Cost Benefit Analysis Template

Section A Descriptive Information

Vote	Social Development
Responsible Minister	Hon Anne Tolley
Initiative title	Funding for specialist sexual violence services – first response services

Funding Sought ($m)	2016/17	2017/18	2018/19	2019/20 & outyears	TOTAL
Operating	9(2)(g)(i) Free and Frank				
Capital	-	-	-	-	-

Problem Definition

Thousands of people in New Zealand are sexually victimised every year

- 3,700 sexual assaults were reported to New Zealand Police in 2014
- The Treasury estimates that the total number of sexual assaults is at least five times the number reported[1]
- The rate of reported incidents of violence again women alone place New Zealand third among all countries, double the world average – over 16% of women in New Zealand report having been sexually victimised[2]
- 20% of females in New Zealand have experienced some form of sexual assault[3]

Women are the primary target of sexual violence

The cohort of victim/survivors of sexual violence is diverse. However, New Zealand research has shown that victim/survivors of sexual violence in New Zealand are more likely to be:

- Women
- Under the age of 29 ***(17-24 priority population)***
- Māori and/or Pasifika
- Special needs.[4]

First response services can support victim/survivors of sexual violence

First response psycho-social services support victim/survivors during the first 72 hours after a crisis event. They are highly responsive services that may include:

- Advice, referral, and advocacy
- Crisis social work
- Crisis counselling
- Accompaniment during medical treatment, the medical forensic process and Police interviews
- Guidance in the immediate aftermath of a crisis event to help victim/survivors to heal in the short run
- Connecting victim/survivors with services that help improve their long-term wellbeing.

First response psycho-social services are delivered by community-based NGOs.

These services are about to lose funding

In 2013 the Social Services Select Committee commissioned an inquiry into the funding of specialist sexual violence services. The inquiry identified that funding for many services was inadequate or non-existent.[5,6] In response to early

[1] The Treasury, (2003). 'Estimating the costs of crime in New Zealand 2003/04.'

[2] Abrahams, et al (2014). 'Worldwide prevalence of non-partner sexual violence: a systematic review.'

[3] Fanslow, J., & Robinson, E. (2004). 'Violence against women in New Zealand: prevalence and health consequences. The New Zealand Medical Journal 117(1206).'

[4] Ministry of Women's Affairs. (2009). 'Restoring soul: Effective interventions for adult victim/survivors of sexual violence.'

[5] MSD, (2013). 'Inquiry into the funding of specialist sexual violence social services: Initial briefing to the Social Services Select Committee.'

[6] MSD, (2014). 'Report on submissions to the Inquiry into the funding of specialist sexual violence services.'

findings from the Select Committee inquiry, Ministers provided two years of interim funding – $10.4m per year in 2014/15 at Budget 2014 and 2015/16 – to stabilise the specialist sexual violence services sector.

This funding is currently being used, in part, to provide first response services. The funding expires on 30 June 2016. A review of other baseline spending on these services under Vote Social Development indicates that, without the funding requested, central government funding for these services will effectively be eliminated.

In the absence of new funding, NGO providers will not be able to continue to provide first response services. Many victim/survivors will need to present directly to hospitals with Sexual Abuse Assessment and Treatment Services (SAATS) and/or Police, where personnel may not be specialised in supporting victim/survivors of sexual violence. It is likely that the formality of medical examination and/or Police interview – combined with a lack of personal support and advocacy – will disincentivise victim/survivors of sexual violence from seeking help. ***As a result, the thousands of victim/survivors of sexual violence every year will not receive the crisis support they need.***

Initiative Description

We have an opportunity to provide a highly effective first response services

Over the last two years, MSD and partner agencies have been undertaking work to scope the requirements of a highly effective first response system for New Zealand. A full service delivery model has been designed based on lessons learned from the Australian sexual violence services sector, and an understanding of what is needed here in New Zealand. This delivery model will ensure the long-term success and stability of first response services going forward.

This initiative will implement an effective first response service system

At its meeting on 16 September 2015, the Ministerial Group for Family and Sexual Violence acknowledged that additional funding was now required, and agreed to seek this funding through the Budget 2016 process. MSD seeks funding to implement the first response system it has designed over the next few years.

Relative to services provided under the interim funding arrangements, funding for the proposed future-state for first response services will fully enable NGOs to:

- Provide support for all victim/survivors in New Zealand
- Implement a national 24/7 helpline providing counselling, social work, and referral services
- Service a proportion of latent demand
- Deliver specialist counselling and social work services of adequate duration and intensity through appropriately specialised and trained staff, and multiple modes of communication, including social media, texting, and web-based services
- Cover overheads, including training and workforce development.

