also available from:

- the ACC website, at www.acc.co.nz, or
- counsellors who are part of the pilot.

This information may change and should only be used as a guide. December 2006.
Who can attend?
The parenting support service is designed for the abused child’s parent(s) or carer(s). Other family members can attend, but you must first get your counsellor’s agreement to this. Remember, the aim of the parenting support sessions is to give parents and carers specific coping and support strategies – they are not intended as a ‘family conference’ or extra counselling for your child.

If you are separated but have shared custody of the abused child, both parents can attend the parenting support sessions, either together or separately. Please be aware that a maximum of five sessions is available, so if you attend separately you will need to divide the sessions between you.

If there is any confusion or disagreement over who the child’s carers are, contact ACC to discuss the situation.

You cannot attend these parenting support sessions if you are the person alleged to have carried out the abuse.

Is there any cost?
The Needs Assessment and five parenting support sessions are funded by ACC. If our funding doesn’t cover what your counsellor charges, you may be asked to pay the balance.

What is not included?
The help available under the pilot is limited to one assessment and five sessions per child client. This means if another person has already received parenting support sessions while your child was in their care, no further sessions are available.

If you feel that ACC should offer more sessions or other types of help, you can give us your feedback during your final session. This feedback will help us to decide on the types of service we may be able to offer in the future.

Under the pilot, we cannot pay for any other costs related to your parenting support sessions, including travel, childcare, home help and loss of earnings.

Can I choose which counsellor I see?
Yes, but the counsellor you see must have a contract with ACC to provide parenting support sessions as part of the pilot programme.

If you wish to give us any feedback on this, you will be invited to do this during your final session.

Does my child need to know I have attended parenting support sessions?
We appreciate that in some situations, parents or carers may not want their child to know they have attended parenting support sessions.

However, under the Privacy Act ACC is required to release this information to your child, if they ask. If this is a concern for you, we suggest you consider it carefully before you apply for this service.

What if my child is in Child Youth and Family Services (CYFS) care?
If your child is in CYFS care and you want to attend parenting support sessions, you will need to discuss this with your child’s social worker and counsellor. This is because CYFS is legally responsible for your child.

Any questions?
If you have any questions about the parenting support service being offered please contact the Sensitive Claims Unit, ACC on freephone 0800 272 726.

This information may change and should only be used as a guide. December 2006.
Appendix A2: Information for Counsellors

Parenting Support Pilot Programme

ACC is currently piloting parenting support sessions for non-offending parents and carers of children with a mental injury resulting from sexual abuse. The information below provides details for counsellors about this pilot.

Purpose of the pilot

This service aims to give parents and carers coping strategies to help them better understand and manage their child’s behaviour.

By helping parents and carers to cope better, we expect a child’s recovery will also be enhanced. The service is not intended to be an extension of a child’s counselling. Rather, its focus is on allowing the parents and carers to discuss issues and attitudes related to the child but which may be inappropriate for the child to hear. Following this discussion, the counsellor will facilitate the parents’ or carers’ establishment of practical goals for the sessions.

Requirements for counsellors

To deliver this service, counsellors must:

- be currently registered with ACC, and
- have indicated an interest in working with children when they registered with ACC, and
- have provided ACC-funded counselling to children in the past 36 months, and
- use a goal/task/skills-focused model for these sessions.

Sessions overview

The pilot includes an initial ‘Needs Assessment’ to establish the parents’ or carers’ specific concerns and goals in relation to their child. This assessment is followed by five sessions that should be undertaken over a three-month period.

During the final session an ‘Achievement Summary’ is completed. This records progress the parents or carers have made during the sessions and also provides reference material for ACC.

The parenting support sessions run parallel to counselling the child is receiving, regardless of whether the parents or carers are present at the child’s sessions.

Who can attend the parenting support sessions?

The service is aimed at the parents or primary carers of the abused child. If the parents or carers want anyone else to attend their sessions eg, other family members, this is at the counsellor’s discretion and should be discussed carefully at the Needs Assessment.

Focus of individual sessions

Consistent with current research findings, the parents or carers will be encouraged to develop specific strategies to support the child’s coping in different situations and over time eg, at home, at school and in wider family gatherings.

The focus of each of the sessions will be expected to be on specific goals in areas such as:

- coping skills
- child management
- education about abuse.
During the sessions the parents' or carers' personal and relationship issues, including experience of sexual abuse, may arise. This pilot programme is not intended to address personal issues, so counsellors should respond by outlining the options that are available – through ACC or other service providers – to address such issues.

**Research**

This pilot is research based, which means counsellors will be required to provide ACC with information that helps us to evaluate the pilot programme’s success. For example, counsellors will be asked to:

- tell us if they and the parents or carers felt the parenting support service achieved its stated outcomes
- comment on the efficiency of the process, from beginning to end
- give their opinion about whether the service should be included in ACC’s usual range of services
- tell us about any obstacles that affected the pilot’s effectiveness.

**Measures**

Specific measures we will use to evaluate the pilot programme’s success include:

- comparing the Needs Assessment and Achievement Summary to gain a “before and after” measure of changes to the parents’ or carers’ attitudes, concerns and confidence in managing their child’s behaviour
- the parents’ or carers’ rating of the cultural acceptability of the treatment model and delivery
- the counsellor’s rating of:
  - their own skills in implementing the parenting support programme, and
  - their training needs, and
  - the utility of the treatment model
- follow-up phone research with a sub-group of parents and carers (within two years) to gain feedback on the ongoing effects of treatment.

The follow-up phone research will be the only direct contact between pilot participants and researchers or evaluators. Parents and carers will be asked if they consent to take part in this research when they apply for inclusion in the pilot programme. They can decline to take part at any time by phoning the Sensitive Claims Unit on 0800 272 736.

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**Need more information?**

If you are interested in being part of the pilot programme, or have any questions about it, please contact the Sensitive Claims Unit, phone 0800 272 736.
## Appendix A4: Response and Consent Form

**Response and Consent Form**

*For parents and carers of children with a mental injury resulting from sexual abuse.*

Please complete this form to advise ACC if you are interested or not interested in taking part in the parenting support pilot programme named above.

Even if you don’t want to take part we would appreciate you completing the relevant sections of this form, as it will help us to evaluate the pilot.

Once you have completed this form, please send it to:

**ACC**
Sensitive Claims Unit
PO Box 1426
Wellington
Attn: Vanessa Kenny

### SECTION 1: RESPONSE DETAILS

Are you interested in attending parenting support sessions, to help you to support your child during their recovery from sexual abuse?

- [ ] Yes
- [ ] No

If you answered yes, please complete Sections 2 and 3 below.

If you answered no, we would appreciate it if you could please complete Section 4 below, but you do not have to do this if you do not want to.

### SECTION 2: DETAILS OF CLAIMANT, COUNSELLOR AND PARENT/CARER

All parents/carers fill out this section please.

<table>
<thead>
<tr>
<th>Child’s/claimant’s name:</th>
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<td>ACC claim number:</td>
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<tr>
<td>Child’s date of birth:</td>
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<td>Child’s ethnicity:</td>
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</table>

**Child’s current living arrangements (i.e. who is the child living with?)**

______________________________

**Child’s counsellor’s name (if known):**

**Parent/s/Carer’s name:**

**Parent/s/Carer’s postal address:**

______________________________

**Parent/s/Carer’s contact phone number:**

**Parent/s/Carer’s ethnicity:**

**Relationship of parent/s/Carer to child (e.g. mother, father, grandmother, Child, Youth and Family Services carer etc.):**

**Relationship of alleged abuser to child (please do not name the alleged abuser):**
**SECTION 3: CONSENT TO TERMS OF THE PARENTING SUPPORT PILOT PROGRAMME**

Please fill out this section if you are interested in taking part in the pilot programme.

I understand that if I participate in this pilot programme:
- I will take part in an initial Needs Assessment session with my counsellor to identify my needs and goals, and
- following the Needs Assessment, I can attend up to five parenting support sessions, and
- during my final session, I will be asked questions about my goals and whether I achieved them during the sessions. My counsellor will record my responses on an Achievement Summary, which ACC will use to help evaluate the success of the trial, and
- there is no provision for further funded sessions at the end of my five sessions, and
- the Needs Assessment and Achievement Summary completed by my counsellor will be sent to ACC and stored as part of the client's file, subject to Privacy Act provisions, and
- any information provided during the pilot programme may be used by my counsellor and an ACC Claims Manager to help my child. The information will also be used to evaluate the effectiveness of the pilot, and
- the information collected and analysed as part of the evaluation of the pilot will be collected by a researcher independent of ACC and the counsellor.

Name:

Signature:  
Date:

Can a researcher phone you at the end of the pilot (approx. September 2009) as part of our evaluation process?  
☐ Yes  ☐ No

If you answer yes and decide later that you don't want to receive this call, you can let us know at any time by contacting Vanessa Kennedy, ACC, on freephone 0800 272 735.

**SECTION 4: REASONS FOR NOT WANTING TO TAKE PART**

Please fill out this section if you do NOT want to take part in the pilot programme. We would appreciate your feedback as it will help us to help others.

