Summary

The aim of this study was to determine what type of psychosocial support is offered by Victim Support Netherlands (*Slachtofferhulp Nederland;* SHN) to victims of serious violent and sexual crimes (*Ernstige Geweld en Zedenzaken;* EGZ cases); together with any theories underlying its policy, and to investigate whether the support offered is in line with what is known in current scientific literature. We divided the research into a number of sub-studies, in which various methods were used: desk research; interviews with SHN employees; interviews with victims; a survey among former clients; and research in SHN's registration systems.

Policy theory

In 2013, the Ministry of Justice and Security published a policy vision on victims' guidelines, reflecting the social trend towards more attention for victims. Annually, 1 in 4 citizens becomes a victim of crime. Several societal changes have catalyzed government responsibilities for victimization to increase over the years. Women's emancipation and the associated attention to female victims, the general increase in crime, which has led to an increase in victimization, the individualization of society, in combination with an increasingly highly educated population, have led to higher expectations of citizens. Victims have been given higher, informed expectations and want to actively contribute to the criminal process. The increased attention for support and reintegration of convicts has also disproportionately widened the gap with victims. Research has shown that victims need 1) recognition and careful treatment (including information) 2) justice, 3) protection, 4) support and 5) compensation and damages. In addition, the government must also conform to international regulations and conventions, such as the European Victims Directive. Based on the above, the victim policy department of the Ministry of Justice and Security has drawn up five policy objectives. One of these is that victims who need it, receive support in overcoming the consequences of an offense (policy goal 4), which is examined in this report. A recent policy review on the strategy pursued by the Ministry from January 2014 to December 2019 (published in September 2021) states that support for victims is specialized into three categories: common crimes, high-impact crimes and serious violent - and sex crimes (EGZ)[1]. SHN is seen as an important partner organization in providing support for all

[1] Feedback from the supervisory committee stated that this division into the three categories was not determined by the ministry, but by one of the partner organizations.

three categories. SHN has created case managers specifically for surviving relatives of victims and complex EGZ cases (a case is referred to as complex if there are practical/financial, medical, psychosocial and legal problems). The other victims of serious crimes are assisted by unpaid employees. The TENTS guidelines (2008), as well as the Dutch Multidisciplinary Guideline for Psychosocial Help in Disasters and Crises (2014), the guideline Psychosocial Support after Major Events (NtVP, 2018) and Akwa GGZ Care Standard (2020) are also regulatory. Based on this, SHN are obliged to offer psychoeducation and stepped care with watchful waiting, while paying attention to self-reliance and resilience. The implicit theory behind this policy is that most victims will recover with the help of this psychosocial support (psycho-education, monitoring, watchful waiting) from SHN. A distinction is made between non-complex EGZ cases that can be supported by an unpaid employee with a few contacts, and complex EGZ cases that are supervised more intensively by a case manager. The small group of victims and victim's relatives who (are at risk of) develop(ing) long-term and/or complex complaints are not to be supported by SHN and are referred by SHN to specialist assistance.

Psychosocial support

SHN provides support with requests for practical, legal and psychosocial help. This research demonstrates in the affirmative that SHN provides psychosocial support in line with the guidelines and that it can be assumed that it contributes to the processing of a traumatic event. The role of SHN is to provide information about stress responses, what is typical in such circumstances and what to expect. If the stress responses persist for longer, and sufferers do not recover on their own, SHN has the role of referral.

In theory, support for EGZ victims has been endowed with case management (pilot phased in 2014 for homicide, common practice since 2017, and expanded to include serious traffic, violence and sex crimes). The current research indicates that case management is used only for complex EGZ cases, but that 90% of cases falling under the definition of EGZ are handled by unpaid employees. Case managers are deployed for complex EGZ cases; are available 24/7; and form a link between various partner organizations among the criminal justice chain. Both case managers and 'unpaid employees' work with principles such as watchful waiting and focus on normalizing, monitoring, and reducing stress responses. If symptoms do not decrease or worsen,

the standard policy is to refer the patient to the general practitioner (stepped care). To receive support from SHN, it is a condition that the client is a victim, close relative or next of kin (not an offender). For support in general, bystanders, passengers and others involved can also call on SHN. The latter also focuses (especially with online service providers) on formal and informal victim support.

