Sexual Assault Support Service for Canterbury

Research to Inform Service Design

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Dr Lesley Campbell

ACKNOWLEDGMENTS

Sexual violence is a pervasive social problem and yet it is often described as one of the most hidden types of crimes. Within this context it might be assumed that there would be challenges in uncovering the critical ingredients for designing a sexual assault support service that has the potential to achieve positive outcomes for victims/survivors. Yet despite this assumption, this research has been informed by the incredibly generous and insightful contributions of numerous and varied empirical and experiential sources. For this I am grateful and indebted to all of these sources.

I would like to especially acknowledge those who contributed to this research, either through participating in an individual or group interview. The experiential wisdom you brought to this research and your willingness to share your well-considered views and advice has been critical to the assembly of the rich source of data with which to inform the design of a sexual assault support service for Canterbury. Your voices brought depth, authenticity and realism to this research endeavour. My thanks also to the agencies and their representatives who provided administrative data included in this report.

I would also like to extend my gratitude to the many researchers, evaluators and policy makers who, over many decades, have tirelessly explored the issue of and responses to sexual violence. Your efforts have provided an extensive empirical foundation upon which to draw for the purposes of this research. Most importantly I wish to acknowledge the published contributions made by those with lived experience of sexual violence. It is your voices that best illuminate 'what works' in the provision of services and supports for victims/survivors.

Finally I would like to thank Aviva, START and the Ministry of Social Development who provided me with the opportunity to conduct this research to inform the design of an evidence-based sexual assault support service for Canterbury.

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EXECUTIVE SUMMARY

Introduction and Background for the Research

Sexual violence is a serious public health and human rights issue. While there is a growing understanding of its prevalence and the short- and long-term negative psychosocial and economic impacts for individuals, families/whānau and communities, both in New Zealand and across international jurisdictions the focus of attention has shifted to defining intervention strategies that are effective for those affected by sexual violence and offer a return on investment.

The evidence suggests that an optimal, comprehensive and effective strategy for reducing and ultimately eliminating sexual violence should include interventions that are designed to target the individual-, interpersonal-, community- and societal-level factors that influence its occurrence. This targeted, four-level ecological model of interventions would enable risk factors to be modified and protective factors to be built and sustained.

In essence, a continuum of primary, secondary and tertiary prevention specialist sexual violence interventions and services would operate contemporaneously, with each level of intervention supporting the efforts of the others. Primary sexual violence prevention services are implemented before sexual violence occurs and aim to prevent victimisation. Secondary sexual violence prevention services include a range of responses that seek to prevent further harm and reduce re-offending. They are delivered in the immediate- and intermediate term following a sexual assault. Tertiary prevention services include long-term responses, such as counselling for victims/survivors and sex offender treatment programmes.

It is the domain of the secondary prevention specialist sexual violence services that is the focus of this research project – a service, for those who have acute and/or historic experiences of sexual violence, that is positioned to respond in the immediate and intermediate term following a traumatic event that resulted in help seeking by a victim/survivor and/or those in their natural ecology. Sexual assault

support services throughout the world are set up in many different ways, however their services will include some or all of the following elements: free 24/7 telephone and/or other information communication technology support services; face-to-face emotional and practical support, including support immediately following a sexual violence incident as well as follow-up and outreach support; group and peer support; information services; advocacy and accompaniment within police, health and court settings; brokerage and referral to other cross-agency and cross-discipline services; training and consultancy to other mainstream agencies; and community education programmes.

Research Objectives and Methodology

Until July 2014, secondary prevention specialist sexual assault services in Canterbury New Zealand were delivered by the Survivors of Sexual Violence Trust at the Monarch Centre. When this service closed, the Ministry of Social Development invited START in partnership with Aviva to deliver such services on an interim basis until decisions about more permanent contracting arrangements could be made.

It was within the context of these interim arrangements that START and Aviva commissioned an independent research project. The overall purpose of this research was to assemble an empirical and experiential evidence base to inform investment and operational decisions about the future design, development and implementation of an exemplary and sustainable sexual assault support service for Canterbury. The specific objectives of this research were:

- To review the literature and identify and describe an empirically-based framework with which to design a sexual assault support service that is sustainable and based on models and practices that have proven to make a difference for the target group and the communities of stakeholders with which the service intersects.
- To collect, collate and report the practice wisdom of professional stakeholders who are engaged in providing sexual assault support services or who deliver policies and programmes that interact with such sexual assault support services.

The research employed a 'proactive approach' that sought to surface the extent of the demand and need amongst the defined target client population for a sexual assault support service; synthesize what is known in the empirical and grey literature about models, approaches and practices associated with sexual assault support services that have potential to achieve maximum effects; and draw on the experiential wisdom of key national and local stakeholders within the sexual violence and other sectors to illuminate 'good practice' benchmarks of structure and practice associated with secondary prevention specialist sexual violence services.

The research project adopted a multiple methods approach in order to maximise the comprehensiveness of the qualitative and quantitative information collected to answer the research questions and address the research objectives. The principle research methods used included the synthesis of international and national literature (secondary data) and the operationalisation of a survey design through in-depth individual and group interviews (primary data).

Findings

Target Client Population for the Canterbury Sexual Assault Support Service: Size and Demographic and Social History Characteristics

Size

Estimating the size of the potential client target population of a sexual assault support service for Canterbury was challenging. There are two main reasons that explain the difficulty in estimating the demand for this service. First, the evidence suggests that for a variety of reasons many people do not disclose their experience of sexual violence. Second, estimates of service demand are to a large extent reliant on police data, data from survey research and administrative data from clinical settings and non-government organisations. The literature suggests that such data is not only fraught with data quality issues, but also only reflects a small proportion of the actual prevalence of sexual violence (for example, New Zealand research suggests that only 7% of sexual assaults are reported to the police). Moreover, international research shows that a good number of people may seek assistance from non-government specialist sexual violence services and/or other types of non-

government services whilst having no interaction with either criminal justice or health responses to sexual violence.

Canterbury-specific data sourced for this research and accessed via personal communication, indicated that there are between 300-350 reports of sexual assault to the police annually (reference to those received by the Canterbury District Police's Adult Sexual Assault Team), approximately half of which chose to receive forensic/medical services; between 625-635 sensitive claims were lodged with the Accident Compensation Corporation during 2014 – an estimated 19% of the prevalence of sexual violence in this region; and some 188 people interacted with the Sexual Assault Support Service Canterbury during the period July 2014 to May 2015.

Administrative data sourced from other specialist sexual assault support services in other New Zealand regions suggest that services of this nature could deliver between 500 and 1,300 telephone helpline interventions per annum; around 100 face-to-face support interventions at police interviews and/or forensic/medical examinations; and about 100 accompaniments through court processes.

While this historical information provides some guidance about the potential client demand for a sexual assault support service for Canterbury, both the qualitative data and trends within the administrative data suggest that increases in the demand for a sexual assault support service should be factored into out-year forecasts. For example, New Zealand-wide police data show steady year-on-year increases in reported sexual violence between 2010 and 2014. The Accident Compensation Corporation expects an increase in the numbers of sensitive claims lodged, following the introduction of the Integrated Services for Sensitive Claims service delivery model late in 2014 and based on the part-year number of claims lodged in the first part of 2015. International studies have shown that following natural disasters there is an increase in people's vulnerability to violence, including sexual violence and child abuse. Moreover, once primary prevention strategies take effect by raising awareness about sexual violence and helping options, and promotional activities undertaken by the local service are intensified, the number of self-referrals to a

sexual assault support service may also influence an increase in demand for this service.

Demographic and Social History Characteristics

While the literature acknowledges that sexual violence is experienced by women and men of every age and across the continuum of socio-economic backgrounds, research into the risk factors (particularly the individual and relationship risk factors) for victimisation of sexual violence provides some guidance about the probable demographic and social history characteristics of the client target group for this sexual assault support service. The international and national evidence suggests that there are higher levels of sexual violence among women compared to men; Māori compared to Non-Māori; among younger people, with Pacific young people noted in New Zealand research; among those with low education; among those who have experienced child maltreatment; among those with mental health issues; and among those with substance abuse issues.

Moreover, those presenting for service are more likely to have experienced sexual violence with a known party; and may have had either a recent of historic experience of sexual violence.

The members of the victim/survivor's informal support network are also pertinent to considerations about the potential client group. There is mounting evidence to suggest that the impacts of sexual violence can be ameliorated by the responses of family and friends if they are provided with information about the effects of sexual violence and supported to offer appropriate help to the victim/survivor. Moreover, some studies have found that the victim/survivor's informal network can experience secondary victimisation (that is, traumatised by the knowledge of the sexual violence) and without appropriate support this may negatively impact on intimate partner and/or the parent/child relationships.

Recommendation 1:

Use existing administrative data and trends and empirical data to map the demand and characteristics of the target client group to inform current and out-year supply and demand planning, including human resource and financial planning

Enhancing Access and Service Responsiveness

There is recognition across international jurisdictions that equity of access to sexual violence services is a human rights issue.

Yet studies shows that there are a range of barriers to help seeking for victims/survivors – barriers that deny people support and service opportunities with which to minimise the detrimental effects of sexual violence and recover.

Personal-level barriers identified in the literature include lack of understanding of the legal definitions of sexual violence and/or not regarding the incident as significant enough to report to the police; feelings of shame and embarrassment; regarding it as a private matter and wanting to deal with it themselves; fear of disbelief; feelings of self-blame and/or fear of blame or judgement by others; distrust of the police, courts and/or the legal process; fear of informal networks and the public knowing and being labelled as a crime victim; fear of retaliation by the perpetrator; fear of the statutory repercussions for family members, in particular children being taken into the care of child protection services; language and communication issues; and not knowing how to access helping services.

In addition to these personal-level barriers, the literature notes a number of system-level barriers including lack of services in some communities; lack of service visibility; services questioning the credibility of victims/survivors from some population sub-groups; inadequate training for professionals on identifying sexual violence and ways in which to enable victims/survivors to access appropriate services; and poor coordination across sectors and disciplines that deny victims/survivors access to health, education, housing and other social services needed to meet their often complex array of presenting needs.

In addition, the literature has identified a range of hard-to-reach groups (those working in the sex industry; those with disabilities; young people; men; those identifying as lesbian, gay, bisexual or transgender; elders; those in institutional settings; people from culturally and linguistically diverse communities; Māori; Pacific Peoples; those with mental health issues; and those with substance abuse issues) – many of whom face a range of barriers to access the support of a specialist sexual violence service.

While the literature offers many suggested strategies for enhancing access to, and the responsiveness of, sexual assault support services for victims/survivors, purposeful collaboration; inclusive communication and promotion; and outreach were noted as strategies that had the greatest potential to be impactful.

Purposeful Collaboration

The empirical and experiential evidence suggests that the design of a sexual assault support service should be grounded in a collaborative paradigm – a paradigm that recognises the 'no-wrong-door' principle; that facilitates a seamless pathway and referral process to a range of services designed to meet the complex array of presenting needs of victims/survivors; that is mandated within contractual arrangements with funding bodies; and that includes a continuum of purposeful joint actions across sectors and services, and at varying levels of intensity.

This continuum of collaboration would include three levels of joint working – collaboration; cooperation and coordination. The sexual assault support service would ideally prioritise joint working with agencies that engage intensively with victims/survivors (for example, government and non-government agencies within the specialist sexual violence sector, including medical and criminal justice sector professionals that deliver primary, secondary and tertiary prevention specialist sexual violence services and those that deliver such services to Māori, children and young people and men). This joint-working arrangement would require the development and implementation of formal service-level agreements.

At the next level of joint working, cooperative arrangements would be formalised through memorandum of understanding with providers of specialist services for hard-

to-reach groups (for example, culturally and linguistically diverse communities; elders; those with disabilities; street workers' collective; lesbian, gay, bisexual, transgender community). Such arrangements could involve the exchange of expert consultancy services and/or joint working with victims/survivors.

At the coordination end of the continuum, agencies would engage periodically to exchange service-related information to ensure that passed to victims/survivors was accurate and current. Studies have found that operationalising this collaborative paradigm enhances client outcomes and increases practitioner skills, knowledge and job satisfaction.

Inclusive Communication

The evidence suggests that when specialist sexual violence services develop 'recognition and confidence' messages within their promotional materials, access is enhanced for victims/survivors. Such messages could include using people-first language; graphics and stories that reflect a broad range of experiences of sexual violence and backgrounds; clarity about the service's mission, location and hours of operation; assurance of privacy and confidentiality; and availability of trained interpreters when required.

Outreach and Community Engagement

The findings suggest that outreach and engagement strategies enhance access and responsiveness for victims/survivors. Particular strategies noted in the findings include delivering cross-agency training that assists practitioners across sectors and disciplines to recognise the signs of sexual violence experiences, to increase their confidence to routinely use screening questions for sexual violence, and to increase their understanding of pathways to specialist sexual violence services. In addition, outreach and engagement can involve delivering education programmes that dispel myths about sexual violence and promote help seeking amongst sub groups in the community; wide distribution of promotional materials; and engagement with the media.

Information Communication Technologies

The findings indicate that a specialist sexual assault support service should maximise its use of a variety of information and communication technologies to enhance access. In particular, good practice standards suggest that the service include free 24/7 telephone access. More recently a number of jurisdictions have implemented online interventions such as person-to-person, real-time practitioner support – an intervention that recent evaluations have shown increases people's confidence about disclosing experiences of sexual violence; overcomes geographical barriers, such as those experienced by people living in rural areas; and enhances people's ongoing engagement with support services.

Recommendation 2: Develop and implement a 'collaboration plan' that includes purposeful and evidence-based strategies for collaboration, cooperation and coordination

Recommendation 3: Include person-first language and diverse graphics and stories in all promotional materials

Recommendation 4: Integrate a range of information, communication technologies into the service

Recommendation 5: Implement a range of outreach strategies including cross-sector and cross-discipline training and community education

Key Elements, Approaches and Principles of a Sexual Assault Support Service

Overall there is considerable consensus across the empirical literature, the experiential sources and advice from victims/survivors about the core elements of a sexual assault support service. These core elements include:

- Free 24/7 telephone and/or other information communication technology support services
- Face-to-face emotional and practical support immediately following a sexual assault incident as well as follow-up and outreach support. In the immediate and

intermediate term such support appears to take the form of brief intervention; and provide on-going engagement whilst the victim/survivor waits for long-term counselling. Some studies reported that victims/survivors found that their emotional and practical needs were met by a sexual assault support service regardless of whether they accessed any other type of service.

- Information services – information about forensic/medical, police and court processes; information about how to enhance their feelings of safety and security; information about victim-support funds; information about what to expect following a sexual assault; information about their rights; and information about how to access other services
- Advocacy (both specific and general) and accompaniment within police, forensic/medical and court settings
- Brokerage and referral to other cross-sector and cross-discipline services
- Training and consultancy to other main-steam agencies.

There is some support in the findings for a sexual assault support service to deliver support within group settings. Group interventions described in the literature include self-help groups; drop-in discussion groups; and crisis-orientated and survivor support groups. These types of interventions are believed to reduce isolation; furnish mutual support; and create a place where victims experience empathy, acceptance and encouragement.

Within the context of these identified key elements of a sexual assault support service, the findings strongly endorse the use of two practice approaches – psychological first aid and crisis intervention. Commentators offer several observations about these practice approaches. First, there is some overlap between the two approaches, for example the first three stages in the crisis intervention model align with those in psychological first aid. Second, crisis intervention delivered in the context of a sexual violence service needs to take account of the fact that the impact of such experiences can last for many years and therefore trigger responses at any time – an observation that supports the contention that this approach is suitable for those who present for service with experiences of either acute or historic sexual

violence. Third, the evidence suggests that these approaches are an appropriate response immediately following presentation for service as well as up to three months following this first presentation – a finding that supports the positioning of a sexual assault support service as an immediate and intermediate response to sexual violence and as a bridging service to long-term counselling.

The findings suggest that both the key elements of a sexual assault support service and the associated evidence-based practices need to be underpinned by a number of key operating principles. These principles require the service to be trauma informed, that is all aspects of the management and delivery of the service are based on victim/survivors' experiences and perceptions – perceptions of safety, trust, choice and control, collaboration, empowerment and cultural relevance. Moreover, such services need to be couched as gender responsive (that is, recognise issues of equality, human rights and feminism); delivered in a client-centred manner; and be designed and implemented with reference to a range of empirical and experiential knowledge and skill.

Recommendation 6: Implement all elements of a sexual assault support service as identified in international standards

Recommendation 7: Train workforce in psychological first aid and crisis intervention practice approaches

Recommendation 8: Examine all aspects of the sexual assault support service, its infrastructure and management to ensure the trauma-informed, gender responsive, client-centred and evidence-based principles are evidenced in all policies and procedures and carried out in practice

Infrastructure Requirements to Support an Effective Sexual Assault Support Service

The findings indicate that there are a range of considerations related to the infrastructure required to deliver an effective sexual assault support service. These included:

- Structural options
- Cross-sector and inter-agency coordination
- Workforce considerations
- Sustainability success factors including shared ownership; funding; sustained workforce; policies and procedures; responsiveness to the external environment; and demonstrating results.

Structural Options

Across the empirical and experiential sources of evidence, there was much debate about the pros and cons of the various options for structuring a sexual assault support service – options such as housing the sexual assault support service within a family violence agency or within a large organisation such as a hospital, or as part of a multi-sector team, or within a stand-alone non-government specialist sexual violence agency. In essence these debates have centred on resourcing matters, accessibility and responsiveness, and the comprehensiveness of the services for victims/survivors. While there are no studies undertaken to date to compare the comparative effectiveness of the various options for housing a sexual assault support service, on balance there is the most support for housing it within a stand-alone non-government agency that delivers the full range of primary, secondary and tertiary prevention services. The evidence suggests that under this arrangement, the service would attract an adequate budget; facilitate greater inclusiveness and accessibility for victims/survivors; referral agents and the community would be more aware of the existence of the service; be more likely to operate a client-centred, survivor-driven service; be immersed in an environment which fosters expert specialised knowledge and skill; and provide a full complement of specialist sexual

violence services which would enable a seamless transition for the victim/survivor from the sexual assault support service to long-term counselling.

The literature suggests that housing a sexual assault support service within the context of a multi-disciplinary team comprising health and criminal justice professionals has a number of advantages, for example, access to a range of services in one place. However, other advantages noted in the literature were at odds with the experiential evidence offered by the informants. For example, while the literature states that this structure more effectively balances the needs of the victim/survivor with those of the health and criminal justice sectors, some of the respondents' experiences suggested otherwise.

Likewise there was disagreement between some of the respondent's views and that presented in the literature regarding the option of housing a sexual assault support service within a family violence agency. On the one hand, the literature suggested that under this arrangement, the sexual assault support service would attract less financial support and have less visibility and fewer referrals. On the other hand some commentators in the literature argue that sexual violence and family violence services have more commonalities (mission and goal alignment; easy access for clients experiencing other types of family violence as well as intimate partner sexual violence), than differences (each type of service requires a unique set of specialist knowledge and skills). Moreover, they argued that as long as the budget, management and promotion of the two services were separated this is a feasible arrangement.

There was little support for the remaining options – housed within a large organisation, such as a hospital; or located within a hub of social service agencies.

Recommendation 9: Develop a long-term strategy for housing the sexual assault support service within a specialist sexual violence agency from the NGO Sector.

Optimising Cross-Sector and Inter-Agency Coordination

The findings suggest that there are a range of benefits from coordinating service across sectors and agencies. Identified benefits are avoiding systems working at cross purposes; avoiding duplication of effort; facilitating referrals; increasing awareness of multiple services' needs and goals; enhanced access to a range of services for clients; improved access for hard-to-reach groups; and improved rates of prosecuting cases of sexual violence.

The evidence suggests that such benefits can be realised by implementing a range of business support practices including the use of memorandum of understanding; cross-agency and cross-discipline training; joint work with victims/survivors; and conducting system-wide assessments of need and efficacy of joint effort.

Workforce Considerations

Both the empirical and experiential evidence suggests there are mixed views about whether the employees recruited to deliver a sexual assault support service should hold professional qualifications. On the one hand some argue that qualified professionals are essential to working with the complexities and vulnerabilities of the target client group. Moreover, they provide assurance of the quality of the service, for example they are subject to a professional code of ethics. In addition, those holding this position are of the view that a sexual assault support service workforce should be paid rather than voluntary – the rationale for this position being that there is a high turnover among the voluntary workforce and little return on investment.

On the other hand, others argue that the use of unqualified, but well-trained individuals is aligned with the philosophy of mutual aid; and that the work is mainly providing support, not a therapeutic intervention.

The findings indicate that there is more agreement across the evidence about the experience of those employed to deliver a sexual assault support service. In general the evidence suggests that it advantageous for workers to have life experience as long as they have grown and learned from such experiences. Moreover, on the matter of 'lived experience' the evidence suggests that caution is needed to ensure these individuals are well advanced on their recovery journey and they have

personal and professional strategies to effectively manage the issues of triggering, vicarious trauma and stress.

The literature provides guidance on the skills, knowledge and attributes required for a sexual assault support service workforce. For example, the literature suggests that new recruits receive a minimum of thirty hours training; and that this workforce is provided with facilities to debrief, attend clinical supervision and participate in ongoing professional development.

While the empirical literature does not appear to provide any guidance on the structure of a sexual assault support team, the advice from many of the respondents was to employ workers on a full-time basis and roster them on shifts to undertake the after-hours on-call work. They argued that the current system (whereby volunteers were responsible for the after-hours crisis response whilst qualified employees worked during business hours), was less than satisfactory. For example, victims/survivors were denied the opportunity to build a trusting professional relationship with one person. Rather they may see one worker at the point of crisis and another worker for follow-up support. In addition, the fluctuating and unpredictable nature of crisis work often resulted in volunteers having lengthy periods of time without work – a factor that resulted in the loss of practice expertise. In addition, there was some evidence that indicated that because of the isolated nature of the work outside office hours, there was a greater risk of experiencing vicarious trauma and stress and a greater risk of delivering services of inconsistent quality.

Recommendation 10: Provide a programme of professional support and professional development that includes at least 30 hours of induction training; access to an on-site clinical supervisor for debriefing and receipt of professional supervision; and schedule on-going (at least monthly) training

Recommendation 11: Conduct a feasibility study to explore the option of shifting from a combined volunteer/paid workforce to a qualified full-time workforce that was responsible for all aspects of delivering a sexual assault support service

Success Factors for Sustainability

The evidence suggests that sustainability – safeguarding current and future success – is dependent upon a number of factors, and such factors need to be factored into the design and on-going life of the sexual assault support service. While the findings identified a number of success factors for sustainability, those regarded as most significant included:

- ***Shared stakeholder ownership***: The service is owned, supported and championed by internal and external stakeholders. This is achieved by involving them in all aspects of the design, implementation and evaluation of the service.
- ***Funding***: The service develops a fund-development plan that identifies multiple and diverse sources of funding; methods for securing full-cost recovery; and strategies for engaging funding bodies. In addition, the evidence suggests that the budget needs to be driven by the service's mission and tied to outcomes.
- ***Sustained workforce***: The evidence suggests that the workforce for a sexual assault support service is a critical mediating factor for the achievement of outcomes. Moreover, the findings suggest that in order to ensure they are effective and maintain their commitment to the work the organisation must employ competent, motivated people with a 'helping personality' and provide a supportive workplace environment including the provision of on-going professional development opportunities.
- ***Policies and procedures***: Strong management through the development and implementation of robust policies and procedures has also shown to be a mark of sustainability.
- ***Responsive to the external environment***: Service sustainability has been linked to the host organisation's ability to be adaptive and respond to the changing socio-political factors in the external environment and the changing needs of the community in which the service is located.
- ***Demonstrating results***: A critical success factor for service sustainability is demonstrating results. This was regarded as particularly pertinent in the current environment in which funders are increasingly looking to purchase services that

are based on the best available evidence. During service design, stakeholders should clearly define the service's goals and draw on research and experiential knowledge to describe the way in which the inputs and activities of the proposed service contribute to the outcomes sought for victims/survivors. Such articulation of outcomes sought and the service elements that contribute to those results, facilitates service designers to build a monitoring framework for collecting and collating pertinent data for reporting purposes.

Recommendation 12: Develop a fund-development plan

Recommendation 13: Develop policies and procedures that are 'trauma informed;' and comply with regulatory requirements and contract specifications

Recommendation 14: Develop a programme theory model and performance monitoring framework to guide the collection of outcome data for reporting purposes

Securing a Return on Investment

Evidence from New Zealand and international sources show that in order to make a significant impact on the problem of sexual violence, an evidence-based, integrated, cross-sector portfolio of primary, secondary and tertiary prevention specialist sexual violence services needs to be designed and implemented. A sexual assault support service is one of the responses in this portfolio – a critical service that provides the 'front door' for victims/survivors who seek assistance on their journey to recovery following an experience of sexual violence. It is a secondary prevention strategy that is positioned as an immediate and intermediate response following a sexual violence crisis experience. It is a service that recognises that the needs of victims/survivors are diverse and may change over time as the person moves in and out of help seeking. It is a victim/survivor-focused intervention that includes a diverse array of service elements.

Worldwide, the financial and social costs of sexual violence to society are acknowledged. In New Zealand the annual cost of sexual violence in 2012 was $1.8

billion. Reportedly, it is the most expensive crime per incident and there are both public costs (including those borne by the criminal justice and health sectors) and private costs (loss of earnings; loss of quality of life; pain and suffering; medical costs; and counselling costs).

The evidence suggests that there are several reasons for investing in a sexual assault support service. These reasons include:

- ***Contribution to New Zealand's mandate to meet international obligations and Government priorities:*** There is a strategic fit between investing in a specialist sexual assault support service and a range of Government policies (Better Public Services; Children's Action Plan; Youth Crime Action Plan; Investing in Services for Outcomes; Community Investment Strategy). Moreover, there are a range of international resolutions and conventions of which New Zealand is a signatory – resolutions and conventions that provide the mandate for this country to address sexual violence in a systematic way, including the purchase of specialist sexual violence services.
- ***Cost savings:*** The findings demonstrate that investing in appropriate and effective sexual violence interventions mitigates the costs and consequences of sexual violence. There is evidence from the United States of a reduction in the societal costs of sexual violence following the implementation of the Women against Violence Act which included a mandate to fund and deliver sexual violence services. Moreover, in the United Kingdom investing in specialist sexual violence services showed a social return on investment.
- ***Improved outcomes:*** The value proposition of a specialist sexual assault support service is that it achieves results. The research consistently demonstrates that sexual assault support services facilitate improvements in victim/survivors' psychological functioning; increases access to health and criminal justice services; improves criminal justice outcomes; and contributes to the prevention of long-term health and mental health problems for victims/survivors.

In sum, the findings from this research demonstrate that an evidence-based sexual assault support service offers investors a return on investment as well as significant

benefits for individuals, families/whānau and communities affected by sexual violence.

PART ONE: INTRODUCTION AND CONTEXT

1. Introduction

In 2010 Dame Vivien Stern wrote:

> *"Rape is a serious and deeply damaging crime. It is unique in the way it strikes at the bodily integrity and self respect of the victim, in the demands it makes on those public authorities required to respond to it and in the controversy it creates ... Women, men, children and people of all ages and societal groups can become rape victims"* (Stern, 2010:7).

Regardless of whether sexual violence occurs in the context of an intimate partnership, within the larger family/whānau or community structure, or during times of conflict, it is a deeply violating and painful experience for the victim/survivor. Moreover, the consequences of sexual violence not only impact on the health and wellbeing of individuals, but also have short- and long-term impacts for families/whānau, communities and society (Morrison, Quadra & Boyd, 2007; Ellsberg, 2006; United Nations Development Fund for Women, 2002).

The prevalence of sexual violence in New Zealand is a serious public health and human rights issue for this country. For example, a 2014 study that compared the prevalence of sexual violence in fifty-six countries placed New Zealand third highest with a rate of 16.4% of women – a rate that was more than double the world average (Abrahams, Devries, Watts, Pallitto, Petzold, Shamu & Garcia-Moreno, 2014). In a 2011 progress report prepared by the United Nations Women New Zealand, this country came twelfth out of twelve Organisations for Economic Cooperation and Development (OECD) countries with 14% of New Zealand women having experienced sexual violence from an intimate partner (UN Women New Zealand, 2011). Concern about New Zealand's continued high, and increasing, levels of violence against women has been expressed by the Committee on the Elimination of Discrimination against Women. [1] Amongst the recommendations in this Committee's

[1] There are a number of international legal instruments that relate to responses that seek to address sexual violence including: the Convention on the Rights of the Child (1989) and its Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography (2000); the Convention Against Transnational Organised

2012 report was an appeal to "provide adequate assistance and protection for women victims of violence, including Māori and migrant women, by ensuring they receive the necessary legal and psychosocial services" (Committee on the Elimination of Discrimination against Women, New Zealand, 2012:6). [2] In line with this recommendation are the observations offered by the two caucuses of New Zealand's national collective of sexual violence organisations and providers, Te Ohaakii a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST). In 2009 they recognised the significant contribution that the provision of specialist services and supports could make to assist victims/survivors to heal from the trauma of sexual violence.

> Ngā Kaitiaki Mauri wrote: *"Utilising holistic concepts of health, a key objective is the restoration of mana to individuals and their whānau. This recognises that sexual violation has a critical impact on whānau health and wellbeing (whānau ora) and without appropriate support people may be affected for the rest of their lives."*
>
> The Tauiwi caucus wrote: "*Sexual violence events are frequently traumatic and can have long-lasting effects ... Some victims/survivors wait many years before seeking support, and the nature of ongoing trauma requires longer-*

Crime (2000) and its supplemental Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (2000); the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (1984); and the Convention on the Elimination of All forms of Discrimination Against Women (1979) (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). New Zealand ratified the 1979 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) in 1985; and ratified the 1999 Optional Protocol of CEDAW in 2000. This ratification requires countries party to this Convention to take appropriate steps to end violence, including sexual violence.

[22] Other recommendations offered by the Committee included: take necessary measures to encourage the reporting of domestic and sexual violence cases, including ensuring the education of professionals, health-care providers and social workers and that they are familiar with relevant legal provisions and are sensitised to all forms of violence against women and are capable of complying with the obligation to report cases; and strengthening the training for the police, public prosecutors, the judiciary and other relevant government bodies on domestic and sexual violence.

term recovery and support services to help ensure their needs are met" (Taskforce for Action on Sexual Violence, 2009:114).

While there is a growing understanding in the literature about the impact of sexual violence, Garcia-Moreno and Watts (2011) and others (WHO, 2005a; Lalor, 2004) state that services for victims/survivors remain inadequate. Moreover, the World Health Organisation (2004) observed that there is a need to strengthen the quality of existing services that support people who are affected by sexual violence. For example commentators have called for more evidence about the effectiveness of interventions; increased effort to integrate what is known into existing services to increase their likelihood of success; and for evaluation to be integrated into new services to monitor and improve their impact (Loots, Dartnall & Jewkes, 2011; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010).

2. New Zealand Context

Within the context of this growing understanding of the prevalence and impact of sexual violence and the support for evidence-based strategies to address this public health issue, the New Zealand policy environment has, over recent years, increasingly prioritised sexual violence as a key area of focus. This prioritisation is reflected in the strategic and policy efforts of:

- Taskforce for Action on Sexual Violence
- Cross-government review of the specialist Sexual Violence Sector [3]
- Social Services Select Committee into the Funding of Specialist Sexual Violence Social Services
- Accident Compensation Corporation's Integrated Services for Sensitive Claims

[3] The cross-government Review defines the specialist Sexual Violence Sector as having services that: 'have a sole, or predominant focus on delivering psychosocial and/or medical support to survivors of sexual violence; provide assistance to victims at the point of crisis (noting that crisis might not occur immediately following the assault); have a sole, or predominant focus on preventing sexual violence from occurring; have a sole, or predominant focus on delivering treatment to perpetrators of sexual violence; and have staff with the necessary specialist knowledge and skills relating to sexual violence to deliver quality professional services' (Ministry of Social Development, October 2013).

- Law Commission's investigation into improved support for victims/survivors of sexual violence through court processes
- Budget 2014: Additional funding for specialist sexual violence services
- Ministry of Social Development's Community Investment Strategy and its contribution to the Government's Better Public Services; Youth Crime Action Plan; and the Children's Action Plan.

2.1 Taskforce for Action on Sexual Violence: Specialist Sexual Violence Crisis Response

In 2007 a Taskforce for Action on Sexual Violence (the Taskforce) was established for a two-year period to develop advice for the New Zealand Government on effective strategies to prevent and respond to sexual violence. Throughout the period 2007 to 2009 the Taskforce, in collaboration with TOAH-NNEST, focused on six priority areas: prevention; early intervention and crisis response; recovery and support services for victims/survivors; treatment and services for those who perpetrate sexual violence; the effectiveness of criminal justice responses to sexual offending; and the responsiveness of the justice system to victims/survivors.

The Taskforce's work on early intervention and crisis response and recovery and support services for victims/survivors included a Ngā Kaitiaki Mauri stocktake of existing services; [4] a Tauiwi stocktake of existing services; [5] the development of

[4] The Nga Kaitiaki Mauri stocktake found that tangata whenua models of health provide a template for practice, but services are likely to adapt this template to suit local whānau/hapu/iwi preferences; that tangata whenua models of health place whānau at the centre of the healing process, although the focus may be individual; and issues identified by providers included funding, population diversity, workforce development and coordination of services (Hamilton-Katene, S., 2009).