International evidence highlights both the benefits of effective first response services and the potential harm caused by poor first response. In particular, services delivered by professionals trained in dealing with victim/survivors of sexual violence:

- Avoid trauma – or 'secondary victimisation' – caused by ineffective first response
- Maximise the probability of delivering good outcomes for the victim/survivor over time.

The services will be coordinated with SAATS delivered through hospitals and Police services. Social workers will provide accurate and timely information to victim/survivors about other first response services, and will accompany them as required.

The first response services will directly support victim/survivors *and* enable them to access additional services

First-response services fulfil two functions – they provide effective crisis support in their own right, and they also act as a point of access to follow-up response and long-term recovery services. The elements of the sexual violence first response services are detailed below.

Service system entry pathways

Victim/survivors will be able to access community-based first response services by:

- Presenting in person to a specialist NGO
- Contacting an NGO directly via phone, text, web, or social media
- Calling the 24-hour national helpline
- Referral from Police, medical, educational, whānau, or community pathways.

Depending on the mix of services accessed by each victim/survivor, the proposed first response services may include:

- Call-out support
  - Advice (45 minutes)
  - Referral for further treatment (60 minutes)
- Helpline services
  - Advice (10 minutes)
  - Referral for further treatment (60 minutes).

First response services

Depending on the mix of services accessed by each victim/survivor, the proposed first response services may include:

- Call-out support
  - Crisis counselling and advocacy services (300 minutes)
  - Specialist counselling services (200 minutes)
  - Accompaniment to Medical Forensics (SAATs) (300 minutes)
  - Accompaniment to Police (240 minutes)
- Helpline services
  - Crisis counselling services (60 minutes).

Key features of the service system

- **Access, eligibility, and availability** – The services will be universal in that, regardless of age, gender, sexual orientation, special needs or ethnicity, a victim/survivor will have access to the full set of services. Services will be designed and contracted in order to be fully responsive to the needs of particular population groups (e.g. using therapeutic approaches based on Te Ao Māori, family-focused services). Services will be available 24 hours per day, seven days per week throughout New Zealand. Once fully implemented, the services are expected to support over 13,000 victim/survivors per year.

- **Service integration and referral** – Detailed service design will ensure smooth transitions between agencies and protect against secondary victimisation. Stronger relationships between agencies will promote awareness and use of the services available. In addition, improved coverage and experience with first response services will increase utilisation of long-term recovery services, including ACC's Integrated Services for Sensitive Claims (ISSC).

- **Professional, paid workforce** – A key feature of the proposed system design is a fully qualified work force. Staff will be given specialist training, professionally accredited, and appropriately remunerated.

- **Fully funded** – This initiative will provide full service funding. NGOs will not be required to top up funding received by MSD in order to deliver first response services.

- **Supporting infrastructure** – NGOs will be supported and enabled by a coherent policy framework and supporting infrastructure, including demand and coverage analysis, data collection and management, research and evaluation, shared good practice standards and a workforce development plan.

- **Implementation** – The proposed future state will be fully implemented by 2019/20, with services scaling up from roughly current levels in 2016/17 to full implementation over the forecast period. The implementation process is intended to include detailed co-design and consultation with service providers.

Alternative Options Considered

A low case has been prepared

While there is a strong case for investing in this initiative as outlined (the base case), we have also prepared a low case that provides many of the same service elements included in the base case at lower volumes.

Investing in the low case will impact the quality and level of services

The low case still provides for the full range of services and channels (including a 24-hour national helpline), however the service level and quality of services will be impacted. The key implications of the low case (when compared with the base case) are:

- **There will be shortages of services** – In the low case the services included in this initiative will meet existing demand, but they will not meet new demand. When fully operational, the low case will fund services for less than 11,000 victim/survivors (compared with more than 13,000 in the base case). Should the new service system have the desired effect of encouraging greater rates of reporting and help-seeking, the low case will not provide funding to cover any of this latent demand.

- **For victim/survivors that do receive services, they will receive less support** – Victim/survivors will benefit from accessing multiple services in a coordinated service system. The average number of first response service providers (including medical facilities, Police, specialist NGOs and the helpline) victim/survivors will access in the base case is assumed to be 2.3 per person. In the low case this drops to 1.8 per person.

- **The quality of services may suffer** – The low case does not include funding for the policy framework and infrastructure that will support the sector to coordinate, continuously improve, and develop its workforce.