Please tell us why you do not want to take part in the pilot programme (this information will help us to decide on the usefulness of the service for other parents and carers). You will not be identified and we can assure you that there will be no further follow-up by ACC or anyone else after this.


Thank you for taking the time to fill out this form

The information collected by ACC on this form will be used to fulfill the requirements of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.
Appendix A5: Needs Assessment Form

PARENTING SUPPORT PILOT PROGRAMME

Needs Assessment

For parents and carers of children with a mental injury resulting from sexual abuse.

This form is completed by the counselor conducting the Needs Assessment.

Section 1 records details of those participating in the assessment. Sections 2 and 3 comprise a 'structured interview'. Therefore, please:

- ask the questions listed in these sections in the order given to facilitate a broad-ranging discussion, and
- record the key details of the parents/parents' or carers' carers' responses as accurately as possible.

Participants can receive a copy of the Needs Assessment at any time, if they want one. Once you've completed the assessment, please send this form to:

ACC
Sensitive Claims Unit
PO Box 1426
Wellington
Attn: Vanessa Kennedy

SECTION 1: PARENT/CARER AND COUNSELLOR DETAILS

Please Print Clearly

Parents/Carers postal address:

Parents/Carers phone number:

Which parent or carer attended the assessment?

Counsellor's name:

Counsellor's postal address:

Counsellor's phone number: ( )

Child/Claimant's living arrangements:

SECTION 2: CONCERNS, ISSUES AND BACKGROUND INFORMATION

1. How do you feel the sexual abuse has affected your child?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. What is your understanding of why your child's behaviour has changed?

________________________________________________________________________

________________________________________________________________________

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<th>Question</th>
<th>Response</th>
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<td>3(a) Is your child currently having any contact with the alleged abuser?</td>
<td>Yes/No</td>
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<td>3(b) If yes, what contact is that, and in what circumstances?</td>
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<td>3(c) How safe is this contact for the child?</td>
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<td>4. What are your biggest concerns today about your child?</td>
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<td>5. How well are you managing your child’s behaviour at the moment?</td>
<td>Very well/Moderate/Well/Not well</td>
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</table>
9. How has finding out about the sexual abuse affected relationships with other family members?

10(a). What difficulties, if any, are you having with your child at home?

10(b). What would you normally do to deal with these problems?

11. How do you feel about your child's behaviour since the abuse?

12. Is your child having any difficulties at school since the abuse?  
☐ Yes  ☐ No  ☐ Don't know

If yes, what kind of problems is your child having?

If yes, is the school or ACC giving your child extra help for these problems?

13(a). What kind of help does your child need from you now to deal with the sexual abuse?

13(b). How confident are you that you can provide this? (please tick the one that describes how you feel today)

☐ Very confident  ☐ Confident  ☐ Not sure  ☐ Not much confidence  ☐ Not confident

13(c). What do you see as obstacles for you in trying to give your child the help you think they need?
14. What help do you need now to improve things for your child?


15. Who do you go to for support at the moment?

☐ Parents    ☐ Friends    ☐ Doctor    ☐ Other family members    ☐ Social worker    ☐ No one

☐ Other — please specify:

16(a) Are your/your child involved with any other agencies at the moment?  ☐ Yes  ☐ No

16(b) If yes, which agencies?


17. Is there anyone else in your child's family that you think needs to be involved in these sessions, to best help the child?


18. How confident are you that you will be able to manage the effects of the abuse on your child over the longer term? (Please tick the description that is the best fit for you)

☐ Very confident    ☐ Confident    ☐ Some confidence    ☐ Little confidence    ☐ Not confident

**SECTION 3: PARENT/CAREER GOALS**

Please describe goals in the format provided. You can set as many goals as you like. However, the goals must be in the areas of:

- parent/carer self-management and coping, or
- management of child’s behaviour, or
- education about sexual abuse and its effects on the child, now or in the future.

**Sample of goal setting:**

**Current problem:**

My daughter won’t go to bed in her room; can’t sleep, has nightmares, and gets up several times per night and gets into my bed. I’m losing lots of sleep and it’s making it hard for me to cope with all the kids the next day. I’m taking out my frustration on her.

**Skill to be learned or change to be made:**

Get her to sleep better somehow and use her own bed so that I get some more sleep myself.

**Name of parent/carer(s) who will work on this goal**

Jane Doe - mother.

**How do you believe this change will help the child?**

She would not be so grumpy, not start arguments at school and with her brothers so much. I know it makes her worse when I scolded and lose it at her. She feels like it’s her fault that the whole family is at each other’s throats. I think she would feel better if I didn’t yell at her. She starts the school day upset if I yell at her in the morning.

**To achieve this goal the counsellor will:**

Provide information about links between sexual abuse and sleeping problems, and discuss with you why your child might be reluctant to be in her own bed. Suggest ways you might be able to help your child sleep better.
To achieve this goal the parent/carer will:
Try out the suggested changes, and tell the counsellor how that went.

GOAL 2
Current Problem
[Guidance for counsellors – same problem as above, so no need to rewrite this]

Skill to be learned or change to be made:
Keeping my cool when my child is acting out and I am tired/stressed.
[Guidance for counsellors – the problem the parent described has been broken down into two goals. Splitting the goals makes it clearer to the parent/carer what is going to be worked on, and shows when progress has been made.]

Name of parent/carer(s) who will work on this goal
Jane Doe – mother

How do you believe this will help the child?
[Guidance for counsellors – same as above, so no need to rewrite this]

To achieve this goal the parent/carer will:
Help you to find ways to ‘keep your cool’ when you are tired, ask you to practice them between sessions, and work out which ones work best for you. Explore ways you might be able to get friends or family to help you get some catch-up sleep. Be practically supportive.

To achieve this goal the parent/carer will:
Tell the counsellor about the child’s situation. Try out the suggested changes, and tell the counsellor how they went.

SECTION 1 SESSION GOALS

GOAL 1
Current problem:

Skill to be learned or change to be made:

Name of parent/carer(s) who will work on this goal

How do you believe this change will help the child?
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<th>GOAL 3</th>
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<td>Name of parent/carer(s) who will work on this goal:</td>
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<td>How do you believe this change will help the child?</td>
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<td>GOAL 4</td>
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<td>Current problem:</td>
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<td>To achieve this goal the counsellor will:</td>
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**GOAL 2**

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<th>Name of parent/carer(s) who will work on this goal</th>
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<th>How do you believe this change will help the child?</th>
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<th>To achieve this goal the counsellor will:</th>
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</table>
Name of parent(ren) who will work on this goal:

How do you believe this change will help the child?

To achieve this goal the counsellor will:

To achieve this goal the parent/parenter will:

Please list the goals in order of how important they are for you to help your child get over the abuse.

Most important to least important

Goal number

Goal number

Goal number

Goal number

Write any extra goals here:

Please continue goals on separate sheets of paper if necessary

The information collected by ACC on this form will be used to fulfill the requirements of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Ombudsman.
Appendix A6: Achievement Summary Form

**Parenting Support Pilot Programme**

**Achievement Summary**

For parents and carers of children with a mental injury resulting from sexual abuse.

This Summary is completed by the counsellor at the end of the parenting support sessions.

Section 1 records attendance details at each session. The questions in Section 2 comprise a structured interview. Therefore, please:

- ask these questions in the order given, encouraging a broad-ranging discussion, and then
- record the key details of the parent(s)/parent's or carer(s)/carer's responses as accurately as possible, and
- make sure that a completed copy of the Needs Assessment is available for you and the parent(s)/carer(s) to refer to during the discussion.

Once you have completed this Achievement Summary, please:

- tell participants they can get a copy of it at any time, and
- remind the parent(s)/carer(s) that they can decline to take part in the follow-up phone research at any time, by phoning Vanessa Kennedy, ACC, on freephone 0800 272 730, and
- send this summary to:

  ACC  
  Sensitive Claims Unit  
  PC Box 1426  
  Wellington  
  Attn: Vanessa Kennedy

### Section 1: Participant and Attendance Details

<table>
<thead>
<tr>
<th>Parent/Carer name(s)</th>
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<table>
<thead>
<tr>
<th>Counselor's name:</th>
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<table>
<thead>
<tr>
<th>Child/Claimant's name:</th>
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<table>
<thead>
<tr>
<th>Session</th>
<th>Date</th>
<th>Who Attended</th>
<th>Relationship to Claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</table>

### Section 2: Goals and Outcomes Achieved

1(a) Which of the goals set at the beginning of the sessions have been completely achieved? (please give goal number and full description)

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
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</table>
1(b) Which goals set at the beginning of the sessions have been partly achieved?

<table>
<thead>
<tr>
<th>GOAL NUMBER AND FULL DESCRIPTION</th>
<th>PLEASE DESCRIBE THE IMPROVEMENTS</th>
</tr>
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1(c) Were any goals added during the session?  
☐ No  ☐ Yes – if yes, what were these goals?

1(d) Which goals were not able to be addressed at all during the session – why?