[5] The Tauiwi stocktake found that there was a lack of access to services in some areas; that there were few services for male victims/survivors; that there were waiting lists for counselling services; that there were barriers to access to services; that there was a need for effective tripartite relationships among the police, health and specialist crisis support sexual violence services; staff and funding shortages; and gaps in meeting the needs of Pacific communities (TOAH-NNEST Tau Iwi Caucus, 2009).

'good practice' guidelines for mainstream crisis support services – round 1; [6] and a project that identified improvements to existing Accident Compensation Corporation services. In their December 2009 'Te Toiora Mata Tauherenga – Report of the Taskforce for Action on Sexual Violence' (the Report), the Taskforce noted the criticality of effectively investing in front-line immediate- and long-term services for victims/survivors (as well as services for non-mandated perpetrators of sexual violence), in particular noting that only seventy percent of New Zealanders had access to 24/7 specialist sexual violence crisis support services and the need to enhance the capability of the Sexual Violence Sector workforce (Taskforce for Action on Sexual Violence, 2009:96). Of the seventy-one recommendations in the Taskforce's Report, thirty-four related to the enhancement of frontline services. For crisis support services, recommendations included: a review of funding arrangements that support collaborative approaches; immediate funding for workforce training and development and service coordination; funding for kaupapa Māori services; and the development of an implementation plan and services for Pacific peoples.

2.2 Specialist Sexual Violence Sector Review and Inquiry into the Funding of Specialist Sexual Violence Social Services [7]

Early in 2013 the Minister for Social Development agreed to take on the ministerial responsibility for sexual violence sector portfolio in New Zealand. This was the first time that this responsibility was held by one minister. Previously responsibility for

[6] McPhillips, K. (14 December 2009) Mainstream Crisis Support Services Responding to Sexual Violence Perpetrated Against Adults: Good Practice Project - Round 1 (Report to the Ministry of Social Development Taskforce for Action on Sexual Violence: 14 December 2009).

[7] The New Zealand Ministry of Women's Affairs (2009) state that "*specialist sexual violence services predominantly provide services for victims/survivors. They encompass two broad categories:*

- *Crisis support services provide emergency psychosocial support or practical and emotional assistance in the period immediately after a sexual assault. Services are provided by phone, face-to-face and include support at police interviews and medical examinations*
- *Support and recovery services provide on-going and long-term support such as therapeutic and advocacy services for both recent and historical assaults. Crisis can be triggered well beyond the immediate post-rape period and are likely to be dealt with by support and recovery services*
- *Sexual violence prevention programmes"* (Ministry of Women's Affairs, 2009:44; Mossman, S.E., MacGibbon, L., Kingi, V., and Jordan, J. (2009: 138).

the sexual violence sector portfolio had been split across a number of Government Ministers (Justice; Health; Police; Accident Compensation Corporation; Ministry for Social Development). The Social Development Minister initiated a review of the specialist sexual violence sector – a review thought sought to investigate the efficiency of funding provision; what drives demand for services; and service duplication and gaps in the sector. There were seven areas identified for this review: prevention; preventing re-victimisation; ensuring short-term sector stability; quality services; easy access to support; addressing harmful sexual behaviour; and supporting informal helpers (Ministry of Social Development, October 2013). The outcome of this review was to develop a comprehensive, sustainable long-term plan for the Sexual Violence Sector. [8]

In August 2013 the Social Services Select Committee (the Committee) initiated an inquiry into the funding for specialist sexual violence services. The terms of reference for this inquiry included:

- To review the state of specialist services and determine whether they reflect an integrated approach to service delivery, full coverage, and best practice

- To review the specialist services, including those for Māori and other diverse communities, and assess whether they are accessible, culturally appropriate, and sustainable (Social Services Select Committee, 21 August 2013).

The Committee invited the public to offer submissions on the inquiry. The main themes identified within the 997 submissions received by the Committee included:

- *"There is a lack of stable funding for specialist sexual violence social services—all the submissions said that services are under-funded and are struggling to meet demand*

[8] From August 2013, the Senior Officials Group that was undertaking the work for the Review of the Specialist Sexual Violence Sector shifted its focus to support the Inquiry into the Funding of Specialist Sexual Violence Social Services.

- *Many services are relying on unpaid work and volunteers to support service delivery, and this is not sustainable in the long term*

- *There are significant barriers to services for some groups, and culturally responsive services are not always available*

- *Coverage of services varies across the country, resulting in gaps in service*

- *More emphasis is needed on preventing sexual violence*
- *Funding arrangements are disjointed and ad hoc, and an overarching comprehensive strategy is needed to guide the Government in purchasing services*

- *Funding limitations at times mean organisations are not always able to deliver on their commitment to be client-focussed, holistic, wrap-around, and family- or whānau-friendly, as per the sector's standards for best practice*

- *The impact on staff working in the sector under difficult conditions*

- *The high costs of sexual violence to individuals, families, and communities"* (Social Services Select Committee, 2014).

The continuance of the inquiry and recommendations for addressing these identified issues was deferred to the select committee of the 51st Parliament. In the meantime, a number of initiatives have been implemented that are expected to make a contribution to addressing some of the issues identified by the inquiry.

2.3 Specialist Sexual Violence Services: Strategies for 2014/2015 and Beyond

During 2014/2015 a number of new Government and other initiatives were established to address sexual violence within New Zealand. These included:

Accident Compensation Corporation (ACC) Integrated Services for Sensitive Claims: In November 2014 ACC launched a new integrated and client-centred strategy for action on sexual violence – a strategy that seeks to bring together a range of prevention, crisis- and long-term response and recovery services (Accident Compensation Corporation, 06 October 2014).

In response to the recommendations of an independent review of the Sensitive Claims Clinical Pathway, ACC has changed the way in which it manages sensitive claims and redesigned the services available to those who have experienced sexual violence (Sensitive Claims Review Panel, September 2010). For example the sensitive claims system was redesigned to be more flexible and take into account the sensitivity, length of time and cost of addressing the trauma of sexual violence; through its new contracting arrangements, all core services (support, assessment, treatment) are offered by the same service provider in order to simplify the client journey to wellbeing; a range of services are available and tailored to suit clients' individual needs and preferences (for example, clients may select from one-to-one counselling, family/whānau sessions, cultural support, and/or group therapy) and provide support to family/whānau and support people during the recovery process; fund access to forty-eight therapy sessions over twelve months; following treatment clients can access up to four sessions per year for three years to align with the wellbeing focus of the strategy; and services are fully funded so clients do not have to make contributory payments. ACC expects a ten percent increase in sensitive claims per year until 2020 as awareness of sexual violence increases and the stigma of reporting is increasingly reduced (Accident Compensation Corporation, 02 March 2015; Social Services Select Committee, 2014).

Better Support for Victims of Sexual Violence through Court Processes: In 2007 the New Zealand Law Commission completed a report entitled 'Disclosure to Court of Defendant's Previous Convictions, Similar Offending and Bad Character (Law Commission, November 2007). Of relevance here is the report's recommendation that an inquiry should be initiated into whether the present adversarial trial process should be changed, particularly for cases that involved

sexual violence. After completing a preliminary review of pre-trial and trail processes for criminal offending in 2012, the project was put on hold.

In late 2014 New Zealand's Justice Minister requested the Law Commission to resume work on proposals for better supporting victims/survivors of sexual violence through court processes. [9] In support of this work and the Government's reforms for the Sexual Violence Sector the Evidence Amendment Bill was introduced to the house in May 2015 and the first reading was passed in early July 2015. The Bill seeks to make participating in court processes less traumatic for child and adult victims/survivors of sexual violence by introducing a range of changes including: improved court processes for child witnesses; enhanced court processes for complainants in sexual violence cases; and introducing safeguards for video recording evidence for vulnerable witnesses (Retrieved from: http://beehive.govt.nz/release/bill-better-support-sexual-violence-victims-underway).

Additional Funding for Specialist Sexual Violence Services: A 2013 briefing paper to the Minister for Social Development stated that in 2012/2013 government agencies paid $29.07 million to non-government sexual violence organisations for services for victims/survivors and perpetrators of sexual violence. These services included: medical and forensic services; crisis response; counselling; social work support; enabling access to the criminal justice system; treating those with harmful sexual behaviour; and sexual violence prevention services. In addition, ACC provided funding of $33.6 million for financial, treatment and rehabilitation supports

[9] The Terms of Reference for project include: Commission undertakes a high-level review of pre-trial and trial processes in criminal cases. In particular, it considers whether the adversary framework within which those processes operate should be modified or fundamentally changed in order to improve the system's fairness, effectiveness and efficiency.
The Commission includes within its review an examination of inquisitorial models and considers whether all or any part of such models would be suitable for incorporation into the New Zealand system. The Commission puts particular emphasis upon the extent to which a new framework and/or new processes should be developed to deal with sex offence cases. However, it also considers the desirability of alternative approaches in other categories of cases, such as those involving child victims, child witnesses and family violence, and considers the extent to which the system needs to be modified more generally (Retrieved from: http://www.lawcom.govt.nz/our-projects/alternative-models-prosecuting-and-trying-criminal-cases).

for sensitive claims clients in 2012/2013. In 2014 the Government announced additional and new funding of $10.4 million over the 2014/2015 and 2015/2016 years. This funding was allocated through Vote Health and was to be administered by the Ministry of Social Development. The purpose of this additional funding was to provide immediate stabilisation for frontline crisis-response services, and fund community-based treatment services for those presenting with harmful sexual behaviour, services for male victims/survivors and support services for people accessing medical and forensic services. This later resource was intended to provide an interim solution whilst cross-sector work on a long-term strategy for the Sexual Violence Sector was completed (Ministry of Social Development, 2013; Social Services Select Committee, 2014).

In relation to the distribution of this new funding for the provision of specialist sexual violence crisis response services for victims/survivors, the Ministry of Social Development issued a request for proposal in January 2015 inviting interested and existing specialised sexual violence service providers to submit applications to fund identified service gaps. This request for proposal identified certain types of sexual violence acute crisis response services including:

- Helpline/Online: A service for people affected by sexual violence that provides information, crisis advice and referrals to other services by means of telephone, internet and other communication technologies
- Callout Support: A service for victims of sexual violence that provides support for the person throughout any treatment and other processes immediately following an event. Support may include counselling and legal and medical advice and advocacy.
- Crisis counselling: A service for victims of sexual violence that provides face-to-face or remote counselling during and/or following a crisis. It is provided until ACC or other longer-term counselling arrangements are in place (Ministry of Social Development, 2015). [10]

[10] Source: Ministry of Social Development (January 2015) *Sexual Violence Crisis Response Services for Current Gaps in Service. Request for Proposal.* Reference: MSD 2015.037.

Ministry of Social Development's Community Investment Strategy: In June 2015 the Ministry of Social Development released its Community Investment Strategy (the Strategy). The Strategy identified three priority result areas including:

- Supporting vulnerable children and children in hardship and reducing maltreatment [11]
- Supporting vulnerable young people, including youth offenders, and reducing youth crime
- Supporting adult victims/survivors, addressing perpetrators' behaviour, and reducing violent crime (Ministry of Social Development, 2015:7).

These result areas aim to contribute to the Government's Better Public Services targets and integrate with the work being implemented by the Children's Action Plan, the Youth Crime Action Plan and the results of the family violence and sexual violence Ministerial work programme as they are completed. Moreover, the Strategy emphasises the need for evidence-based decision making and action; and measurement to assess results for the 'most vulnerable' and to guide continuous improvement.

Relevant to the current focus of this report is the Strategy's emphasis on family violence and sexual violence interventions – a focus which is described as the Ministry of Social Development's contribution to achieving the Better Public Service targets of reducing crime and reoffending. [12] The Strategy describes the types of services it plans to fund in order to achieve desired outcomes for victims/survivors of sexual violence (and family violence) and prevent offending and/or reoffending of those who perpetrate such violence. These services (and the funding allocated) include those that:

[11] In the second volume of the White Paper for Vulnerable Children, child maltreatment is defined as encompassing "a range of acts, omissions and inadequacies of parents and caregivers that cause avoidable harm to their children including .... sexual abuse" (White Paper for Vulnerable Children: Volume 11:32).

[12] See the State Services Commission's website for a full explanation of these Better Public Service targets (http://www.ssc.govt.nz/bps-reducing-crime#result7).

- "*Respond to crisis, to support the recovery of victims/survivors and provide services for perpetrators ($37.9 M)*
- *Deliver harmful sexual behaviour reduction programme, home visits to families with an intimate partner violence component and other intensive services to young people ($6M)*
- *Deliver early intervention services, including relationship services ($3.2M)*
- *Build awareness of sexual violence and how to prevent it, as well as social change and education programmes to prevent family violence, and reduce elder abuse and neglect, which can occur in a range of settings including families ($9.9M)"* (Ministry of Social Development, June 2015:20).

While the Ministry of Social Development recognises that "there is a cross over between family violence and sexual violence" (that is sexual violence against children and adults can occur within the context of family violence), that organisation also acknowledges that "the nature, dynamics and impacts of (sexual) violence is very different" and therefore in the immediate future "they will be regarded as distinct issues until the risks and benefits of closely aligning them have been examined, particularly in terms of service delivery" (Ministry of Social Development, 2015:20-21). This examination is one aspect of the work to develop a whole-of-government, integrated strategic direction for family violence and sexual violence for the future.

3. Canterbury Specialist Sexual Violence Sector Services

3.1 An Overview of the Formal Support System for Victims/Survivors [13]

In New Zealand the formal support system for victims/survivors of sexual violence includes services funded and delivered by government and non-government agencies (Ministry of Women's Affairs, 2009). In 2015 TOAH-NNEST, together with

[13] This section is focused on services for victims/survivors of sexual violence. However, within the Canterbury region STOP is also identified as a specialist sexual violence provider of services for those who perpetrate sexual violence. STOP provides community-based assessment and intervention services for adolescents and adults who have engaged in harmful sexual behaviour and for children who have engaged in concerning sexual behaviour. STOP also provides training and consultation to government and community professionals (Retrieved from: http://rpe.co.nz/find-a-sexual-assault-support-centre-near-you/#Canterbury).

the Ministry of Social Development, developed and agreed a list of New Zealand non-government organisations that were designated as specialist sexual violence service providers that offered acute crisis response and on-going support services for victims/survivors of sexual violence. TOAH-NNEST defined specialist sexual assault support services as:

> "... *a non-government organisation that provides services with a sole or primary focus on delivering psycho-social support to people affected by sexual violence"* (TOAH-NNEST, January 2015).

TOAH-NNEST identified three non-government organisations in Canterbury that provided such specialist sexual violence support services:

- *START*: This agency is described as a specialist non-government agency social service that has significant experience in the field of sexual assault recovery work with child, youth and adult victims of sexual crime. It offers specialist and professional sexual assault counselling; family works services and support to whānau alongside victim counselling; consultation regarding sexual assault issues to members of both the general and professional community; and educational workshops regarding concerns of sexual assault to members of the professional and general community (Retrieved from: http://www.starthealing.org/aboutus.html).

- *Male Survivors of Sexual Abuse Trust*: A support agency for male victims/survivors of childhood sexual abuse, providing telephone support, one-to-one peer support, weekly support group, and support for parents, partners and caregivers (Retrieved from: http://mherc.org.nz/directory/all-listings-alphabetical/male-survivors-of-sexual-abuse-trust).

- *Te Puna Oranga*: A Kaupapa Māori service provider delivering services from a Māori worldview/Te Ao Māori and committed to tautokouwhanau oranga through the process of holistic healing. The agency provides a range of services including Māori sexual abuse counselling/healing; abuse/prevention education; Māori youth and whānau advocacy services; and whānau trauma line (Retrieved from: http://www.familyservices.govt.nz/directory/viewprovider.htm?id=862&back=searc

hprovideralphabetical.htm?letter=t&providerId and http://www.linkage.co.nz/provider/1280/te-puna-oranga-inc).

Together with the services provided for victims/survivors by specialist sexual violence non-government services in Canterbury, the Cambridge Clinic (DSAC Canterbury Ltd) provides medical/forensic services for male and female adults, adolescents and children in this region and the West Coast who have been sexually assaulted whether recently or in the past (Retrieved from: http://2cu.co.nz/canterbury/listings/101254-cambridge-clinic-dsac-canterbury-ltd). In New Zealand Sexual Abuse Assessment and Treatment Services (SAATS), such as the Cambridge Clinic, are jointly funded by the Ministry of Health, the New Zealand Police and the Accident Compensation Corporation (ACC) through contracts with the local District Health Boards or individual providers and managed by ACC as the lead funder (Mossman et al., 2009). Under these contracts SAATS are required to provide a range of services for victims of suspected or alleged sexual violence or assault including: expert medical treatment; early identification; manage immediate emotional and physical trauma; address immediate safety of victims; and ensure forensic and medico-legal requirements are met (Retrieved from: http://www.acc.co.nz/for-providers/contracts-and-performance/all-contracts/PRD_CTRB131885). These services are carried out by medical practitioners who have received training from Doctors for Sexual Abuse Care (DSAC) or are DSAC accredited.

As in many other regions across New Zealand, the Canterbury Sexual Abuse Assessment and Treatment Service, the crisis support provided by the specialist sexual violence service provider and the police have developed a cooperative relationship referred to as the tripartite response. This tripartite response is operationalised by a local tripartite agreement that outlines the relationships and responsibilities of the three parties.

For their part in providing support for adult sexual violence complainants, the New Zealand Police provide victim safety and offender accountability support facilities.

These are safe facilities provided by the Police for receiving, examining and interviewing complainants and ensuring investigations are carried out according to the Adult Sexual Assault Investigation Guidelines (Retrieved from: http://www.oag.govt.nz/2015/police-conduct/part2.htm).[14] In Canterbury these investigations are undertaken by a specialist Adult Sexual Assault Team.

In addition to the Adult Sexual Assault Team, the Police also have a specialist team of staff (the Child Abuse Unit) who work with Child Youth and Family (CYF), members of the Canterbury District Health Board's (CDHB) Child and Family Safety Service [15] and other specialist sexual violence services to provide a prompt response to cases of serious child abuse (for example, sexual abuse; physical abuse; serious family violence where a child is a witness). The Child Protection Protocol between the New Zealand Police and Child Youth and Family (2013) describes the roles and responsibilities of these two parties following reports of concern about serious child abuse (Retrieved from: http://www.cyf.govt.nz/documents/working-with-others/final-child-protection-protocol.pdf).

[14] In 2007 the Commission of Inquiry into Police Conduct (the Commission) released its report. In response to the recommendations in the Commission's report the New Zealand Police put in place a comprehensive work programme. The recommendations included: monitor and conduct an independent assessment of sexual assault investigations to ensure they comply with the Adult Sexual Assault Investigations Guidelines; ensure sexual assault complainants are kept informed during Police investigations of their complaints; and implement adult sexual assault investigation training courses (that aim to raise awareness about sexual violence; change attitudes towards sexual violence complainants and complaints and ensure these are dealt with in an effective manner) for all Police staff and ongoing skills development. The Office of the Auditor General has conducted three audits (2009; 2010; 2012) to assess the degree to which the New Zealand Police's work programme has been implemented (Office of the Auditor General, 2009, 2010, 2012).

[15] The Child and Family Safety Service is a multidisciplinary team comprising a Child Protection Coordinator; a Child Protection Worker; paediatrician; and administration staff who work within inpatient and community settings. This service's role includes: providing guidance to Canterbury District Health Board (CDHB) staff on child protection matters; receiving referrals from CDHB staff where there are care and protection issues; receiving referrals from CYF and the Police for paediatric medical assessments where there are concerns of abuse and neglect; providing education and training for CDHB staff and other professionals in child protection; and supporting collaborative interagency practices between Health, CYF, Police and the Cambridge Clinic (Retrieved from: https://www.cdhb.health.nz/Hospitals-Services/Child-Health/Documents/Child%20Protection%20Service%20(CPS).pdf).

3.2 Sexual Assault Support Service in Canterbury: Events of 2014/2015

Canterbury's government and non-government system of specialist sexual violence services for victims/survivors includes a sexual assault support service. For twenty-two years the Survivors of Sexual Violence Trust at the Monarch Centre provided various kinds of support for victims/survivors of sexual violence. These services included: counselling; support groups; individual and family/whānau support; and an acute service known as SafeCare. [16] On 04 July 2014 SafeCare, a 24-hour crisis response service for victims of rape and sexual assault in Canterbury, was wound up when the Monarch Centre (the agency that delivered the service) closed. In a media release, the chairperson of the Survivors of Sexual Violence Trust Board explained the reasons for the closure of this service:

> *"The Board of Trustees of the Survivors of Sexual Violence Trust at the Monarch Centre have made the very difficult decision to close our services because we could not access ongoing funding. We did not meet MSD criteria for funding in that we did not have ongoing funding to be solvent"* (Retrieved from: http://www.healthychristchurch.org.nz/news/signatory-notice-board/2014/7/closure-of-survivors-of-sexual-violence-trust).

Between 05 and 19 July 2014 arrangements were made for Victim Support to provide support for victims/survivors of sexual violence whilst the Ministry of Social Development (MSD) negotiated a more permanent arrangement for the provision of a sexual assault support service in Canterbury. These negotiations began with an approach to START, who in turn invited Aviva to work in partnership with them to deliver the service between July 2014 and July 2015.

[16] The Monarch Centre provided the following description of the agency's core business: "The Monarch Centre provides support and healing for those affected by sexual crime whether rape, sexual assault or long term sexual abuse. This may be recent or historic abuse. We provide counselling and support to enable victims to become survivors. This support is safe, confidential, and individual to clients needs, however diverse. Most clients are able to be financially assisted by either ACC or Work and Income. We also support parents, care givers, partners and whānau of children who have been sexually abused. Group healing is often the most appropriate process for our clients and we provide both ACC Group support and non ACC Support Groups. Our acute service, SafeCare, is available 24/7. Through our crisis line 364 8791 we provide Crisis Support workers who assist victims through medical examination and police statement. The Monarch Centre is the trading name of The Sexual Abuse Survivors Trust, a not-for-profit organisation working in the community since 1992" (Retrieved from: http://.iglobal.co/new-zealand/addington/monarch-centre).

Known as the Sexual Assault Support Service Canterbury (SASSC), the service is hosted and managed by Aviva whilst START provides specialist sexual assault consults for clients as well as providing clinical guidance and supervision for the service's workforce. The Sexual Assault Support Service Canterbury provides a 24/7 information and support line; support, information and advocacy services for people during forensic examinations, interviews with the Police and/or during court processes; support and information services for family/whānau and friends; and, brokerage, referral and safety planning services. The service is provided by a coordinator and a team of volunteers.

PART TWO: RESEARCH METHODOLOGY

4. Research Methodology

4.1 Research Purpose and Key Questions

Within the context of the interim nature of the twelve-month contract with the Ministry of Social Development to deliver the Sexual Assault Support Service Canterbury to July 2015, Aviva and START commissioned an independent research project. The overall purpose of the research was to assemble an empirical and experiential evidence base to inform investment and operational decisions about the future design, development and implementation of an exemplary and sustainable sexual assault support service for Canterbury. In essence this purpose is instrumental and utilisation focused – a purpose that positions the research to produce information that is useful for the intended users and supports their decisions and actions (Henry & Mark, 2003; Patton, 2008). [17]

The key questions associated with this purpose and identified by those who commissioned the research are listed in Table 1.

[17] Ramirez and Brodhead (2013) and Patton (2012) offer research and evaluation frameworks for optimising the participatory nature of such endeavours that are intended to enhance use by the intended users. Such participation includes engaging the intended users in framing the research purpose, questions and methods. Within the context of this research, a consultation meeting was held in December 2014 (as well as additional meetings during the early part of 2015) with those who commissioned the research and those involved in the management and implementation of the Sexual Assault Support Service Canterbury. These early engagements provided the opportunity to frame the research questions; identify the principles underpinning the research; and identify the key research respondents.

Table 1: Key Research Questions

Key Research Questions
• Q1: What is the extent and nature of the diverse needs amongst the defined target population for an exemplary sexual assault support service? • Q2: What are the demographic and social history characteristics of the defined target population for an exemplary sexual assault support service? • Q3: What are the barriers to accessing an exemplary sexual assault support service for the defined target population and how can these barriers be overcome? • Q4: What are the key components of an exemplary sexual assault support model of service that is designed and delivered to be effective for multiple and diverse user groups and those providing support within clients/tangata whai ora natural relationship and family/whānau systems? • Q5: What research-proven practices and approaches can be applied to the investment, design and delivery of an effective model of service for the Sexual Assault Support Service Canterbury and other New Zealand sexual violence crisis response services? • Q6: What are the infrastructure requirements required to support an exemplary sexual assault support model of service?

- Q7: In what ways would an exemplary sexual assault support service effectively contribute to the New Zealand response system and continuum of sexual violence services?

- Q8: In what ways would an exemplary sexual assault support service effectively interface with cross-sector services and cross discipline professionals to offer a client/tangata whai ora-centred and seamless pathway of service and supports for the target population?

- Q9: What are the political, economic, social and legal costs of the investment in an exemplary and sustainable sexual assault support service for Canterbury and other New Zealand regions?

- Q10: What are the political, economic, social and legal costs of not investing in an exemplary and sustainable sexual assault support service for Canterbury and other New Zealand regions?

4.2 Research Objectives

The specific objectives of this research were:

- To review the literature and identify and describe an empirically-based framework with which to design a sexual assault support service that is sustainable and based on models and practices that have proven to make a difference for the target group and the communities of stakeholders with which the service intersects.
- To collect, collate and report the practice wisdom of professional stakeholders who are engaged in providing sexual assault support services or who deliver policies and programmes that interact with such sexual assault support services.

4.3 Proactive Research Approach

In order to meet the purpose and objectives of this research project, a 'proactive research approach has been employed. Owen (2001:231) argues that a 'proactive

research approach' is ideally suited to situations where evidence is required to synthesise a service innovation, for example in situations where no programme exists or where stakeholders wish to introduce radical changes to an existing programme informed by the 'best and most appropriate evidence.' This 'proactive research' is concerned with:

- The extent of the demand for and the nature of the need amongst the defined target population for a sexual assault support service. Owen (2001) observes that an assessment of the potential demand for service, together with information about available resources, is fundamental to decisions made by policy, purchase-of-service contracting and service delivery agencies. [18]

- Synthesizing what is known in the existing research and grey literature about models, approaches and practices associated with sexual assault support services that have the potential to achieve maximum effects. Head (2008:6) notes that "these forms of knowledge primarily comprise works of professionals trained in systematic approaches to gathering and analysing information."

- Reviewing ways in which sexual assault support interventions in other jurisdictions and locations have responded to the needs of the identified target population; as well as examining the ways in which other services and professionals in the pertinent community of policy and practice connect with and influence the intervention under examination (Head, 2008; Owen, 2001; Wenger, 1998).

In order to operationalise this proactive research approach and develop the empirical and experiential evidence base to support investment, development and implementation decisions and actions for the sexual assault support service for Canterbury this research has adopted three key lenses with which to collect the

[18] Owen (2001:232) comments that demand and resource information provides a more 'analytic and rational approach' to resource-allocation decisions made within restricted fiscal environments. For example, such information enables decision makers to "determine priorities in geographic areas, among client groups and across areas of support; train and allocate staff appropriately; and, locate services and facilities to achieve maximum effect."

required information. The lenses through which this information was collected included:

- *Assessment of demand and need*: A description of the prevalence, impacts and needs of the target population for a sexual assault support service enabled through the collection, collation and analysis of administrative data and dated sourced from key respondent interviews

- *Research synthesis*: This involved a focused review of the international and national literature, including journal articles, books, grey literature and official publications and statistics. This analysis of the literature provided comprehensive background information for understanding the current knowledge about various elements of sexual assault support services and provided the basis for comparing and contrasting the findings from the qualitative data collected from the key respondent interviews. Moreover, this examination of the literature continued throughout the qualitative research process as key respondents introduced new concepts and questions during the in-depth interviews (Creswell, 2009).

- *Practical implementation knowledge*: This involved drawing on the experiential wisdom of key stakeholders working within the sexual violence sector to surface, through an inductive approach, 'good practice' benchmarks of structure and practice associated with implementing sexual assault support services. [19] This qualitative experiential knowledge was collected via in-depth interviews with identified key respondents who brought a diverse range of perspectives to the research – for example, perspectives from policy managers, programme delivery managers, programme delivery professionals and para-professionals and those whose cross-sector services may intersect with a sexual assault support service (Pawson, Boaz, Grayson, Long & Barnes, 2003).

4.4 Research Design and Procedure

[19] Wenger (1998) maintains that managers and professionals are communities of learning and provide the source for information about best and effective practices – practices that frequently become codified within standards and guidelines.

The research study adopted a multiple methods approach in order to maximise the comprehensiveness of the information collected to answer the research questions. The principle research methods used included:

- The synthesis of the pertinent international and national literature (secondary data)
- The operationalisation of a survey design through in-depth face-to-face individual and group interviews and in-depth individual telephone interviews (primary data).

Green and Caracelli (1997a, 1997b) and others (Green, Benjamin & Goodyear, 2001; Sieber, 1998) maintain that the combination of different methods provides a way to gain several layers of understanding about the subject of the research and a strategy to clarify the results of the research – an approach that introduces complementarity to the collection and collation of the data. Moreover, that a mixed methods design enables both methods triangulation (using different methods) as well as data triangulation (using different sources of data, for example collecting data from people with different perspectives on the subject of the research) – an approach that enables an analysis of the convergence and/or cross validation of the findings to enhance credibility (Denzin, 1978; Greene, Caracelli & Graham, 1989; Yauch & Steudel, 2003).

4.4.1 Synthesis of the Research Literature: Overview and Procedure

Overview

The overall aim of the systematic review of the literature on sexual assault support services was to gather, analyse and summarize the existing body of completed and published works produced by researchers, scholars and practitioners (Fink, 2005; The Campbell Collaboration, 2001). Pertinent research and information was collected from a variety of sources including articles, books, theses, government publications, conference papers and official statistics. The research and information derived from these different sources were designed for different purposes and different processes were used to collect, collate and disseminate the information. In

this context, the analysis of the literature involved harnessing them together as usefully as possible.

Procedure

Two literature searches were conducted during the review period utilising electronic databases and a set of search terms. The initial literature search was conducted in February 2015. A second search was conducted in April and May 2015 to enable the inclusion of concepts and topics raised by the respondents during the in-depth interviews. Research literature and information was sourced from a multi-search database link that included a range of electronic bibliographic databases including ERIC, PubMed, EBSCO, Web of Science and CSA. In addition to the databases, the internet was searched using the Google Scholar and Google Books search engines for additional 'grey' literature.

Search terms were selected on the basis of a range of inclusion criteria that were established to focus the review of the literature on secondary prevention sexual assault support interventions. These inclusion criteria included:

- Literature published in English between 1990 and 2015 – criterion selected to ensure the literature reflected the most recent knowledge in the sexual violence field of study

- Publications and data that were included in peer-reviewed and professional journals, books, dissertations, government reports and official and administrative statistics

- Publications that referenced sexual assault support services and/or secondary prevention sexual assault interventions and the target population for these

programmes (including those that described the target population's demographic and social history characteristics) [20]

Search terms used for this literature review included: 'sexual assault support services;' 'secondary sexual assault prevention;' 'sexual assault victims/survivors demographics;' 'sexual assault victims/survivors social history characteristics;' sexual assault services' evaluations;' 'effectiveness of sexual assault services;' 'barriers to sexual assault services;' 'prevalence of sexual assault;' 'effects of sexual assault;' 'best practice sexual assault services;' 'sexual assault victims/survivors help seeking;' 'evidence-based sexual assault support services;' 'designing sexual assault support services;' and, 'sexual assault support services collaboration/partnerships.' In order to gain better control over the literature searching process, Boolean operators (AND, OR, or NOT) were used. For example, various combinations of words, such as 'sexual assault and trauma' were used to isolate the search around particular areas of interest.

Analysis of the data within the body of the literature about sexual assault support services involved describing and summarising the information within selected categories and areas of interest associated with the research questions. In particular, the categories focused on topics of interest associated with the target population and pertinent elements of sexual assault support service responses that were evidence-based and sustainable.

4.4.2 Key Respondent Face-to-Face and Telephone Interviews: Overview and Procedure

Overview

[20] Morrison, Hardison, Mathew & O'Neil (2004) note a number of limitations associated with using 'inclusion criteria' for focusing literature reviews. These limitations include reducing the scope of the documents sourced. For example, including a criterion for only English-language publications is likely to result in a review of fewer publications with a limited perspective. In addition, they observe that publications on a similar topic are often difficult to compare because different interventions have different inner workings, use different outcomes that have been measured in different ways over different time periods.

In juxtaposition with the findings from the review of the literature, key respondent in-depth interviews were undertaken to collect the primary, qualitative data used to answer the research questions. Grinnell and Unrau (2014:446) state that in-depth interviewing is the 'best survey design.' Moreover, Boyce and Neil (2006) contend that interviewing is useful when the research is focused on exploring innovations or new ideas in depth and when the investigation requires a local context in addition to other data sources such as the findings from a literature review. Such conditions apply to the 'design- and regional-focus' of this research project.