The costs of the low case are compared with the base case in the table below:

Service type (real, undiscounted)	2016/17	2017/18	2018/19	2019/20 & outyears	TOTAL
Base case	9(2)(g)(i) Free and Frank				
Low case					

Section B Impact Analysis

Impact Analysis

Costs

A summary of the costs of this initiative (the base case) are outlined in the table below. They include service costs (the cost of payments made to NGOs for the services they provide), as well as the cost of implementation activities and supporting infrastructure for the sector.

Cost (real, undiscounted)	2016/17	2017/18	2018/19	2019/20 & outyears	TOTAL
Service costs	9(2)(g)(i) Free and Frank				
Implementation activities and supporting infrastructure*					
Total					

* Excludes activities that will be funded out of MSD baseline.

The service costs include the cost of social worker and counsellor FTEs and overheads incurred by NGO providers. The activities and supporting infrastructure costs include analyst and specialist consultant/contractor costs and including overheads.

Full details of the costs and underpinning assumptions are included as an appendix to the completed Budget Initiative Summary Template for this initiative.

Benefits

This initiative will:

- Directly reduce the severity and longevity of psycho-social and resulting socio-economic impacts of sexual violence by minimising harm in the crisis moment and shortening the duration of time without support
- Indirectly reduce the severity and longevity of psycho-social and resulting socio-economic impacts of sexual violence by increasing access to follow-up response and long-term recovery services which enable continued recovery.

The table below details these psycho-social and socio-economic impacts in more detail.

Psycho-social impacts of effective first response	
Direct, short-term impacts (within 72 hours)	**Indirect, long-term impacts**
- Improved safety: The victim/survivor will have a safety plan in place. - Improved support and reassurance: The service provides support to reduce perceived isolation for victim/survivors. For those who access medical treatment, the service provides reassurance around sexually transmitted diseases and physical health. - Learning self-help techniques: Victim/survivors have improved ability to cope, to self-regulate behaviours/ thoughts, and to normalise reactions to trauma. - Avoided secondary victimisation: The service provides a support system and advocate to prepare the victim/survivor for the justice and health aspects of the post-crisis process. This reduces clinical trauma. - For some victim/survivors, avoided secondary victimisation and support will reduce the severity and/or duration of symptoms arising from depression, anxiety and post-traumatic stress disorder (PTSD).	- Improved access to long-term support: Victim/survivors are referred to long-term response and psycho-social recovery services. - Reduced severity and/or duration of symptoms associated with depression, anxiety and post-traumatic stress disorder (PTSD). This improves quality of life and reduces probability of suicidality and propensity to self-harm. - Long-term resilience and self-regulation of thoughts and behaviours. - Improved knowledge and understanding of experience and the support available. - Reduced strain on family and other relationships, including divorce and family dysfunction and/or dissolution. - Reduced revictimisation through access to successful long-term psycho-social support.

Socio-economic impacts of effective first response	
Direct, short-term (within 72 hours)	**Indirect, long-term**
- Plans in place for missed work, childcare and accommodation: While work may still be missed, an advocate can assist the victim/survivor in positive communication will employers and childcare providers. - Better access to the services and practicalities required immediately, including housing/refuge, clothes, transport, and financial support.	- Victim/survivors are able to return to 'normality' earlier as a result of reduced severity and/or duration of symptoms associated with depression, anxiety and PTSD. This includes returning to work earlier and shorter time spent on welfare benefits. - Victim/survivors reintegrate into the community sooner, contribute and engage, resulting in increased social capital. - Victim/survivors are better able to resist and/or avoid reliance on drugs and alcohol, self-harm and/or gambling. - Victim/survivors may need less healthcare related support, including for mental illness. - Increased willingness and ability to seek and pursue justice.

An intervention logic map for this initiative is provided as Appendix 1. This has been used as the basis of the CBAx modelling described below.