<table>
<thead>
<tr>
<th>GOAL NUMBER AND FULL DESCRIPTION</th>
<th>PLEASE DESCRIBE WHY THE GOAL WAS NOT ADDRESSED</th>
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</table>

2. What difficulties, if any, are you having at the moment with your child?

   
   
   

3. How well are you managing your child’s behaviour at the moment? (Please tick the description that is the best fit for you)
   
   ☐ Very well  ☐ Well  ☐ Moderately well  ☐ Not very well  ☐ Not well

4(a) What are your biggest concerns today about your child?

   
   
   

4(b) What are your biggest concerns about your child’s recovery in the future?

   
   
   

4(c) How confident are you that you will be able to support your child’s recovery from the abuse over the longer term? (Please tick the description that is the best fit for you)

- [ ] Very confident
- [ ] Confident
- [ ] Some confidence
- [ ] Little confidence
- [ ] Not confident

5(a) What kind of help does your child need from you now to deal with the sexual abuse?

- 

5(b) How confident are you that you can provide this? (Please tick the one that describes how you feel today)

- [ ] Very confident
- [ ] Confident
- [ ] Not sure
- [ ] Not much confidence
- [ ] Not confident

5(c) Are there problems for you in trying to give your child that help? (Please specify)

- 

6. Can you see any changes in your child now that you think are the result of your getting this parenting support?

- 

7. Can we contact you by phone to discuss how useful this parenting support was for you?

- [ ] Yes
- [ ] No

8. Have your contact details changed since you began the sessions?

- 

The information collected by ACC on this form will be used to fulfil the requirements of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.
APPENDIX B:
Manager Interviews – Face-to-face
Appendix B1: Interview Schedule

Thank you for agreeing to participate in this interview regarding the Parenting Support programme you are currently involved with in your role as Manager.

Please remember you are under no obligation to do this interview with us, and you are able to decline answering any questions you do not wish to answer. The interview should take between 30 minutes to an hour, so please let me know if you want any breaks.

1. What can you tell me about the current processes and what is working well?

2. Is the “Parenting Support” programme working efficiently?
   Possible follow-up questions:
   a. What is working well?
   b. Are there delays in processes? What are these?
   c. What is being done to improve the delays in processes?
   d. What else would help improve the “Parenting Support” programme efficiency?

3. What other elements of the initiative could be improved?

4. To what extent has the initiative been taken up by those eligible?
   Possible follow-up questions:
   a. Which caregivers do you think need the initiative most?
   b. Have they picked up the initiative?
   c. Why have parents declined support?
   d. Were there cases where there was a request for a change of Counsellor?
   e. How were such requests dealt with?
   f. Do such requests commonly occur within ACC’s services?

5. Are ACC’s processes meeting the needs of the pilot research?
   Possible follow-up questions:
   a. To what extent is the initiative being picked up by appropriate providers?
   b. Are the objectives of the initiative being met by the current design?

6. How are cultural needs being met?
   Possible follow-up questions:
   a. Has this potentially limited access for some caregivers?
   b. Were there enough culturally appropriate Counsellors available when requested?
   c. Is anything being done to address these issues? If so, what?

7. Any other comments to add?
PARTICIPANT INFORMATION SHEET - MANAGERS

Project Title: Evaluation of Parenting Support – Pilot Programme

Principal Investigator: Annik van Toledo

Dear Potential Participant,

My name is Annik van Toledo from the Department of Psychology at the University of Auckland. We are currently undertaking a study commissioned for, and funded by ACC titled “Evaluation of Parenting Support – Pilot Programme”. Other members of the research team are Associate Professor Fred Seymour, Dr Heather McDowell, Dr Ian Lambie and Erana Cooper (Māori Consultant). We are all in the Department of Psychology at the University of Auckland.

I am writing to you about this study as you have been involved in the “Parenting Support” pilot initiative in your role as an ACC Manager and have agreed to be contacted by our research team.

About the Study

ACC is currently piloting a new parental support intervention to provide coping and understanding strategies to safe parents/caregivers of children with a sensitive claim (mental injury as a result of sexual abuse). This study will provide a process evaluation of the “Parenting Support” pilot programme, and is part of a bigger evaluation of this new service provided by ACC. This phase of the evaluation would be completed by November 2007, providing feedback on the pilot initiative from both the provider and recipients’ viewpoints.

The results of this study will be presented in a report to ACC. It will also form part of my Doctor of Clinical Psychology thesis.
Participation

You are invited to participate in this study and are under no obligation to do so. Participation is voluntary (your choice), and you may withdraw at any time. Participation/non-participation will not affect your employment within ACC.

We will endeavour to telephone you approximately one week after sending you this information sheet to ask if you are interested in participation. If you agree to participate, this would involve being interviewed either over the telephone, through video conference, or in person about the pilot initiative “Parenting Support” being provided by ACC. Consent may be audio-taped over the telephone (separate from interview transcripts) for telephone and video conference interviews, or provided in writing for face-to-face interviews. Each interview will be audio taped and the tapes will later be transcribed. Transcripts will be made available to you upon request. Audiotapes may be switched off at any time at your request. The interviews should not take longer than 1.5hrs and will occur at a time of your convenience.

Storage of Information

The tapes of the interviews will be stored securely while they are being transcribed and then be destroyed. Transcripts and any other information related to you will be kept in a locked filing cabinet at the University of Auckland for six years, and then destroyed. The taped consent will be stored securely in a place separate from other material. They and all other printed material will be shredded six years after the project is finished. Electronic records (computer files, discs etc.) will also be deleted at that time.

Confidentiality

All the information you provide will remain confidential and any research assistants employed (e.g., transcribers) will be required to sign a confidentiality agreement to this effect. This means that if any of the information you provide is reported or published, it will be done in a way that does not identify you as its source.

Withdrawal

You are free to withdraw from the project at any time without giving reasons. You may also withdraw any data related to you until two weeks after your interview. In this case please contact me, and any documents related to you would be destroyed.

Risks and Benefits of Participation

Your participation will contribute to the evaluation of the “Parenting Support” programme currently being piloted by ACC, and as such may lead to recommendations for its improvement.

It is possible, that as a result of this evaluation issues around malpractice amongst service providers arises. Although this is not the target of the evaluation, if the research team is made aware of these issues they would be reported to ACC management.

Thank you for your time and help in making this study possible. If you have any questions or would like to discuss participation, please contact any of us at the addresses/phone numbers below:
CONTACTS

The primary investigator Annik van Toledo can be contacted at (09) 373 7599 x 82266 or 027 256 9243, or e-mail at a.vantoledo@gmail.com, or by mail at Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

The primary supervisor and Head of Department (Psychology) is Associate Professor Fred Seymour, (09) 373 7599 x 88414, f.seymour@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is Dr Heather McDowell, (09) 373 7599 x88556, h.mcdowell@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is Dr Ian Lambie, (09) 373 7599 x 85012, i.lambie@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

The Māori consultant is Erana Cooper, (09) 373 7599 x88557, el.cooper@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

For Ethical Concerns about this project contact: The Chair, Multiregional Ethics Committee, c/-Ministry of Health, 2nd floor, 1 - 3 The Terrace, PO Box 5013, Wellington, multiregion_ethicscommittee@moh.govt.nz

APPROVAL FOR PROJECT:
This study has received ethical approval from the Multi-region Ethics Committee, which reviews National and Multi regional studies.
CONSENT FORM - MANAGERS
(This consent form will be stored for a period of six years)

Project Title: Evaluation of Parenting Support – Pilot Programme

Principal Investigator: Annik van Toledo

I have read and understood the Participant Information Sheet for this project for volunteers taking part in the study designed to evaluate the “Parenting Support” pilot programme implemented by ACC. I have had the opportunity to ask questions and have them answered and have been given time to consider whether to take part. I understand that taking part in this study is voluntary (my choice) and that I am free to withdraw myself and any information traceable to me, at any time up to two weeks after participation without giving a reason.

• I understand that my participation or non-participation will not affect my employment with ACC.

• I understand that my interview will be audio-taped and that I have the right to turn off the tape at any time.

• I understand that this consent form will be stored separately to any other data related to me. These will be stored in a locked filing cabinet in Associate Professor Fred Seymour’s office at the University of Auckland for a period of six years after which all information relating to me will be securely destroyed.

• I understand that confidentiality cannot be guaranteed in written reports due to the small number of Managers involved in the pilot initiative.

NAME:

SIGNED:  DATE:
APPENDIX C:
Peer Reviewers Interviews – Face-to-face
Appendix C1: Interview Schedule

Thank you for agreeing to participate in this interview regarding the Parenting Support programme you are currently involved with as a Peer Reviewer.

Please remember you are under no obligation to do this focus group with us, and you are able to decline answering any questions you do not wish to answer. The focus group should take between 30 minutes to an hour, so please let me know if you want any breaks.

1. What can you tell me about the current processes and what is working well?

2. Is the “Parenting Support” programme working efficiently?
   Possible follow-up questions:
   a. What is working well?
   b. Are there delays in processes? What are these?
   c. What is being done to improve the delays in processes?
   d. What else would help improve the “Parenting Support” programme efficiency?

3. How are Counsellors and caregivers doing in terms of completing the Needs Assessment Forms and Achievement Summaries?
   Possible follow-up questions:
   a. What are they doing well?
   b. What areas could be improved?
   c. What could be done to make this process easier?