This qualitative data collection method has many advantages: response and completion rates are higher; questionnaires can be longer and more complex than mailed surveys and include open-ended questions; and, the interview process can include some adaptability and extension, for example the interviewer can enhance the depth and meaning of responses by following up ideas, probing responses and investigating motives (Babbie, 2007; Bell, 2010). Whilst such advantages offered the potential to increase the quality of the data collected for this research, it was also carried out in a way to counter potential threats to the reliability and validity of the data collected. For example, a personalised and engaging interviewing approach was adopted to increase the thoughtfulness and validity of the respondents' answers to the questions posed. Simultaneously, this approach was balanced with an interviewing process that ensured each respondent had a consistent interview experience (that is, the same questions were asked in the same way by the same person who reacted similarly to answers) – an interview approach that offered the potential to enhance the reliability of the data collected (Grinnell & Unrau, 2014; Groves, 1989).

Various interview forms were used for this research including individual face-to-face interviews (seven), one-to-one telephone interviews (nine), and group face-to-face interviews (three). These various interview forms were utilised to suit the preferences of respondents, and/or because respondents were located outside of Christchurch.

In relation to telephone interviewing, earlier research suggests that there is little difference in the quality of the responses to open-ended questions utilised in either face-to-face, or telephone interviewing (Jordon, Marcus & Reeder, 1980:217); and, various commentators in the literature contend that data collected via telephone interviews is just as valid and reliable as responses recorded via other interview forms (Aneshensel, Frerichs, Clark, & Yokopenic, 1982:119; Cannel and Fowler, 1965; Denscombe, 1998; Hochstim, 1967; Klecka & Tuchfarber, 1978:113; Locander, Sudman & Bradburn, 1976; Martin, 1983; Siemaitycki, 1979:244; Thomas & Purdon, 1995).

Of group face-to-face interviews, Gray (2014) and others (Bell, 2010; Freeman, 2006) state that this data collection method facilitates the collection of both differing, and corroborating, perspectives on the questions posed, and having more than one respondent present can also allow for some to provide additional detail that others have omitted. Moreover, Kitzinger (1994, 1995) comments that group interviews provide the opportunity to facilitate discussions about sensitive issues such as sexual violence. Against these perspectives, Hayes (2000:395) observes that some respondents within a group interview context "may feel socially constrained and not contribute freely to the discussion." In order to counter this potential issue, Laws, Harper and Marcus (2003:300) suggest that researchers facilitating group interviews "periodically check whether all group members are in agreement with statements being made by asking 'Is that what everyone thinks?' or 'Does everyone agree with xyz?'"

Nineteen key respondent individual/group face-to-face/telephone interviews were undertaken during April and May 2015.[21] These respondents were purposefully selected on the basis that they possessed a body of knowledge, experience, and diversity of perspectives on sexual assault support services. The respondents included representation from New Zealand's Non-Government Organisations Sexual Violence Sector who deliver primary, secondary and tertiary prevention sexual

[21] A total of thirty-one respondents participated in interviews for this research – fourteen individuals participated in the one-to-one telephone/face-to-face interviews and seventeen individuals participated in the face-to-face group interviews.

violence services for women, men, young people, children and Māori (including organisational management, cross-discipline practitioners, and clinical and administrative supervisors); government policy and purchase-of-service contracting bodies; representation from Criminal Justice, Health and Child and Family Sectors working within the Sexual Violence Sector; representation from the Refugee and Migrant Sector; representation from the Family Violence Sector (including management and practitioners); and representation of those responsible for implementing and managing the interim Sexual Assault Support Service Canterbury (including management, paid and volunteer practitioners and clinical and administrative supervisors). The aim was to maximise variability in order to gather multiple perspectives on the proposed design of a sexual assault support service for Canterbury, as well as the context of the Sexual Violence Sector within which this service operates.

A structured data collection instrument was used to guide these in-depth respondent interviews. The interview schedule included mostly open-ended questions. This form of questioning was adopted in order to gain an understanding of the full range of perspectives held by the respondents about the design of a sexual assault support service for Canterbury. Moreover, questioning did not pre-suppose responses, but rather provided the opportunity for the uniqueness of respondents' perspectives and experiences to emerge. The interview questions were developed, to illicit information about topics that pertain to the various elements associated with the design of a sexual assault support service for Canterbury. These topics included contextual factors associated with the Sexual Violence Sector, including matters of coordination and collaboration; the demand and need for the service; service structure, principles for operation, service elements and practices and approaches, including issues of accessibility and responsiveness; supporting infrastructure requirements; service outcomes and performance indicators; and, cost-benefit and sustainability issues.

Each respondent interviewed was asked the same questions and in the same order and manner. This procedure ensured that each respondent was responding to the

same stimulus – a procedure that provided comparable responses and had the potential to generalise from the data collected (Hesse-Biber & Leavy, 2011). Simultaneously, the interviews were conducted in a semi-structured manner, that provided the opportunity for respondents' views and experiences to flow naturally, making room for unexpected and emerging issues, to be explored. The interview began by introducing the purpose of the interview, how the information would be used, and how ethical issues were managed. Each respondent's informed consent to participate in the research and for digitally-taping their interview was confirmed. Questioning began with enquiries that were easy to answer, and concerned experiences that were easy to recall and were non-threatening. Questions on similar topics were grouped together, and statements were used to lead each respondent from one topic to another. The interview schedule finished by inviting respondents to add any additional information that they thought had been overlooked. Their responses were coded in thematically -orientated categories.

Procedure for Collecting and Analysing the Primary Data

Pre-testing the Interview Schedules: The draft interview schedule was pre-tested to check the cultural appropriateness of the questions; identify and remove any ambiguities within questions in order to maximise the way respondents understood the questions; omit any redundant questions or add others to ensure all information sought was covered; and, rearrange some questions to facilitate the logical progression of themes within the interview schedule (Gillham, 2007). The interview schedule is located in Appendix 1-D.

Letter of Introduction: Introductory letters were sent to prospective respondents. The introductory letters are one mechanism used to enhance response rates, informant cooperation and the quality of the information received.

The introductory letter described the background, purpose and subject matter of the research project; identified the agent who commissioned the research; described the time and focus of each potential participant's involvement in the research; provided an explanation of the ethical issues associated with the research and how they

would be managed; and invited the recipients of the letters to consider participating in a research interview.

Attached to the introductory letters to key respondents was a Participant Information Sheet. The Participant Information Sheet included:

- Details about the aims and proposed benefits of the research
- Identified the researcher
- Detailed the time and focus of each participant's involvement in the research process
- Described the way in which the ethical issues associated with the research had been addressed; and,
- Invited participants to seek more information and ask questions about the research and provided a point of contact for that purpose.

Introductory letters and the Participant Information Sheet were distributed by email. A sample letter of introduction and the Participant Information Sheet are located respectively in Appendix 1-A and Appendix 1-B.

Initial Telephone Contact: Shortly after the introductory letters were sent to potential respondents, the researcher made an initial contact by email or telephone. The purpose of this contact was to answer any outstanding questions posed by potential respondents, and to ascertain their willingness and consent to participate. Once consent was given, mutually suitable dates, times and places for the face-to-face and telephone interviews were established.

Individual and Group Key Respondent Face-to-Face and Individual Telephone Interviews: The in-depth interviews were conducted throughout April and early May 2015. The contents of the Consent Form were explained to each respondent and each was invited to sign it (or give verbal consent to participate in the research in instances where the interview was conducted by telephone) before the interview commenced. A sample Consent Form is located in Appendix 1-C. The average time to conduct the respondent interviews was 1 hour and 45 minutes. All interviews were

digitally-taped and the researcher took hand-written notes of the respondents' responses to the questions posed.

Letters of Thanks: All those who participated as respondents in the research project received letters of thanks.

Data Analysis: Data collected from the in-depth, key respondent interviews was coded. Each type of response within each response category was tabulated and grouped. The organised data was interpreted and synthesised into general conclusions and understandings. These results were complemented with examples that described each different response type grouping, including the use of quotes.

4.5 Guiding Principles and Ethical Considerations

Guiding Principles

Those who commissioned this research identified a number of guiding principles to underpin the investment and operational decisions for an exemplary sexual assault support service that would be informed by the empirical and experiential evidence base outlined in this report. These identified guiding principles included:

- High quality
- Reflects international best practice
- Clinically and professionally sound
- Flexible and tailored to ensure accessibility and responsiveness to diverse groups within the target population
- Client centred and provides a seamless pathway along the journey to wellbeing
- Trusted
- Sustainable.

Ethical Considerations

There were a range of ethical implications associated with undertaking this research project. For example, there are potential risks associated with any study carried out within the sexual violence response and prevention services sector and the research project was committed to putting in place a range of procedures and adequate

precautions to maintain the safety of those involved. To counter some of the ethical issues, including concerns about safety, that may have arisen as a result of this research project a number of preventative measures were put in place (Berg, 2001; Punch, 2005; Sieber, 2009).

Informed Consent: All potential respondents were advised in the introductory letter of the background, purpose and nature of the research project so they could exercise choice about whether to be involved or not. Informed consent was sought from all potential respondents. The research project was conducted within the premise that it is each individual's right to decide whether and how to contribute information. Their judgement on these matters will be respected. In addition, respondents were invited to ask questions at any time. [22]

Freedom to Withdraw: Participation in this research project was voluntary and any respondent was free to withdraw at any time and/or refuse to answer any questions without negative consequence.

Confidentiality: The anonymity of the respondents and/or the organisations that they represent was maintained. Notes from interviews and observations do not have any names attached. Rather names were replaced by a code number. The key that links names or any other identifiers and codes is kept in a locked file. Information collected from particular individuals was collated and presented in aggregate form. At no time was there be any reference to the names of particular individuals, organisations or places which might be used as identifiers.

Conflicting Interests: Research that is conducted within a contestable environment is bound to be confronted with conflicting interests. For example, there may be subtle

[22] Elements of informed consent included in the Respondent Consent Form and the Research Information Sheet included: identification of the researcher; identification of the agencies managing the service and the research project; identification of the research purpose; identification of the benefits of participating in the research; identification of the type and level of respondents' involvement; guarantee of anonymity and confidentiality; assurance that respondents could withdraw at any time; and, provision of names of persons to contact if questions arise (Sarantakos, 2005)

pressure to ignore evidence or suppress negative results. To counter this ethical issue, the research was conducted without bias and the results will be disseminated in a sensitive manner.

Storage and Use of Data: Data collected during the course of the research project is securely stored to ensure the material is only used for the purpose for which it was gathered. Respondents were advised that the data is to be used for the purpose of gathering information to support decisions about the future model of service for a sexual assault support service in Canterbury.

Promises to Supply Information Fulfilled: All requests for interview notes were met.

Wellbeing of Respondents: The research may expose the vulnerabilities of some of the respondents invited to participate. To counter this ethical issue, the research was conducted in a sensitive manner and in a way that respects human dignity and worth.

Guided by Internationally Recognised Ethical Standards for Research and Evaluation: The research project was conducted in robust manner and complied with the Australasian Evaluation Society Incorporated 'Guidelines for the Ethical Conduct of Evaluations' and the American Evaluation Association's 'Guiding Principles for Evaluation'. In addition, the researcher is a member of the Aotearoa New Zealand Evaluation Association, which aims to promote excellence in research and evaluation conducted in Aotearoa New Zealand and in particular, focuses on the maintenance of appropriate ethical standards for members of the profession.

PART THREE: LITERATURE REVIEW

In New Zealand and worldwide sexual violence is recognised as a significant public health issue – an issue that is a human rights violation; an injury to health; a crime; and costly to societies and economies. The consequences of sexual violence are significant, long lasting, may carry over generations, and have a rippling impact on individuals, families/whānau, communities and society (Dubourg, Hamed & Thorns, 2005; Ellsberg, 2006; Garcia-Moreno & Watts, 2011; Lalor, 2004; Miller, Cohen & Wiersema, 1996; Morrison, Quadara & Boyd, 2007; Post, Mezey, Maxwell & Wibert, 2002; World Health Organisation, 2005a).

Yet despite this recognition of the impact of sexual violence, Garcia-Moreno and Watts (2011) and others (Lalor, 2004; World Health Organisation, 2005) state that services for victims/survivors remain inadequate. They argue that more investment in interventions that prevent and respond to sexual violence is needed. Moreover other commentators in the literature advise using available evidence of what has already worked to strengthen the quality of new and existing services that support people who have experienced sexual violence – strengthening that will increase the likelihood that efforts will be successful (World Health Organisation, 2004; World Health Organisation/London School of Hygiene and Tropical Medicine, 2010).

In light of this advice, this review of the empirical literature seeks to describe an evidence base with which to inform the future design of a sexual assault support service for Canterbury. Kettner, Moroney and Martin (1999) maintain that there are several stages in designing social services to maximise their effectiveness. These stages include defining the social problem; identifying and understanding the needs of the target client population; selecting service objectives; developing an appropriate intervention and supporting infrastructure to address the identified need; and, evaluating the results. This service design framework has provided the foundation with which to review the empirical literature concerned with the provision of sexual assault support services. The review of the literature focuses on evidence to support the design of a 'best practice' support service for those impacted by sexual violence and the findings are presented in sections covering the following topics:

- Extent and nature of the problem of sexual violence
- Demographic and social history characteristics of the target client population
- Barriers to accessing sexual assault support services and amelioration strategies
- Elements of effective sexual assault support services
- Proven practices and approaches for delivering sexual assault support services
- Infrastructure requirements for a sexual assault support service
- Contribution and intersection of sexual assault support services to the system of response for victims/survivors and those who support them
- Benefits of investing in sexual assault support services.

5. Understanding the Extent and Nature of the Problem of Sexual Violence

5.1 What is Sexual Violence?

When defining sexual violence, commentators in the literature often refer to that offered by the World Health Organisation in their 2002 publication: 'World Report on Violence and Health.'

> "*Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"* (Krug, Dahlberg Mercy, Zwi & Lozano, 2002).

Krug et al. (2002) state that the word coercion used within this definition refers to physical force, psychological intimidation, blackmail, or threats of physical harm, of being dismissed from a job, or of not being given a fair grade for academic work. Additionally, sexual violence may occur when a person is unable to give consent, for example while intoxicated, asleep or mentally incapable of understanding the situation (World Health Organisation, 2012).

Sexually violent acts can take a range of forms and occur in a variety of contexts. Kelly (2005) comments that sexual violence includes (but is not limited to) rape and sexual assault; sexual abuse; trafficking and sexual exploitation; sexual harassment; female genital mutilation; acid throwing; and forced/early marriage; and crimes in the name of honour. Krug and colleagues (2002) observe that sexual violence can occur in a range of contexts and under a multitude of circumstances. Some examples of these described by these authors are included in the following text box.

Forms and Contexts of Sexual Violence	
• *Rape within marriage or dating relationships* • *Rape by strangers* • *Systematic rape during armed conflict* • *Unwanted sexual advances or sexual harassment, including demanding sex in return for favours* • *Sexual abuse of mentally or physically disabled people* • *Sexual abuse of children* • *Forced marriage or cohabitation, including the marriage of children*	• *Denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases* • *Forced abortion* • *Violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity* • *Forced prostitution and trafficking of people for the purpose of sexual exploitation*

Source: Krug et al., 2002:149-150

While the literature has adopted a broad definition of sexual violence, the New Zealand Crimes Act 1961 refers to a range of sexual acts that are illegal in this country. [23] Examples of illegal sexual acts noted in this Act include rape or sexual violation - "rape of another person or has unlawful sexual connection with another person (section 28(1) Crimes Act.1961); [24] [25] attempted sexual violation and assault with intent to commit sexual violation (section 129 Crimes Act 1961); incest (section 130 Crimes Act 1961); sexual conduct with dependent family member (section 131 Crimes Act 1961); sexual conduct with a child under 12 years old (section 132 Crimes Act 1961); sexual conduct with a young person under 16 years old (section 134 Crimes Act 1961); and indecent assault (section 135 Crimes Act 1961).

5.2 Extent of the Problem of Sexual Violence

Prevalence: Challenges of Accuracy

The true prevalence of the many forms of sexual violence is not known. Jewkes and Abrahams (2002) liken the data on sexual violence to the tip of an iceberg. A small

[23] Mossman et al. (2009:11-12) note that New Zealand introduced changes to the Crimes Act, 1961, (as well as the Evidence Act, 1908 and the Summary Proceedings Act, 1957) in 1985. These changes included the introduction of the broader category of sexual violation; sexual violation was made gender neutral (recognising that men and/or women could be victims and/or offenders); the abolishment of spousal immunity that recognised the possibility of rape within marriage; the requirement that grounds for a belief in consent needed to be reasonable; and changes to court processes that sought to make victims' experiences of giving evidence less traumatic and limiting the publication of personal and incident details. These researchers observed that since these changes were introduced a number of commentators were of the view that more was required in practice to improve the experiences of victims/survivors involved in court processes. Notably, in 2014 New Zealand's Minister of Justice requested the Law Commission to develop proposed options for better supporting victims of sexual violence during pre-trial and trial processes (Retrieved from: https://www.beehive.govt.nz/release/govt-resumes-sexual-violence-trial-proceedings-work).

[24] Section 28 of the Crimes Act, 1961 is located in the Appendix.

[25] Wellington Community Law (2011) provides definitions of rape and unlawful sexual connection.

> *"Rape means the penetration of the genitalia by the penis, without consent. It is a man-on-woman offence (although either the offender or victim may have had gender reassignment surgery)."*
>
> *"Unlawful sexual connection includes forcing someone to give or receive anal sex or oral sex, it includes same-sex offending, and it includes offending with an object. It is still a 'sexual connection' no matter how slight the contact with the offender's genitalia or anus, or with the survivor's genitalia or anus – it includes penetration, and it includes touching."*

tip at the top represents police data; a slightly larger section below this represents data sourced from survey research, clinical settings and non-government-organisation data management systems; and at the bottom is the substantial and hidden problem of sexual violence.

While data is available about different populations using a variety of measures of sexual violence, the accuracy of that data is affected by data quality issues (e.g. varying definitions of sexual violence across studies) and non-reporting (Henderson, 2012; Krug et al., 2002; Lievore, 2003; Neame & Heenan, 2003). In New Zealand, Morris, Reilly, Berry and Ransom (2003) commented that people who are sexually assaulted are the least likely of all victims of crime to report to the police. In support of this view, the 2009 New Zealand Crime and Safety Survey found that only seven percent of sexual offences were reported to the police (Justice Sector Strategy Group, 2010). [26] Mayhew and Reilly (2007) contend that there are several reasons for such a low rate of reporting. These reasons included people choosing not to report a known assailant as they believed such actions would exacerbate their situation;[27] people experiencing shame and/or blamed and preferring to keep their experiences of sexual assault a secret; and, people not knowing that what happened to them was a crime (Henderson, 2012; Krug et al., 2002; World Health Organisation, 2012).

Reported Sexual Violence in New Zealand

Table 2 shows the annual reported 'sexual assault and other offences' in New Zealand recorded by the New Zealand Police during the period from 2010 to 2014 and sourced from Statistics New Zealand. These statistics illustrate an annual increase in recorded sexual offences over the years 2010 to 2014.

[26] While these authors note that people who experience sexual assault do not report such incidents to the police, other studies have found that many victims/survivors do not ever tell anyone about such incidents and if they do they are likely to disclose to family/whānau or friends (Kingi & Jordan, 2009). Moreover, such disclosures may be many years after the sexual violence incident. For example, McGregor's (2003) study estimated that only 4 percent of the respondents told anyone at the time of the incident and the average time to disclosure was 16.3 years.

[27] Mossman, Jordan, MacGibbon, Kingi & Moore (2009) reported that three-quarters of those who experience sexual violence know their assailant.

Table 2: Annual Recorded 'Sexual Assault and Other Offences' 2010-2014

2010		2011		2012		2013		2014	
recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved
3016	1676	3466	1963	3512	1889	3919	2030	4056	1932

Source: Retrieved from Statistics New Zealand: http://nzdotstat.stats.govt.nz/wbos/Index.aspx?gclid=CjwKEAjwpYeqBRDOwq2DrLCB-UcSJAASIYLj7jrD_At_965CNGmv45E9Lvn5BGulq0H8YrZvQs6n_RoCAnDw_wcB

Adult Experiences of Sexual Violence in New Zealand

A 2006 the New Zealand Crime and Safety Survey found that 29% of women and 9% of men experienced unwanted sexual contact over their lifetime (Mayhew & Reilly, 2007). Mayhew and Reilly (2009) reported that 73% of these assaults against women and 54% of the assaults against men were carried out by a partner, ex-partner or other family member – statistics that support the view that the majority of sexual violence occurs between known parties. [28] This survey found a 12-month prevalence rate of 3% for people aged 15 years and older who had experienced sexual violence on one or more occasions during 2005. This equated to 6.4 incidents per one hundred adults (9 per 100 for women and 3 per 100 for men). This research suggests that twice as many women experience sexual violence as men; twice as many Māori experience sexual violence compared to non-Māori; and, young Pacific people also report high levels of sexual assault. [29]

[28] A 2009 Ministry of Justice report supports this view. Referencing the same survey data, their report states that over a third of the sexual offences were committed by a current partner; a quarter by a friend; one in ten by a boyfriend or girlfriend; and one in twenty by a work colleague (Ministry of Justice, 2009). These findings are supported by research in other international jurisdictions. For example, Kelly, Lovett & Regan (2005) and others (Krug et al., 2002) report that although sexual offences are perpetrated by strangers and recent acquaintances the majority were carried out by current and ex-partners; family and community members and professionals in a relationship of trust.

[29] In 2014, the British journal, the Lancet, published a report entitled 'Worldwide Prevalence of Non-Partner Sexual Violence: A Systematic Review. This publication reported that the rate of sexual assault in New Zealand (16.4% of women) was far higher than the world average and was the third highest rate alongside Australia (Abrahams, Devries, Watts, Pallitto, Petzold, Shamu & Garcia-Moreno, 2014).

Tables 3, 4 and 5 show that over the last five years the number of reported sexual offences against adults in New Zealand continued to increase; the number of recorded apprehensions included assaults on women, men and undefined gender, although the majority of these sexual assaults were on women and perpetrated by men; and there was a small increase in the percentage of apprehensions prosecuted for each of the years 2012, 2013 and 2014.

Of the total sexual violence charges prosecuted in 2014 (1704) 46% (779) were convicted in New Zealand District Courts. This percentage of convictions was an increase on that (39%) reported in 2010 (Family Violence Clearing House, 2015a).

Table 3: Reported and Resolved Sexual Offences against Adults (>16 years)

2010		**2011**		**2012**		**2013**		**2014**	
recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved
1481	819	1536	851	1617	857	1848	866	1888	772

Source: Statistics New Zealand http://www.stats.govt.nz/tools_and_services/nzdotstat/recorded-crime-statistics/ASOC-apprehension-calendar-year-statistics.aspx

Table 4: Apprehensions for Sexual Offences against Adults (>16 years) [30]

	2010	**2011**	**2012**	**2013**	**2014**
Total apprehensions sexual assault	820	871	845	836	785
Assaults on a women	674	728	696	650	581
Female perpetrator	8	13	4	8	12
Male perpetrator	666	715	693	642	569
Assaults on a man	42	34	29	47	41
Female perpetrator	0	2	2	2	2
Male perpetrator	41	32	27	45	39

[30] The term apprehension relates to the number of offences, not the number of individuals.

Assaults on undefined gender	104	109	120	139	163
Female perpetrator	2	1	5	3	3
Male perpetrator	102	108	115	136	160

Source: Statistics New Zealand http://www.stats.govt.nz/tools_and_services/nzdotstat/recorded-crime-statistics/ASOC-apprehension-calendar-year-statistics.aspx

Table 5: Outcomes of Apprehensions for Sexual Assault Offences against Adults

	2010	**2011**	**2012**	**2013**	**2014**
Total Apprehensions	820	871	845	837	785
Apprehensions that were prosecuted	638	697	660	687	656
% of total apprehensions prosecuted	78%	80%	78%	82%	84%

Source: Statistics New Zealand http://www.stats.govt.nz/tools_and_services/nzdotstat/recorded-crime-statistics/ASOC-apprehension-calendar-year-statistics.aspx

Children's and Adolescents' Experiences of Sexual Violence in New Zealand

A number of studies have explored the prevalence of sexual violence amongst children and young people. A study conducted by van Roode, Dickson, Herbison and Paul (2009) found that 1 in 3 women and 1 in 10 men reported having experienced child sexual abuse. Replicating the World Health Organisation Multi-Country Study on Women's Health and Domestic Violence against Women, a survey of a representative sample of 2,855 New Zealand women aged between 18 and 64 years was carried out in 2003. Study participants were asked whether they had been touched sexually or made to do something sexual that they did not want to do before the age of 15 years. In total 573 (20%) women reported having experienced child sexual abuse (Fanslow, Robinson, Crengle & Perese, 2007). [31] More recently,

[31] This study, which included respondents from Auckland (an urban area) and Waikato (a rural area), found that the overall prevalence rate for historical childhood sexual abuse was 23.5% for women from Auckland and 28.2% for those from the Waikato. Māori women reported higher rates of abuse than both European women and those of other ethnic groups (that is, for the respondent sample in the urban area respectively 30.5% vs. 17.0%; and for the respondent sample in the rural area respectively 35.1% vs. 20.7%). The study noted that

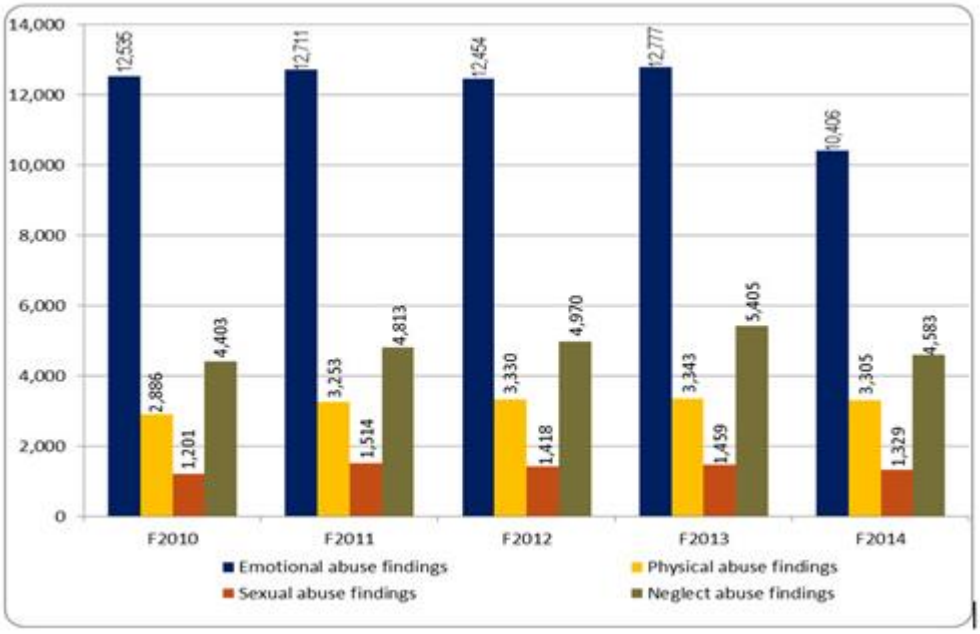
a 2012 New Zealand study found that 9% of male youth and 20% of female youth had been exposed to sexual violence during the previous twelve months. Of the respondents in this study, 53% of the females and 71% of the males reported that they had not told anyone about the sexual violence (Clarke, Fleming, Bullen, Denny, Crengle, Dyson, Fortune, Lucassen, Peiris-John, Robinson, Rossen, Sheridan, Teevale & Utter, 2013).

A number of studies have considered the link between child sexual abuse and sexual violence re-victimisation in childhood, adolescence and adulthood (Flemming, Mullen, Sibthorpe & Bammer, 1999). In 2011, Carroll-Lindt, Chapman and Raskauskas reported findings from a national survey of children aged between 9 and 13 years. This study asked respondents if they had ever experienced unwanted sexual touching or asked to do unwanted sexual things. 11% reported lifetime prevalence and 2% reported lifetime prevalence of re-victimisation. In addition, the findings from a survey of women aged eighteen years and older found that 13% of respondents reported sexual abuse during childhood and 10% of respondents reported multiple experiences of child sexual abuse (Flett, Kazantzis, Long, MacDonald, Millar, Clark, Edwards & Petrik, 2012).

Administrative data sourced from Child Youth and Family show that of the total care and protection reports of concern with substantiated abuse findings in F2014 (19,623), 1,329 (6.8%) involved sexual abuse findings. Figure 1 shows the total substantiated abuse findings, by abuse type. Figure 2 shows distinct numbers of children and young people with a substantiated abuse finding, by abuse type and shows that in F 2014 1,294 (6.6%) children had substantiated sexual abuse findings.

these rates are higher than those of any of the ten countries studied in the World Health Organisation Multi-Country Study (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005).

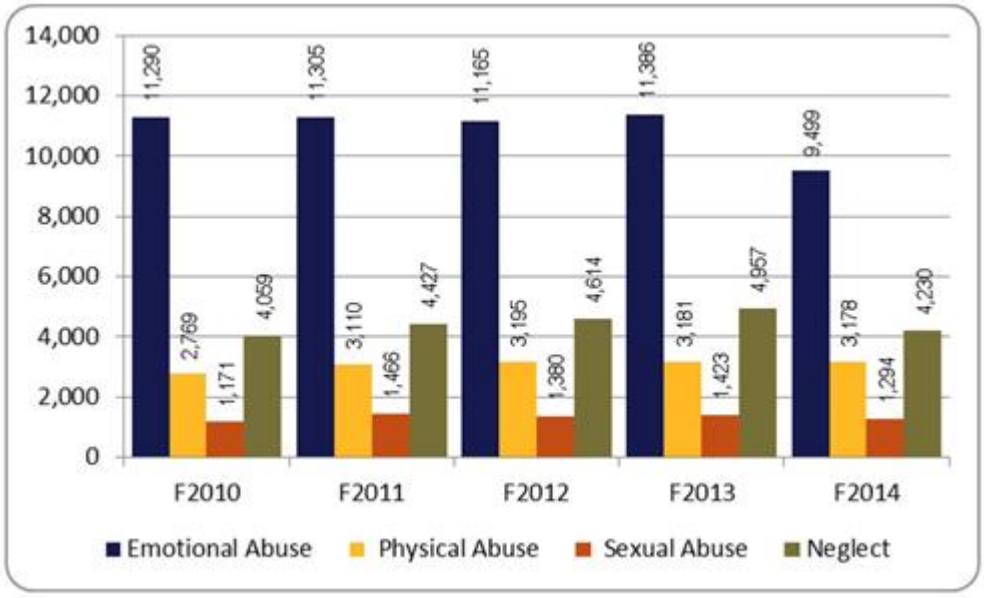
Figure 1: Graph of Total Substantiated Abuse Findings, by Abuse Type



Note: Children and young people may have more than one finding during the same period. This occurs when clients have more than one finding on the same investigation or assessment, or have more than one investigation or assessment during the same year.

Source:http://www.cyf.govt.nz/about-us/key-statistics/care-and-protection-reports-of-concern-requiring-further-action-and-substantiated-abuse.html

Figure 2: Graph of Distinct Children and Young People with a Substantiated Abuse Finding, by Abuse Type



Source:http://www.cyf.govt.nz/about-us/key-statistics/care-and-protection-reports-of-concern-requiring-further-action-and-substantiated-abuse.html
http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE7407

Table 6 shows that in 2014, 2,168 sexual offences against a child were recorded by the New Zealand Police. This was an increase of 29% on that recorded in 2010.

Table 6: Reported and Resolved Sexual Assault Offences on a Child (16 years and under)

2010		2011		2012		2013		2014	
recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved
1535	857	1930	1112	1895	1032	2071	1164	2168	1160

Source: Statistics New Zealand http://www.stats.govt.nz/tools_and_services/nzdotstat/recorded-crime-statistics/ASOC-apprehension-calendar-year-statistics.aspx

Table 7 shows that there was a 20.8% increase in the total number of apprehensions for sexual assault on a child between 2010 and 2014; and that sexual assaults on children are mainly perpetrated by men.

Of the total prosecutions for sexual violence against children in 2014 (3,429) 53% (1,822) were convicted in New Zealand District Courts. This percentage of convictions was an increase on that reported in 2010 (44%) (Family Violence Clearing House, 2015b).

Table7: Apprehensions for Sexual Assault on a Child (16 years and under)

	2010	**2011**	**2012**	**2013**	**2014**
Total apprehensions sexual assault	815	1081	999	1111	1029
Assaults on child under 12	343	470	406	457	475
Assaults on girls under 12	251	390	284	368	386
Female perpetrator	4	8	4	8	10
Male perpetrator	247	382	280	360	376
Assault on boys under 12	78	69	109	82	77
Female perpetrator	0	3	6	2	3
Male perpetrator	78	66	103	80	74
Gender not defined	14	11	13	7	12
Female perpetrator	0	3	6	2	3
Male perpetrator	14	8	7	5	9
Assaults on child 12-16 years	472	611	593	654	554
Assaults on girls 12-16 years	322	409	353	402	331
Female perpetrator	4	2	3	7	2
Male perpetrator	317	407	349	394	329
Assaults on boys 12-16 years	35	56	84	91	67
Female perpetrator	2	3	4	2	0
Male perpetrator	33	53	80	89	67

Gender not defined	115	146	156	161	156
Female perpetrator	6	7	19	13	15
Male perpetrator	109	139	137	148	141

Source: Statistics New Zealand http://www.stats.govt.nz/tools_and_services/nzdotstat/recorded-crime-statistics/ASOC-apprehension-calendar-year-statistics.aspx

Sexual Violence and Canterbury

As a region affected by a series of earthquake events in recent years, the Canterbury region may experience an increased rate of sexual violence (together with child abuse and intimate partner violence). Although studies of post-disaster violence rates are few and mainly from the United States of America, those studies that do exist suggest that sexual violence is highly prevalent after natural disasters. The World Health Organisation (2012) states that natural disasters increase individual's, families' and communities' vulnerability to violence of all kinds including sexual violence and child abuse. Identified factors that increase vulnerability include: increased stress and feelings of powerlessness; mental health problems, such as post-traumatic stress disorder; breakdown of social networks; disruptions to the economy; and cessation of violence prevention and other social support programmes.[32]

Annual Recorded Sexual Assault and Other Offences for Calendar Years: Canterbury District

Table 8 shows the annual reported 'sexual assault and other offences' in Canterbury sourced from Statistics New Zealand. These statistics show an annual increase in recorded sexual offences over the years 2010 to 2013 with a 7% drop in reported

[32] Recommendations from earlier research on effective responses to the increased incidence of violence of all kinds following a natural disaster and during the recovery stage include: programmes that address sexual and other forms of violence should be revitalised and strengthened; increase community awareness campaigns that inform people about how to report acts of violence, what services are available and where they can go for help; and provide training to primary health workers on how to identify victims of sexual and other forms of violence, how to engage with them appropriately, and how to refer them to specialised services (UNHCR, 2003; WHO, 2002b; WHO 2005b).