Impact Summary Table

Impacts $m present value	Option/scenario Base case	 High case	Assumptions and evidence (quantify if possible, and use ranges where appropriate)	Certainty
Estimated impact on key outcomes				
Reduced severity and duration of depression and PTSD	15% of people are ***directly*** impacted and 2.25% are ***indirectly*** impacted. (15% accessing the long-term services and15% successful due to these services. 15%*15% =2.25%)	20% of people are ***directly*** impacted and 3% are ***indirectly*** impacted. (15% accessing the long-term services and 20% successful due to these services. 15%*20% =3%)	**Direct impact on depression and PTSD** We assume 15% of victim/survivors experience reduced severity and duration of depression and PTSD directly as a result of an effective, holistic, and connected first response service that helps avoid secondary victimisation. Evidence suggests that this effect could be as high as 18%-30%.[7] **Indirect impact on depression and PTSD** We assume that 15% of victim/survivors receive long-term response and recovery services that would not have accessed these services otherwise. These counselling services include but are not limited to cognitive behavioural therapy (prolonged imaginal exposure, in vivo exposure, and cognitive restructuring) and present-centred therapy. Studies estimate the effectiveness of these services in alleviating the symptoms of PTSD to be 13%-27.1% relative to control groups.[8,9,10] We assume that 15% of victim/survivors experience reduced severity and duration of depression and PTSD indirectly as a result of on-going counselling. **Commencement** We assume that any direct effects commence immediately and that referral to ISSC occurs during the first 72 hours. Research shows that around 14 weeks of counselling treatment is required to see results – we have rounded up to six months of ISSC counselling required to deliver indirect impacts.[11] **Duration** We attribute the positive impacts to the programme for four years for the victim/survivors who have reduced depression and PTSD. Research used shows no significant reductions in positive impacts over follow-up periods assessed.[12] The benefits of successful counselling services could last a lifetime but we have assumed that after four years a victim/survivor may require further treatment.	Medium

[7] Resnick, H., Acierno, R., Holmes, M., Kilpatrick, D. G., & Jager, N. (1999). 'Prevention of post-rape psychopathology: preliminary findings of a controlled acute rape treatment study.' *Journal of Anxiety Disorders*, 13(4), 359-370.

[8] Chard, (2005). 'An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse.' *Journal of Consulting and Clinical Psychology*, vol. 73, no. 5.

[9] McDonagh, et al., (2005). 'Randomised trial of Cognitive-Behavioural Therapy for chronic post-traumatic stress disorder in adult female survivors of childhood sexual abuse,' *Journal of Consulting and Clinical Psychology*, vol. 73, no. 5.

[10] Foa, et al., (2013). 'Prolonged exposure vs supportive counselling for sexual abuse–related PTSD in adolescent girls: a randomized clinical trial,' *Journal of the American Medical Association*, vol. 310, no. 24.

[11] McDonagh, et al., (2005). 'Randomised trial of Cognitive-Behavioural Therapy for chronic post-traumatic stress disorder in adult female survivors of childhood sexual abuse,' *Journal of Consulting and Clinical Psychology*, vol. 73, no. 5.

[12] Chard, (2005). 'An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse.' *Journal of Consulting and Clinical Psychology*, vol. 73, no. 5.

Cost of the Initiative				
Fiscal operating costs	9(2)(g)(i) Free and Frank		Costing figures have been developed in consultation with service providers and MSD within a rigorous costing model. Full details of the costs and underpinning assumptions are included as appendices to the completed Budget Initiative Summary Template for this initiative.	[redacted]
Government Benefits/(Costs)				
Increased PAYE received as a result of increased employment	3.0	4.0	Meta-analysis suggests that those with depression may be 20%-40% more likely to be unemployed than those without.[13] For conservatism, we will assume that, for the 15% of victim/survivors who suffer from less severe symptoms of depression and PTSD, 20% will be employed who otherwise would not have been employed. The PAYE component of the increase in annualised minimum wage is savings for the government.	[redacted]
Reduced welfare payments as a result of increased employment	37.1	49.5	Meta-analysis suggests that those with depression may be 20%-40% more likely to be unemployed than those without.[14] For conservatism, we will assume that, for the 15% of victim/survivors who suffer from less severe symptoms of depression and PTSD, 20% will be employed who otherwise would not have been employed. We assume that this 20% would have been on the Jobseeker Support benefit and that this cost is avoided as a result of the services.	Medium
Reduced outpatient hospital visits as a result of reduced depression and PTSD	35.5	47.3	Evidence indicates that depressed patients with PTSD visit an outpatient clinic six more times per year than those without PTSD.[15]	Medium
Increased utilisation of ACC sensitive claims services as a result of increased referrals	(16.0)	(16.0)	The 15% of victim/survivors who will be successfully referred to long-term response and recovery services will give rise to an average cost for ACC of $3,[illegible] per sensitive claim.[16] We would note that ISSC costs may include the cost of income support and direct financial assistance where the incident prevents the victim/survivor from working.	[redacted]
Total Quantified Government Impact	**59.6**	**84.8**		[redacted]
Wider Societal Benefits/(Costs)				
Increased private income from increased employment as a result of reduced depression and PTSD	16.2	21.6	Meta-analysis suggests that those with depression may be 20%-40% more likely to be unemployed than those without.[17] For conservatism, we will assume that, for the 15% of victim/survivors who suffer from less severe symptoms of depression and PTSD, 20% will be employed who otherwise would not have been employed. The component remaining after removing PAYE and the welfare benefits they would have received under the counterfactual is private income for the individual.	[redacted]

13 Lerner, D., & Henke, R. M. (2008). 'What does research tell us about depression, job performance, and work productivity?'. *Journal of Occupational and Environmental Medicine*, 50(4), 401-410.