4. What elements of the initiative could be improved?

5. To what extent has the initiative been taken up by those eligible?
   Possible follow-up questions:
   a. Which caregivers do you think need the initiative most?
   b. Have they picked up the initiative?
   c. Why have parents declined support?
   d. Were there cases where there was a request for a change of Counsellor?
   e. How were such requests dealt with?
   f. Do such requests commonly occur within ACC’s services?

6. Are ACC’s processes meeting the needs of the pilot research?
   Possible follow-up questions:
   a. To what extent is the initiative being picked up by appropriate providers?
   b. Are the objectives of the initiative being met by the current design?

7. How are cultural needs being met?
   Possible follow-up questions:
   a. Has this potentially limited access for some caregivers?
   b. Were there enough culturally appropriate Counsellors available when requested?
   c. Is anything being done to address these issues? If so, what?

8. Any other comments to add?
PARTICIPANT INFORMATION SHEET – PEER REVIEWER

Project Title: Evaluation of Parenting Support – Pilot Programme

Principal Investigator: Annik van Toledo

Dear Potential Participant,

My name is Annik van Toledo from the Department of Psychology at the University of Auckland. We are currently undertaking a study commissioned for, and funded by ACC titled “Evaluation of Parenting Support – Pilot Programme”. Other members of the research team are Associate Professor Fred Seymour, Dr Heather McDowell, Dr Ian Lambie and Erana Cooper (Māori Consultant) who are all staff members in the Department of Psychology at the University of Auckland.

I am writing to you about this study as you have been involved in the “Parenting Support” pilot initiative in your role as a Peer Reviewer and have agreed to be contacted by our research team.

About the Study

ACC is currently piloting a new parental support intervention to provide coping and understanding strategies to safe parents/caregivers of children with a sensitive claim (mental injury as a result of sexual abuse). This study will provide a process evaluation of the “Parenting Support” pilot programme, and is part of a bigger evaluation of this new service provided by ACC. This phase of the evaluation would be completed by November 2007, providing feedback on the pilot initiative from both the provider and recipients’ viewpoints.

The results of this study will be presented in a report to ACC. It will also form part of my Doctor of Clinical Psychology thesis.
Participation

You are invited to participate in this study and are under no obligation to do so. Participation is voluntary (your choice), and you may withdraw at any time. Participation/non-participation will not affect your employment within ACC.

We will endeavour to telephone you approximately one week after sending you this information sheet to ask if you are interested in participation. If you agree to participate, this would involve being part of a focus group about the pilot initiative “Parenting Support” being provided by ACC with two other Peer Reviewers. This focus group could occur via telephone-conference or in person. The focus group will be audio-taped and the tapes will later be transcribed. Audiotapes may be switched off at any time at your request. The focus group should not take longer than 1.5hrs and will occur at a time that is convenient for all focus group participants. We are unable to supply interpreters; therefore the ability to converse in English is a requirement of participation.

Storage of Information

The tapes of the focus group will be stored securely while they are being transcribed and then be destroyed. Transcripts and any other information related to you will be kept in a locked filing cabinet at the University of Auckland for six years, and then destroyed. The consent forms/taped consent will be stored securely in a place separate from other material. They and all other printed material will be shredded six years after the project is finished. Electronic records (computer files, discs etc.) will also be deleted at that time.

Confidentiality

Due to the nature of the focus group, confidentiality cannot be guaranteed. Confidentiality will be respected in any report writing, which means that if any of the information you provide is reported or published, it will be done in a way that does not identify you as its source. However, due to the small number of ACC Peer Reviewers involved in this pilot initiative, it is possible that some of the information you provide may be identifiable. Any research assistants employed (e.g., transcribers) will be required to sign a confidentiality agreement.

Withdrawal

You are free to withdraw from the project at any time without giving reasons. Due to the nature of the focus group, it is not possible to withdraw your information after participation.

Risks and Benefits of Participation

Your participation will contribute to the evaluation of the “Parenting Support” programme currently being piloted by ACC, and as such may lead to recommendations for its improvement.

It is possible, that as a result of this evaluation issues around malpractice amongst service providers arises. Although this is not the target of the evaluation, if the research team is made aware of these issues they would be reported to ACC management.

Thank you for your time and help in making this study possible. If you have any questions or would like to discuss participation, please contact any of us at the addresses/phone numbers below:
CONTACTS

The primary investigator Annik van Toledo can be contacted at (09) 373 7599 x 82266 or 027 256 9243, or e-mail at a.vantoledo@gmail.com, or by mail at Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

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Another supervisor is Dr Heather McDowell, (09) 373 7599 x88556, h.mcdowell@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is Dr Ian Lambie, (09) 373 7599 x 85012, i.lambie@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

The Māori consultant is Erana Cooper, (09) 373 7599 x88557, el.cooper@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

For Ethical Concerns about this project contact: The Chair, Multiregional Ethics Committee, c/-Ministry of Health, 2nd floor, 1 - 3 The Terrace, PO Box 5013, Wellington, multiregion_ethicscommittee@moh.govt.nz

APPROVAL FOR PROJECT:
This study has received ethical approval from the Multi-region Ethics Committee, which reviews National and Multi regional studies.
CONSENT FORM – PEER REVIEWER
(This consent form will be stored for a period of six years)

**Project Title:** Evaluation of Parenting Support – Pilot Programme

**Principal Investigator:** Annik van Toledo

I have read and understood the Participant Information Sheet for this project for volunteers taking part in the study designed to evaluate the “Parenting Support” pilot programme implemented by ACC. I have had the opportunity to ask questions and have them answered and have been given time to consider whether to take part. I understand that taking part in this study is voluntary (my choice) and that I am free to withdraw at any time. I understand that due to the nature of the focus group, it is not possible to withdraw my information after participation.

- I understand that my participation or non-participation will not affect my employment with ACC.
- I understand that the focus groups will be audio-taped.
- I understand that this consent form will be stored separately to any other data related to me. These will be stored in a locked filing cabinet in Associate Professor Fred Seymour’s office at the University of Auckland for a period of six years after which all information relating to me will be securely destroyed.
- I understand that due to the nature of the focus group confidentiality cannot be guaranteed.
- I understand that confidentiality cannot be guaranteed in written reports due to the small number of Peer Reviewers involved in the pilot initiative.

**NAME:**

**SIGNED:**

**DATE:**
APPENDIX D:
Counsellor Interviews – Face-to-face
Appendix D1: Interview Schedule

Thank you for agreeing to participate in this interview regarding the Parenting Support programme you are currently involved with as a Counsellor.

Please remember you are under no obligation to do this interview with us, and you are able to decline answering any questions you do not wish to answer. The interview should take between 30 minutes to an hour, so please let me know if you want any breaks.

1. What are your thoughts about the “Parenting Support” programme?

2. How did you hear about and sign up to the programme (what were the processes)?
   Possible follow-up questions:
   a. Was this easy? Do you think others would have the same experience as you?
   b. Would other Counsellors sign up to the programme also?

3. Is the “Parenting Support” programme working efficiently?
   Possible follow-up questions:
   a. What is working well?
   b. Are there delays? If so, where?
   c. Do you think that the “Parenting Support” programme is offered at an appropriate/the best time for caregivers?
   d. What else would help improve the “Parenting Support” programme efficiency?

4. Did you use the 0800 number?
   Possible follow-up questions:
   a. How was this experience?
   b. Would other people find this helpful also?

5. Are there other elements of the initiative could be improved? What are these?

6. To what extent has the initiative been taken up by those eligible?
   Possible follow-up questions:
   a. Who do you think needs the initiative most?
   b. Have they picked up the initiative?
   c. Are they receiving the support when they most need it?
   d. Do you think that co-payments may be a barrier to caregiver participation in this programme?
   e. Did any caregivers fail to turn up to their initial/subsequent appointments?
   f. Have any caregivers dropped out of the “Parenting Support” programme? Why do you think this happened?
   g. Have any parents declined support? Were any reasons given? Why do you think this would happen?

7. Are cultural needs being met? How is this achieved?
   Possible follow-up questions:
   a. Has this potentially limited access for some caregivers?
   b. Is anything being done to address these issues? If so, what?
8. Are the number of sessions (5) provided within the initiative enough to meet the stated objectives of the “Parenting Support” service

9. Were goals adequately identified in the Needs Assessments?
   
   **Possible follow-up questions:**
   
   a. What processes did you employ in identifying people’s needs and goals?
   b. Is the time available adequate to complete the Needs Assessment form?
   c. If not, what are the difficulties in completing these?
   d. Did this identify parents/caregivers attitudes, concerns and confidence in managing their child’s behaviour

10. How did the peer review process work for you (processes)?
   
   **Possible follow-up questions:**
   
   a. Does the feedback from these get provided to you?
   b. Were their comments helpful?

11. In your experience, do you think parents are able to achieve their stated goals as a result of the programme?

12. Did you feel confident in implementing the programme?
   
   **Possible follow-up questions:**
   
   a. Were you provided with any guidelines on how to run the programme? What were these?
   b. What are your training and supervision needs? Are these currently being met?
   c. Why would some Counsellors choose not participate in this programme?
   d. Do you intend on continuing providing this service to caregivers? Why/why not?
   e. Would you recommend your colleagues to take up this initiative?