'sexual offences and other offences' between 2013 and 2014. In April 2014, Superintendent Gary Knowles commented on the reasons for the reported rates of sexual violence in this region including "increased reporting, better police family violence processes and the ongoing impacts of alcohol" (New Zealand Police, 2014., paragraph 26).

Table 8: Annual Recorded 'Sexual Assault and Other Offences' 2010-2014

2010		2011		2012		2013		2014	
recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved	recorded	resolved
318	158	370	181	442	210	442	214	411	145

Source:http://nzdotstat.stats.govt.nz/wbos/Index.aspx?gclid=CjwKEAjwpYeqBRDOwq2DrLCB-UcSJAASIYLj7jrD_At_965CNGmv45E9Lvn5BGulq0H8YrZvQs6n_RoCAnDw_wcB

Sensitive Claims Lodged with Accident Compensation Corporation for Canterbury Region

Table 9 shows the number of sensitive claims lodged with New Zealand's Accident Compensation Corporation (ACC) in the Canterbury region between the financial years 2012 to 2015. A personal 2015 communication with a research respondent from ACC commented that the number of sensitive claims lodged is estimated to be about 19% of the prevalence of sexual violence within the population.

Table 9: Annual Number of Sensitive Claims Lodged with New Zealand's Accident Compensation Corporation in the Canterbury Region, 2012-2015

2012	2013	2014	2015 (part year as at April 2015)
575-585	635-645	625-635 [33]	285

Source: New Zealand Accident Compensation Corporation

[33] ACC's Business Information and Reporting Team advised that the organisation suppresses the numbers of statistics published by creating ranges for totals. This procedure seeks to protect the privacy of clients so that individuals cannot be identified.

This data suggests that there was a 9% increase in sensitive claims lodged between 2012 and 2013; a 2% decrease between 2013 and 2014; and a projected increase between 2014 and 2015 based on part-year numbers of claims lodged during 2015. With the introduction of the Integrated Services for Sensitive Claims (ISSC) contract, ACC is expecting sensitive claim lodgement numbers to increase as this service has been designed to be client centred, flexible and holistic (ACC personal communication with respondent, 04 May 2015).

Table 10 shows that of the percentage of sensitive claims lodged from those residing in Canterbury by gender for the financial year 2014, just over three quarters were female and just under a quarter male.

Table 10: Number (and Percent) of Sensitive Claims Lodged by Those Residing in Canterbury by Gender for Financial Years 2012 to 2014

Gender	Claim Count (%) by FY		
	2012	2013	2014
Female	435-445 (76%)	521 (82%)	481 (76%)
Male	135-145 (24%)	118 (19%)	149 (24%)
Total	**575-585 (100%)**	**639 (100%)**	**630 (100%)**

Table 11 shows that of the percentage of sensitive claims lodged from those residing in Canterbury by ethnicity for the financial year 2014, almost three quarters identified as European; 20% identified as Māori; and 2% identified as Pacific Peoples. The 2013 New Zealand Census data indicates that 86.9% of people residing in Canterbury identified as European; 8.1% identified as Māori; and 2.5% identified as Pacific Peoples (Statistics New Zealand, 2013, para. 3).

Table 11: Number (and Percent) of Sensitive Claims Lodged by People Residing in Canterbury by Ethnicity Prioritised for Financial Years 2012 to 2014

Ethnicity Prioritised	Claim Count (%) by FY		
	2012	2013	2014
Asian	<10 (<2%)	<10 (<2%)	<10 (<2%)
European	439 (76%)	457 (72%)	461 (73%)
Maori	95 (16%)	114 (18%)	127 (20%)
Other Ethnicity	19 (3%)	23 (4%)	16 (3%)
Pacific Peoples	16 (3%)	21 (3%)	11 (2%)
Not defined	<10 (<2%)	20 (3%)	10 (2%)
Total	**575-585 (100%)**	**635-645 (100%)**	**625-635 (100%)**

Table 12 shows that of the percentage of sensitive claims lodged from those residing in Canterbury by age group for the financial year 2014, 27% were aged between 20 and 29 years; 22% were aged between 11 and 19 years; and 17% respectively were aged between 30 and 39 years and 40 and 49 years. These statistics are aligned with findings both in New Zealand and other international jurisdictions – statistics that suggest that young people (16-24 years) are at highest risk of sexual assault (Acierno, Resnick, Kilpatrick, Saunders & Best, 1999; Clark, Robinson, Crengle, Galbreath & Sykora, 2009; Greenfeld, 1997; Heise, Pitanguy & Germain, 1994; United States Department of Justice, 2004; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002).

Table 12: Number (and Percent) of Sensitive Claims Lodged by People Residing in Canterbury by Age Group (age at lodgement) for Financial Years 2012 to 2014

Age at Lodgement	Claim Count (%) by FY		
	2012	2013	2014
0-10 years	38 (7%)	32 (5%)	36 (6%)
11-19 years	148 (26%)	161 (25%)	138 (22%)
20-29 years	144 (25%)	157 (25%)	169 (27%)
30-39 years	85 (15%)	89 (14%)	108 (17%)
40-49 years	104 (18%)	114 (18%)	109 (17%)
50-59 years	48 (8%)	66 (10%)	50 (8%)
60-69 years	12 (2%)	16 (3%)	15 (2%)
70 years and over	<10 (<2%)	<10 (<2%)	<10 (<2%)
Total	**575-585 (100%)**	**635-645 (100%)**	**625-635 (100%)**

Christchurch Health and Development Study

Of the prevalence of child sexual abuse in the Canterbury region, data from a Christchurch Health and Development Study provides some insight (Fergusson, McLeod & Horwood, 2013). This longitudinal study asked participants at age 18 and 21 years whether before the age of 16 anyone had attempted to involve them in sexual activities that they did not want to happen. Of the 1,265 born in the Christchurch urban region during mid-1977, 86% (840) reported no experiences of sexual abuse; 3% (28) reported non-contact sexual abuse (for example, indecent exposure, public masturbation or unwanted sexual propositions); 5% (52) reported contact child sexual abuse (for example, sexual fondling, genital contact and/or

attempts to undress the respondent); and, 6% (64) reported severe child sexual abuse (for example attempted or completed vaginal, oral or anal intercourse).

Sexual Assault Support Service Canterbury

Data sourced from the administrative data collected by the Sexual Assault Support Service Canterbury from 14 July 2014 to 20 May 2015 indicated that during this ten-month period the service supported 52 victims/survivors during a forensic/medical examination; supported 14 victims/survivors at police interviews (11 at police interviews and 3 at police outcomes meetings); and received 133 plus telephone inquiries. While during that period the service did not support anyone at court, it did support some people during the preparation for court hearings. The only demographic data collected during that period was that related to gender – 177 females and 11 males (SASSC administrative data, May 2015).

5.3 The Etiology of Victims/Survivors of Sexual Violence

5.3.1 Risk Factors and Sexual Violence

Understanding the etiology of victims/survivors and/or perpetrators of sexual violence is challenging. Henderson (2012:6) writes that "women and men of every age, race and religious background are raped and sexually assaulted." While Holmes and Holmes (2009) note that such variability across the demographics of people who experience sexual violence (either as victims/survivors or perpetrators) make describing common characteristics or traits challenging, a United States Department of Justice (2004) brief comments that factors that predict sexual violence are likely to involve a complex interplay of a combination of individual, relationship, community and societal factors.

The Centres for Disease Control and Prevention (2004) maintain that appropriate responses to sexual violence can only be developed if there is a greater understanding of the risk factors associated with such incidents. The World Health Organisation and London School of Hygiene and Tropical Medicine (2010:30) have

identified some of the individual, relationship, community and societal root causes of both the perpetration and victimisation of sexual violence. The identified risk factors for victimisation include:

- Individual risk factors
- Relationship risk factors
- Community risk factors
- Societal risk factors

Individual Risk Factors: Previous research has identified a number of individual risk factors associated with sexual violence. These individual risk factors include demographics (young age, low education, divorced/separated/single women); exposure to child maltreatment (intra-parental violence and sexual abuse); mental health issues (depression); and, substance abuse (illicit drug use and harmful use of alcohol). [34]

Studies carried out by Acierno et al., (1999) and others (Greenfeld, 1997; Heise, Pitanguy & Germain, 1994) have found that young women are at greater risk of rape than older women. While Holmes and Holmes (2009:253) observe that the popular stereotype of "the most likely victim of sexual assault is a female between 18 and 36 years old," these and other authors note that young girls are particularly vulnerable. For example, Synder and Sickmund (1999) found that one in three sexual assaults is committed against a child under the age of 12 years; Greenfeld (1997) found that 77.7% of all victims of imprisoned sexual offenders were under the age of 18 years with the median age of the victims being 13 years; and, the Australian Bureaux of Statistics (2003) recorded that girls between 10 and 14 years of age experienced the highest rate of sexual assault (462 per 100,000). Krug et al., (2002) note that young

[34] These identified risk factors appear to be supported by research undertaken in New Zealand. For example, Mossman, Jordan, MacGibbon, Kingi and Moore (2009) reported that a third of adults who experience sexual violence are aged between 16-20 years and, two-thirds are under 29 years; women who are sexually abused as children or young people are more likely to be sexually assaulted as adults; and, people with experience of disability (physical, intellectual and psychiatric) are at higher risk of sexual violence.

age is associated with certain forms of sexual violence, for example that taking place in schools and colleges and trafficking for sexual exploitation.

While studies have identified that being young is a risk factor associated with sexual violence, there is growing evidence that shows that sexual assault early in life (childhood or adolescence) increases vulnerability for repeat sexual victimisation in adulthood (Ferguson & Horwood, 1997; Flemming, Mullen, Sibthorpe & Bammer, 1999; Koss & Dinero, 1989; Tjaden & Thoennes, 2000). Russell's (1986) seminal study found a correlation between childhood sexual assault and repeat sexual victimisation in adulthood. This finding has been supported by a number of studies since then. For example, Siegal and Williams (2003) have found that women who experience childhood sexual assault were two to three times more likely to be sexually assaulted as adults; and Desai, Arias, Thompson and Basile (2002) found that male survivors of childhood sexual assault were 5.5 times more likely to be victimised as an adult. Moreover, Arata (2002) has shown that the more severe the sexual assault in childhood (e.g. use of force; penetration; longer duration; close relationship to perpetrator), the higher the risk of victimisation. According to Jankowski, Leitenberg, Henning and Coffey (2002), the underlying reason for the increased risk of victimisation in these circumstances is the cumulative impact on development and coping.

Other studies have sought to examine the mediators underlying the relationship between sexual assault and further victimisation. Fry (2007) observed that there is a high rate of alcohol abuse amongst victims/survivors of childhood and adolescent sexual violence and that alcohol abuse increases the risk of sexual assault. Crowell and Burgess (1996), comment that consuming alcohol and drugs makes it more difficult for people to protect themselves by interpreting and acting on signs of risk. Moreover, these commentators observe that alcohol may place people in places where the chances of encountering a potential offender are greater.

Having multiple sexual partners has also been found to increases the risk of sexual violence (Crowell & Burgess, 1996; Koss & Dinero, 1989; Pederson & Skrondal,

1996), although such studies are unclear about whether this is a cause or consequence of abuse. Finkelhor and Browne (1985) found that survivors of childhood sexual abuse often have multiple partners and have sex with people less well known to them as a result of what they term as “traumatic sexualisation.” Other studies, across multiple jurisdictions (Nigeria, Norway, New Zealand), support the finding that people who experienced childhood and/or adolescent sexual assault were more likely to have multiple sexual partners compared to non-abused people (Ferguson et al., 1997; Olsson, Ellsberg, Berglund, Herrera, Zelava, Pena, Zelava & Persson, 2000; Pederson & Skrondal, 1996).

Other individual level risk factors associated with sexual violence and identified in the literature include being involved with sex work; becoming more educated and/or economically independent; and poverty (Krug et al., 2002).

Omorodion and Olusanya (1998) and Omaar and Waal (1994) found that those involved in sex work were at higher risk of sexual violence.

Jewkes and Abrahams (2002) found that there was an increased risk of sexual assault for women in intimate partner relationships if they were more educated and/or more economically independent. Jewkes, Penn-Kehana and Levin (2002) are of the view that the greater empowerment experienced by educated and economically independent women ‘brings with it more resistance from women to patriarchal norms so that men may resort to sexual violence in an attempt to gain control’.

Krug et al. (2002:158) comment that women and girls who experience poverty may be more at risk of sexual violence in their daily lives (e.g. women working home alone at night after work; and/or ‘children of poor women may have less parental supervision when not at school since their mothers may be at work and unable to afford childcare’).

***Relationship risk factors*:** Several studies have examined relationships that may increase the risk of experiencing sexual violence. In line with the findings from previous research, Holmes and Holmes (2009) and Astbury (2006), note that the vast majority of victims/survivors of sexual violence knew the person who assaulted them. Catalano (2005) found that two-thirds of rapes of victims over the age of 12 years were committed by someone known to them, half by a friend or acquaintance, 17% by an intimate partner and 3% by another relative. Moreover the findings from a National College Women Sexual Victimisation study undertaken by Fisher, Cullen and Turner (2000) showed that college women were even more likely to known their perpetrator. In this study 90% of victims/survivors knew the offenders.

Krug et al. (2002:157) state that "one of the most common forms of sexual violence around the world is that which is perpetrated by an intimate partner, leading to the conclusion that one of the most important risk factors for women – in terms of vulnerability to sexual assault – is being married or cohabitating with a partner." For example, in one of the first cross-country studies of patterns of intimate partner violence the World Health Organisation (2005a) found that in most countries that participated in the study between 30% and 50% of women who experienced intimate partner violence reported both physical and sexual violence. [35] Moreover, a study of a representative sample of 6,000 men carried out by Martin (1999) found 7% reported having been physically and sexually assaulted by their wives and 22% reported having been victims of sexual violence alone.

Community risk factors: Several authors note that poverty and weak community sanctions are community-level risk factors for sexual violence (World Health Organisation, 2012). Heise, Ellsberg and Gottemoeller (1999), and Rozee (1993), state that the social environment within a community can either ameliorate or exacerbate the risk of sexual violence. These authors maintain that in communities

[35] For example, in a Canadian study Randall and Haskell (1995) found that 30% of the women were raped by intimate partners; and in a US study 46% of the women reported that they had experienced rape or attempted rape by a spouse or ex-spouse, current or former cohabiting partner, a date, or boyfriend/girlfriend, with over half of the sexual violence committed by a current or former cohabiting partner (Tjaden & Thoennes, 2000).

where there is a general tolerance of sexual violence and minimal sanctions against offenders (for example, in communities where the police treat complaints, of sexual assault by a victim's husband or during a date, leniently), sexual violence is more likely to take place.

Societal risk factors: The World Health Organisation (2012) note that societal-level risk factors are associated with traditional gender inequality norms and social norms supportive of violence (for example, rape is a sign of masculinity); ideologies of male sexual entitlement (e.g. sexual intercourse is a man's right in marriage); and, weak legal sanctions. Other societal-level risk factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society (Colorado Coalition against Sexual Violence, 2011).

According to the Centres for Disease Control and Prevention (2004) this four-level model of factors that influence sexual violence, together with an increased understanding about the elements within each level, assists with prioritising efforts to address the risks for people experiencing and/or perpetrating sexual violence. They argue that a continuum of strategies should be implemented across the multiple levels of the model. Table 13 includes some examples of these strategies. Moreover, they recommend that each strategy is developmentally appropriate and conducted across the life span. In their view this whole-of-system approach to addressing the issue of sexual violence is more likely to bring about sustainable change than any single intervention.

Table 13: Individual, Relationship, Community and Societal Strategies for Responding after Sexual Violence Incidents

	Individual	Relationship	Community	Societal
After a Sexual Violence Incident: Response Strategies	• Provide crisis intervention services for victims/survivors • Provide offender treatment services for perpetrators	• Provide services for family members of sexual assault victims to assist them in resolving the impact of the assault and to help them be sensitive and supportive of the survivor	• Develop police protocols for responding to and investigating reports of sexual assaults • Hold 'Take Back the Night' rallies that raise community awareness of the scope, nature and impact of sexual violence	• Assist in educating legislators about the importance of mandatory legislation that ensures all survivors of sexual assault the provision of forensic examination at no cost

Source: Centres for Disease Control and Prevention (2004). Retrieved from: http://www.cdc.gov/violenceprevention/pdf/svprevention-a.pdf

5.3.2 Impacts of Sexual Violence

Understanding the impacts of sexual violence is complex. This complexity is due to the fact that the impacts of sexual violence are unique to each individual. For example, not all people experience all of the known impacts of sexual violence and the impacts that are experienced may emerge in the short term for some and in the

longer term for others. Moreover, factors in each person's ecology may either ameliorate and/or exacerbate their respective experiences of the potential impacts.

Daane (2005) found that a range of factors can influence the impact of sexual violence for individuals. These factors include: the victim/survivor's relationship to the perpetrator; the extent and severity of any accompanying psychological or physical abuse; the severity of the abuse; the extent of physical harm; the length of time over which the abuse occurred; the responses of family and friends of the victim/survivor; the person's experience of the various systems (health, police, courts etc.) with which they may have contact following the assault; and, the personal history of the victim/survivor. In earlier research conducted directly with victims of sexual violence, Koss and Harvey (1991) reported that responses to this trauma will differ depending on a range of factors that operate in the victim/survivor's environment. The variables identified by these authors included: the individual's personal circumstances; prior abuse history; relationship to the perpetrator; interventions offered to the victim; available support networks and services; degree of safety and control the victim/survivor felt before and after the trauma; prevailing community attitudes and values about sexual violence; and the quality and accessibility of care.

The impacts of sexual violence identified in the literature include:

- Psychological and emotional impacts
- Physical impacts
- Social and community impacts.

***Psychological and Emotional Impacts*:**

Astbury (2006:4) states that the short-term impacts of sexual violence include "shock, fear and feelings of helplessness;" while Wang and Rowley (2007) note other immediate responses such as anger, sadness or controlled emotions. Peterson, Olasov and Foa (1987) and others (Koss, Goodman, Browne, Fitzgerald, Kelta & Russo, 1994) found that for many individuals, feelings of fear peak about three weeks after the incident although for others such feeling can last for more than one

year. Previous research has shown that such fear and anxiety can be related to reminders of the incident (for example, medical examinations, interactions with the criminal justice system, being in certain locations or with certain people); risk of contracting sexually transmitted diseases and/or pregnancy (Holmes, Resnick, Kilpatrick & Best, 1996; NHS England, 2013; Resnick, Acierno & Kilpatrick, 1997); and/or perceptions of the community as unsafe – perceptions that can restrict participation in social and community activities (Crome & McCabe, 1995; Wasco, 2003).

Longer-term psychological and emotional impacts of sexual violence include suicidal ideation (Petrak, 2002; Stepakoff, 1998); forgetting or denying aspects of the experience (Crome & McCabe, 1995); and, low self-esteem, self-blame and guilt (Boyde, 2011). Many commentators in the literature state that the trauma of sexual violence strongly predicts the subsequent development of post-traumatic stress disorder (PTSD). For example, Regehre, Alaggia, Dennis, Pitts, and Saini (2013) found that PTSD is more likely for those who have experienced sexual violence than any other types of trauma and the Taskforce for Action on Sexual Violence (2009) notes that the Diagnosis and Statistical Manual of Mental Disorders (DSM-1V) lists survivors of rape as having the highest prevalence of PTSD of any crime. Moreover, Kessler, Sonnega, Bromet, Hughes and Nelson (1995) state that those who have experienced rape are six times more likely to develop PTSD at some point in their lives than those who have not had this experience. The Sexual Violence Research Initiative (2011) notes that PTSD symptoms (for example, nightmares, flashbacks, heightened arousal and/or numbness) gradually increase in the first three weeks after the incident. Moreover, they report that indicators of the likely development of chronic PTSD include persistent dissociation, rumination, self-blame, disorganised memories of the trauma, maladaptive coping strategies, substance abuse, depression and physical reminders of the attack.

***Physical Health Impacts*:**

A number of studies describe a range of chronic health problems experienced by those who have experienced sexual violence either as a child or as an adult

(Kilpatrick & Acierno, 2003; Koss, Bailey, Yuan, Herrera & Lichter, 2003). These physical health issues include sexual and reproductive health problems, chronic pain, eating disorders (Krakow, Schrader, Tanberg, Hollifield, Koss & Yau, 2002). In addition, sexual violence can be associated with increased dependence on prescription medicine (Sturza & Campbell, 2005) and alcohol (Ullman, Filipas, Townsend & Starzynski, 2005).

***Social and Community Impacts*:**

Previous research has found that interpersonal relationships between the person who experienced the sexual violence and their partners, friends and family can also be affected. These affects appear to be mitigated to some extent by the degree to which family and friends understand the impact of sexual violence and the way in which they respond to the disclosure (Coker, Davis, Arias, Desai, Sanderson & Brandt, 2002; Fleming, Mullen, Sibthorpe & Brammer, 1999; McMahon, Goodwin & Stringer, 2000). Littleton & Breitkopf (2006) found that when family and friends were better informed about the effects of sexual violence, they were better able to support the victim/survivor.

While the support of family and friends can assist with the healing journey for the person who has experienced sexual violence, they too can experience what some researchers refer to as 'secondary victimisation.' Morrison, Quadara and Boyd (2007) maintain that knowledge of the sexual violence can in itself be a traumatising experience for family and friends. Holmes and Holmes (2009) comment that anyone who has intimate or personal contact with a victim/survivor of sexual violence can be impacted, both in the immediate and longer term. These authors note that the victim's experience can trigger an aversion to sexual contact which in turn can precipitate a lack of trust and/or intimacy within intimate partner relationships. Moreover, they note that it is not only intimate partner relationships that can be adversely affected, but also those between the victim/survivor and their children. For example, the victim/survivor may retreat from family life and be unable to provide "the type of nurturance that a child may need to develop into a well-adjusted adult" (Holmes & Holmes, 2009:256; Noll, Trickett, Harris & Putnam, 2009). These

circumstances suggest that family and friends also may need support following events of sexual violence. [36]

Other research has found that the experience of sexual violence can also negatively impact on people's confidence at work and many are reticent about going out in their communities (Koskela & Pain, 2000; Morrison, Quadara & Boyd, 2007).

How communities react to incidents of sexual violence within their membership is often governed by prevailing ideas about sexuality and the status of women. In some societies for example the victim/survivor is required to marry the person who committed the sexual assault to preserve the integrity of a women and her family by legitimising the union (UNICEF Innocenti Research Centre, 2001). Apart from marriage, Mollica and Son (1989) state that some culturally and linguistically diverse communities may put pressure on the victim/survivor not to report the sexual violence. Other commentators note that in some cultural settings men may reject their partners if they have been raped; and in other settings lost honour for the community means the victim/survivor can be ostracized (Mercy, Abdel Megid, Salem & Lotfi, 1993).

While Andrews, Corry, Slade, Issakidis and Swanston (2004) note that women and girls bear additional burdens of injury and disease from sexual violence (e.g. sexual and reproductive health consequences such as unwanted pregnancy, unsafe abortion and higher risk of sexually transmitted diseases), the evidence suggests that both men and women victims/survivors of sexual violence experience similar social, mental health and behavioural consequences (Dube, Anda, Whitfield, Brown, Felitti, Dong & Giles, 2005; Patel & Andrew, 2001).

[36] Campbell and Raja (1999) and Ahrens (2006) also use the phrase 'secondary victimisation' in relation negative experiences victims/survivors have with professionals (for example, those working within health, criminal justice system and counselling services). These authors have found increased psychological distress and/or delayed recovery can occur if professionals are victim blaming, offer minimising or disbelieving responses at disclosure and/or do not provide or link the person with needed services in a timely manner.

Impacts of Sexual Violence in Childhood and Beyond

Itzin, Taket and Barter-Godfrey (2010) note that the impacts of childhood sexual abuse need to be considered within the context of each child's experience of powerlessness in such circumstances, as well as their lack of control over what happened to them. Moreover they argue that these particular circumstances often result in children adopting strategies that allow them to gain some sense of control – strategies which some researchers observe are often seen as signs of pathology, rather than coping mechanisms; and often provide the basis for a range of problems in adult life (Jenny, Christian, Hibbard, Kellogg, Spivack, Stirling, Albers, Hermon, & Mason, 2008).

A review of the literature on the neurobiological effects of child abuse was undertaken by Neigh and colleagues in 2009 (Neigh, Gillespie & Nemeroff, 2009). This review found a range of effects from the experience of childhood sexual abuse including: delayed/ reduced development and poor educational attainment (Dixon, Reed, Rogers & Stone, 2006); poorer physical health and injuries (Kemp, Dunstan, Harrison, Morris, Mann, Rolfe, Datta, Thomas, Sibert & Maguire, 2008); antisocial and offending behaviour (Evans, Davies & DiLillo, 2008); sleep disorders (Wells, McCann, Adams, Voris, & Ensign, 1995); anxiety and psychological problems (Valente, 2005); eating disorders (Smolak & Murnen, 2002); depression and PTSD (Luthra, Abramovitz, Greenberg, Schoor, Newcorn, Schmeidler, Levine, Nomura & Chemtob, 2009); self-harm, suicidality and suicide (Valente, 2005); dissociative disorders (Collin-Vezina & Herbert, 2005); and ADHD and hyper-arousal (Glaser, 2000).

5.3.3 Affects of Trauma: Understanding the Victims'/Survivor's Journey of Healing from Sexual Violence

The literature includes a number of models that describe 'typical' stages of a victim/survivor's response to an experience of sexual violence. Within each stage people may encounter any one of a range of problems and reactions depending on their individual circumstances and the support they receive from within their natural and/or professional environment. The following models of the victims/survivors'

journey of healing from the trauma of sexual violence and the associated issues that may be experienced by them at each stage are outlined in the following paragraphs including:

- Burgess and Holmstron's 'Rape Trauma Syndrome'
- Herman's Three-Staged Recovery Model
- Itzin, Taket and Barter-Godfrey's 'Three-Staged Approach for Adult Victims of Rape and Sexual Assault'
- Holmes and Holmes' 'Stages of Victims' Responses to Sexual Assault'

Burgess and Holmstrom (1974a) provided one of the first staged models of the psychological, physical and emotional effects of sexual violence – a model they referred to as the 'rape trauma syndrome.' This model includes an acute phase and a longer term process of reorganisation with a period of adjustment between them. Olle (2005) comments that the research that underpinned this model provided the basis for the formal recognition of post-traumatic stress disorder now listed in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM1V) (American Psychiatric Association, 2000); as well as the foundation for more recent models of trauma recovery, such as that described by Herman (1997). The main features of Burgess and Holmstrom's 'rape trauma syndrome' model are outlined in the following text box.

Rape Trauma Syndrome Model (Burgess & Holmstrom, 1974a)

Acute Phase: Occurs immediately following the assault and lasts for several weeks, resulting in the complete disruption of the victim/survivor's life. Reactions may include some of all of the following:

- Emotional Reactions – the immediate response to the sexual assault is characterized by disbelief, shock, and a wide range of emotions. Although fear of physical injury, mutilation, and/or death is the most common emotion, the person may also experience intense feelings of anger, humiliation, degradation, shame, embarrassment, self-blame, and guilt. These feelings of anger, fear, and anxiety

can express themselves in crying, sobbing, smiling, shaking, restlessness, and tenseness. Alternatively, the person may hide their feelings and seem to be calm, composed, or subdued. Sometimes this controlled response is misinterpreted as evidence that the assault did not really affect the person, or that it did not even occur. It is important not to interpret a controlled response as evidence that the assault did not really happen or that the events did not really affect the person.

- Physical Reactions – the person's physical reactions include soreness and bruising specific to areas where they may have been injured; headaches, fatigue, and sleep disturbances; loss of appetite and nausea; vaginal discharge, infection, and pain associated with gynaecological symptoms; and side effects from anti-pregnancy and HIV-related medication such as nausea or temporary disruptions of a woman's menstrual cycle.

- Behavioural Reactions –behavioural reactions may include disturbances in sleeping patterns because of nightmares; in eating patterns because of a decrease or increase in appetite, complaints of food not tasting right, or nausea; and in their ability to concentrate because they cannot block out thoughts about the sexual assault.

Outward Adjustment: A second phase that occurs is apparent outward adjustment as realistic problems and consequences replace the emotional turmoil created by the assault. Characteristics of this phase are that immediate anxiety subsides, the survivor returns to normal pursuits and seems to forget about the assault for a while. There is often a heavy measure of denial, suppression, or rationalization. Anger and depression may be diminished or subdued. The survivor will probably not want to talk to a practitioner about the assault during this stage. Some of the practical problems facing the survivor may include: deciding to move to a new location, and having to talk to friends, or co-workers.

Long-term Response: This is the sexual assault reorganisation phase, where the

person strives to come to terms with the sexual assault and incorporate it into a framework that they can understand. This phase may overlap with the first phase and continue for months or years and encompasses the survivor's process of reorganizing their disrupted life. At this stage, the issues that come up for the victim/survivor will be complex. For example, a person who has been assaulted may experience some or all of the following:

- Changes in lifestyle – This may involve general upheaval in their living patterns, such as curtailing normal activities or not going to work or school. They may change their place of residence or employment, or drop out of school in order to avoid being constantly reminded of the assault. They may change their phone number to give themselves a feeling of safety. They may reach out in new directions for support.
- Nightmares – Victims/survivors report two main types of nightmares: - flashback dreams of the actual assault in which the person wakes up screaming or fighting; and/or mastery dreams in which they gain power over the assailant or obtain revenge.
- Phobias – A person may develop fears in reaction to the circumstances of the assault. For instance, they may be afraid of being alone, or leaving the house, or of people who in some way resemble the assailant. If these fears are not acknowledged or validated, they can develop into paranoia, global anxiety, or phobias.
- Sexual Dysfunction – A person may experience a range of reactions such as physical pain, loss of sexual pleasure, disinterest in sex, or dread of sex. Sexual activity may trigger flashbacks and feelings of vulnerability and disgust.
- Compound Reactions – Sometimes a person's reactions are compounded by problems with family, money, school or work. Sometimes they might have problems with alcohol or drug abuse.

Source: Adapted from 'Sexual Assault: Victim Service Worker Handbook' (1993) Victim Assistance Program, Ministry of Attorney General. Canada (Olle, 2005).

Both Herman (1997) and Itzin et al. (2010) describe three-staged healing journeys for those who have experienced the trauma of sexual violence. The stages in Herman's model include: establishing safety; retelling the story of the trauma event; and reconnecting with others. Throughout this model, Herman describes a range of victim/survivor reactions to sexual violence, but particularly emphasises their experiences of disempowerment, disconnection from others, safety concerns and grief.

> *"Trauma destroys the social systems of care, protection and meaning that support human life. The recovery process requires the reconstruction of these systems. The essential features of psychological trauma are disempowerment and disconnection from others. The recovery process therefore is based upon empowerment and restoration of relationships. The recovery process is conceptualised in three stages: establishing safety; retelling the story of the traumatic event; and reconnecting with others. Treatment of post-traumatic stress disorder must be appropriate to the survivor's stage of recovery." (Herman, 1998:145)*

Itzin et al. (2010:90) describe a three-staged model that is akin to Herman's model and includes the 'safety and stabilisation' stage; the 'processing of memories' stage; and the 'reconnection' stage. Of particular interest in the context of this review is their list of "symptoms to be stabilised." This list includes 'anxiety and panic; depression; sexual difficulties; self-image difficulties; self-harm; alcohol/drug abuse; eating disorders; anger difficulties; flashback and nightmares; dissociation; self-esteem difficulties; relationship difficulties; and obsessive compulsive difficulties."

In their 'Stages of Victims' Responses to Sexual Assault' model, Holmes and Holmes (2009) outline a three-staged model of recovery: shock; denial; and integration. These authors state that the 'shock stage' occurs immediately following victimisation and they estimate that it may last between 60 and 90 days. During this stage victim/survivors may experience anxiety, guilt and fear and many "exhibit behaviour that runs the gamut from hysteria to behavioural numbness" (Holmes and Holmes, 2009:267). The duration of the 'denial stage' varies between several months to several years and is often associated with victims/survivors seeking to put the experience of sexual violence behind them and return to their regular routine. During

the final ‘integration stage’ victims/survivors are adjusting to a level of acceptance of the incident, however Holmes and Holmes (2009) advise that they may continue to experience panic attacks; relationship breakdowns, employment difficulties; and other psychosocial problems.