14 Ibid.

15 Chan, P., Cheadle, A. D., Reiber, G., Unützer, J., & Chaney, E. F. (2009). 'Health care utilization and its costs for depressed veterans with and without comorbid PTSD symptoms.' *Psychiatric services*, 60(12), 1612-1617.

16 ACC (2014). 'Memo of indicative pricing for the Integrated Services for Sensitive Claims contract'.

17 Lerner, D., & Henke, R. M. (2008). 'What does research tell us about depression, job performance, and work productivity?'. *Journal of Occupational and Environmental Medicine*, 50(4), 401-410.

Reduced absenteeism as a result of reduced depression and PTSD	14.7	19.6	Those with depression are absent 0.3-3.8 days per month more than those without.[18] We assume one day per month of absent time is avoided, or roughly 5% of lost productivity in each working year. For the 60% of the age group that are employed, their employer is paying 4.8% more in wages than received in productive work. We assume minimum wage.	Medium
Increased quality of life as a result of reduced depression and PTSD	28.2	37.5	In New Zealand, 20-24 year olds with mental disorders lose 0.07815 in disability adjusted life years (DALY) each year as a result of their illness.[19] As this figure includes very severe mental illnesses, we have halved this figure and used 0.03905 DALYs avoided as a result of reduced depression and PTSD.	Medium
Reduced suicide risk as a result of reduced depression and PTSD	3.2	4.2	The suicide rate for the population of 20-24 year olds in NZ is 21.6 deaths per 100,000.[20] The rate for those with anxiety disorders is 267.7 deaths per 100,000.[21] We have halved the anxiety suicide rate and applied the benefit to those who have reduced depression and PTSD from long-term support and counselling (indirect)	Medium
Total Quantified Wider Societal Impact	**62.2**	**82.9**		Medium
Net Present Value of Total Quantified Societal Impacts	9(2)(g)(i) Free and Frank	[redacted]		Medium

18 Ibid.

19 Ministry of Health, 2013. 'New Zealand Burden of Diseases Statistical Annexe'. URL: http://www.health.govt.nz/publication/new-zealand-burden-diseases-statistical-annexe

20 Statistics NZ, 2011. 'New Zealand suicide statistics'. URL: http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/suicide.aspx

21 Khan, A., Leventhal, R. M., Khan, S., & Brown, W. A. (2002). 'Suicide risk in patients with anxiety disorders: a meta-analysis of the FDA database.' *Journal of affective disorders*, 68(2), 183-190.

Section C Conclusions

Conclusions

The research and analysis conducted suggests:

1. ***First response services protect and support some of the most vulnerable New Zealanders.*** The victim/survivors of sexual violence represent some of the most marginalised and vulnerable of the 17-24 year old priority population. Immediately following a crisis event, a victim/survivor is most susceptible to secondary victimisation by the services intended to support them. In the absence of high quality, specialised sexual violence first response services, it is likely that victim/survivors of sexual violence will be disincentivised from seeking the help and support they need in times of crisis. ***The results of a monetary CBA for first response services should be interpreted in light of the moral imperative to support this vulnerable population.***

2. ***The impact of first response services should be viewed through a broad societal lens.*** The proposed first response services will deliver significant positive changes in the lives of victim/survivors. Benefits associated with the reduced psycho-social and socio-economic impact of this trauma are private benefits for the victim/survivor, their families, and their employers. ***The societal ROI calculated here indicates that for every $1 spent by the Crown first response services, society will receive $3.91 worth of benefits in return.***

3. ***Investment in this initiative is sound from a government ROI perspective.*** Given the conservatism we have applied in our assumption-setting, we have a high level of confidence in the government ROI. The impact of first response services in improving employment outcomes and reducing healthcare utilisation by victim/survivors means ***the government will recoup its investment in this initiative – while realising the wider societal benefits described.***

Summary of monetised results

Use ranges for values where appropriate	Discount Rate	
	Base case - 8% real (default)	Base case - 4% real (sensitivity)
Net Present Value (NPV)	9(2)(g)(i) Free and frank	
Benefit Cost Ratio (BCR)		
Return on Investment (ROI) – Societal Total		
Return on Investment (ROI) – Government		

Supporting Evidence

Abrahams, et al., (2014). 'Worldwide prevalence of non-partner sexual violence: a systematic review.'

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Appendix 1: Intervention logic map for first response services