13. What skills do you think Counsellors need to do this work particularly well?
   
   a. What support is needed for them to provide the best service?

14. Any other comments to add?
PARTICIPANT INFORMATION SHEET - COUNSELLORS

Project Title: Evaluation of Parenting Support – Pilot Programme
Principal Investigator: Annik van Toledo

Dear Potential Participant,

My name is Annik van Toledo from the Department of Psychology at the University of Auckland. We are currently undertaking a study commissioned for, and funded by ACC titled “Evaluation of Parenting Support – Pilot Programme”. Other members of the research team are Associate Professor Fred Seymour, Dr Heather McDowell, Dr Ian Lambie and Erana Cooper (Māori Consultant). We are all in the Department of Psychology at the University of Auckland.

I am writing to you about this study as you have been involved in the “Parenting Support” pilot initiative in your role as an ACC Counsellor and have agreed to be contacted by our research team.

About the Study

ACC is currently piloting a new parental support intervention to provide coping and understanding strategies to safe parents/caregivers of children with a sensitive claim (mental injury as a result of sexual abuse). This study will provide a process evaluation of the “Parenting Support” pilot programme, and is part of a bigger evaluation of this new service provided by ACC. This phase of the evaluation would be completed by November 2007, providing feedback on the pilot initiative from both the provider and recipients’ viewpoints.

The results of this study will be presented in a report to ACC. It will also form part of my Doctor of Clinical Psychology thesis.
Participation

You are invited to participate in this study and are under no obligation to do so. Participation is voluntary (your choice), and you may withdraw at any time. Participation/non-participation will not affect your employment within ACC.

We will endeavour to telephone you approximately one week after sending you this information sheet to ask if you are interested in participation. If you agree to participate, this would involve being interviewed either over the telephone, through video conference, or in person about the pilot initiative “Parenting Support” being provided by ACC. Consent may be audio-taped over the telephone (separate from interview transcripts) for telephone and video conference interviews, or provided in writing for face-to-face interviews. Each interview will be audio taped and the tapes will later be transcribed. Transcripts will be made available to you upon request. Audiotapes may be switched off at any time at your request. The interviews should not take longer than 1.5hrs and will occur at a time of your convenience.

Storage of Information

The tapes of the interviews will be stored securely while they are being transcribed and then be destroyed. Transcripts and any other information related to you will be kept in a locked filing cabinet at the University of Auckland for six years, and then destroyed. The taped consent will be stored securely in a place separate from other material. They and all other printed material will be shredded six years after the project is finished. Electronic records (computer files, discs etc.) will also be deleted at that time.

Confidentiality

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Withdrawal

You are free to withdraw from the project at any time without giving reasons. You may also withdraw any data related to you until two weeks after your interview. In this case please contact me, and any documents related to you would be destroyed.

Risks and Benefits of Participation

Your participation will contribute to the evaluation of the “Parenting Support” programme currently being piloted by ACC, and as such may lead to recommendations for its improvement. It is possible, that as a result of this evaluation issues around malpractice amongst service providers arises. Although this is not the target of the evaluation, if the research team is made aware of these issues they would be reported to ACC management.

Thank you for your time and help in making this study possible. If you have any questions or would like to discuss participation, please contact any of us at the addresses/phone numbers below:
CONTACTS

The primary investigator **Annik van Toledo** can be contacted at (09) 373 7599 x 82266 or 027 256 9243, or e-mail at a.vantoledo@gmail.com, or by mail at Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

The primary supervisor and Head of Department (Psychology) is **Associate Professor Fred Seymour**, (09) 373 7599 x 88414, f.seymour@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is **Dr Heather McDowell**, (09) 373 7599 x88556, h.mcdowell@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is **Dr Ian Lambie**, (09) 373 7599 x 85012, i.lambie@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

The Māori consultant is **Erana Cooper**, (09) 373 7599 x88557, el.cooper@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

**For Ethical Concerns about this project contact:** The Chair, Multiregional Ethics Committee, c/-Ministry of Health, 2nd floor, 1 - 3 The Terrace, PO Box 5013, Wellington, multiregion_ethicscommittee@moh.govt.nz

**APPROVAL FOR PROJECT:**
This study has received ethical approval from the Multi-region Ethics Committee, which reviews National and Multi regional studies.
CONSENT FORM - COUNSELLORS
(This consent form will be stored for a period of six years)

Project Title: Evaluation of Parenting Support – Pilot Programme

Principal Investigator: Annik van Toledo

I have read and understood the Participant Information Sheet for this project for volunteers taking part in the study designed to evaluate the “Parenting Support” pilot programme implemented by ACC. I have had the opportunity to ask questions and have them answered and have been given time to consider whether to take part. I understand that taking part in this study is voluntary (my choice) and that I am free to withdraw myself and any information traceable to me, at any time up two weeks after participation without giving a reason.

• I understand that my participation or non-participation will not affect my employment with ACC.

• I understand that my interview will be audio-taped and that I have the right to turn off the tape at any time.

• I understand that this consent form will be stored separately to any other data related to me. These will be stored in a locked filing cabinet in Associate Professor Fred Seymour’s office at the University of Auckland for a period of six years after which all information relating to me will be securely destroyed.

• I understand that if I disclose any issues of malpractice the researchers are obligated to report this to ACC management.

NAME:

SIGNED:          DATE:
APPENDIX E:
Caregiver Interviews – Face-to-face
Appendix E1: Interview Schedule

Thank you for agreeing to participate in this interview regarding the Parenting Support programme you have recently completed through ACC counselling.

Please remember you are under no obligation to do this interview with us and you are able to decline answering any questions you do not wish to answer. The interview should take between 30 minutes to an hour, so please let me know if you want any breaks.

1. How did you find out about the “Parenting Support” programme?
   Possible follow-up questions:
   a. How did you access information about the programme?
   b. How did you access the programme?
   c. What would have helped you access the programme?

2. When did you find out about this programme?
   Possible follow-up questions:
   a. Were there any gaps/delays in your application to the programme?
   b. When were you offered your first appointment?
   c. When was your first appointment?
   d. When did you finish the “Parenting Support’ sessions?
   e. Were there any delays in accessing the support and where/when did these occur?
   f. Were you required to provide co-payments? Did this make it more difficult for you to access the programme?
   g. Did you find that the support was offered when it was most useful to you?

3. Did you have a choice of Counsellors for this programme?

4. How are cultural needs being met?
   Possible follow-up questions:
   a. Did this limit your access to what you needed?
   b. How could this be improved?

5. Needs Assessment – were goals adequately identified?
   Possible follow-up questions:
   a. What were the goals identified?
   b. On reflection, what do you think about these goals?
   c. Did this identify your attitudes, concerns and confidence in managing your child’s behaviour?
   d. Were there other things you would have liked to receive support for that were not on the goals list?
   e. What progress did you make on each of the goals in the sessions?
   f. Were the goals you set achievable in five sessions?

6. What information was provided during the session (including verbal, written and other forms of information)?
   Possible follow-up questions:
a. Was this information helpful in attaining your goals?
b. Was the information presented well?
c. How much of the information were you able to remember over time?

7. Do you feel that the parenting support service achieved its stated outcomes?
   Possible follow-up questions:
   a. How is your child doing now?
   b. Are there any ways in which your child’s behaviour is more worrying than before participation in the programme? In what ways?
   c. Are there any positive changes you have seen in your child’s behaviour since your participation in the programme? What are these?
   d. Do you feel greater confidence in dealing with your child’s behavioural and emotional problems?
   e. Do you feel greater confidence in dealing with your child’s questions?
   f. Did the service help you to understand your child and how abuse affects them?
   g. Do you feel better able to resolve issues and move on with your life as a family?
   h. Do you feel hopeful for the future of your child?

8. Is the “Parenting Support” service worthwhile?
   Possible follow-up questions:
   a. What did you like about the parenting support programme?
   b. What aspects of the support were most helpful?
   c. What is working well?
   d. Would you recommend the “Parenting Support” service to other people?
   e. Overall, were you happy with the support provided?

9. Are there elements of the initiative that could be improved?
   Possible follow-up questions:
   a. What else would you like from the service?
   b. What recommendations for changes would you make for the initiative (areas for improvement)?

10. What did you think of the evaluation process?

11. Any other thoughts to add?
PARTICIPANT INFORMATION SHEET - CAREGIVERS

Project Title: Evaluation of Parenting Support – Pilot Programme
Principal Investigator: Annik van Toledo

Dear Potential Participant,

My name is Annik van Toledo from the Department of Psychology at the University of Auckland. We are currently carrying out a study for ACC called “Evaluation of Parenting Support – Pilot Programme”. Other members of the research team are Associate Professor Fred Seymour, Dr Heather McDowell, Dr Ian Lambie and Erana Cooper (Māori Consultant). We are all in the Department of Psychology at the University of Auckland.

I am writing to you about this study as you have taken part in the “Parenting Support” programme and have agreed to be contacted by our research team.