5.3.4 Resilience and Protective Factors and Sexual Violence

Price, Hilsenroth, Petretic-Jackson and Bonge (2001) note that the impacts of sexual violence vary in intensity and duration for different people and Hartling (2008) believes that resilience is a useful concept for better understanding such differential responses. Itzin et al., (2010) and others (Boyde, 2011; Connor & Higgins, 2008) have found that there are features within resilient contexts which may attenuate the impact of sexual violence. These factors include:

- Social, economic and employment security
- Advocacy and autonomy
- Access to safety and separation from those who commit the sexual violence
- Speaking out about the sexual assault
- Social acknowledgement of the impacts of sexual violence
- Positive reactions of support (empathy, belief and understanding)
- Strong, empathetic social networks

Of these resilience factors, many researchers have found that strong relationships with family and friends, and their positive support for them, not only reduces the impact of sexual violence but also enhances recovery (Campbell, Ahrens, Sefl, Wasco & Barnes, 2001; Filipas & Ullman, 2001; Menard, 2005; Thomas & Hall, 2008: Ullman, 1996).

6. Accessing Sexual Assault Support Services

6.1 Barriers to Access: A General Overview

In 2008 the Directorate General of Human Rights and Legal Affairs Council of Europe (Council) developed standards for the provision of services for those who experience predominant forms of violence, including domestic and sexual violence (Kelly & Dubois, 2008). One of these standards, equity of access to services by victims/survivors whenever and wherever they needed them and whatever their circumstances, was regarded as a human right – a right to access protection; to access justice; and to access support (Kelly & Dubois, 2008: 17, 28). In order for victims/survivors to experience equity of access to services, the Council recommended that specialist domestic and sexual violence services should be equitably distributed across the geography of each country; that there should be a sufficiency of services to ensure availability and preclude waiting lists; that additional resources should be available to meet the additional access needs of certain groups of potential users (for example, groups such as those with refugee and migrant backgrounds; those with disabilities; those from rural areas); and that funding should be available for non-government organisations delivering specialist domestic and sexual violence services. Moreover the Council was of the view that such services should respect the diversity of service users and engage in anti-discriminatory practices; be free of charge; and crisis provision should be available 24/7.

Yet despite this acknowledgement, that creating the conditions for equitable access to services for people who experience sexual violence is a human right, previous research has shown that sexual violence is often hidden with low rates of disclosure and reporting (Bein, 2011; Contreas et al., 2010; Stern, 2010; World Health Organisation, 2012). [37]

[37] Research undertaken in 2007 within England and Wales estimated that between 75 and 95% of rapes were never reported to the police (HMIC, 2007). Povey, Coleman, Kaiza and Roe (2009) found that 11% of serious sexual offences against people aged 16 years and over were never reported to the police. These reporting rates are similar to those in Australia (Taylor & Gassner, 2009). Moreover, Wainer and Summers (2011) observed that even if people disclosed domestic violence, they were unlikely to report the sexual violence

Kelly (2005) observed that disclosing experiences of adult sexual assault or childhood sexual abuse is made more challenging because in the majority of societies sexual violence is associated with stigma and/or dishonour. Abrahams et al., (2014) agree stating that "sexual violence is highly stigmatised in most settings" (Abrahams, Devries, Watts, Pallitto, Petzold, Shamu & Garcia-Moreno, 2014:5). This and other factors (personal-, service-, and societal-level factors) result in under reporting and create barriers to help seeking and receipt of sexual violence services (Abrahams & Jewkes, 2010; Campbell, 1998; Campbell, Ahrens, Sefl, Wasco & Barnes, 2001; Johnston, Ollus & Nevala, 2008; Henderson, 2012; Kelly, Lovett & Regan, 2005; Logan, Evans, Stevenson & Jordon, 2005; Martin, 2005). Such under reporting and barriers to help seeking mean that people may be denied support and service opportunities to minimise the detrimental effects of sexual violence (including long-term health outcomes, such as post-traumatic stress disorder, stress disorder and sexually-transmitted diseases) and recover (Astbury, 2006).

A number of studies (Campbell, 2008; Henderson, 2012; Kelly & Regan, 2003; Lievore, 2003, 2005; Wainer & Summers, 2011) have identified a range of personal-level and system-level factors that are barriers to disclosure and service access including:

element of this offence. In their study, the reporting rate for domestic violence was 25%, whilst the reporting rate for sexual violence was 11%.

In relation to childhood sexual abuse, Cawson, Wattam, Brooker and Kelly (2000) estimated that about 28% of victims/survivors tell someone at the time.

Davis, Lurigio & Skogan, (1999) observed that victim service programmes reach only a small proportion of crime victims. Langton (2011) estimated that about one in five victims/survivors of rape and other sexual assaults received assistance from a victim service organisation.

- ***Lack of understanding of the legal definitions of sexual violence and/or not regarding the incident as significant enough to report to the police*** [38]

  In Lievore's study, a quarter of the respondents did not define their experience as sexual assault – a situation that meant that victims/survivors delayed access to service, and when they did they did not link the adverse physical, mental health and social impacts they were experiencing with the earlier sexual violence (Lievore, 2005). This finding was supported by other research (Wainer & Summers, 2011). Moreover, Zweig and Burt (2002) and Home Office (2007) observed that some 'vulnerable adults and children,' such as those with intellectual disabilities and/or older adults, may not understand what is happening to them.

  Greenberg and Ruback (1992) noted that societal beliefs and stereotypes about sexual violence influence disclosure and reporting. Moreover, many studies have shown that people are more likely to report a sexual assault to the police if it aligns with the societal stereotype – committed by a stranger, using a weapon or physical force and if they were physically injured requiring treatment (Davies, Lurigio & Skogan, 2007; Campbell, Wasco, Ahrens, Sefl & Barnes, 2001; Felson & Paré, 2005; Kaukinen, 2002; Menard, 2005; Resnick, Holmes, Kilpatrick, Clum, Acierno, Best, et al., 2000). Interestingly, Gavrilovic, Schutzwohl, Fazel and Priebe (2005) found that crime severity was predictive of helping-service usage among adult men and women.

- ***Feelings of shame and embarrassment*** [39]

  For example, of the embarrassment that may be experienced by victims/survivors of sexual violence, Dame Vivien Stern (2010:60) wrote:

  "*Reporting a rape ... is intimate and for most people ... feels humiliating. Very private matters have to be discussed with strangers. Medical tests that are*

[38] Reported in studies undertaken by Kelly (2005); Kilpatrick et al., (1992); and Wainer & Summers (2011).

[39] Reported also in a study undertaken by the World Health Organisation (2012).

intrusive even in normal circumstances where there is no crime and no emotional distress will have to be undertaken. People will be taking an in-depth look at one's private life, and matters could come up that one could be ashamed of."

- ***Regarding it as a private matter and wanting to deal with it themselves*** (Kelly, 2005)

- ***Fear of disbelief*** [40]

  The Stern review of rape reporting procedures identified that fear of disbelief was a major issue for both male and female victims/survivors. However, this review also noted that men have an additional fear that they will be judged as gay if they report that they have been a victim of sexual violence (Stern, 2010).

  A 2015 UK Inquiry on domestic and sexual violence reported a culture of disbelief with the Police when people reported sexual violence (Hawkins & Taylor, 2015). This inquiry cited a 2014 HMIC report on crime reporting that found that 10.8% of rape reports were not classified as crimes by the police, compared to a no-crime rate for overall police-recorded crime of 3.4% (Her Majesty's Inspectorate Constabulary, 2014).

  Moreover, Henderson (2012) observes that those involved in prostitution, or who use substances, are less likely to be believed when they disclose experiences of sexual violence; and Murray and Powell (2008) found that people with physical, intellectual and/or psychiatric disabilities, who disclosed they had experienced sexual violence, were not believed.

[40] Reported also in studies undertaken by Kelly, (2005); Henderson, (2012): Kilpatrick, Edmunds & Seymour (1992); Logan, Evans, Stevenson & Jordon (2005); Quixley (2010); Wainer & Summers (2011); and Wolf, Ly, Hobart & Kernic (2003).

- ***Feelings of self blame and/or fear of blame/judgement by others*** [41]

  Quixley (2010:19) wrote "social and cultural messages suggesting that anyone who is assaulted must have asked for it are alive and well in Australian society." A study undertaken by Ullman (1999) found that self blame was associated with poorer psychological adjustment and that this in turn was fuelled by the negative reactions of blame and doubt of professionals, family and friends. Moreover, research undertaken by Koss and Figueredo (2004) and Koss, Figuredo and Prince (2002) found that the level of emotional distress experienced by victims/survivors is largely determined by their degree of self blame; and an earlier study found that as the number of negative reactions from others increases the emotional and physical health of victims/survivors decreases (Campbell, Ahrens, Sefl, Wasco & Barnes, 2001).

- ***Distrust of the police/courts/legal process, for example fear of not being believed by the police and/or doubting that the legal system will provide redress*** [42]

  In 2013 a state-wide poll was conducted by Californians for Safety and Justice. This study showed that those who did not report were "reluctant to inform the authorities mostly because they struggled with the time and effort required to report, especially if they were doubtful that the police could or would do anything" (Californians for Safety and Justice, 2013:10). This finding was supported by the Her Majesty's Inspectorate Constabulary (2007) study that considered deterrents to disclosure and reporting. One of the identified deterrents was that people did not want to go through the police investigation process and that they were aware of the low rates of conviction for offences of sexual violence.

[41] Reported also in studies undertaken by Kelly (2005); Kilpatrick, Edmunds & Seymour (1992); Mossman, Jordan, MacGibbon, Kingi & Moore (2009); Wainer & Summers (2011); and World Health Organisation (2012).

[42] Reported also in studies undertaken by Kelly (2005); Kilpatrick et al., (1992); Stern (2010); and World Health Organisation (2012).

- ***Fear of family, friends and others knowing/public disclosure/stigma*** [43]

  A Rape in America study, that sought to identify the primary concerns of victims/survivors of sexual assault, found that within the top four concerns were: family knowing they had been sexually assaulted; people outside the family knowing that they had been sexually assaulted; and their name being made public in the media (National Victim Centre & Crime Victim Research and Treatment Centre, 1992). Moreover, Wolf, Ly, Hobart and Kernie (2003) found that a barrier to reporting sexual violence to law enforcement was being labelled or stigmatised as a crime victim.

  Concerns about confidentiality and community backlash was a particular concern for people who reside in rural areas – concerns that Logan, Evans, Stevenson and Jordon (2005) stated precluded disclosure of sexual violence and service access.

- ***Fear of further attack, retaliation or intimidation by the perpetrator*** [44]

  Kilpatrick et al.'s (1992) study of the reasons why victims/survivors do not report their experience of sexual violence to the police found that the most common reason was their fear of retaliation from the perpetrator (22%). Other studies support this finding (Bachman, 1998; Fugate, Landis, Riordan, Naureckas & Engel, 2005; Wolf, Ly, Hobart & Kernie, 2003). Some other studies observed that this fear of reprisal was particularly associated with sexual violence that occurred within the context of intimate partner violence. For example, Logan, Evans, Stevenson and Jordon (2005) found that victim/survivor's economic dependence on the perpetrator was often cited as a barrier to reporting – an economic dependence that meant that there may be adverse financial impacts on the household if the perpetrator was arrested and imprisoned.

[43] Reported also in studies undertaken by Kelly (2005); and Stern (2010).

[44] Also reported in studies undertaken by Fry (2007); Kelly (2005); and World Health Organisation (2012).

- ***Wanting to protect current/ex-partners and their children***

  Stern (2010) observed that some victims/survivors who have experienced sexual violence within the context of an intimate partner relationship may not report the incident to the police for fear that a care and protection agency may become involved and take their children into care. This observation was supported by other studies that also noted a related concern that inhibited victims/survivors disclosing their experiences of sexual violence - jeopardising their children's safety by exposing the children to violence (Davies 2007; Logan, Shannon, Cole & Walker, 2006; Wolf et al., 2003).

- ***Language/communication issues for women with disabilities and/or whose first language is not that of the country where they were sexually assaulted***

  A 2007 report prepared by the Home Office noted that people with refugee or migrant backgrounds may not disclose experiences of sexual violence because of language, immigration and/or religious and cultural matters (Home Office, 2007). Goldolf, Fisher and McFerron (1988) found that people from culturally and linguistically diverse backgrounds may be hesitant to report experiences of sexual violence because of their limited understanding of their legal rights within the country of resettlement. In addition, Dutton and Kropp (2000) and others (Wiist & McFarlane, 1998) found that other obstacles to disclosure and service utilisation included concerns about deportation, language problems and lack of awareness of available services.

- ***Not knowing how to report and/or access service***

  Research undertaken by Zweig, Schlichter and Burt (2002) showed that one of the barriers for people seeking service was that they were unaware that services were available in their communities, nor were they aware of their right to use them. This finding is supported by other studies (Californians for Safety and Justice, 2013; Freedy, Resnick, Kilpatrick, Dansky and Tidwell, 1994; Sims, Yost & Abbot, 2005). In New Zealand, research has documented that of all population sub-groups, Pacific Peoples (as well as Asian people) are least aware of community support agencies (Mayhew & Reilly, 2007).

In addition to these personal-level and system-level barriers to access sexual violence services, Zweig, Schlichter and Burt (2002) identified a number of service-level barriers to service for people who had experienced sexual assault. These identified barriers included:

- Lack of services for victims/survivors within some communities, for example in rural communities (Campbell, 1998; Campbell, Ahrens, Sefl, Wasco & Barnes, 2001; Logan, Evans, Stevenson, & Jordon, 2005; Martin, 2005; Mossman, Jordan, MacGibbon, Kingi & Moore, 2009; Ullman & Townsend, 2007)

- Lack of visibility for those seeking help with sexual violence issues (Lievore, 2005)

- Some services questioning the credibility of certain sub-groups within the population of those who have experienced sexual violence, for example those working in the sex industry, those with experience of mental illness, and those subject to criminal justice sanctions (Roguski, 2013a)

- Some service providers' staff having inadequate professional development training about the special issues and concerns confronting certain sub-groups within the population who have experienced sexual violence and/or identifying issues other than the sexual violence. The sub-groups identified in the literature that might be affected by this access issue include elders; men; people with disabilities; people from culturally and linguistically diverse communities; and people presenting with multiple issues (including sexual violence, and/or family violence, and/or mental health issues, and/or substance abuse issues, and/or housing, transport, employment, income dependence, poverty issues). For example, Henderson (2012:6) writes that lack of identification of experiences of sexual violence, and therefore access to services, "may be due to a lack of awareness among agency staff and/or the absence of routine inquiry approaches." Moreover, Roguski (2013b) noted that professionals working with people with disabilities may identify and address presenting issues such as

financial abuse and 'locked in' abuse, but not identify and provide services for the person's experience of sexual abuse.

- Some services not following up on initial contacts from people who experience and are affected by sexual violence (Zweig et al., 2002).

- Lack of collaboration between specialist sexual violence services and services operating within other sectors – a situation that may mean that victims/survivors do not gain access to the range of services required to address their multiple presenting issues (Quixley, 2010; Zweig et al., 2002). Research undertaken by Cashmore and Shackel (2013) and others (Widom, 1995; Widom & Ames, 1994) found that those who experienced childhood sexual abuse had an increased risk of facing a range of difficulties in adulthood – difficulties such as further victimisation, health and mental health problems (for example, depression, anxiety, attempted suicide, somatic symptoms, sexual maladjustment), substance abuse and social instability including difficulties with jobs, education, criminal behaviour and housing. Davies (2007) supports these findings and states that victims/survivors issues are often complex and cut across systems and disciplines (for example, services such as crisis intervention, support, mental health, alcohol and drug, health care, economic support and legal advocacy) and that collaboration across agencies is required to address these myriad of issues. In 2009 Sara Payne conducted a review of the experiences of rape victims/survivors and those who participated in the focus groups described their experiences of poor cross-service coordination:

  > *"Services provided to victims tend to be done so in isolation, and again vary from area to area. The needs of a victim are not confined to support offered by criminal justice agencies. Health, education, housing and social services were frequently involved in these cases but there was a complete lack of co-ordination of these services"* (Payne, 2009a:24).

Other service-level issues associated with access and identified within the literature included: lack of physical access to building for people using a wheelchair (Fry,

2007); and prior negative experiences with providers of service (Fry, 2007; Thomas & Hall, 2008; Zweig, Schlichter & Burt, 2002).

6.2 Under-Served Groups: Barriers to Access and Strategies for Enhancing Access

Several authors have identified groups of people who are hard to reach and who have experienced sexual violence, including those working in the sex industry, those with disabilities, young people, men, those identifying as lesbian, gay, bisexual and transgender, elders, people in institutional settings, people from culturally and linguistically diverse communities, Māori, Pacific Peoples, those with mental health issues and those with substance abuse issues (Hardcastle, Hughes & Bellis, 2013; Henderson, 2012; Mossman, Jordan, MacGibbon, Kingi & Moore, 2009; Quixley, 2010; Wainer & Summers, 2011; Zweig, Schlichter & Burt, 2002). Henderson (2012:6-7) comments that 'hard-to-reach groups', "through choice or isolation or exclusion or other vulnerability may never come to the attention of an agency" or face a range of barriers to access the support of a specialist sexual violence service. In response to this challenge and included in the practice principles underpinning the national standards for sexual assault treatment services in Ireland, O'Shea (2014:28) writes about 'diversity and fair access,' stating that "services must respect the diversity of service users and positively engage in anti-discriminatory practices." In order to improve access for hard-to-reach groups, a number of authors have published practice guidelines for improving access to under-served groups who have experienced sexual violence. [45]

[45] See Quixley (2010), Colorado Coalition Against Sexual Assault. (2011) and West Virginia Protocol for Responding to Victims of Sexual Assault (2011:23-29) for overviews of suggested responses by sexual assault services for victims/survivors residing in rural areas; men who have experienced sexual violence; people from culturally and linguistically diverse communities; young people who have experienced sexual assault; people with disabilities who have experienced sexual violence; and, people who are imprisoned and who have experienced sexual assault.

See Vierthaler (2008) for an overview of best practices for working with elders who have experienced sexual violence.

See Health Services Executive (2011) for an overview of best practices for working with children and young people who have experienced sexual violence.

6.2.1 Men: Access Issues and Strategies for Overcoming These

Disclosure and Barriers to Help Seeking

Research indicates that men who have experienced sexual violence, either in childhood or as an adult, have not told anyone and find it less easy to ask for help (Henderson, 2012; Holmes & Slap, 1998; KPMG, 2009; Stern, 2010). Of childhood sexual abuse, O'Leary and Barber (2008) found that compared to girls boys were less likely to disclose at the time of the sexual abuse; and O'Leary and Gould (2010) found that on average men disclose childhood sexual abuse some twenty-two years after the assault (ten years later than women). In relation to men's experiences of adult sexual violence, Hunter (2011) found that men make fewer and less disclosures than women; and are one and a half times less likely to report such incidents to the police compared to women (Pino & Meier, 1999). Sorsoli, Kia-Keating and Grossman (2008) state that men's decisions to disclose and access service is influenced by a number of factors including: male role expectation stereotypes (Lisak, 2005); questions related to sexuality (for example, homophobia and people thinking he is gay) (KPMG, 2009; Teram, Stalker, Hovey, Schachter & Lasiuk, 2006; Wainer & Summers, 2011); and the widely-believed assumption that males who experience sexual violence automatically become sex offenders (Sorsoli et al., 2008). Foster, Boyde and O'Leary (2012:6) comment that such stereotypes and assumptions must be challenged in order for men to disclose and seek support; and men "need reassurance that they will be believed, taken seriously, and not evaluated against normative masculine expectations."

See Gentlewarrier (2009) for an overview of culturally competent service provision to lesbian, gay, bisexual and transgender survivors of sexual assault.

See Du Mont, Macdonald, White & Turner (2013) for a review of the literature on male rape and sexual assault; and, Burrows & Horvath (2013) for the findings from a study on men's use of sexual violence treatment services; and, Chaitowitz, van de Graaff, Herron & Strong (2009) for a description of services for men who have experienced sexual assault or child sexual abuse.

See Blanch (2008) for models of trauma healing with people from culturally and linguistically diverse communities who have experienced sexual violence.

See Wisconsin's Violence Against Women with Disabilities and Deaf Women's Project (2011) for working with people with disabilities who have experienced sexual violence.

Strategies for Enhancing Service Responsiveness

- Develop promotional materials that are gender specific and describe the difficulties that men may be facing (Hardy, 2007)

- Provide confidential telephone help lines and websites that can offer information in an anonymous way as a stepping stone for men to engage with specialist sexual violence services (Craig, 2010; Foster, 2011; Wilkins & Baker, 2004)
- Provide services in an adaptive manner that meets men's diverse cultural and social identities, for example being responsive to gay and men who 'may have become homophobic as a reaction to being sexually abused' (Department of Families, Housing, Community Services and indigenous Affairs, 2009)

- Provide an immediate response to men's help seeking as there is often a short window of opportunity to engage at the time of crisis

- Offer after hours support services, as often men are reluctant to take time off work to access support services

- Create a male-friendly agency environment (MacDonald, Brown & Gethin, 2009)

- Offer a choice of practitioner, for example the option to engage with a man or a woman (Chowdhury-Hawkins, McLean, Winterholler & Welch, 2008; Denov, 2004)

- Recognise that men may present at services other than a specialist sexual assault support service and not name the sexual violence as the presenting issue. For example, O'Leary (2009) states that drug and alcohol misuse is often a common form of coping for men who have experienced sexual violence, and often professionals fail to identify the sexual violence and make the appropriate referral to specialist sexual violence services. In these circumstances, commentators in the literature offer two recommendations for non-core sexual violence services: provide professional development to enhance appropriate recognition and

response; and develop strong relationships with specialist sexual violence services for men in order to facilitate referrals.

6.2.2 Elders: Access Issues and Strategies for Overcoming These

Disclosure and Barriers to Help Seeking

The prevalence of sexual violence amongst older people is difficult to quantify. However, a national study undertaken by Rennison (1997) found that 3% of people who experience rape/sexual assault were fifty years and older; and more recent data from the 2000 National Crime Victimisation Survey identified 3,270 of 261,000 people with experience of sexual violence were aged 65 years and older (Rennison, 2002). Within the context of a multi-state study of 429 cases of sexual violence that occurred within care facilities, there were 124 victims/survivors aged between 60 and 101 (Ramsey-Klawsnik, Teaster, Mendiondo, Marcum & Abner, 2008).

The incidence of reporting and subsequent access to specialised sexual violence services amongst elders is low. One study estimated that for every case reported, five remained undisclosed (The National Centre on Elder Abuse & Westat Inc., 1998); and another estimated that only 30% of elders, who experienced sexual violence, contacted the police (Rennison, 2002).

As with many victims/survivors of sexual violence, many older adults do not disclose experiences of sexual assault. The literature has identified a number of barriers to disclosure and help seeking including:

- Many older people depend on family members and home-based and residential caregivers for their care (Anetzberger, 2000; Wyandt, 2004). Nerenberg (2002a, 2002b) stated that many older people are sexually assaulted by such caregivers. Moreover, in a study of older women who had been sexually assaulted, 81% of this violence was perpetrated by the person's primary caregiver (United States Census Bureau, 2004). In such circumstances, Chihowski and Hughes (2008) commented that many victims/survivors may not disclose sexual violence and/or seek help because they are afraid of losing the assistance of their primary caregiver, their independence, and/or their home.

- Elders with experience of disability (for example, dementia; major psychiatric illness) may be less able to communicate with others about their experience of sexual violence. Ramsey-Klawsnik and Brandl (2009) commented that such communication difficulties precluded gathering sufficient evidence with which to inform decisions about whether or not to substantiate the allegations of sexual violence.

- Older adults are more at risk of not being believed because of the stereotypes about older adults (for example, Burgess (2006) noted that such stereotypes are founded within ageism and the perception of older people as asexual) and assumptions about lack of mental capacity (Ramsey-Klawsnik & Brandl, 2009).

- Some elders may have difficulty talking about body parts and using 'sexual words' and may not be aware of existing sources of help and specialist sexual violence support services (Ramsey-Klawsnik & Brandl, 2009).

Strategies for Enhancing Service Responsiveness

Vierthaler (2008:307) wrote:

> "*Rape myths have left elders out of the image of victims of sexual violence and without an appropriate community response when they are victimised. Thus while elder sexual assault victims may require more assistance and specialised help due to age-related disabilities and other factors, they often receive fewer services and interventions than younger victims."*

Commentators in the literature believe that more is required of sexual assault crisis and support services to be more responsive to the needs of elders who experience sexual violence. Suggested strategies for enhancing responsiveness include:

- Tailor promotional information to include elders and raise awareness about help seeking procedures and the availability of specialised sexual violence services (Department of Health, 2012)

- Develop a memorandum of understanding with a specialist agency working with older people to provide a referral pathway to a specialised sexual violence support agency and/or enabled access to expert advice about appropriate ways to advocate and support elders who have experienced sexual violence (Department of Health, 2012)

- Provide professional development training on the recognition of and response to elder victims/survivors of sexual violence (Department of Health, 2012; Teitelman & Copolillo, 2002; Vierthaler, 2008)

- Refer to the guidelines for talking to elders who are victims/survivors of sexual violence and may experience communication barriers (Ramsey-Klawsnik & Klawsnik, 2004)

- Provide clear guidelines about confidentiality for sexual assault support workers engaging with elders who have experienced sexual violence (Pearsall, 2006)

6.2.3 Lesbian, Gay, Bisexual, Transgender (LGBT): Access Issues and Strategies for Overcoming These

Disclosure and Barriers to Help Seeking

Commentators in the literature observe that there is a paucity of data about the prevalence of sexual violence among gay, lesbian, bisexual and transgender individuals. The 2010 National Intimate Partner and Sexual Violence Survey (Survey) found that rates of some forms of sexual violence among LGBT people is high compared to heterosexual men and women (Walters, Chen & Breiding, 2013). This Survey found that approximately 1 in 8 lesbian women (13%/214,000), nearly half of bisexual women (46%/1.5 million), and 1 in 6 heterosexual women (17%/19 million) have been raped in their lifetime; and four in 10 gay men (40%/1.1 million), nearly half of bisexual men (47%/903,000), and 1 in 5 heterosexual men (21%/21.6 million) have experienced sexual violence other than rape in their lifetime.

A review of seventy-one articles on 75 studies undertaken in the United States between 1989 and 2009 found that the reported prevalence of child sexual abuse ranged from 15% to 76% for women who identified as lesbian or bisexual and 4% to 59% for men who identified as gay or bisexual; reported prevalence of adult sexual assault ranged from 11% to 53% for women who identified as lesbian or bisexual and 11% to 53% for women who identified as lesbian or bisexual; reported prevalence of intimate partner sexual assault ranges from 2% to 45% for women who identified as lesbian or bisexual, and from 10% to 57% for men who identified as gay or bisexual; and reported prevalence of sexual assault as a hate crime ranged from 1% to 12% for women who identified as lesbian or bisexual, and from 3% to 20% for men who identified as gay or bisexual (Rothman, Exner & Baughman, 2011).

The literature describes a number of barriers to disclosure of sexual violence and help seeking among individuals who identify as LGBTQ. These barriers include:

- Perceived homophobic and trans-phobic bias within the criminal justice system that reduces the likelihood of LGBTQ reporting their experiences of sexual assault to the police (National Sexual Violence Research Resource Centre, 2012: Wainer & Summers, 2011)

- Previous experiences of unequal treatment and disrespect from professionals at rape crisis centres (Grant, Mottet, Tanis, Harrison, Herman & Keisling, 2011)

- Fear that services may pressure victims/survivors to question their sexuality and/or that they will experience discrimination whilst receiving services

- Fear that they will be ostracized from the LGBT community

- Reluctance to disclose to family and friends who may not approve of their lifestyle
- Victims/survivors who are not 'out' may not seek service for fear that doing so will mean disclosing their sexual orientations as well

- Fear that, if they tell others about their experience of sexual violence, their confidentiality and privacy will be breached and everyone will know, particularly within small and tight-knit communities (Gentlewarrior, 2009; University of Michigan Sexual Assault Prevention and Awareness webpage: http://sapac.umich.edu/article/58)

Strategies for Enhancing Service Responsiveness

Anderson and Holliday (2007) and others (Gentlewarrier, Martin-Jearld, Skok & Sweetser, 2008; Long, Ullman, Long, Manson & Starznski, 2007; Van Den Bergh & Crisp, 2004) offer a number of recommendations for enhancing service providers' responsiveness to clients who identify as LGBTQ and the cultural competence of practitioners who work with them. These recommendations include:

- Engaging in ongoing identification and rectification of any employee attitudes or behaviours predicated in homophobia, bi-phobia, and/or trans-phobia

- Committing to developing a knowledge base about LGBT individuals that includes: information about their historical and current experiences of oppression; and knowledge regarding the coming out and identity development processes

- Using LGBT-affirmative practice models such honouring clients' multiple and inter connected social identities and effectively serving clients in view of these identities

- Providing professional development opportunities for employees focused on the self awareness, knowledge and skills needed to offer culturally competent services to LGBT survivors of sexual violence.

6.2.4 Māori: Access Issues and Strategies for Overcoming These

Disclosure and Barriers to Help Seeking

The 2001 New Zealand National Survey of Crime Victims found that rates of sexual violence among Māori are higher than for other population groups within this country (Morris, Reilly, Berry & Ransom, 2003). Moreover, the Ministry of Women's Affairs (2009:7-8) observed that rates of sexual violence are highest among Māori and

young women and that given the “median age of Māori is younger than the total population, (there) is an overlap of vulnerability factors (and) the effects of sexual violence ripple out to whānau, friends and wider social networks.

Hamilton-Katene (2009) identified a range of barriers for Māori in relation to disclosing experiences of sexual violence and accessing specialist support services including:

- There are no kaupapa and tikanga Māori organisations that provide immediate crisis response (24/7) for people who experience sexual violence, which means that “whānau are more likely to be referred to tauiwi services that are less likely to provide the necessary cultural support required by whānau” (Hamilton-Katene, 2009:26)

- Referral pathways direct individuals and whānau to service providers that are culturally inappropriate

- Māori who present for service are not offered appropriate options of healing for experiences of sexual violence because they are not made aware of kaupapa and tikanga Māori service providers

- Whānau often access services with a range of presenting needs but the underlying issue of sexual violence is often not recognised

- Rural isolation presents an access barrier for some Māori who seek help for experiences of sexual violence

- There is a paucity of specialist sexual violence services available for Māori men to address the impact of sexual violence.

In addition to these identified barriers to service access, Kingi and Jordon (2009) commented that the relationship to the person who perpetrated the sexual violence

was often a deterrent for Māori reporting such incidents to the police. Moreover, Māori did not disclose for fear of the negative impact on whānau

Strategies for Enhancing Service Responsiveness

A number of New Zealand studies have offered suggestions for enhancing service access and responsiveness for Māori including:

- Recognise that there are a number of pathways for Māori to access service – kaupapa and tikanga Māori; bicultural organisations; and tangatawhenua workers (Hamilton-Katene, 2009)

- Crisis response services for Māori need to include provision to deliver services immediately following a sexual assault, as well as services that provide 'periodic crisis support' – support that recognises that whānau members might need to re-access support to deal with a crisis that can arise at any time in their lives; that may need to address a range of presenting issues; and that responds appropriately to the complexities associated with cultural identity (Hamilton-Katene, 2009: 15)

- "Whānau members are better assisted through culturally appropriate forms of support" (Hamilton-Katene, 2009:29)

- Provide equitable access to resources for kaupapa and tikanga Māori services (Hamilton-Katene, 2009)

- Provide services for Māori that are holistic; include appropriate support from whānau; and, based on Māori models of health and wellbeing (Mossman, Jordon, MacGibbon, Kingi & Moore, 2009)

- Provide cultural competency training for the sexual violence sector workforce (Hamilton-Katene, 2009)

6.2.5 Pacific Peoples: Access Issues and Strategies for Overcoming These

Disclosure and Barriers to Help Seeking

Research undertaken by Morris, Reilly, Berry and Ransom (2003) suggests that 7% of Pacific women have experienced sexual violence in their lifetime. Auckland Sexual Abuse HELP (2002) noted that for young Pacific women the notion of being taught to obey and respect adults was a factor in under-reporting of sexual violence by this group. Moreover, research completed by Mayhew and Reilly (2007) found that Pacific Peoples are least aware of community-based services and supports than any other population in New Zealand.