The aim of the support is to allow clients to take back control of their own lives as quickly as possible. In principle, the offer of support is the same for both EGZ victims, within which, however, individualized support is offered. The same applies to victims and relatives of deceased victims: for example, support for surviving relatives initially involves arranging the funeral, but the focus is different when supporting victims.

On the basis of the data available to the researchers, it was neither possible to determine how often what type of assistance was provided on an annual basis, nor how often and when victims or relatives are referred on to further assistance.

In accordance with the design of the Dutch healthcare system, it appears that referrals are mainly made to the general practitioner, although case managers also sometimes give advice about therapy options.

SHN's mechanisms for providing support are evaluated internally and externally. Internally by means of intervision between employees and - specifically for case management - a final evaluation meeting between case manager and client. Incidentally, the results of these conversations are not registered. An external evaluation is carried out on behalf of the WODC, as was also the case for this study. The external evaluations concern research into referral (2008), case management (2013; 2016) and services in general, in the context of the victim monitor (2013; 2017).

Clients generally react (very) positively about the support, both in the past and based on the current survey, but there are also a number of dissatisfied respondents. There are victims who would like more support from SHN, such as a longer aftercare, specific referrals to lawyers, care

providers or agencies. Some victims simply have requests that cannot be met by SHN. Based on the data we were able to collect, we were unable to give an unequivocal answer about average satisfaction.

Scientific literature

First of all, literature shows that most people recover on their own after a major event and therefore do not need additional psychological support. Consequently, 'watchful waiting' will suffice and it is important, for example, to normalize emotions and to promote everyday circumstances that encourage recovery, such as social support. For those experiencing persistent psychological distress, referral to mental health support will be required.

In our search for scientifically proven effective psychosocial support for EGZ matters, only clinical interventions appeared. The assistance process *after* referral (for example, to mental health care) is no longer part of SHN's services. However, since it can nevertheless be useful for SHN to be aware of the most recent scientific expertise about psychosocial care for EGZ victims and surviving relatives, the literature review offers a relevant summary. According to the reviewed literature, cognitive behavioral therapy is effective in reducing psychological complaints after major events such as EGZ. This also applies to EMDR and exposure therapy. Trauma-oriented treatments appear to be more effective than non-trauma-oriented treatments. Psychoanalytic and psychodynamic treatments have not really shown such clear positive effects; these approaches are also being used less and less for the treatment of psycho trauma. Much scientific research has focused on victimization of sexual violence; however, there seems to be no reason to suspect that the findings on the effectiveness of treatment after trauma of sexual violence would not apply to treatment of other serious violent crimes. Most evidence is available for the effectiveness of treatments belonging to cognitive behavioral therapy; such treatments are also most researched to date.

Conclusion

All in all, SHN's means of support of providing information, normalization and watchful waiting is in line with the Dutch and European guidelines. Due attention is paid to the client's self-reliance and resilience, and referrals are made if treatment seems desirable, in line with the stepped care principle, in line with what is known about this from the literature and therefore

evidence-based. SHN's support contributes to reaching the policy objective of providing victims who need it with support in overcoming the consequences of an EGZ offence.

We recommend examining whether it would be possible to provide aftercare for some clients since some clients indicate that the service occasionally stops too abruptly. A moment of contact afterwards, also in the context of possible referral, seems desirable. Second, we note the absence of available standardized data for evaluation at SHN. There is structural intervision, but it is not registered. The internal registration system, which is intended for day-to-day operations and tracking work processes, provides too little information for evaluation. For evaluation purposes, another source such as a standard victim panel would be interesting. The third recommendation concerns referral. We were unable to get a good picture of the 'victim journey' taken by victims, which organizations they finally use after referral and whether any 'drop-out' occurs. A subsequent evaluation could conduct more focused research into this in order to gain a better understanding of this aspect.