About the Study

The “Parenting Support” programme was introduced by ACC to help parents/caregivers of children who have a sensitive claim (mental injury as a result of sexual abuse). ACC has to decide whether or not to keep providing this programme (programme evaluation) and have asked our research team to gather information to help decide this. To do this, we will be gathering information from parents/caregivers who have been part of the “Parenting Support” programme and from ACC staff involved with the programme.

The results of this study will be presented in a report to ACC. It will also form part of my Doctor of Clinical Psychology thesis.

Participation

You are invited to take part in this study. You do not have to participate in this study, it is your choice, and you may withdraw at any time. Whether you participate or not, you will still receive the same service from ACC. Please take your time to think about the study and decide whether you wish to take part in it.

About one week after sending you this information sheet we will phone you to ask if you are interested in taking part. If you agree, you would be interviewed either over the telephone, or
in person, about the “Parenting Support” programme. If you are interviewed by phone, we will audiotape your consent for this. If you are interviewed in person, then we will ask for you to sign a consent form. Each interview will be audio taped and the tapes will later be transcribed. Transcripts will be made available to you upon request. You may stop the interview at any time and do not have to answer all the questions. At any time, you can ask to have the audiotape switched off. The interviews will be about 1 hour long and we will do these at a time and place to suit you.

Storage of Information

The tapes of the interviews will be stored securely while they are being transcribed and then be destroyed. Transcripts and any other information related to you will be kept in a locked filing cabinet at the University of Auckland for six years, and then destroyed. The taped consent will be stored securely in a place separate from other material. They and all other printed material will be shredded six years after the project is finished. Electronic records (computer files, discs etc.) will also be deleted at that time.

Confidentiality

All the information you provide will remain confidential and any research assistants employed (e.g., transcribers) will be required to sign a confidentiality agreement to this effect. This means that if any of the information you provide is reported or published, it will be done in a way that does not identify you as its source.

Withdrawal

You are free to withdraw from the project at any time without giving reasons. You may also withdraw any data related to you until two weeks after participation. In this case please contact me, and any documents related to you would be shredded.

Risks and Benefits of Participation

Your participation will contribute to the evaluation of the “Parenting Support” programme currently being piloted by ACC, and as such may lead to recommendations for its improvement. Due to the sensitive nature of the topic area that is being studied, it is possible that you may experience some psychological distress as a result of participation. All my co-investigators are registered Clinical Psychologists in New Zealand and would be available for support if this is required. Additionally, we can provide you with contact details of Counsellors available in your local area if needed.

It is also possible, that as a result of this evaluation, issues around malpractice amongst service providers arises. Although this is unlikely, if the research team is made aware of any such issues they would be reported to ACC management. Similarly, if you told us about any ongoing abuse of a child in your care, we would be obliged to report this to Child Youth and Family.

Thank you for making the time to read about, and consider taking part in this study. If you have any questions or would like to discuss participation, please contact any of us at the addresses/phone numbers over the page:
CONTACTS

The primary investigator Annik van Toledo can be contacted at (09) 373 7599 x 82266, or e-mail at a.vantoledo@gmail.com, or by mail at Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

The primary supervisor and Head of Department (Psychology) is Associate Professor Fred Seymour, (09) 373 7599 x 88414, f.seymour@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

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For Ethical Concerns about this project contact: The Chair, Multiregional Ethics Committee, c/-Ministry of Health, 2nd floor, 1 - 3 The Terrace, PO Box 5013, Wellington, multiregion_ethicscommittee@moh.govt.nz

APPROVAL FOR PROJECT:
This study has received ethical approval from the Multi-region Ethics Committee, which reviews National and Multi regional studies.
CONSENT FORM – CAREGIVERS
(This consent form will be stored for a period of six years)

**Project Title:** Evaluation of Parenting Support – Pilot Programme

**Principal Investigator:** Annik van Toledo

I have read and understood the Participant Information Sheet for this project for volunteers taking part in the study designed to evaluate the “Parenting Support” pilot programme implemented by ACC. I have had the opportunity to ask questions and have them answered and have been given time to consider whether to take part. I understand that taking part in this study is voluntary (my choice) and that I am free to withdraw myself and any information traceable to me, at any time up to two weeks after participation without giving a reason.

- I understand that my participation or non-participation will not affect the services I receive by ACC.
- I understand that my interview will be audio-taped and that I have the right to turn off the tape at any time.
- I understand that this consent form will be stored separately to any other data related to me. These will be stored in a locked filing cabinet in Associate Professor Fred Seymour’s office at the University of Auckland for a period of six years.
- I understand that if I disclose any issues of malpractice, ongoing abuse, issues related to the safety of my child, or information that may affect any current court proceedings, the researchers are obligated to report this to ACC and other relevant authorities as outlined in the information sheet.

**NAME:**

**SIGNED:**

**DATE:**
APPENDIX F:
Caregiver Interviews – Telephone Survey 1
Appendix F1: Interview Schedule

Thank you for agreeing to participate in this interview regarding the Parenting Support programme you have recently completed through ACC counselling.

Please remember you are under no obligation to do this interview with us and you are able to decline answering any questions you do not wish to answer. Please let me know if you do not understand a question or you would like me to repeat it.

1. What are your general impressions about the “Parenting Support” programme?
   Possible follow-up questions:
   a. How did you hear about the programme?
   b. How did you access information about the “Parenting Support” programme?
   c. Was the “Parenting Support” programme easy to access?
   d. Were there any significant delays in getting the support? Why did these occur?
   e. Was the “Parenting Support” programme carried out at the best time for you? When was this and should it have been earlier/later?
   f. Did you and your child get counselling from the same person/same time? Do you think your way worked well? What do you think would be best?

2. What did you like about the “Parenting Support” programme?
   Possible follow-up questions:
   a. What did you think was the most helpful to you?

3. What were the goals you worked on in the programme?
   Possible follow-up questions:
   a. Were the goals you set met? If not, why not?

4. Have you noticed changes in your child since your participation in the “Parenting Support” programme?
   Possible follow-up questions:
   a. Are there any ways in which your child’s behaviour is more worrying than before participation in the programme? In what ways?
   b. Are there any positive changes you have seen in your child’s behaviour since your participation in the programme? What are these?
   c. Do you feel greater confidence in dealing with your child’s behavioural and emotional problems?
   d. Do you feel better informed about sexual abuse?

5. Do you feel better able to resolve issues and move on with your life, as a family?

6. Did you feel the “Parenting Support” programme was sensitive to your cultural needs? How could this be improved?

7. Did you feel that the number of the “Parenting Support” sessions was appropriate?

8. What changes to the programme would you like to see?
9. What did you think of completing this evaluation?
   a. Did the material feel OK to discuss?
   b. Was it helpful to receive the letter before the phone call?

10. Any other comments to add?

It is important for us to understand whether you have found the support you received helpful, and how this has helped you compared to other caregivers. I will now ask you ten questions on a 5-point scale about this. Please answer Strongly Disagree, Disagree, Neutral, Agree or Strongly Agree (will repeat scale for each question):

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I felt the “Parenting Support” Programme was worthwhile</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>I would recommend the “Parenting Support” Programme to other caregivers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>The programme helped me to gain coping skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>The programme helped me to better manage my child’s behaviour</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>The programme helped to educate me about child sexual abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>I feel confident in my ability to support my child’s recovery from the abuse over longer term</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>I feel the skills I gained through the programme have resulted in positive changes in my child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I felt the programme was appropriate to my culture</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>I felt my rights were protected throughout the programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>I felt that the evaluation of the programme was done in an appropriate manner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
RE: Evaluation of ACC “Parenting Support Pilot Programme”

Dear [Name],

We are writing to you as you have recently been involved with the ACC “Parenting Support Pilot Programme” and have kindly agreed to be contacted by researchers who are evaluating this. We would like to interview you by phone to discuss your experience of the programme.

Attached is a participant information sheet and consent form for you to have a look at. In the next couple of weeks one of the researchers will phone you to ask if you will agree to take part in this evaluation.

The purpose of this evaluation is to find out how helpful the programme was to people and what improvements can be made to the programme if needed. The evaluation will focus on your experience of the “Parenting Support Pilot Programme” and will not include any discussions of the events that led you to be part of this programme.

If you have any queries, please do not hesitate to contact us.

Yours Sincerely,

Annik van Toledo
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The University of Auckland
Private Bag 92019
Auckland, New Zealand
Ph: +64 9 373 7599 ext 82266
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Associate Professor Fred Seymour
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f.seymour@auckland.ac.nz
PARTICIPANT INFORMATION SHEET - CAREGIVERS

Project Title: Evaluation of Parenting Support – Pilot Programme

Principal Investigator: Annik van Toledo

My name is Annik van Toledo from the Department of Psychology at the University of Auckland. We are currently carrying out a study for ACC called “Evaluation of Parenting Support – Pilot Programme”. Other members of the research team are Associate Professor Fred Seymour, Dr Heather McDowell, Dr Ian Lambie and Erana Cooper (Māori Consultant). We are all in the Department of Psychology at the University of Auckland.

I am writing to you about this study as you have taken part in the “Parenting Support” programme and have agreed to be contacted by our research team.