A New Zealand study of sexual violence and Pacific communities identified a range of barriers to disclosing and help seeking by Pacific Peoples who experience sexual violence (Tiatia, 2008). These identified barriers included:

- Loyalty towards family, pressure from family not to disclose, and the need to uphold the family's reputation
- Fear of losing reputation if an experience of sexual assault was disclosed
- Fear of being re-abused, disowned by the family, and/or made to feel ashamed and guilty
- Reluctance to discuss sexuality, issues of sexuality and cultural taboos around sexual violence
- Reluctance to discuss "non-heterosexual' preferences and the need to maintain confidences about gay, lesbian, fa'afifine family members
- Direction from a church minister to not disclose experiences of sexual violence where a male's reputation was important, especially if they held a leadership role in the church

- Few Pacific specific services for victims/survivors of sexual violence

Strategies for Enhancing Service Responsiveness

Tiatia (2008) and others (Mossman et al., 2009) offer a number of suggested strategies for enhancing access to services for those identifying as Pacific Peoples who have experienced sexual violence including:

- Recognise that disclosure may take time and that Pacific women often prefer to address other issues initially (for example, budgeting issues, housing issues, etc.) before feeling comfortable to discuss the issue of sexual violence

- Where English is a second language, provide access to professional interpreters who are not only able to offer translation services but also use Pacific discourses of understanding that convey meaning for Pacific Peoples clients. In addition, include service and other information about sexual violence in Pacifica languages

- Confidentiality is important for Pacific Peoples with experience of sexual violence to feel safe

- Include aiga in the provision of sexual assault support services

- Providers of service for Pacific Peoples should have an understanding of the role of the church

- Whilst Pacific Peoples specialist sexual violence services cater best for Pacific clients' needs, in localities where such services are not available, mainstream specialist sexual violence services should seek cultural advice from Pacific Peoples services

6.2.6 Culturally and Linguistically Diverse (CaLD) Groups: Access Issues and Strategies for Overcoming These

Disclosure and Barriers to Help Seeking

Pittaway and Eckert (2013) note that the refugee experience is characterised by exposure to high levels of violence, including either witnessing or being subject to rape, torture, murder and disappearance of family members (Martin, 2010; Pittaway, Bartolomei & United Nations Commission for Refugees, 2011). An Australian study found that between 78% and 86% of women who resettled in that country as refugees had been tortured and traumatised through sexual violence (Pittaway & Bartolomei, 2005). Moreover, as they are dealing with the impact of these multiple trauma that may have been experienced during the conflict in their respective countries of origin, during their flight from such conflict, and their time in refugee camps, they are also coping with the complexities of resettlement in a new country with a different culture.

Dimopoulos and Assafiri (2004) note that people with refugee and migrant backgrounds are less likely to receive appropriate social support and services. This situation, they argue, is because those who deliver such services lack cross cultural competencies. Moreover, commentators in the literature have identified a range of barriers to disclosing sexual violence and accessing services among people from CaLD groups including:

- Many do not understand the legal definitions of sexual violence within their country of resettlement and therefore do not recognise their experiences of sexual violence as criminal

- Some cultures do not have a concept of a professional helper (Barker, 1991)

- Many do not have knowledge about the existence and location of services and supports for those who experience sexual violence

- Some are fearful of the consequences of disclosing sexual violence as they are economically dependent upon their partner and have limited access to independent means to support themselves

- Experiences of shame are frequently a barrier to disclosing sexual violence and accessing services. Eckert, Pittaway and Bartolomei (2012) maintain that for some communities the sense of shame is not only experienced by the person who was raped, but also experienced by their family and their community because such assaults are regarded as an attack on their 'collective' honour. In such circumstances, people who have experienced sexual violence will not tell, either informal or formal sources of support, for fear that they will be ostracised by their community or even killed (Hajdukowski-Ahmed, Khanlou & Moussa 2009; Ostapiej-Piatkowski & Allimant, 2013).

- Some people from CaLD communities chose not to disclose sexual violence because of their previous negative experiences with law enforcement and/or other statutory agencies. For example, Quixley (2010) notes that some women have had their children taken into the care of a child protection agency after reporting family violence

- For some a barrier to access service and support is that interpreters are either not used or practitioners do not know when to use an interpreter and what constitutes a professional interpreter (for example, gender appropriate, trained, confidential and culturally appropriate). There is a growing body of evidence from controlled research trials and case study evaluations that highlight the issues confronted by people from CaLD groups who do not have access to professional interpreters when they require helping services. These issues include: less likely to access primary and secondary prevention services; less likely to seek help for psychosocial problems; less likely to understand informed consent and confidentiality standards; less likely to understand assessment, planning and intervention services; less likely to implement social service intervention strategies; and less likely to be referred to specialist services and

supports. In addition, the empirical literature suggests that without professional interpreters to support psychosocial intervention services, people from CaLD communities are more likely to be subject to interventions that are not appropriate and tailored to meet their needs; and more likely to repeatedly and unnecessarily go to different service providers for the same problems (Bischoff, Bovier, Rrustemi, Gariazzo, Eytan & Loutan, 2003; Bowen, 2001; Drennan, 1996; Ku & Flores, 2005).

Strategies for Enhancing Service Responsiveness

According to previous research, improved access and service responsiveness for those from CaLD communities who have experienced sexual violence requires implementation of the following strategies:

- Providing information about laws, definitions of sexual violence and available support services (including clearly defining the role of each agency) – knowledge that enables people to navigate the social and legal infrastructure of the country in which they have resettled (CRR, 2011a, 2011b; Ombudsman, Victoria, 2006). [46] Previous research shows that once people with refugee and migrant backgrounds receive such information, they seek helping services (Lievore, 2005)

- Engaging professional interpreters who are trained and credentialed by an interpreting service; fluent in at least two languages (English and one other); and who are culturally competent. [47] [48] The empirical literature suggests that the use of

[46] The Victorian Police, Victorian Multicultural Commission, Centres Against Sexual Assault and local CaLD agencies developed a pamphlet for members of the CaLD communities that included information about sexual assault, support services and reporting options (Ombudsman Victoria, 2006).

[47] Kaplan (1998:163) provides detailed guidelines for working with interpreters.

[48] The literature suggests that less than optimal outcomes occur for people from CaLD communities if service providers use untrained interpreters, for example family or members from the person's immediate community. Examples of the issues associated with using untrained interpreters include: misinterpreting information provided by clients; compromising confidentiality; and clients not disclosing information that may breach cultural taboos (Bischoff et al., 2003; Ku & Flores, 2005; Flores, Laws, Mayo, Zuckermann, Abreu, Medina & Hardt, 2003).

professional interpreting services within the context of service delivery can increase access which in turn contributes to equity in service provision (Jacobs, Shepard, Suaya & Stone, 2004; Ombudsman, Victoria, 2006; Quixley, 2010). [49]

- Building trauma-informed inter-agency partnerships between the specialised sexual assault support services and services that specialise in working with individuals and families from CaLD communities (Ombudsman, Victoria, 2006). Blanch (2008) comments that many people from CaLD groups have developed trusting relationships with specialist refugee and migrant services and such services provide a bridge for clients to access specialist sexual violence support services. Moreover, such partnerships enable a holistic and wellbeing approach to meeting the needs of people from CaLD groups who experience sexual violence.

- Providing specialised sexual assault support within the frame of reference adopted by each person from the CaLD community presenting for service, including each person's perspective of their ethnic ('a survivor narrative'), gender ('a victim narrative characterised by feelings of guilt and shame, hiding their experiences from family and friends, and trauma symptoms') and collective (a group cohesion which helped each cope with the hardships they have experienced during the journey to resettlement) identities (BenEzer, 2007; Gozdziak, 2002; Skjelsbaek, 2006; Volkan, 2001).

- Working with members of the CaLD community who have experienced sexual violence in a way that takes account of their cumulative experiences of trauma, life stresses and loses during the pre-migratory, migration and resettlement stages of their lives (Blanch, 2008)

[49] The Health and Disability Commission's Code of Health and Disability Services Consumers' Right Regulation, 1996 (Right 5), requires service providers to facilitate access to trained interpreters where necessary and practicable. In addition, the Human Rights Act, 1993 states that "every individual has the legal right to an interpreter."

- Adopting what Mollica (2006) refers to as a 'listener-storyteller relationship' in which the support worker uses active listening skills to fully understand the each person's unique experience of sexual violence and other stresses and trauma (Bailey-Smith, 2001)

6.3 General Strategies for Enhancing Access and Service Responsiveness

The literature offers many suggested strategies for enhancing access to sexual assault support services and responsiveness of those services (Bien, 2011; Colorado Coalition Against Sexual Assault, 2011; Zweig, Schlichter & Burt, 2002; Gentlewarrier, 2009; Macy, Giattina, Montijo & Ermentrout, 2010; Vierthaler, 2008; Quixley, 2010; Wainer & Summers, 2011). These strategies include:

Inclusive language: The Colorado Coalition Against Sexual Assault (2011) notes that the language used by sexual assault support services may prove to be a barrier to service access for people. For example, Bein (2011) and others (Logan, Evans, Stevenson & Jordon, 2005) note that the use of words such as 'rape' and 'crisis' in services' promotional materials may exclude some people who have experienced sexual violence, particularly adult survivors of child sexual abuse. Throughout the literature, reference is also made to the combined use of the terms 'survivor' and 'victim.' The term 'survivor' has been adopted to emphasize respect, dignity, strength and courage of the person who has experienced sexual assault, whilst the term 'victim' acknowledges that people have been victims of a serious crime and that its effect can be a long, painful process of recovery. Be that as it may, some writers recommend that workers within sexual assault support services listen to the language used by those they work with and mirror the terminology each person chooses to use. In relation to enhancing men's access to sexual assault support services, Du Mont, Macdonald, White and Turner (2013) suggest that 'gender-centred,' rather than female-specific language, would encourage more reporting of sexual violence incidents by men as the use of such language would perceive that their experience and needs were acknowledged. By far the literature recommends using People First Language (that is, the experience of sexual assault is one aspect of the whole person, rather than the defining characteristic of the individual).

Moreover, Garcia-Browning (2011) found that promotional materials that emphasised messages of solidarity (for example, 'you are not alone') motivated help-seeking behaviour amongst those who experienced sexual violence.

Ensuring victims/survivors have the information required to self-refer to specialist sexual violence sector agencies*:* Increasing access to support services through self-referrals requires information to be provided to the public – information that includes service location, hours of operation and the support that is provided. The target client group should be reassured that the service will not report the incident to the police. This information should also include the hotline number that can be saved to mobile phones so people can easily access service (Wainer & Summers, 2011).

Assure Confidentiality: In their study of the factors that may influence a person's decision not to report a sexual violence incident to the police, Wainer and Summers (2011) found that one of the enablers for disclosure and help seeking was to assure the victim/survivor that they could access a specialist sexual violence service and have their evidence gathered in a way that was anonymous to the police. These authors discovered that assurance that information people provided would be treated in confidence and that people were not obliged to report the matter to the police not only increased people's willingness to access support and service from sexual assault referral centres, but in the longer term increased the incidence of reporting to the police. For example, respondents in this study cited cases where once the victim/survivor's suspicion that they had been raped and/or experienced a drug-assisted sexual assault were confirmed, they then decided to report the incident to the police.

Availability of Specialist Sexual Violence Services in Neighbourhoods: Studies conducted in the United Kingdom found that there was an increase in self referrals when specialist sexual violence services, such as sexual assault referral centres, were available in communities. These studies suggest that access to services

increases when they are provided in neighbourhoods and people are aware of their existence through the distribution of marketing materials (Wainer & Summers, 2011).

On-line Communication Technology*:* Research indicates that financial issues, logistical issues (for example, transport), geographical issues (for example, residing in rural locations) and telling someone for the first time are barriers to accessing specialist sexual violence support services. In order to address these barriers, some jurisdictions are using information communication technologies to enhance accessibility for those who experience sexual violence. According to Benight, Ruzek and Waldrep (2008) such on-line interventions are showing promising results with increasing access to support for victims/survivors of sexual violence. Examples of such internet-based interventions for those who experience the trauma of sexual violence include: interactive psycho-education modules about sexual violence (Ruggiero, Resnick, Acierno, Carpenter, Kilpatrick, Coffey, et al., 2006); and multiple-week, practitioner assisted support services (Lange, Schrieken, van de Ven, Brodeweg, Emmilkamp & van der Kolk, 2000; Litz, Engel, Bryant & Papa, 2007). In New South Wales, a Rape Crisis Online service provides person-to-person, on-line, real-time support for those who have been sexually assaulted. This service was particularly targeted at young people. Of this on-line service, Astbury (2006:19) writes:

> *"(During) the first seven months of operation ... a total of 149 contacts were made by 93 individuals ... around a third had never spoken to anyone before ... the majority were aged between 16 and 34 years, with approximately 30% from rural areas ... over a third made subsequent contact with (the sexual violence support service). On line contacts followed the same pattern as telephone contacts with 68% being received between 3pm and 11pm."*

Outreach*:* The literature described several outreach strategies for enhancing access to services for those who have experienced sexual violence. These strategies included engagement in community education programmes that aimed to counter myths about sexual assault and promote help-seeking behaviour; [50] distribution of

[50] More recent awareness-raising campaigns have targeted the whole community and messages have focused on addressing attitudes and myths about sexual violence and increasing understanding about sexual assault, in

flyers and posters and engaging with the media; transporting victims/survivors to the sexual assault referral centre; and, engaging with 'hard-to-reach' groups in their natural environment – a strategy that some studies noted was particularly used to enable sex workers to access service and support (Archambault & Lonsway, 2013; Wainer & Summers, 2011; Zweig, Schlichter & Burt, 2002).

***Increased Training for Non-Specialist Agencies**:* A number of studies have recommended providing training to non-specialist agencies about the signs that sexual violence may have occurred; [51] what to do when adults, adolescents and children disclose they have been sexually assaulted; and how to contact specialist sexual violence services. These studies have observed that many people who experience sexual violence may not report this to the police, but rather seek assistance from primary (for example, general practitioners, midwives) and secondary (for example, the accident and emergency department) health professionals and/or other helping agencies. Moreover, these studies have found that frequently such service providers do not routinely use screening questions for sexual violence.

***Cross-Agency Training**:* Vierthaler (2008) maintains that a fruitful way in which to enhance sexual violence services' responsiveness to 'hard-to-reach' groups is to bring together the professionals from the sexual violence sector and professionals who work with those who infrequently access such services. While some authors suggest such training events could focus on building understanding about the each

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particular, understanding about what constitutes a sexual assault. This kind of focus and target audience has been used to counter earlier criticisms of the 'keeping safe' messages that have focused on potential victims of sexual violence, whilst diminishing the responsibility of offenders (Rape Crisis Scotland, http://www.thisisnotaninvitationtorapeme.co.uk/).

[51] Quixley (2010:25) and others (Ministry of Women's Affairs, 2009) note that common symptoms of unresolved trauma following sexual assault include: "loss of confidence therefore stability (e.g. an inability to hold down a job); disengagement from community, social networks and family; behaviour changes (e.g. isolation or promiscuity); depression, suicidal ideation or self harming; difficulties engaging in family life, such as parenting or relating to partners; diminished capacity to deal with day to day matters, such as financial management; and health issues (e.g. eating disorders; substance abuse; sexual health problems)"

different sector's work, Zweig et al. (2002) maintain that the most fruitful training topic is building joint understandings about the barriers to help seeking and joint cross-sector agreements about ways in which the parties can work together to increase access and responsiveness to hard-to-reach groups.

Community Resource Knowledge*:* Those working within sexual assault support service agencies should be knowledgeable about the resources within communities that support 'hard-to-reach' groups.

Partnerships*:* Throughout the literature there is a considerable amount of support for adopting collaborative or partnering approaches to enhance service access and responsiveness for people who have experienced sexual violence (Henderson, 2012; Quixley, 2010; Victorian Government Department of Human Services, 2006; Walby, Olive, Towers, Francis, Strid, Krizsan, Lombado, May-Chahel, Franzway, Sugarman & Agarwal, 2013; Zweig & Burt, 2007; Zweig, Schlichter & Burt, 2002). For example, the Overview of Worldwide Best Practices prepared by the European Parliament refers to 'coordination and collaboration' as one of five approaches for effective sexual assault support services for victims/survivors; and, most countries' (Ireland, Australia, Canada, United States, England, Scotland) standards for sexual violence sector services include the requirement for collaboration across primary, secondary and tertiary prevention sexual violence sector services and with other sectors that may interact with those who have experienced sexual violence (Walby et al., 2013).

In 2006, the Victorian Government's Department of Human Service undertook a 'Partnership Project' that explored the factors that helped and hindered partnership working as well as surfacing the benefits of collaborative work. While this Partnership Project identified a range of challenges associated with partnership working between the domestic violence, sexual violence and mental health sectors, they also identified strategies that support collaboration. These strategies included:

- Management support and leadership for developing organisational cultures of collaboration and providing time for partnership working

- Promoting formal interactions between agencies and sectors, rather than relying on the ad hoc cooperation between individual workers. For example, it was recognised that for collaborative approaches to be sustainable, agencies within and across sectors needed to develop formal protocols for working together that built a lasting understanding of respective roles, boundaries and practices for interacting. Moreover, such approaches needed to consider tiers of collaborative efforts and give priority to such formal arrangements with 'primary partner agencies' (primary, secondary and tertiary prevention sexual violence sector services; and, medical and criminal justice sector agencies who worked intensively with those who experienced sexual violence; etc); and, develop other forms of less-intensive partnering (networking; coordination; cooperation) with other agencies

- Explicit recognition of the cultural differences between agencies and sectors and open discussion about working across paradigms (for example, the medical model, ecological model, etc.) and along the continuum of complexity of meeting the presenting needs and circumstances of their respective client target groups

- Being willing to understand services and sectors outside core business by letting go of a 'territorial perspective,' by recognising than one agency alone cannot meet clients' needs and by finding a common purpose and ground for working holistically and from a client-centred perspective – understanding that would ensure client referrals were appropriate; and, that expectations about what can be achieved are managed

- Negotiate contracts and funding arrangements that support collaborative work and cross-sector learning

In practice collaborative working across the domestic violence, sexual violence and other sectors would involve one-off forums to discuss issues that were pertinent to the parties; a scheduled cross-agency professional development and training programme; development of service-level agreements with primary partners;

secondary consultation with service providers who are well placed to provide advice and information to support each agency work with its client target group; and, joint delivery of services to clients (particularly those with multiple presenting needs). The benefits of collaborative working, identified by the Partnership Project, included enhanced outcomes for clients; staff skill and knowledge development; and, increased staff satisfaction through shared roles and responsibilities for working with clients in common (Victorian Government Department of Human Services, 2006).

7. Key Elements of a Sexual Assault Support Service

7.1 Timing for Disclosure and Help Seeking

While there are a number of identified barriers to help seeking for those who experience sexual violence, studies also suggest that many do not access specialised sexual violence support services immediately following an assault (Quixley, 2010). Rather, these studies indicate that disclosure and service access may be many days, weeks, months or years after the sexual violence incident. For example, McGregor's (2003) study estimated that only 4% of the respondents told anyone at the time of the incident and the average time to disclosure was 16.3 years. Quixley (2010) reported that most people do not access support during the two to four week period after a sexual assault; that one community-based service in her study found that the most common time for service access was twelve months after a sexual assault; and another service in her study observed that service access was linked to people's experience of the full impact of sexual violence – impact which may take between three and six months to be recognised.

7.2 Motivators for Help Seeking

The literature identifies a myriad of reasons that influence people's decisions to seek help for their experiences of sexual violence including:

- To prevent further incidences of sexual violence and the need to personal protection (Kelly, 2005)

- Access to justice and a belief in the criminal justice system (Kelly, 2005)

- It's safe to tell (Bien, 2011): Quixley (2010:24) observes that immediately following a sexual assault people usually feel unsafe and that it can take a long time for victims/survivors to feel "physically and emotionally safe ... (to) address the long term effects ... of the trauma."

- Another victim tells and that gives the survivor strength (Bien, 2011; Kelly, 2005)

- Triggers like a death, anniversaries or becoming a parent causes the survivor distress (Bien,2011; Quixley, 2010)

- Impacts of the sexual violence have a negative effect on a person's everyday life, for example feeling unsafe and vulnerable in multiple contexts and/or inability to engage in intimacy with a partner (Quixley, 2010)

- A television programme inspires the victim/survivor to call a hotline (Bien, 2011; Quixley, 2010)

- A crisis centre opens and advertises services for those who have experienced sexual violence (Bien, 2011)

- Trust is built with a provider of a service other than a specialist sexual violence agency, for example, providers of parenting programmes – a situation that Quixley (2010:24) contends underlines the "value of co-locating sexual assault services in a multi-service environment."

7.3 Pathways to Help Seeking

There are diverse findings within the literature concerning the pathways used by victims/survivors to access support following an experience of sexual violence – a diversity of findings that suggest that those who decide to disclose their experience

of sexual violence use a range of pathways when seeking either informal support or formal services [52] (Kelly, 1999; Wilcox, 2000). While Fry (2007) and Lievore (2005) found that the first point of contact for people after a sexual assault was an emergency number or the police, Astbury (2006) and others (Kelly, 1999; Wilcox, 2000) comment that people are more likely to disclose to friends (especially female friends). Moreover, these researchers state that after disclosure to friends, victims/survivors are more likely to seek support from family and counsellors than the police or medical services. A number of studies indicate that family and friends play a critical role in motivating victims/survivors to report the incident to the police and/or seek out other sources of assistance such as health care and victim advocacy (Archambault & Lonsway, 2013; Lovett, Regan & Kelly, 2004).

Langton's (2011) analysis of trends associated with serious violent crime victimisations found that while sexual assault victimisations accounted for 12% of this type of crime in the United States, 24% who reported the offence to the police received support from a formal social support agency and for those who chose not to contact the police 35% accessed such formal support services. Langton (2011) concludes that this finding may suggest that victims/survivors access specialised sexual violence support services either by self referring or by being referred by services that are not part of the criminal justice system (for example, referrals from medical and/or counselling services). This finding is supported by New Zealand research which found that victims/survivors most commonly accessed specialist sexual violence support services by self referring; and that they were more likely to seek assistance from such specialised services compared to other helping services (for example, mental health services; refuge services; generic counselling services, kaupapa Māori services; Pacific services) (Ministry of Women's Affairs, 2009).

[52] Kelly and Dubois (2008:10) state that formal support services "encompass (non-government and government) organisations providing a range of options that enable (people) to create safety, seek justice and undo the harm of violence ... listening; advice; advocacy; shelter; self-help; counselling; protection and prosecution; and access to activism."

7.4 What Victims/Survivors Say They Need from Sexual Assault Support Services

Henderson (2012) emphasises that the needs of those who experience sexual violence vary depending on whether the experience was recent or historic; whether the experience occurred in childhood or as an adult; the intensity, level and frequency of the violence; and the level of social support and personal resilience.

A number of studies have sought the views of those who have experienced sexual violence and invited them to describe the types of service and support that were helpful immediately after the assault and in the longer term (Campbell, 2006; Fry, 2007; Kingi & Jordan, 2009; Lonsway, 2005; Lovett et al., 2004; Reid Howie, 2005; Victim Experience Review, 2009). Several main themes have emerged from these victim/survivor self-assessments of need including:

- ***Emotional Support***: Many survivors/victims report that the emotional support they receive from sexual assault support services facilitates their respective journeys of healing from the trauma of sexual violence (Abrahams & Jewkes, 2010; Steiner, Benner, Sondorp, Schmitz, Mesmer, & Rosenberger, 2009). Commonly noted characteristics of such emotional support included engagements that were empathetic; sensitive; included active listening; assured people that their experiences were believed and validated; and that they were treated with dignity (Christofides, Muirhead, Jewkes, Kekana, & Conco, 2006; Payne, 2009a). Respondents in these studies stated that they wanted access to such emotional support immediately after a sexual assault as well as in the longer term; and, most importantly they wanted access to this support on a 24/7 basis. [53] For example, a qualitative study carried out by Arend, Maw, de Swardt, Denny and Rowland (2013) found that providing regular opportunities for "someone to lean on (discuss their feelings and problems openly, and engage in consistent, supportive communication, either in person or by telephone)," contributed to people's sense

[53] Lovett et al.'s (2004) study of Sexual Assault Referral Centres indicated that victims/survivors wanted access to support after hours in the immediate aftermath of a sexual assault, especially in the evenings.

of personal strength, and helped them overcome feelings of hopelessness and thoughts of suicide. The authors in this study concluded that such support offered the opportunity to enhance survivors' emotional and psychological outcomes.

- ***Information and Brokerage Services***: Some studies have reported that the information and service referral needs of those who experience a sexual assault have not been met (Brickman et al., 2002) – a service gap that appears to be a barrier to recovery and may impede ongoing engagement with health and criminal justice system professionals. In particular, respondents wanted information about what to expect from forensic, police and court processes; information about ways in which to enhance their sense of security and safety both in situations where they know or do not know the assailant; information about 'victim compensation funds' to replace personal items and/or cover the costs of professional services; information about what to expect following an experience of sexual assault; information about their rights; and, information about how they and their family could access mental health and other services (Astbury, 2006; Brickman et al., 2002; Lovett et al., 2004; Reid Howie, 2005; Payne, 2009a). [54]

- ***Advocacy***: Respondents in these client-focused studies also wanted to work with an advocate both during the immediate aftermath of a sexual assault, but also in the longer term (Brickman et al., 2002; Lovett et al., 2004; Reid Howie, 2005). For example, in the immediate term they wanted an advocate to ensure their rights and welfare needs were met during their engagements with forensic and police services. Within this context a study undertaken by Campbell (2006) found that if an advocate supported a person during initial police interviews and attendance at medical services, they were more likely more likely to have police reports taken; had fewer negative interactions with medical and criminal justice personnel; received more medical services, such as emergency contraception and sexually transmitted disease prophylaxis; and, were less distressed by such engagements.

[54] Henderson (2012) identified a range of types of assistance that victims/survivors may need including help with housing, welfare benefits, practical assistance such as accessing safety alarms and referral to alcohol and drug and mental health services.

Moreover, Lonsway (2005) found that partnerships between sexual assault support services and the police, increased the level of victim/survivors' cooperation with the police investigations; and, encouraged more people, especially those who experienced acquaintance sexual assault, to report crimes.

In the longer term, advocacy was regarded as important by some study respondents who were experiencing the disempowering effects of sexual violence. In these situations, victim/survivors stated that they valued the support provided by an advocate to access legal protections and protect their rights during ongoing engagements with the police and the court (Brickman et al., 2002; Lovett et al., 2004; Reid Howie, 2005).

7.5 Core Intervention for Sexual Assault Support Services

Article 1 of the Council of Europe Istanbul Convention (2001) recommends that "*parties shall take the necessary legislative and other measures to provide for the setting up of appropriate, easily accessible rape crisis or sexual violence referral centres for victims in sufficient numbers to provide for medical, forensic examination, trauma support and counselling for victims."* An analysis of the literature shows that there is considerable consensus amongst professionals and service users about the core specialist services recommended for those who have experienced sexual violence (Campbell & Martin, 2002; Clemans, 2004; Kelly & Dubois, 2008; Lovett et al., 2004; Macy, Giattina, Sangster, Crosby & Montijo, 2009; Macy, Johns, Rizo, Martin & Giattina, 2011; Reid Howie, 2005; Walby et al., 2013). [55] These core services include:

- Free 24/7 telephone and/or other information communication technology support services
- Face-to-face emotional and practical support, including support immediately following a sexual violence incident as well as follow-up and outreach support
- Group and peer support
- Information services

[55] Kelly & Dubois (2008) also include 'services for perpetrators rooted in women's safety and prevention.'

- Advocacy and accompaniment within police, health and court settings
- Brokerage and referral to other cross-agency and cross-discipline services
- Counselling
- Training and consultancy to other mainstream agencies
- Shelters

7.5.1 Support Services

Without exception, the literature recommends that sexual violence support services include support lines that are available 24/7 throughout the year and that callers have immediate access to trained workers. The majority of support line services described in the literature provide crisis intervention services to primary and secondary victims of sexual violence. Such services seek to reduce the immediate impact of the sexual assault; enhance victims'/survivors' capacity to cope effectively with the incident; increase understanding about sexual violence and the short- and long-term impacts and the medical and legal issues associated with sexual violence; and, offer advocacy services. The literature states that such support-line services should be delivered in a way that is non-judgmental, use active listening skills, and offer empathetic responses; ensure callers' safety and security; help callers clarify and identify their feelings; explore their options, assist with problem solving; and, emphasis callers' intra-personal strengths and interpersonal supports and resources (Macy et al., 2009).

In addition to telephone support lines, some jurisdictions have introduced on-line support services. These on-line services provide one-to-one, real time information and support for those who have been sexually assaulted. The NSW Rape Crisis Centre (2005) reported that the service was designed to overcome the difficulty people have disclosing their experiences for the first time. These authors report that 93 individuals accessed this on-line support service within the first seven months; the majority were aged between 16-34 years; a third had never spoken to anyone before about the sexual violence; and, a third of those who first engaged on-line subsequently engaged with support services by telephone.

A number of studies have sampled users of crisis support line and electronic services. Overall, these studies found that service users found such services helpful, while a number of respondents stated that they preferred such services to face-to-face counselling (Mishara, Chargon, Daigle, Balan, Raymond, Marcous, Bardon & Campbell, 2005; Reese, Conoley & Brossart, 2002, 2006; Wark, 1984).

Campbell (2006) and others (Dean, Hardiman & Draper, 1998; KPMG, 2009; Wasco, Campbell, Barnes & Ahrens, 1999) state that access to specialised face-to-face support services mitigates the negative impact of the trauma for victims/survivors of sexual violence. It does this by supporting the victim/survivor to gain control over their body and decision making – control that is linked to improved prognoses for recovery. In addition, research has shown that those who access support services experience less distress; are less likely to experience self-blame, feeling bad about themselves, guilt and depression; have fewer physical and emotional health problems (Campbell, Ahrens, Sefl, Waco &Barnes, 2001); experience less long-term mental health outcomes (Murthi & Espalage, 2005; Ullman & Filipas, 2001); and, are more likely to engage with the criminal justice system (Campbell, 2006; Campbell, Bybee, Ford & Patterson, 2009; Wasco et al., 1999). Moreover, Quixley (2010) maintains that the provision of holistic support services ameliorates the long-term consequences of sexual assault and has benefits for the community in terms of savings on the high health and other associated costs. Quixley (2010:22) states that such sexual assault support services address a range of possible client/informal support people's needs and need to be delivered flexibly to meet the diverse needs of each individual:

- Physical and emotional safety issues
- Practical support needs, including arranging access to money, transport and housing
- Forensic issues – access to forensic examination and advice about the process
- Medical needs such as sexual health needs
- Police reporting options
- Personal support needs such as enabling access to family and friends and/or support with disclosure to them

- Counselling options, both in the immediate and longer term
- Privacy and confidentiality of personal information.

7.5.2 Support Groups

There are a range of support group formats described in the literature, including self-help groups; drop-in discussion groups; and crisis-orientated and survivor support groups led by therapists (Koss & Harvey, 1991). Such groups appear to include educational, skill development and therapeutic components; seek to reduce isolation and create a sense of belonging; furnish mutual support through members meeting with others who understand the experience and may offer adaptive coping strategies; and, to establish an environment where victims/survivors experience acceptance, empathy and encouragement (Bien, 2010; Lievore, 2005). In terms of the policies and procedures associated with such support groups, the literature suggests attendance at such groups about six months or after the sexual assault; weekly participation over a three-month period; facilitated by two workers (trained support worker in conjunction with a registered therapist or social worker); and, that issues of accessibility (venue location; child care; etc) need to be addressed (Arkansas Coalition against Sexual Violence, 2004; Carey, 1998).

7.5.3 Advocacy Services

The literature describes general, legal and medical advocacy provided within the context of sexual assault support services.

General advocacy is described as helping to normalise reactions to the sexual violence (Daane, 1996); providing non-judgmental support (Berger, 1997; Resnick et al., 2005); and, providing outreach through telephone calls and personal visits (Florida Coalition Against Sexual Assault, n.d.). Advocacy is also described as helping victims/survivors navigate the medical and legal systems (Campbell, 1998); assisting victims/survivors access services, ensuring their interests are represented and rights upheld, and serving as a buffer to prevent secondary victimisation (Campbell, 2006: Florida Coalition Against Sexual Assault, n.d.); and, assisting

marginalised and underserved people get their needs met (Campbell, 2006; Dunlap et al., 2004).

Legal advocacy is described as accompanying the victim/survivor to police interviews, legal appointments and to trials and sentencing hearings. In addition, advocates also assist their clients with securing protective orders (e.g. Protection Orders) and with completing crime compensation applications (Texas Association Against Sexual Assault, 2004). The literature suggests that in some cases this legal advocacy support service may be a longer-term service due to the lengthy nature of some legal processes (Daane, 1996). The literature also notes that the provider of these legal advocacy services needs to be knowledgeable about legal policies and processes and be able to accurately answer questions from the victims/survivors.

Osterman et al. (2001) maintain that the goal of medical advocacy is to assist the victim/survivor to take an active part in all medical decisions associated with the sexual assault. Commentators in the literature note a range of elements associated with medical advocacy including being present to reassure the client before, during and after forensic and medical examinations; provide information about the medical processes; and normalise responses to the sexual assault and explore helpful coping strategies (Berger, 1997; Osterman et al., 2001; Resnick et al., 2005; Texas Association Against Sexual Assault, 2004). In addition, the literature recommends that the advocate undertake a confidential follow-up each week following the assault until the advocacy services are no longer required (Daane, 1996; Illinois Association Against Sexual Assault, 2004; Texas Association Against Sexual Assault, 2004). Resnick et al., (2005) found that medical advocacy reduces the impact of the trauma and the anxiety associated with medical procedures thereby reducing the likelihood of later mental health problems.