About the Study

The “Parenting Support” programme was introduced by ACC to help parents/caregivers of children who have a sensitive claim (mental injury as a result of sexual abuse). ACC has to decide whether or not to keep providing this programme (programme evaluation) and have asked our research team to gather information to help decide this. To do this, we will be gathering information from parents/caregivers who have been part of the “Parenting Support” programme and from ACC staff involved with the programme.

The results of this study will be presented in a report to ACC. It will also form part of my Doctor of Clinical Psychology thesis.

Participation

You are invited to take part in this study. You do not have to participate in this study, it is your choice, and you may withdraw at any time. Whether you participate or not, you will still receive the same service from ACC. Please take your time to think about the study and decide whether you wish to take part in it.

About one week after sending you this information sheet we will phone you to ask if you are interested in taking part. If you agree, you would be surveyed over the telephone about the
“Parenting Support” programme at two time points. We will audiotape your consent for this or you can send us the consent form in the mail. Each survey would be audio taped and the tapes will later be transcribed. The survey should not take longer than 30 minutes and will occur at a time of your convenience. You may stop the survey at any time and do not have to answer all the questions. This survey will happen twice; the first at 6 weeks to 3 months after completing the “Parenting Support” programme and the second 12 months after completion. Both times we will send you this information sheet and consent form. Even if you have participated in the first survey, you are free to decline participation in the follow-up survey.

Storage of Information

The tapes of the interviews will be stored securely while they are being transcribed and then be destroyed. Transcripts and any other information related to you will be kept in a locked filing cabinet at the University of Auckland for six years, and then destroyed. The taped consent will be stored securely in a place separate from other material. They and all other printed material will be shredded six years after the project is finished. Electronic records (computer files, discs etc.) will also be deleted at that time.

Confidentiality

All the information you provide will remain confidential and any research assistants employed (e.g., transcribers) will be required to sign a confidentiality agreement to this effect. This means that if any of the information you provide is reported or published, it will be done in a way that does not identify you as its source.

Withdrawal

You are free to withdraw from the project at any time without giving reasons. You may also withdraw any data related to you until two weeks after participation. In this case please contact me, and any documents related to you would be shredded.

Risks and Benefits of Participation

Your participation will contribute to the evaluation of the “Parenting Support” programme currently being piloted by ACC, and as such may lead to recommendations for its improvement. Due to the sensitive nature of the topic area that is being studied, it is possible that you may experience some psychological distress as a result of participation. All my co-investigators are registered Clinical Psychologists in New Zealand and would be available for support if this is required. Additionally, we can provide you with contact details of counsellors available in your local area if needed.

It is also possible, that as a result of this evaluation, issues around malpractice amongst service providers arises. Although this is unlikely, if the research team is made aware of any such issues they would be reported to ACC management. Similarly, if you told us about any ongoing abuse of a child in your care, we would be obliged to report this to Child Youth and Family.

Thank you for making the time to read about, and consider taking part in this study. If you have any questions or would like to discuss participation, please contact any of us at the addresses/phone numbers over the page:
CONTACTS

The primary investigator Annik van Toledo can be contacted at (09) 373 7599 x 82266, or e-mail at a.vantoledo@gmail.com, or by mail at Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

The primary supervisor and Head of Department (Psychology) is Associate Professor Fred Seymour, (09) 373 7599 x 88414, f.seymour@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

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Another supervisor is Dr Ian Lambie, (09) 373 7599 x 85012, i.lambie@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

The Māori consultant is Erana Cooper, (09) 373 7599 x88557, el.cooper@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

For Ethical Concerns about this project contact: The Chair, Multiregional Ethics Committee, c/-Ministry of Health, 2nd floor, 1 - 3 The Terrace, PO Box 5013, Wellington, multiregion_ethicscommittee@moh.govt.nz

APPROVAL FOR PROJECT:
This study has received ethical approval from the Multi-region Ethics Committee which reviews National and Multi regional studies.
CONSENT FORM – CAREGIVERS
(This consent form will be stored for a period of six years)

Project Title: Evaluation of Parenting Support – Pilot Programme
Principal Investigator: Annik van Toledo

I have read and understood the Participant Information Sheet for this project for volunteers taking part in the study designed to evaluate the “Parenting Support” pilot programme implemented by ACC. I have had the opportunity to ask questions and have them answered and have been given time to consider whether to take part. I understand that taking part in this study is voluntary (my choice) and that I am free to withdraw myself and any information traceable to me, at any time up to two weeks after participation without giving a reason.

- I understand that my participation or non-participation will not affect the services I receive from ACC.
- I understand that my survey will be audio-taped and that I have the right to turn off the tape at any time.
- I understand that this consent form will be stored separately to any other data related to me. These will be stored in a locked filing cabinet in Associate Professor Fred Seymour’s office at the University of Auckland for a period of six years.
- I understand that if I disclose any issues of malpractice, ongoing abuse, issues related to the safety of my child, or information that may affect any current court proceedings, the researchers are obligated to report this to ACC and other relevant authorities as outlined in the information sheet.
- I understand that I will be contacted in approximately 12 months for a follow-up survey, and that I have the right to decline participation to the follow-up.

NAME: 
SIGNED: 
DATE: 
APPENDIX G:
Caregiver Interviews – Telephone Survey 2
Appendix G1: Interview Schedule

Thank you for agreeing to participate in this interview regarding the Parenting Support programme you have recently completed through ACC counselling.

Please remember you are under no obligation to do this interview with us and you are able to decline answering any questions you do not wish to answer. Please let me know if you do not understand a question or you would like me to repeat it.

1. On reflection, what did you like about the “Parenting Support” programme?
   Possible follow-up questions:
   a. What did you think was the most helpful to you?

2. Have you noticed changes in your child since we last spoke?
   Possible follow-up questions:
   a. Are there any ways in which your child’s behaviour is more worrying than before we last spoke? In what ways?
   b. Are there any positive changes you have seen in your child’s behaviour since we last spoke? What are these?
   c. Do you feel greater confidence in dealing with your child’s behavioural and emotional problems?
   d. Have you sought any additional help in the time since we last spoke?

3. Do you feel better able to resolve issues and move on with your life, as a family?

4. On reflection, what changes to the programme would you like to see?

5. What did you think of completing this follow-up evaluation?
   a. Did it feel OK doing the follow-up?
   b. Was it useful getting the letter beforehand?

6. Any other comments to add?

It is important for us to understand whether you have found the support you received helpful, and how this has helped you compared to other caregivers. I will now ask you ten questions on a 5-point scale about this. Please answer Strongly Disagree, Disagree, Neutral, Agree or Strongly Agree (will repeat scale for each question):
<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I felt the “Parenting Support” Programme was worthwhile</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>I would recommend the “Parenting Support” Programme to other caregivers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>The programme helped me to gain coping skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>The programme helped me to better manage my child’s behaviour</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>The programme helped to educate me about child sexual abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>I feel confident in my ability to support my child’s recovery from the abuse over longer term</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>I feel the skills I gained through the programme have resulted in positive changes in my child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>I felt the programme was appropriate to my culture</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>I felt my rights were protected throughout the programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>I felt that the evaluation of the programme was done in an appropriate manner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
RE: Evaluation of ACC “Parenting Support Pilot Programme”

Dear [Name],

We are writing to you, as you have been involved with our evaluation of the ACC “Parenting Support Pilot Programme”. As indicated when we first spoke, we are contacting all caregivers 12 months from Programme completion for follow-up phone interviews as part of our evaluation.

Attached is a participant information sheet and consent form for you to have a look at. In the next couple of weeks one of the researchers will phone you to ask if you will agree to take part in the follow-up part of the evaluation.

This follow-up interview will be shorter and focus on the same areas covered in the initial interview with you. If you have any queries, please do not hesitate to contact us.

Yours Sincerely,

Annik van Toledo  
Pikihuia Pomare  
Associate Professor Fred Seymour

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PARTICIPANT INFORMATION SHEET - CAREGIVERS

Project Title: Evaluation of Parenting Support – Pilot Programme
Principal Investigator: Annik van Toledo

My name is Annik van Toledo from the Department of Psychology at the University of Auckland. We are currently carrying out a study for ACC called “Evaluation of Parenting Support – Pilot Programme”. Other members of the research team are Associate Professor Fred Seymour, Dr Heather McDowell, Dr Ian Lambie and Erana Cooper (Māori Consultant). We are all in the Department of Psychology at the University of Auckland.

I am writing to you about this study as you have taken part in the “Parenting Support” programme and have agreed to be contacted by our research team.

About the Study

The “Parenting Support” programme was introduced by ACC to help parents/caregivers of children who have a sensitive claim (mental injury as a result of sexual abuse). ACC has to decide whether or not to keep providing this programme (programme evaluation) and have asked our research team to gather information to help decide this. To do this, we will be gathering information from parents/caregivers who have been part of the “Parenting Support” programme and from ACC staff involved with the programme.

The results of this study will be presented in a report to ACC. It will also form part of my Doctor of Clinical Psychology thesis.

Participation

You are invited to take part in this study. You do not have to participate in this study, it is your choice, and you may withdraw at any time. Whether you participate or not, you will still receive the same service from ACC. Please take your time to think about the study and decide whether you wish to take part in it.

About one week after sending you this information sheet we will phone you to ask if you are interested in taking part. If you agree, you would be surveyed over the telephone about the “Parenting Support” programme at two time points. We will audiotape your consent for this or
you can send us the consent form in the mail. Each survey would be audio taped and the tapes will later be transcribed. The survey should not take longer than 30 minutes and will occur at a time of your convenience. You may stop the survey at any time and do not have to answer all the questions. This survey will happen twice; the first at 6 weeks to 3 months after completing the “Parenting Support” programme and the second 12 months after completion. Both times we will send you this information sheet and consent form. Even if you have participated in the first survey, you are free to decline participation in the follow-up survey.

Storage of Information

The tapes of the interviews will be stored securely while they are being transcribed and then be destroyed. Transcripts and any other information related to you will be kept in a locked filing cabinet at the University of Auckland for six years, and then destroyed. The taped consent will be stored securely in a place separate from other material. They and all other printed material will be shredded six years after the project is finished. Electronic records (computer files, discs etc.) will also be deleted at that time.

Confidentiality

All the information you provide will remain confidential and any research assistants employed (e.g., transcribers) will be required to sign a confidentiality agreement to this effect. This means that if any of the information you provide is reported or published, it will be done in a way that does not identify you as its source.

Withdrawal

You are free to withdraw from the project at any time without giving reasons. You may also withdraw any data related to you until two weeks after participation. In this case please contact me, and any documents related to you would be shredded.

Risks and Benefits of Participation

Your participation will contribute to the evaluation of the “Parenting Support” programme currently being piloted by ACC, and as such may lead to recommendations for its improvement. Due to the sensitive nature of the topic area that is being studied, it is possible that you may experience some psychological distress as a result of participation. All my co-investigators are registered Clinical Psychologists in New Zealand and would be available for support if this is required. Additionally, we can provide you with contact details of counsellors available in your local area if needed.

It is also possible, that as a result of this evaluation, issues around malpractice amongst service providers arises. Although this is unlikely, if the research team is made aware of any such issues they would be reported to ACC management. Similarly, if you told us about any ongoing abuse of a child in your care, we would be obliged to report this to Child Youth and Family.

Thank you for making the time to read about, and consider taking part in this study. If you have any questions or would like to discuss participation, please contact any of us at the addresses/phone numbers over the page:
CONTACTS

The primary investigator **Annik van Toledo** can be contacted at (09) 373 7599 x 82266, or e-mail at a.vantoledo@gmail.com, or by mail at Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

The primary supervisor and Head of Department (Psychology) is **Associate Professor Fred Seymour**, (09) 373 7599 x 88414, f.seymour@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is **Dr Heather McDowell**, (09) 373 7599 x88556, h.mcdowell@auckland.ac.nz, Department of Psychology (City Campus), The University of Auckland, Private Bag 92019, Auckland.

Another supervisor is **Dr Ian Lambie**, (09) 373 7599 x 85012, i.lambie@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

The Māori consultant is **Erana Cooper**, (09) 373 7599 x88557, el.cooper@auckland.ac.nz, Department of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

**For Ethical Concerns about this project contact:** The Chair, Multiregional Ethics Committee, c/-Ministry of Health, 2nd floor, 1 - 3 The Terrace, PO Box 5013, Wellington, multiregion_ethicscommittee@moh.govt.nz

APPROVAL FOR PROJECT:
This study has received ethical approval from the Multi-region Ethics Committee which reviews National and Multi regional studies.
CONSENT FORM – CAREGIVERS (2)
(This consent form will be stored for a period of six years)

Project Title: Evaluation of Parenting Support – Pilot Programme
Principal Investigator: Annik van Toledo

I have read and understood the Participant Information Sheet for this project for volunteers taking part in the study designed to evaluate the “Parenting Support” pilot programme implemented by ACC. I have had the opportunity to ask questions and have them answered and have been given time to consider whether to take part. I understand that taking part in this study is voluntary (my choice) and that I am free to withdraw myself and any information traceable to me, at any time up to two weeks after participation without giving a reason.

• I understand that my participation or non-participation will not affect the services I receive from ACC.

• I understand that my survey will be audio-taped and that I have the right to turn off the tape at any time.

• I understand that this consent form will be stored separately to any other data related to me. These will be stored in a locked filing cabinet in Associate Professor Fred Seymour’s office at the University of Auckland for a period of six years.

• I understand that if I disclose any issues of malpractice, ongoing abuse, issues related to the safety of my child, or information that may affect any current court proceedings, the researchers are obligated to report this to ACC and other relevant authorities as outlined in the information sheet.

• I understand that I am free to decline participation even though I participated in the original survey approximately 12 months ago.

NAME: 
SIGNED: 
DATE: 

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APPENDIX H:
Interim Recommendations from the Process Evaluation
The following recommendations aim at addressing process weaknesses identified during the evaluation, while at the same time maintaining and utilising the processes in place that are working well.

These recommendations are:

1. Parent and referrer awareness of the existence of the Parenting Support Pilot Programme should be improved.
   a. All caregivers should be provided with the letter from ACC containing information about the Parenting Support Pilot Programme in a timely way.
   b. This informative letter could also be supported by a telephone call to provide the caregiver with a verbal explanation of the programme, and enable them to ask questions.
   c. Potential referral agencies such as Child Youth and Family (CYF) Social Workers, Police, Doctors, and School Guidance Counsellors should also be provided with mail outs containing information about the Parenting Support Pilot Programme. Additionally, awareness could be increased through doing a road-show through New Zealand.

2. Counsellor awareness and knowledge of the programme should be improved. This includes general awareness of the existence of the Parenting Support Pilot Programme and specific knowledge about the purposes and processes of the programme.
   a. Further awareness of the existence of the programme may be improved through more advertisements in the ACC newsletter, another round of mail outs, and/or by doing some form of ‘road show’.
   b. More training and support should be provided to participating Counsellors, which may be addressed by a training ‘road show’ through New Zealand, though group supervision, and/or through the provision of additional written material.

3. The number of Counsellors delivering the programme should be increased, ensuring that there is adequate geographical cover and availability of Counsellors from a variety of cultural backgrounds.
   a. Consideration should be given to extending the current criteria to include Whanau counselling models.

4. The processes within ACC should to be improved with the aim to improve timeliness of the Parenting Support Pilot Programme.
   a. Standardised programme processes should be manualised and provided to the Sensitive Claims Unit to assist in staff training.
   b. Consideration should be given to using the ACC 45 form to trigger counselling for caregivers, rather than caregivers needing to wait for cover determination.
   c. Re-training of the Sensitive Claims Unit staff should be considered around the pilot aims and processes. This would assist in improving the delivery of need assessment forms to Peer Reviewers, and developing a mechanism to check that the pilot has been notified of each new claim.

5. Improvements to the needs assessment and goal setting processes should be made.
   a. The Needs Assessment form should be updated to be more streamlined, simplified with repeated questions omitted.
   b. ACC should include a space for the caregivers to sign off the Needs Assessment and Achievement Summary forms.
c. More information and training about how to complete the Needs Assessment should be provided to Counsellors. This may include a pack of sample goals, which could be developed from a content analysis of goals achieved to date.

d. Consideration should be given to increasing the number of sessions available to complete the Needs Assessment form, allowing the Counsellors flexibility to establish rapport with the caregivers before filling out paperwork.

e. Peer Reviewers should have direct access to the child claimant’s goals, thereby improving the quality and timeliness of the reviews provided back to Counsellors.

6. Caregiver access to the Parenting Support Pilot Programme should be improved.
   a. Local availability of Counsellors should be increased.
   b. Consideration should be given to travel allowances, taking into account the combined transportation to counselling by the whole.
   c. Funding for childcare should be considered.
   d. Consideration should be given to controlling the cost of accessing the programme by fully funding sessions, thereby eliminating co-payments.
   e. Where there are two guardian parents living apart, both should be provided with access to parenting support sessions.
   f. Consideration should be given to extending the caregiver programme eligibility to include caregivers of intellectually handicapped adult claimants. The mental age of these claimants should be considered, even if their chronological age puts them outside the scope of this programme.
   g. Communications between ACC and caregivers should be user-friendly and sensitive to their needs to encourage utilisation of the Parenting Support Pilot Programme. Therefore when ringing the Sensitive Claims Unit, caregivers should be provided with a choice about whether to be taped for training purposes, rather than having to allow this.

7. ACC should consider how to contact the caregivers of teenagers, when teenagers have signed the ACC 45. One option would be to contact the teenage claimant directly, or alternatively, by asking the school Counsellor to contact the claimant.

8. Consideration should be given to increasing the number of sessions for caregivers who need them.
   a. A mechanism could be developed for applying for an additional allotment of session within normal time frames.
   b. Consideration should be given to making subsequent sessions available to provide for follow-up.

9. Consideration should be given to providing supplementary information to improve the quality of the support provided to caregivers.
   a. Supplementary information could be provided in the form of pamphlets, recommended books, and DVDs.
   b. Information could be provided to caregivers about complementary programmes such as support groups and help-lines, and caregivers should be informed about how to access counselling when needed for their own abuse history.
REFERENCES


References