7.5.4 Brief Intervention

In general the literature supports long-term counselling being undertaken by registered counsellors and therapists and therefore is beyond the scope of this literature review. However, Bien (2011) views sexual assault support services as

one of a range of services along the continuum of sexual violence services; and that such services provide the opportunity for victims/survivors to receive information about counselling options. In addition, Bien (2011:8) notes that "many survivors find comfort and connection in the crisis intervention service at centres, whether or not they seek any other type of service." This author further notes that the availability of a brief intervention by a sexual assault support service worker for people who may be struggling with 'flashbacks or triggers of abuse,' for example those who have experienced child sexual abuse, may be useful as an interim strategy prior to accessing long-term counselling. Moreover, in a number of international jurisdictions, sexual assault service centres offer both acute and long-term counselling options within the one agency – a service delivery model that Olle (2005) states recognises the need for responses over time and over life-spans.

8. Underlying Principles and Proven Approaches for Sexual Assault Support Services

8.1 Operating Principles for Sexual Assault Support Services

The literature describes a number of key operating principles associated with the delivery of a sexual assault support service. These operating principles include the requirement for such services to be:

- Trauma informed
- Gender responsive
- Victim centred
- Expert and evidence based.

8.1.1 Trauma-Informed Service

Trauma-Informed Service: Illustrative Policy Definition
A trauma informed and responsive system provides services that are not specifically designed to treat symptoms or syndromes related to sexual, physical abuse or other trauma, but is informed about, and sensitive to, trauma related issues. A trauma informed and responsive system is one in

which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking health and human services. Health and human service staff are knowledgeable of the prevalence of trauma history as a frequent co-existing condition in individuals who receive services. A trauma informed and responsive system delivers services in a way that avoids inadvertent re- traumatisation and facilitates consumer participation. Our programs, policies and services are designed to work respectfully and collaboratively with the person who has experienced trauma to promote healing and recovery. Core principles of a trauma informed and responsive system are the provision of an environment of safety, trustworthiness, choice, collaboration and empowerment. It also requires, to the extent possible, closely knit collaborative relationships with public and private sector service systems for treatment referral and to secure resources.

Source: Wisconsin Department of Health and Family Services and New Partnerships for Women Inc. (May 2007:25) *Report from the Trauma Summit* Retrieved from: http://www.wafca.org/pdffilesanddirections/trauma%20summit%20report.pdf

The Washington Coalition of Sexual Assault Programs (2012) and Blanch (2008) note that trauma-informed services require agencies to examine the way in which they carry out their business and make the necessary modifications based on an understanding of a victims'/survivors' experiences and perceptions. Moreover, the principles underpinning trauma-informed services can be applied across sectors (for example, health, social services, criminal justice) and disciplines – an application which recognises that not all victims/survivors will disclose their experience of sexual violence and a high proportion will present at services other than specialised sexual violence services.

Thomas (2013) maintains that practices undertaken by trauma-responsive services are founded on an understanding of the demographic, social history and environmental factors that may influence each person's unique path in healing after a sexual assault; and, an understanding of the neuroscience of trauma responses, [56]

[56] The evidence shows that trauma changes the brain resulting in "fragmentation of memories and deregulation of the automatic nervous system and limbic system" – systems that regulate reaction to fear and

the impact on brain development, and the emergence of chronic conditions such as Developmental Trauma, Post Traumatic Stress Disorder and Complex Traumatic Stress.

For example, Yuan, Koss and Stone (2006) describe pre-trauma factors (for example, age, gender, economic status, membership of a marginalised community, past or current victimisation), peri-trauma or during trauma factors (for example, the severity and repetition of the sexual violence, the relationship to the assailant), and post-traumatic factors (for example, how professionals and family respond to the disclosure; family/social support; fears about publicity, family fracture and retaliation) – factors that can either mitigate or exacerbate the trauma. Hence, the diversity of outcomes experienced by those who have been sexually assaulted may be linked to "*characteristics of the violent acts, environmental conditions, survivor attributes, and the availability of social support and resources"* (Yuan et al., 2006:1).

Moreover, McFarlane and Malecha (2005) comment that trauma-informed services recognise that trauma can occur across a lifespan, that is, a person may have experienced a recent trauma of sexual violence; and may have been victimised multiple times during their lives, for example experienced physical and sexual abuse during childhood as well as during their adult lives.

Fallot and Harris (2009) differentiate between trauma-informed services and trauma-specific services that directly address trauma and its impact and facilitate trauma recovery for individual. These and other authors (Elliot, Bjelajac, Fallot, Markoff & Reed, 2005) suggest that trauma-informed services integrate and apply six identified elements of trauma-informed care into all practices and interactions with agency clients and agency workers. [57] Moreover, such integration into practices enables

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trauma. Common issues experienced by those who have experienced sexual violence include: sleep disturbance; loss of trust and sense of control; depression and hopelessness; feeling stigmatised; self-blame and shame; trouble concentrating; globalised fear; flashbacks; etc (Bein, 2011:3; http://www.legalmomentum.org/assets/pdfs/neurobiology.pdf).

[57] Some references in the literature refer to a range of trauma-informed principles with which to guide agencies' operations. For example the Washington Coalition of Sexual Assault Programs (2012:5-6) suggests the following list of principles: Understanding Trauma and its Impact (Understanding traumatic stress and how

workers to support the whole person; operate from the knowledge that people's reactions are a normal response to trauma; and, support people in a way that is respectful of their dignity and choices. In addition to these front-line staff practices, management of a sexual assault support service will know that empowered and respected workers are better placed to empower those affected by sexual violence. Table 14 lists the elements of trauma-informed services and some examples of ways in which they can be operationalised into practice within an agency.

Table 14: Elements of Trauma-Informed Services and Operational Examples

Element	Examples of the Way the Elements can be Operationalised within Agencies
Safety	• Safe relationships are consistent, predictable, non-violent, non-shaming, non-blaming & respectful • Staff feel safe at work, in all locations at work • Staff are attuned to signs of discomfort or distress from clients and know how to respond • The agency maintains confidentiality in a consistent manner

it impacts people, and recognizing that many behaviours and responses that may seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences); Promoting Safety (Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful); ensuring cultural competence (Understanding how cultural context influences one's perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds); supporting consumer control, choice and autonomy (Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms); sharing power and governance (Promoting democracy and equalization of the power differentials across the program; sharing power and decision-making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures); integrating care (Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems); healing happens in relationships (Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma); and recovery is possible (Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals).

Trust	• Workers recognise the long-term and pervasive impact of violence • Relationships have clear boundaries and defined roles • Staff share information with survivors
Choice and Control	• Choices are valued because the personal experience of choice builds the ability to direct life and dream • Giving choices fosters safe relationships • Choices must be conscious, intentional and verbalised • The agency involves survivors in programme evaluation and design
Collaboration	• The agency and workers use a partnership approach to services • Give survivors opportunities to be with other survivors and offer mutual support • Collaboration with survivors gives workers new sources of knowledge and strength
Empowerment	• Workers seek to build on strength because identifying and using strengths builds more strength • Celebrate the whole person • Validate resilience • Create opportunities for survivors to do and give
Cultural Relevance	• Workers take into account social and political factors of a victim's/survivor's life • Workers know that the meaning of violence, and the resources for healing, vary across cultures • Workers and agencies are open to learning and asking questions

Source: Bein, 2011:6

Within the context of these trauma-informed principles for designing and implementing a sexual assault support service, a number of commentators in the

literature reference such principles to the victim/survivor service users' reports of what they are looking for in services. In summary, service users are looking for an integrated range of services that meet their changing needs and take into account their personal and environmental circumstances; services that facilitate their voices being heard; and, services that treat them with respect, offer them information, and interventions that are timely and proactive.

Table 15: Linking Trauma-Informed Principles to Victim/Survivors' Self-Reported Service Requirements

Trauma-Informed Principles	Victims'/Survivors' Self-Reported Service Requirements
Safety [58]	• "*Psychological safety is being able to speak freely to staff who understand the effects of sexual violence, were understanding, compassionate and non-judgmental, provided emotional support, information, a sense of belonging and ran a service that was accessible at all times"* (Lievore, 2005). • To feel safe and comforted; to be treated with dignity; to be reassured it was not their fault (Payne, 2009a) • The need to feel safe during the process of reporting rape (Lovett et al., 2004) • Provision of a safe place (Reid Howie, 2005) • Survivor safety is paramount and in cases of power-based crimes, safety planning and ongoing threat assessments of the offender should be undertaken. Safety planning should take account of each person's environment

[58] Herman's (1992) stages of recovery from trauma references the importance of establishing safety as the first stage of the healing process when people's feelings of being unsafe extend to the external environment, the assailant and their sense of being safe in their own bodies. The second stage of recovery includes remembrance and mourning while the third stage relates to reconnecting with ordinary life. Herman cautions that such stages are a simplistic representation of the journey of recovery from trauma and that in reality people move in and out of the stages throughout their journey of recovery. For example, feelings of insecurity and unsafeness may emerge in any or all of the three stages.

	(Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007) • A sense of security needs to be restored. Therefore, workers need to be aware of community resources that meet this need, such as women's centres, self-defence courses and assertiveness training, home security checks and cell phone security programmes (Lovett et al., 2004; Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007) • Maintaining confidentiality is part of respectful treatment (Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007)
Trust	• Timely, accurate and comprehensive information about justice and other systems they may have to navigate, the process of their case through the system, what to expect in terms of 'normal reactions' to the experience of sexual violence, and resources required to keep safe and get on with their lives (Reid Howle, 2005; Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007)
Choice and control	• To feel in control and be able to make informed choices (Payne, 2009a) • Experience of sexual violence is psychologically damaging because it robs the victim/survivor of their power and control (Herman, 1992). This perspective is aligned with the feminist, rights-based principles that underpin sexual violence services (Astbury, 2006).
Collaboration [59]	• Access to a range of support services beyond forensic

[59] Lievore (2005) found that in order to facilitate a client-centred approach, models of service that respond to the needs of those who experience sexual violence need to be founded on collaboration amongst all the agencies with whom clients might engage.

	and medical services (Lovett et al., 2004; Reid Howie, 2005; Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007) • Group work and opportunities to meet other survivors (Reid Howie, 2005)
Empowerment	• Not to feel like a victim (Payne, 2009a) • Support to move on and opportunities to engage in 'ordinary' events (Reid Howie, 2005) • Survivor's views are actively solicited and they make the decisions (Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007) • Validation of the survivor's experience (to be believed) and ability to cope with life are crucial aspects of empowering people to keep safe (Lovett et al., 2004; Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007)
Cultural relevance	• Services that support them and their families (Payne, 2009a) • Survivors need services that are not only accessible in terms of language, but also sensitive to the various cultural pressures and conflicts (Russell, 2002; British Columbia Ministry of Public Safety and Solicitor General, 2007) • Services need to be sensitive to the particular needs of people with disabilities, very young people, older people, street-involved people, lesbians, gay men, trans people and rural and isolated people (Russell, 2008; British Columbia Ministry of Public Safety and Solicitor General, 2007)

8.1.2 Gender-Responsive Service

Henderson (2012) argues that services for those who have experienced sexual violence need to be underpinned by three guiding principles – equality, human rights and feminism. This requires those who are delivering the service to have an understanding that in many cases sexual violence is a manifestation of the unequal power relation between men and women which have led to domination and discrimination against women and girls; and, that a gendered analysis contextualises the continuum of violence against women and girls in its many manifestations, contexts and global prevalence. Walby et al., (2013) maintain that designing services should include those who are gender experts, women's advocacy groups and the voice of those who have experienced sexual violence. Moreover, Thomas (2013) observes that this foundational principle provides clarity about who was responsible for committing the sexual violence; breaks down the individual's sense of responsibility for the incident and feelings of shame; facilitates practice of interaction between the worker and client as one between equals; and provides a platform for challenging the myths around why sexual violence occurs. Kulkarni, Bell, and McDaniel Rhodes, (2012) and others (Critelli, 2012; Fantini & Hegarty, 2003; Zaidi, 2002) note that a number of sexual violence services include not only a focus on empowering women and promoting their independence, but they also operate at a 'transformational' level engaging with communities and society through education, awareness raising, advocacy and lobbying.

8.1.3 Victim/Survivor-Centred Services

Sexual assault support services should be delivered using a victim/survivor centred model of service – a model that acknowledges the client is the expert in knowing what they need; that requires workers to individualise their practice to match the unique situation of each person; and that ensures practice does not lead to secondary victimisation (Walby et al., 2013; National SATU Guidelines Development Group, 2014). Commentators in the literature maintain that victim/survivor-centred services recognise that sexual violence is experienced by men and women of every age, ethnicity and socio-economic background; that each will have different needs, wants and experiences; and therefore services will need to provide for the diversity

within the population of those who experience sexual violence and respond in a flexible manner with personalised programmes of intervention – interventions that are grounded within sensitive, respectful and responsive practices held within a cultural meaning and context (Henderson, 2012). Walby et al., (2013) and others (Allen, 2006; Bein, 2010; Littel, Malefyt, Walker & Kuriansky, 1998; Olle, 2005) contend, that in order to be accessible and responsive to diversity, centres for the provision of sexual violence services need to integrate and provide health, criminal justice and social services; provide for the short-, medium-, and long-term client needs; and, integrate a range of approaches including feminist, restorative justice

8.1.4 Expert and Evidence-Based Services

In their review of worldwide best practices demonstrated across a range of sexual violence responses (for example, Sexual Assault Crisis Team, USA; Integrated Rape Crisis Service in Yarrow Place, Australia; Sexual Assault Referral Centre, St Mary's UK; Coordinated Community Responses across a number of international jurisdictions; Sexual Relations Education, UK; #talkaboutit, Sweden), Walby et al., (2013:130) found that services based on best practice (that is, 'innovative, proven to make a difference and which can be adopted in other jurisdictions') had been designed and implemented using a range of empirical and experiential knowledge and skill. For example, these 'best practice' services systematically collected data with which to assess need and performance; utilised diverse sources of expertise to guide service design and ongoing improvements with implementation (for example, expertise on working with clients who had experienced recent and/or historic sexual violence; expertise on working with clients across a diversity of ages, genders, and contexts, such as intra-familial sexual violence and workplace sexual violence; and, expertise to assist clients dealing with mental health or substance abuse issues); provided 'centre of excellence' services operationalised using a hub-and-spoke model that ensured consistent delivery and equitable access to services particularly in areas where there was a low uptake of sexual violence service use; and, on-going cross-sectors and cross-discipline professional training.

8.1.5 Principles: Advice from the Council of Europe

The Council of Europe commissioned a research study that sought to develop minimum standards for government and non-government support services (telephone hotlines; counselling and intervention services; shelters/refuges; sexual assault referral and rape crisis centres) that focus on addressing violence against women (Kelly & Dubois, 2008). Within the context of developing these minimum standards the member states agreed a set of agreed principles which would provide a foundation for all service provision – principles based on human rights concepts and the experiential knowledge of non-government organisations that have been effective in supporting people in the aftermath of experiences of violence. These agreed principles and the associated explanations as described in 'Combating Violence Against Women: Minimum Standards for Support Services' are noted in the following text box:

Council of Europe Support Service Principles	
Principles for Support Services	**Explanation**
Working from a gendered understanding of violence against women	Services demonstrate an appropriate and informed approach, relevant to their service users, which recognises the gendered dynamics, impacts and consequences of violence against women within an equalities and human rights framework, including understanding violence against women as both a cause and consequence of inequalities between women and men and the need for women-only services.
Safety, security and human dignity	Services ensure that all interventions prioritise the safety, security and dignity of service users and of staff.
Specialist services	The knowledge and skill base of staff, and forms of provision, are specialised; that is appropriate and tailored to the specific needs, which may be complex, of service users.
Diversity and fair access	Services respect the diversity of service users and

	positively engage in anti-discriminatory practice. Provision should be available free of charge, equitably distributed across geography of the country and crisis provision available 24/7.
Advocacy and support	Services provide both case and system advocacy to support and promote the rights and meet the needs of service users.
Empowerment	Services ensure service users can name their experiences, are familiar with their rights and entitlements and can make decisions in a supportive environment that treats them with dignity, respect and sensitivity.
Participation and consultation	Services promote service-user involvement in the development and evaluation of the service.
Confidentiality	Services respect and observe service users' right to confidentiality and all service users are informed of situations where that confidentiality may be limited.
A co-ordinated response	Services operate within a context of relevant inter-agency co-operation, collaboration and co-ordinated service delivery.
Holding perpetrators accountable	Services work from the twin foundations of belief and respect for victims and that perpetrators should be held accountable for their actions.
Governance and accountability	Services are effectively managed, ensuring that service users receive a quality service from appropriately skilled and supported staff.
Challenging tolerance	Services model non-violence internally and externally and use gender analysis to raise awareness, educate and

	undertake prevention work, both in communities and with individuals.

Source: Kelly and Dubois (2008:28) *Combating Violence against Women: Minimum Standards for Support Services.* Strasburg: Directorate General of Human Rights and Legal Affairs, Council of Europe.

In many respects these principles developed by the members of the Council of Europe incorporate those articulated within the trauma-informed and other frameworks of principles noted in the literature. There is an emphasis on the safety of both clients and staff; ensuring services are tailored to each person's unique experiences, including their cultural background; ensuring clients are believed, empowered and engaged in a collaborative manner; working across sectors and disciplines and advocacy at both client- and system levels; and, skilled and knowledgeable staff delivering accessible and effective services.

8.2 Proven Approaches for Sexual Assault Support Services

Two main evidence-based approaches have been identified in the literature and associated with the delivery of a sexual assault support service. These approaches are:

- Psychological First Aid
- Crisis Intervention Strategies

8.2.1 Psychological First Aid

Rather than providing formal mental health interventions, including processing the trauma, the literature suggests that psychological first aid is the most evidence-consistent helping approach for people during the immediate term (that is, the first fourteen days) following a traumatic event (Gibson, Ruzek, Naturale, Watson, Bryant, & Rynearson, 2006; Ruzek, Brymer, Jacobs, Layne, Vemberg & Watson, 2007). This approach includes:

- Providing flexible emotional support (Lovett, Regan & Kelly, 2004; Williams & Holmes, 1981)

- Offering practical support, such as ensuring the person receives medical and police attention and physical comforts (Burgess & Holmstrom, 1974a, 1974b; Williams & Holmes, 1981)
- Coordinating resources (Decker & Naugle, 2009)

Overall, the evidence suggests that services provided in the aftermath of a sexual violence incident should be guided by the person's stated needs. For example, some studies recommend that service providers explicitly ask the victim/survivor about their needs and provide what is requested with the knowledge that some people will prefer to be left alone (Bard, 1976; McNally, Bryant & Ehlers, 2003; Minden, 1991; Raphael & Dobson, 2001; Westefeld & Heckman-Stone, 2003; Williams & Holmes, 1981).

The literature provides some guidance about the engagement of first-responders with victims/survivors of sexual assault and rapport building between the parties. This guidance includes projecting attitudes of respect and sensitivity (Lovett, Regan & Kelly, 2004); believing the client's story (Kanel, 2007; James & Gilliland, 2001; Wiehe & Richards, 1995); being non-intrusiveness (Westefeld & Heckman-Stone, 2003); and being non-judgmental (Cantu, Coppola & Lindner, 2003). In addition, Cantu, Coppola and Linder (2003) and others (Green, 1988; Kanel, 2007) suggest that sexual assault support workers adopt a calm demeanour to facilitate rapport building and the idea that problems are not insurmountable. [60]

[60] There are many published guidelines that provide guidance about ways in which first-responders should work with people who have experienced sexual violence (Sexual Assault Emergency Protocol Committee, 2008). In general these guidelines suggest that first-responder believe the survivor (people rarely lie about sexual assault); listen to them by concentrating on understanding their feelings; allow them to be silent and do not feel the need to fill in any silences; let them know that you care about their feelings and that you are concerned for them; ask what you can do to be of help to them, for example, offer to accompany them in seeking medical attention, counselling, or in going to the police; help them regain a sense of control by supporting their decisions about how to proceed; remind them that they are not to blame and that the assault is entirely the fault of the assailant; offer to help them find shelter and companionship so that they can feel safe and not be alone; and, help them learn about, recognize, and seek treatment for signs of 'rape trauma syndrome'.

Within the context of providing psychological first aid, the literature provides guidance about the kinds of sexual assault support service practices that appear to be effective. These evidence-based practices include:

- *Assessing Safety*: Early safety interventions for those who have experienced sexual assault include an assessment of whether the person is likely to encounter the assailant, as well as an assessment of the risk of self-harming behaviour (Bassuk, 1980; Gray & Litz, 2005; Green, 1988; Westefeld & Heckman-Stone, 2003). Wiehe and Richards (1995) also recommend that sexual assault support services assist victims/survivors recover a sense of safety.

  A number of studies have identified that there is increased risk for suicidality following a sexual assault (Gray & Litz, 2005; Litz, Gray, Bryant & Adler, 2002; Masho, Odor & Adera, 2005; Ullman & Brecklin, 2002). Littel (2001) and others (Daane, 2006; Minden, 1991) suggest that sexual assault support workers are trained to detect and respond to suicidal ideation and know where to refer such clients for appropriate clinical intervention.

- *Regaining a Sense of Control:* The crisis intervention literature strongly suggests that sexual assault support services work with victims/survivors in a way that facilitates their gaining a sense of control (Daane, 2006; Kanel, 2007; Litz, Gray, Bryant & Adler, 2002). For example, it is recommended that workers allow victims/survivors to set the tone and pace of engagements and offer the opportunity for them to talk about whatever they want.

  A number of commentators in the literature note that following a sexual assault, people have a range of decisions to make and that a practical way to facilitate people gaining a sense of control is to provide them with the opportunity for informed decision making. Westefeld & Heckman-Stone (2003) and others (Lievore, 2005; Littel, 2001) recommend that sexual assault support services offer people information about options associated with each decision; encourage the

victim/survivor to make their own decisions; and support such decisions with the knowledge that victim/survivors are the best judge of his/her needs. [61]

- *Assistance to Access Services:* Campbell (2006) states that many victims/survivors of sexual assault do not receive the services they need. To counter this issue, Kanel (2007) and others (Daane, 2006; James & Gilliland, 2001; Koss & Harvey, 1991) recommend that sexual assault support services should offer victims/survivors information about available services and that such information should be provided to them in both oral and written form.

- *Advocating for Respectful Treatment:* There is a considerable literature that reports 'secondary victimisation' resulting from victim-blaming and negative social reactions to disclosures of sexual assault from medical and legal professionals, as well as from informal sources such as family and friends (Campbell, 2006; Campbell & Raja, 1999; Ullman & Filipas, 2001). Such 'secondary victimisation' has been linked to increased distress and increased severity of post-traumatic stress symptoms. Campbell and Martin (2001) recommend that sexual assault support service workers be trained to effectively prevent or reduce 'secondary victimisation.'

- *Promoting Positive Social Support:* Research has shown that positive social relationships and support from the victim/survivor's family and friends is related to reduced stress experienced by those who have been sexually assaulted (Burgess & Holmstrom, 1976). In line with these findings many researchers recommend that sexual assault support services undertake an assessment of each client's social support network; and encourage the victim/survivor to seek social support, either from informal or formal sources (Heckman-Stone, 2003; Resick & Mechanic, 1995; Westefeld & Heckman-Stone, 2003). In order to promote such

[61] Daane (2006) notes that people need to be informed of their right to refuse certain medical services. Cantu, Coppola & Lindner (2003) maintain that people should be informed of their right to stop a medical examination at any time. Clark (1976) maintains that people have a right to decide whether to involve the police following a sexual assault or not.

positive social support, Weihe and Richards (1995) and Green (1988) advice sexual assault support services to provide early education on sexual assault to support networks to counter the potential for victim blaming and negative responses to disclosure. Moreover, Daane (2006) and others (Brodyaga & Gates, 1982; Koss & Harvey, 1991) suggest that sexual assault support services provide counselling for the victim/survivor's social support network.

- *Providing Information about Possible Trauma Reactions:* While many studies [62] suggest providing victims/survivors with information about common reactions to trauma to 'normalise symptoms and prevent future misinterpretation of symptoms,' the empirical support for this practice is mixed. For example, Rauch, Hembree and Foa (2001) noted that the distribution of such information can result in inadvertent symptom prescription. Authors recommend that if victims/survivors are offered information about common trauma reactions, that it is emphasised that not all people experience such reactions and that if certain reactions are experienced they are likely to be short term (Ruzek, 2006).

- *Access to Counselling:* Daane (2006) and Littel (2001) agree that sexual assault support services should recommend the option of counselling for those who have experienced sexual violence. Furthermore, they advise that such recommendations should be couched in terms of noting that others have benefited from such interventions in the past, rather than implying that such interventions are mandatory. [63]

- *Follow-Up Contact:* Whilst previous research indicates that many who experience sexual violence do not attend follow-up services, many authors suggest that sexual assault support services provide victims/survivors with the opportunity to

[62] These studies included those authored by Kanel, 2007; Koss & Harvey, 1991; and Lewis, DiNitto, Nelson, Just & Campbell-Ruggaard, 2003.

[63] Ruzek (2006) notes that many who experience PTSD do not seek mental health services and that little is known about how to encourage such use.

engage in follow-up sessions and/or receive a follow-up telephone call; and, provide health and legal service provider contact information (Daane, 2006; McConkey et al., 2001; Wilken & Welch, 2003). Westefeld & Heckman-Stone (2003) suggest that such follow-up contacts should be scheduled to occur with 24-48 hours. Such follow-up engagements provide the opportunity for people to address on-going medical issues and psychosocial needs and access specialist sexual violence counselling.

8.2.2 Crisis Intervention Strategies

After reviewing a number of definitions of crisis, James (2008:3) has summarised crisis as "a perception or experience of an event or situation as an intolerable difficulty that exceeds a person's current resources and coping mechanisms." Ledray and Moscinski (2004) note, that with reference to experiences of sexual violence, crisis is often too narrowly defined as the immediate time after the assault (that is, the three-day period after a sexual assault). Rather they advise that crisis within the context of sexual violence needs to take account of the fact that the impact of such events lasts for many years; and that many factors or incidents over time can trigger experiences of crisis for victims/survivors. Moreover, many commentators in the literature have found that crisis following experiences of sexual violence is somewhat different from that experienced in other circumstances. For example, Rowan (2006) and others (Burgess & Holmstrom, 1985; Finkelhor, 1979, 1984, 1987; Gartner, 2005; Lew, 2004; Matsakis, 2003; Williams & Holmes, 1981) have demonstrated that crisis following both childhood and adult experiences of sexual violence differ in nature, intensity and extent from other forms of crisis and that it is marked by significant potential for post traumatic stress disorder.

Jackson-Cherry and Erford (2013) define crisis intervention as psychological care aimed at assisting individuals in a crisis situation to restore equilibrium to their biopsychosocial functioning and to minimise the potential for psychological trauma. Pueblo and McGlothlin (2013) caution that those implementing crisis intervention services need to be clear about the differences between the respective goals of crisis intervention and traditional counselling to ensure that the appropriate

intervention strategies are used when sexual assault victims/survivors present for service. They write:

> *"The goal of traditional counselling is to increase functioning, whereas the goal of crisis counselling is to decrease suffering and increase stabilisation in order to refer the client on for longer term counselling"* (Pueblo & McGlothlin, 2013:13).

Moreover, Pueblo and McGlothlin (2013) note other differences between traditional counselling and crisis intervention services: Crisis intervention happens on the spur of the moment and is not a scheduled or planned event; takes place in a broad range of settings, rather than just in agency settings; the focus of the intervention is to highlight strengths and protective factors (Greene, Lee, Trask & Rheinscheld, 2005); and often involve a team approach that includes crisis support service practitioners and medical and law enforcement professionals.

Typically the crisis intervention model includes six steps:

- *Define the problem*: Gaining an understanding of the crisis situation from the client's perspective, using core listening skills of empathy, genuineness and positive regards (Cormier & Cormier, 1991).

- *Ensure client safety*: Minimising the physical and psychological danger to self and others (Ledray & Moscinski, 2004).

- *Provide support*: James (2008:39) comments that this includes providing emotional support by "communicating to the client that the worker is one person who really cares about you (the client)"; and Cohen (2004) adds that support may also be instrumental (that is, enabling access to basic necessities of living and surviving such as clothes, shelter, etc.) and informational.

- *Examine alternatives*: James (2008) notes that this involves providing clients with choices about support people; choices about actions or resources that may assist

the person get through the crisis; and choices about ways in which to reduce the clients stress and anxiety.

- *Make plans*: Enabling the person to gain control and achieve short-term equilibrium by identifying additional people and resources that may be needed to provide immediate support; and explaining processes, such as medical and legal procedures, so that the person can choose if, when and how they wish to participate.

- *Obtaining commitment*: Enabling the client to commit to one or more "action steps that seek to move the person towards restoring pre-crisis equilibrium" (James, 2008: 41).

Many commentators in the literature note that the first three stages within the crisis intervention model align with the 'psychological first aid' approach (James, 2008; Ledray & Moscinski, 2004; National Institute of Mental Health, 2002; Raphael, 1977). For example, the National Institute of Mental Health (2002) associates psychological first aid with establishing safety, reducing stress-related symptoms, providing rest and recuperation and linking people to resources and social support systems. Moreover, James (2008) reminds readers that crisis intervention, within the context of responding to crises experienced by those who have been sexually assaulted, is not designed to 'fix anything,' but rather it aims to be palliative by providing non-intrusive physical and psychological support.

8.2.3 The Evidence for Sexual Assault Support Services Approaches

In 2013 the World Health Organisation (WHO) developed evidence-based guidance on appropriate responses to sexual violence including clinical interventions and emotional support. [64] In relation to responses to those presenting immediately after

[64] The World Health Organisation (2013) clinical and policy guidelines, for responding to intimate partner violence and sexual violence, were developed by retrieving and assessing current empirical evidence as well as the recommendations from a Guidelines Group (comprising a wide range of stakeholder opinion including that from academics, clinicians/service providers and policy makers working on initiatives to respond to violence

a sexual assault, those presenting after an experience of crisis linked to an experience of sexual violence, and those seeking support during the three months after either of these types of presentation, the guidance recommends using the 'psychological-first-aid' approach (World Health Organisation, 2013). The following text box includes the recommended approach for immediate presentation after sexual violence and crisis and psychological support up to three months after first presentation:

World Health Organisation Evidence-Based Guidance for Appropriate Responses Following Sexual Violence (WHO, 2013)	
Immediate presentation after sexual violence or crisis	Offer first-line support to victims/survivors of sexual assault including: • Providing practical care and support, which responds to the person's concerns, but does not intrude on their autonomy • Listening without pressuring them to respond or disclose information • Offering comfort and help to alleviate or reduce their anxiety • Offering information and helping them to connect to services and social supports • Psychological debriefing should NOT be used

against women). The quality of the evidence was assessed based on the methodological rigor of the research and graded using a methodology developed for WHO by Schunemann, Brozek & Oxman (2009). In circumstances where the evidence was classified as 'indirect,' the guidance and recommendations were based on existing guidelines of best practice and/or practices that addressed human rights and/or address equity issues.

Psychological support up to three months post-trauma	• Continue to offer first-line support and care as described above • Unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, is suicidal or self-harming, or has difficulties functioning in day-to-day tasks, apply 'watchful waiting' for 1–3 months after the event. 'Watchful waiting' involves explaining to the person that they are likely to improve over time and offering the option to come back for further support by making regular follow-up appointments • If the person is incapacitated by the post-rape symptoms (i.e. they cannot function on a day-to-day basis), arrange for cognitive behaviour therapy (CBT) or eye movement and desensitization and reprocessing (EMDR), by a specialist provider with a good understanding of sexual violence • If the person has any other mental health problems (symptoms of depression, alcohol or drug use problems, suicide or self-harm) provide care in accordance with the WHO mhGAP intervention guide (WHO, 2010).

Source: World Health Organisation (2013:4, 7)

This guidance from the 2013 WHO standards suggests that a 'psychological-first-aid' approach should be used by sexual assault support services immediate following

presentation of people who have been sexually assaulted and or experienced a crisis linked to an earlier experience of sexual violence as well as during the first three months following presentation. Thereafter, the WHO standards recommend intervention by a registered therapist. This guidance was strongly recommended by the Guidelines Group and such recommendations were based on 'indirect evidence' – that is evidence sourced from 'best practice' outlined in the World Health Organisation's 2011 publication on psychological first aid. These WHO Standards state that the principles and approach used within the psychological first aid model can be applied by sexual assault support services delivered on an individual and/or group basis (WHO, 2011:33).

9. Infrastructure Considerations for a Sexual Assault Support Service

In order to optimise the accessibility, responsiveness and effectiveness of a sexual assault support service, three main elements of infrastructure require careful consideration. These considerations include:

- Structural options for housing the service
- Optimising cross-sector and interagency coordination
- Workforce considerations
- Elements of sustainability

9.1 Structural Options for Housing a Sexual Assault Support Service

The literature describes a number of different structural options for supporting the delivery of sexual assault support services. These options include:

- Stand-alone, autonomous non-government- organisation sexual violence services that provide primary (for example, social change programmes such as lobbying and community education), secondary (for example, sexual assault support services, such as hotline and advocacy) and tertiary prevention (for example, counselling) services.

- Sexual violence services affiliated with larger organisations such as hospitals, criminal justice services, and/or universities (Macy, 2007; Martin, 2005; Patterson, 2011)

- Sexual violence services housed within family violence services

- Integrated, multi-sectors sexual violence service centres.

Gornick, Burt and Pittman (1985) observe that over time many sexual violence service organisations have merged with other agencies or been folded into other agencies as a business arm – structural arrangements that have largely been driven by funding constraints and/or a desire to better coordinate services to meet multiple presenting client needs. Examples noted by these authors include sexual violence services housed within family violence services.

A few studies have sought to compare and contrast some of these structural options (that is, stand-alone Non-Government Organisation sexual violence organisations; sexual violence services housed within a family violence organisation; sexual violence services housed within a larger organisation) against a number of variables, including financial resources; accessibility and responsiveness; and, comprehensiveness of service types for individuals, families and communities (Macy, Giattina, Sangster, Crosby & Montijo, 2009; Macy, Johns, Rizo, Martin & Giattina, 2011; O'Sullivan & Carlton, 2001; Patterson, 2009; Zweig & Burt, 2004).

Of the resourcing arrangements across these three structural options, Martin (2005) found that stand-alone sexual violence services tended to be staffed by four employees and seventeen volunteers with average annual budgets of around $100,000; those housed with family violence services tended to employ one person and seventeen volunteers with an allocated budget of $10,000; and, those affiliated to larger organisations tended to have larger budgets of between $150,000 and $200,000 and employ five staff with an average of twenty-two volunteers. Sloan (2006) found that sexual violence services housed within family violence services

tended to be allocated less funding. This situation occurred partly because there was less government funding available, at the time, for sexual violence services and partly because of the resource-intensive nature of the residential facilities often associated with family violence services.

Of the numbers served across the three structural options, Martin (2005) found that hospital-based sexual violence services served the greatest number of clients, followed by stand-alone sexual violence services, with those housed with family violence services receiving the least number of referrals. O'Sullivan and Carlton (2001) commented that the client-base of stand-alone sexual violence services tended to reflect the diverse makeup of the communities within which they operated and included people who had a range of sexual violence experiences (for example, acute and historic sexual violence). Moreover, these authors found that stand-alone sexual violence services received more referrals from health and criminal justice sources than other structural options. The smaller number of referrals received by sexual violence services housed within a family violence service may reflect a lack of clarity about the exact nature of such services' target client group. For example, some referral agents may believe that sexual violence services housed within family violence services only serve those who experience sexual violence within the context of intimate partner relationships.

Overall, Sullivan and Carlton (2001) found that stand-alone sexual violence service organisations tended to offer the full-range of services, including primary, secondary and tertiary services. In comparison, Gornick, Burt and Pitman (1985) noted that sexual violence services housed within health settings tended to confine their services to crisis and health services. In contrast to the findings of these two studies, Martin (2005) suggests that of the affiliated structural options, hosting sexual violence services within a family violence organisation held the most promise due to the aligned missions and goals of these two respective services.

Zweig and Burt (2004) examined the various structural arrangements of sexual violence services affiliated with family violence service organisations. In the first

arrangement, the sexual violence services did not have a strong and separate identity – an arrangement which resulted in a reduced awareness within communities about the availability of the service; and many of the sexual violence staff were co-opted into delivering services for family violence clients. In the second arrangement, the sexual violence services retained a separate budget, staff and identity; and staff from both the family violence and sexual services collaborated closely to address the comprehensive needs of clients. In the third family violence/sexual violence arrangement staff were cross trained and provided services for clients who had experienced family violence and/or sexual violence.

To date there have been no comparative studies that have assessed the way in which such structural arrangements impact on the effectiveness of services for clients who have experienced sexual violence. Henderson (2012) argues that stand-alone sexual violence service organisations have more advantages over other structural options – advantages such as greater inclusiveness and accessibility for clients; greater awareness of their availability by referring agents and members of communities; and, tendency to provide primary, secondary and tertiary services. Against this view, Macy et al. (2011) believe that family violence and sexual violence services can be fruitfully combined as both have more commonalities than differences. However, Macy et al. (2009) caution that the needs of those experiencing sexual violence are different from those experiencing family violence and each type of service requires specialised knowledge and skill. Be that as it may, they recommend that the two specialist services collaborate closely.

The literature also describes structural arrangements that involve housing multiple-sectors' sexual violence services within one centre – services that O'Shea (2014) and Park (2012) maintain are client-centred, accessible and meet the physical, psychological and forensic needs of victims/survivors, as well as the requirements of the criminal justice system. Several variations of these cross-sector sexual assault service centres are documented in the literature, including the Sexual Assault Referral Centre model (operating across Canada, Australia, Germany, Switzerland and the United Kingdom); the Sexual Assault Referral Team/Sexual Assault Nurse

Examiner model (operating largely in the United States of America, but also present in Canada); and, the Centres of Excellence Model (operating in Nordic countries, for example, Copenhagen, Oslo, Reykjavik and Uppsala).

Sexual Assault Referral Centres (SARC): SARCs are frequently implemented through partnerships involving the police, health and non-government organisation sectors. They seek to "*coordinate and simplify the pathway for victims/survivors to access health case, social care and criminal justice processes to improve individual health and well-being , as well as criminal justice outcomes*" (Home Office, Department of Health and Association of Chief Police Officers, 2009:4). According to Kelly and Regan (2003), their uniqueness lies in the fact that their underlying operational framework goes beyond the medico-legal model. Rather, SARCs operate from a broader remit that emphasises choice, respect, empowerment and honouring diversity alongside linking prevention, crisis intervention and long-term support. SARCs commonly operate as standalone units providing onsite crisis intervention, forensic examinations, immediate medical care, follow-up tests, legal advice and psychological counselling and support for victims/survivors (Du Mont & Parnis, 2002; Lovett, Regan and Kelly, 2004; Stern, 2010; Tinsley, 2011). [65] [66] These units can

[65] The UK Government has developed minimum standards for SARCs. These standards include: twenty-four hour access, including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit; appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant, throughout the examination process; choice of gender of physician wherever possible; access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children; dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a roust chain of evidence; the medical consultation includes a risk assessment of harm/self harm, together with an assessment of vulnerability and sexual health, immediate access to emergency contraception, post exposure prophylaxis or other acute mental health or sexual health services and follow up as needed; access to support, advocacy and follow up provided through an independent sexual violence advisor service, including support throughout the criminal justice process, should the victim chose that route; well-coordinated interagency arrangements are in place involving third sector service organisations supporting victims and survivors and are renewed regularly to support the SARC in delivering to agreed care pathways and standards of care; and, a minimum data set and appropriate data collection procedures in each SARC (Home Office, Department of Health and Association of Chief Police Officers, 2009:18).

[66] In the UK, Independent Sexual Violence Advisors often work as part of a SARC team. Their role includes –

operate close to hospitals, or are located in police-owned facilities, or are community based. They often provide the facility for the police to interview the victim/survivor. Kelly and Regan (2003) report that SARCs are funded by the state, for example, in Australia they are funded by health and in the United Kingdom they are funded by a budget sourced from contributions from the police, health and local authorities. In the United Kingdom, some SARCs only provide services for adults and older teenagers; some provide services for both adults and children; and, others only provide services for children. SARCs can be accessed by contacting the police, presenting at an emergency department, contacting a sexual assault support service telephone line or by self-referral.

Stern (2010) notes that one of the key advantages of SARCs is that people can access a range of services and treatment without having to contact the police and can then make an informed choice about whether they report the offence. Moreover, a research study, that compared SARCs with non-SARCs, found that SARCs provided more integrated and consistent services; more effectively balanced the needs of the victim/survivor with the needs of the legal system; provided greater access to female medical examiners; facilitated greater victim/survivor control of the examination; encouraged take up of support services; had more embedded referral systems to a greater range of social and other services; provided case-tracking

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- *Advice and support*: providing crisis intervention and non-therapeutic support to victims; and providing other types of practical help and advice ·
- *Supporting victims through the CJS*: giving information and assistance through the criminal justice process as requested/required
- *Multi-agency partnership working*: liaising with partner agencies in a multi-agency context, providing 'institutional advocacy'.

Findings from evaluation studies suggest that this role is "effective and cost effective ... help the victim to make sense of the system; ... help police by supporting the victim through the investigation; ... help the prosecution by supporting victims through the psychologically gruelling process of preparing to give evidence; and, provide a link ... to a range of social services whose help may be needed (i.e. arranging home security checks; sorting out housing problems; liaising with agencies that provide those with learning difficulties with appropriate support. Victims report that an ISVA makes a huge difference to the way in which they feel about what is happening to them." (Stern, 2010).

services to victims/survivors through criminal justice system processes; and, provided procedural justice (Lovett, Regan and Kelly, 2004). This same research recommended that SARCs also include advocacy services and offer more practical support.

St Mary's Sexual Assault Referral Centre, Central Manchester University Hospitals: An Illustration

St Mary's Sexual Assault Referral Centre has been operating since 1986. It is a one-stop facility that provides a coordinated and comprehensive response to those who have experienced a sexual assault regardless of whether a report is made to the police or not.

Aims:

To improve health and criminal justice outcomes by high standards of care; offering informed choice; collection of sound evidence; attending to therapeutic, medical and psychological needs; providing continued care which meets the needs of the victim; and, engagement in a multi-agency response.

Core Services:

- Forensic medical examination
- Post-coital contraception and medical testing
- Screening for STIs and HIV counselling
- Emotional and practical support
- Follow-on support
- One-to-one counselling for clients and supporters
- 24-hour telephone support and information
- Support through criminal proceedings
- Training and consultancy services

Clients and Access:

- Clients can self-refer or are referred by the police, and include women, men and children. In 2004, this SARC worked with 913 clients of whom 75% (687) were referred by the police and 25% (226) were self referrals.
- Of the demographic profile of the clients who accessed St Mary's SARC during 2004, 95% (864) were female and 5% (49) were male; and, 20% (185) were

less than 16 years, 43% (396) were aged between 16-24, 19% (174) were aged between 25-34, 11% (102) were aged between 35-44, 04% (36) were aged between 45-54 and 01% (10) were aged 55 years and over. [67]

Staffing:

The day team includes a centre manager; clinical director; research and development officer; counsellors; support worker; and, forensic nurse examiners.

The on-call team includes 15 female forensic examiners with the option of a male examiner; and, 10 crisis workers.

Client Comment: "*Thanks for all you've done. The respect, kindness and treating me normally made me feel confident and more in control of things."*

Source: Ryan, B. (2005) *St Mary's Sexual Assault Referral Centre: Improving Outcomes for Victims of Sexual Violence - A Strategic Partnership Approach.* Paper presented at the UK National Conference on Sexual Violence dated 16 and 17 November 2005.

Sexual Assault Response Team/Sexual Assault Nurse Examiner (SART/SANE):

SARTs are an on-call team that typical includes the SANE programme (specially-trained forensic nurses who collect forensic evidence, undertake clinical tests and provide medical treatment); law enforcement (police and prosecutor); victim/survivor advocates; and, crisis intervention counsellors – a coordinated, sector-wide response to sexual assault. People can access SART/SANE by contacting the police, presenting at an emergency department or by calling a sexual assault support service helpline. Park (2012) notes that this coordinated response has meant that victims/survivors do not have to re-report the assault to multiple professionals along the care pathway and provides more efficiency and coordination among professionals. Campbell and Bybee (1997) found that SART/SANEs increase the likelihood that people will be provided with a range of services, including the provision of information about the physical and mental health consequences of sexual violence. Moreover, Campbell (1998) and others (Nugent-Borakove et al., 2006; Southern Poverty Law Centre, 2008) have reported that women who accessed

[67] Percentages have been rounded and therefore will not necessarily total one hundred percent.

SART/SANEs had more positive experiences with legal, medical and mental health systems.

Even though victim/survivor-centred rather than legal-centred, SARCs and SART/SANEs improved outcomes for victims/survivors of sexual violence proceeding through the criminal justice systems (Campbell, Bybee, Ford & Patterson, 2009; Lovett et al., 2004; Nugent-Borakove et al., 2006; Southern Poverty Law Centre, 2008). While commentators in the literature describe a number of benefits of SART/SANEs and SARCs, Walby et al., (2013) note that a disadvantage of stand-alone units such as these is that people might not access such services because of the social stigma associated with sexual violence.

Centres of Excellence Model: This model operates in Scandinavia with centres existing in Copenhagen, Denmark; Uppsala, Sweden; Oslo, Norway; and, Reykjavik in Iceland. These units are always hospital based, usually in the capital city and represent a national resource. They have strong links with other agencies, including the police and prosecutors. The services offered by Centres of Excellence include emergency response to recent rape/sexual assault comprising forensic medical examinations and treatment informed by research and crisis counselling. This model's distinguishing feature is that they are well funded and are recognised nationally and internationally as sexual violence experts and their research is published in a range of reviewed journals. Their primary role is to be an example of best practice, continually updating knowledge and skills, in the light of their own and international knowledge base (O'Shea, 2014; Park, 2012).

9.2 Optimising Cross-Sector and Inter-Agency Coordination: Business Process Options

A coordinated and a collaborative cross-sectors' strategy, for delivering services and supports for those affected by sexual violence, is critical for optimising effectiveness, particularly within the context of a restricted economic environment (Burt, Harrell, Raymond, Iwen, Schlichter, Katz, Bennett & Thompson, 1999; Burt, Zweig, Andrews,

Van Ness, Parikh, Uekert & Harrell, 2000; Burt, Zweig, Andrews, Van Ness, Parikh, Uekert & Harrell, 2001; Campbell, 1998; Campbell & Bybee, 1997; Henderson, 2012; Quixley, 2010; Zweig & Burt, 2004).[68] Moreover, this cross-sector strategy is required to ensure service recipients can receive interventions and services (for example, forensic, medical, police and legal services; services that provide emotional and practical support; peer support services; and counselling and therapy services) that are accessible, responsive and address their shared and individualised needs.

There is an abundance of evidence in the literature that emphasises the benefits of cross-sector and inter-agency coordination of services for those affected by sexual violence (Estabrook, Fessenden, Dumas & McBride, 1978; Hardgrove, 1976). Such identified benefits of interagency coordination include:

- Avoids systems working at cross purposes (Bard, 1976)
- Avoids duplication of effort; facilitates referrals; and increases awareness across agencies of their respective services' needs and goals (Hardgrove, 1976).

- Enhanced access to medical, criminal justice and social services for those affected by sexual violence (Campbell & Ahrens, 1998).

- Improved rate of success in prosecuting cases of sexual assault.

- Enhanced access for traditionally underserved groups through the provision of interpreter services, technical advice and training (Epstein & Langenbahn, 1994).

[68] For example, a 2013 service specification prepared by the National Health Service England sought joint commissioning of sexual violence prevention services to ensure people had access to specialised sexual violence sector services as well as an integrated care pathway to other cross-sector services; access to immediate and long-term third sector specialist sexual assault services; equity of access to services by children, young people and adults, particularly those from identified population groups experiencing vulnerability; and, improved governance and peer review of the system of services and supports for those affected by sexual violence (Violence and Social Exclusion Team, Department of Health, 2013:12).

Such benefits can be achieved by implementing a range of practices including, the use of memorandum of understanding that define individual agency and collective roles, duties and responsibilities of the inter-agency effort (Burt, Zweig, Schlichter & Scarcella, 2000; Michigan Sexual Assault Systems Response Task Force, 2001); joint-agency interviewing with victims/survivors; cross training between agencies (Epstein & Langenbahn, 1994); development of referral protocols; collaborative client service planning and case management (Estabrook, Fessenden, Dumas & McBride, 1978); local level analysis of the demographic makeup of the community and needs assessments to enhance access to service by diverse groups (Michigan Sexual Assault Systems Response Task Force, 2001); funded coordinator positions designed to enhance inter-agency coordination and communication (Burt et al., 2001; Martin, 2007); and, evaluation of the efficacy of the coordinated effort (Martin, 2007).

9.3 Workforce Considerations

Qualifications: Outlining the Debate

Macy et al. (2009) observe that the literature lacks clarity about whether sexual assault support services should employ volunteers without qualifications and/or paid staff without qualifications, and/or qualified human service professionals. Riger et al. (2002) observe that over recent decades such service providers have shifted their human resource base from volunteers to professionals – a shift that many observers attribute to funding bodies' requirements for providers of service to use professionally qualified and registered personnel (Campbell & Martin, 2002; Collins & Walen, 1989; Matthews, 1994; Riger et al., 2002). Macy et al. (2009) observe that nowadays many agencies employ professionals (social workers, nurses, psychologists and counsellors) to provide sexual assault support services.

On the one hand the literature supports the use of volunteers, particularly if their roles are focused on providing psychological first aid. McDermott and Garofalo (2004) and O'Sullivan and Carlton (2001) argue that the employment of volunteers is in line with grass-roots foundation of sexual violence movements; and, is consistent with the philosophy of mutual aid. Moreover, Gibson et al. (2006) suggest that

survivors of traumatic events prefer to receive service from trained individuals who are not mental health professionals; and, Macy et al. (2009) states that the use of volunteers can increase community awareness about sexual violence and support for agencies who deliver such services.

In contrast, other authors maintain that qualified staff are required if the sexual assault support service includes more than psychological first aid, for example facilitating support group interventions and/or delivering brief interventions. Some careers advisory sites note that while some organisations may consider that training unqualified, but suitable workers as adequate for sexual assault support workers, they note that most organisations require employees to have a tertiary level qualification (for example, a bachelors degree) (http://careersinpsychology.org/career-as-a-victim-advocate/).

In addition, Decker and Naugle (2009) argue that those providing psychological first aid only should be trained and supervised by a qualified and registered clinician. Ullman (2005) cautions, that if sexual assault support services are provided by the collaborative efforts of both volunteers and qualified and registered staff, that the organisations employing this combination of staff should be sensitive to the power differential and power dynamics that might arise between the two groups. Moreover, they recommend that organisations ensure that such issues do not impact on the quality of services for victims/survivors.

Experience

Roberts (2008:17) and others (Department of Defence Sexual Assault Advocate Certification Program (DSAACP), 2014) have considered the question of whether those employed by a sexual assault support service and who are themselves victims/survivors of sexual violence "have an edge over those who have not suffered the same pain." DSAACP (2014) advise those employing sexual assault support workers to carefully consider whether the emotional trauma experienced by applicants who disclose that they are recovering from a sexual assault may make it difficult for them to remain emotionally objective and demonstrate the stability and

presence needed to assist the victims/survivors who seek their support and services. James (2008:17) writes:

> *"I do not believe crisis workers must have lived in the crisis to be able to understand and deal with it effectively. I do believe that interventionists who have successfully overcome some of life's problems and have put those problems into perspective will have assets of maturity, optimism, tenacity, and tough-mindedness that will help them marshal their psychological resources to assist their clients."*

In essence, the literature suggests that decisions about whether or not to employ a person with lived experience depends on where they are in their own recovery process. Commentators believe that life experiences can serve as a resource for emotional maturity if the individual has learned and grown from them. Moreover, they argue that with ongoing training and supervision they can bring a more resilient perspective to the work (James, 2008).

Role and Responsibilities

The literature describes the essential role and responsibilities of the sexual assault support worker as including:

- Advocacy and support (for example, addressing both emotional and practical needs, such as facilitating the victim's/survivor's decision making; informing them of their rights; conducting safety planning) during the forensic medical examination, law enforcement investigations and court proceedings
- Crisis intervention and/or emotional support for victims/survivors and their families and friends either on a crisis hotline or in person
- Assisting with referrals to and coordination of services to other agencies
- Explaining the criminal justice system and supporting the victim/survivors through the process (accompaniment)

Commentators describe the sexual assault support worker's role as unique with its exclusive focus on the needs and wellbeing of victims/survivors – a role that also includes providing support to the victim's/survivor's family, friends and other support people (Lonsway, 2003; West Virginia Foundation for Rape Information and

Services, 2011). This is in comparison to other services and roles that interact with victims/survivors (for example, victim/witness advocates; police; forensic doctors), that have to balance the objectives of criminal justice system or the medical/forensic service with the wishes and needs of individuals. Essentially they provide the interface with law enforcement, medical staff, and other social and counselling services. Moreover, the sexual assault support worker assists the victim/survivor from 'start to finish,' whereas other roles provide services for the victim at certain points in each case. The West Virginia Foundation for Rape Information and Services (2011:34) describes the role of the sexual assault support worker and the system within which they work as:

> *"If law enforcement, prosecution and medical providers are the building blocks of the response system for sexual violence, the (sexual assault support workers) are the cement that holds the system together for victims."*

While there is agreement within the literature about the core elements of the sexual assault support worker's responsibilities, they are configured in various ways within roles. For example:

- *27/7 Helpline*: In many jurisdictions elements of such services are delivered via 24/7 helplines (Colorado Coalition against Sexual Assault, 2011; Davies, 2007; Itzin et al.,2010; Lovett, Regan & Kelly, 2004; Kelly & Dubois, 2008; Lonsway, 2003; West Virginia Foundation for Rape Information and Services Inc., 2011) and the Council for Europe Minimum Standards recommends that there should be at least one national helpline for each country and where there are more dense populations at least one helpline per region (Kelly & Dubois, 2008)

- *Immediate Post Sexual Assault Support*: In some jurisdictions, elements of such services were delivered face-to-face in the immediate aftermath of a sexual assault and were often referred to as crisis workers or crisis advocates. For example, these roles provided support during forensic examinations and/or police statements (Colorado Coalition against Sexual Assault, 2011; Davies, 2007; Lovett, Regan & Kelly, 2004; Kelly & Dubois, 2008; Lonsway, 2003; West Virginia Foundation for Rape Information and Services Inc., 2011).

- *Intermediate and Longer-Term Support*: In some jurisdictions, elements of such services were delivered in the intermediate- or longer-term; delivered by roles, often referred to as support workers; may offer up to six sessions of flexible support; could be delivered either in a proactive and outreach or opt-in manner; and could be delivered in people's homes. Such roles could be configured as generalist, that is offering most elements of a sexual assault support service (such as the Independent Sexual Violence Advisors who provide a proactive service involving risk assessment and safety planning, enabling access to a range of statutory and non-government services, and providing information and support as people's cases progress through the criminal justice system); or they could be specialised, such as that offered by the Case Trackers – keeping people informed about the progress of a police investigation and the ensuing court case (Colorado Coalition against Sexual Assault, 2011; Davies, 2007; Lovett, Regan & Kelly, 2004; Kelly & Dubois, 2008; Lonsway, 2003; Stern, 2010; West Virginia Foundation for Rape Information and Services Inc., 2011). [69]

Not only are the elements of a sexual assault support worker's role configured in a variety of ways, but they are also delivered from within various types of organisations. For example, some of these workers are employed by 'one stop shops' (for example, Sexual Assault Referral Centres), whilst others are employed by independent specialist sexual violence agencies, such as Rape Crisis Centres (Hawkins & Taylor, 2015). The Council for European Standards recommends that there should be one 'Rape Crisis Centre' per 200,000 women and one 'Sexual Assault Centre' per 400,000 women; and that more specialist sexual violence agencies are required because they serve people who report to the police and those

[69] Research shows that a range of initial and ongoing sexual assault support services (particularly, services that meet people's advocacy and practical needs) are used and valued by those who experience sexual violence; that a variety of services (crisis, support, advocacy) need to be available so that people can access them at times and in forms that suit them – an approach that ensures that unmet needs are identified and addressed; and, in light of the fact that only a portion of people who experience sexual violence access counselling services, victims/survivors value being able to talk to someone in a supportive rather than therapeutic setting on the telephone or face-to-face (Lovett, Regan & Kelly, 2004).

who do not, as well as people who have experienced recent and historic sexual violence (Kelly & Dubois, 2008).

Attributes and Competencies

Quixley (2010:23) and others argue that all people working with people who have experienced sexual violence should have a set of basic competencies to ensure the services they provide are effective (Davies, 2007; D-SAACP, 2012; NSVRC, 2012). These competencies include:

- Sound understanding of trauma and its possible behavioural consequences
- Sound understanding of the causes and consequences of sexual violence, in particular the gendered analysis of sexual violence and its implications for practice (for example, the possible traumatising effects of forensic examination, particularly if undertaken by a male)
- Critical advocacy skills that require an understanding of victimisation and re-victimisation
- Skilled in cross-cultural work and have the capacity to respond appropriately to people from diverse population groups
- Effective communication skills including an understanding of basic communication principles associated with verbal, non-verbal, and cultural variation
- Knowledge of community systems and resources
- Ability to respond with required gravity, regardless of the evidence and potential for prosecution, and following ethical standards that ensure the professional delivery of a client-centred response
- Ability to demonstrate that the client is believed and to validate their experience and their response to it.

In addition to these competencies, the British Columbia Victim Service Workers Handbook (2007) and others list a range of skills for service workers including crisis intervention skills; attending skills; active listening and questioning skills; empowering skills; safety planning skills; advocacy skills; referral and brokerage

skills; and, knowledge about issues of confidentiality and privacy, child care and protection, legislation and legal processes, etc. (D-SAACP, 2012; British Columbia Ministry of Public Safety and Solicitor General, 2007: section 4; NSVRC, 2012).

Kaplan (1998:138) outlines a range of attributes associated with the relationship between the sexual assault support worker and victims/survivors that provides some guidance about the skills and knowledge required for undertaking this role. These attributes include: predictability and consistency; caring attitude and warmth with a genuine interest in the welfare of the person; understanding the causes of behaviour based on knowledge of the reaction to trauma; maximising the person's control in the relationship; ability to listen; working with due regard to the person's cultural and gender reality; respecting confidentiality; and being aware of personal reactions and being aware of appropriate levels of personal involvement and limit setting.

Moreover, James (2008) outlines the characteristics of effective crisis workers: poise – an ability to remain calm and create a stable and rationale milieu that facilitates the restoration to equilibrium (Belkin, 1984); creativity and flexibility – an ability to work with people who are experiencing complex and multiple issues (Aguilera & Messick, 1982; NSVRC, 2012); energy and resilience – an ability to bounce back, take care of themselves physically and psychologically and make wise use of available energy (Carkhuff & Berenson, 1977); and critical thinking and quick mental reflexes – an ability to have fast mental reflexes to deal with constantly emerging issues and circumstances (NSVRC, 2012).

Training

In terms of extent and content of training for sexual assault support workers, the literature again presents little agreement. Of the extent of training, advice varies from between 24 to 40 hours training (Campbell, 2006; Illinois Coalition Against Sexual Assault, 2004; Maine Coalition, 2005; West Virginia Foundation for Rape Information and Services Inc., 2011). Of the content of this training, some advise a focus on philosophies of feminism, self-help and empowerment; whilst others state that the training should include the agency's policies and procedures, dynamics of

sexual violence, confidentiality, privacy and communication, crisis intervention skills, cultural sensitivity, community resources and ethical standards. Ullman and Townsend (2007) and Baird and Jenkins (2003) add that sexual assault support workers should be offered training on ways in which to avoid vicarious traumatisation and burnout. Decker and Naugle (2009) advise that such training should be delivered by a qualified and registered clinician.

The Council for Europe Minimum Standards, for specialist sexual assault service worker training, note that such training should include a minimum of 30 hours and cover: A gendered analysis of violence against women; crisis intervention techniques; confidentiality; communication skills and intervention techniques; how to make appropriate referrals; information on trauma, coping and survival; an overview of criminal and civil justice systems; an update and review of relevant state laws; the availability of national and community resources; non-discrimination and diversity; and empowerment (Kelly & Dubois, 2008).

Organisational Support for the Workforce

Of the organisation's responsibilities for supporting those delivering sexual assault support services, the National Standards for England, Wales and Scotland (Rape Crisis England and Wales and Rape Crisis Scotland, 2012:18) provide some guidance.

- All staff/volunteers receive an induction into the organisation and its values, policies, systems and service knowledge relevant to their role

- The organisation checks that all staff/volunteers have the skills and knowledge required before they start working with service users

- The organisation sets clear development objectives for all staff/volunteers, reviews progress against these regularly, and takes effective steps to improve performance

- All staff/volunteers have a regular opportunity to discuss their work and receive support; and are offered regular clinical supervision [70]

- All staff/volunteers are given opportunities to keep the skills and knowledge required to undertake their roles up to date and in accordance with the requirements of relevant professional bodies

- The organisation has effective methods of sharing, documenting and using the learning that comes out of the experience of individual staff and volunteers

- The organisation has effective policies and procedures in place to support the training, development and performance of staff and volunteers.

Many researchers allude to the challenging nature of working with people who have experienced sexual violence. Van Denoot Lipski (2009) comment that exposure to countless accounts of sexual violence, and the associated trauma, can result in workers experiencing vicarious trauma, stress and/or burnout. Saakvinte, Gamble, Pearlman and Tabor (2000) and Yassen (1995) advise specialist sexual violence organisations to ensure that their workers have both personal and professional strategies in place to ameliorate the risk of these workforce issues. Of the personal strategies, these researchers note that coping mechanisms for workers include humour, relaxation, exercise, good nutrition and having natural support systems (family and friends) with whom to share emotions; and that professional strategies can include balance in the variety and nature of the work; boundary keeping; having trusting professional relationships; and accessing ongoing professional training as a means of replenishment. While the Colorado Coalition Against Sexual Assault

[70] Baird and Jenkins (2003) study of sexual assault support workers found that more educated workers and those with heavier caseloads reported less vicarious trauma; and that unpaid volunteers with lighter caseloads had higher rates of burnout compared to their paid counterparts. The researchers stated that there was a correlation between unpaid volunteers not having access to organisational support systems provided for paid staff; that volunteers with light caseloads reported lower feelings of accomplishment than staff with higher caseloads; and that higher feelings of personal accomplishment helped them ward off burnout (Baird & Jenkins, 2003).

(2011) agrees with these suggestions, they also maintain that organisations have a responsibility to provide sexual assault support workers with the opportunity to debrief (having the opportunity to talk with a supervisor about the feelings and experiences that come up in the course of the work) and the opportunity to access regular clinical supervision.

In addition to this guidance, the Ombudsman Victoria (2006) recommends that organisations, employing people to work with vulnerable population groups, must include police vetting and mandatory referee screening with previous employers as conditions of employment. This latter condition is included because police checks only identify "sex offenders who have been successfully prosecuted and convicted" (Ombudsman Victoria, 2006).

9.4 Sustainability: Understanding the Success Factors

Heady, Kail and Yeowart (2011:3) define sustainability as "the extent to which programmes and services can safeguard both their likelihood of success, and also the success for the future in the coming five to ten years." Moreover, Pluye, Potvin and Denis (2004) and Scheirer (2005) maintain that such success is dependent upon maintaining the activities and resources required to achieve service objectives.

Commentators in the literature have described multiple models of service sustainability (Beery, Senter, Cheadle, Greenwald, Pearson, Brosseau, et al., 2005; Goodman & Steckler, 1989; Johnson, Hays, Center, and Daley, 2004; Mancini and Marek, 2004; Shediac-Rizkallah & Bone, 1998). These models include a range of success factors for sustainability – factors that they maintain need to be considered when services are being designed. Indeed a number of authors maintain that sustainable services engage in purposeful, strategic planning for sustainability during the service design phase and throughout the life of the initiative (Beery et al., 2005; Goodman and Steckler, 1989; Johnson et al., 2004; Mancini and Marek, 2004; Shediac-Rizkallah and Bone, 1998). Factors supporting sustainability and identified in the literature include:

- Shared ownership

- Funding
- Sustained workforce
- Policies and procedures
- Responsiveness to the external environment
- Demonstrating results

9.4.1 Shared Stakeholder Ownership and Sustainability

According to the majority of commentators in the literature, stakeholder ownership both within and external to the organisation that hosts a service is a critical success factors for sustainability. For example, Weiss, Coffman & Bohan-Baker (2002) and others (Goodman & Steckler, 1989; Johnson et al., 2004; Mancini & Marek, 2004; Pluye, Potvin & Denis, 1989; Scheirer, 2005; Shediac-Rizkallah & Bone, 1998) argue that sustainable services are 'owned,' supported, and championed by both internal and external partners who believe in its principles and objectives and understand the way in which it contributes to the broader outcomes sought by the range of services and programmes within a particular sector. Moreover, sustainable services are embraced by a host organisation that has a culture that is accepting of change and that fully integrates the service into its ongoing operation (Johnson et al., 2004; Goodman & Steckler, 1989). According to these authors, such ownership may be secured by involving internal and external stakeholders in service design, implementation, evaluation, and decision making; maintaining ongoing engagement; and, for those stakeholders involved in the delivery of the service, having clearly defined roles and responsibilities.

9.4.2 Funding Considerations and Sustainability

Heady, Kail & Yeowart (2011) and others (Johnson et al., 2004; Mancini & Marek, 2004; New Philanthropy Capital, 2011) suggest that funding matters have a significant influence on the sustainability of a service.

New Philanthropy Capital (2011) noted that a number of factors place a service's stability and sustainability at risk. These identified risk factors included reliance on one source of government funding; not securing full-cost recovery – a situation that

may threaten its stability because the agency would have to separately fundraise for its core costs; and, the lack of specific funding sources for specialised services. [71]

In order to maximise opportunities for service sustainability, the Altarum Institute (2009) recommends that those involved in designing services need to give early consideration to identifying possible funding sources to replace 'seed funding. Moreover, the Centre for Mental Health Services (2008) and Mancini and Marek (2004) urge organisations designing new services to create a fund development plan that prescribes a course of action for systematically identifying and pursuing funding. They note a number of strategies that can be addressed within such plans including diversifying funding sources (for example, donations, grants and contracts) and developing capacity to attract, nurture and sustain relationships with funding bodies.

In addition to developing a fund development plan to support service sustainability, the literature also notes that demonstrating good financial management skills is a prerequisite for obtaining funds from varying sources. Identified best practices for effectively managing resources include: keeping good records, making sure that financial data are kept up to date, and using generally accepted accounting principles; meeting reporting requirements of funders; establishing and maintaining effective communication with funders regarding assistance with budget preparation or when there is a chance that some budgeted funds cannot be spent; ensuring that the budget is driven by the mission and objectives and supports operations and

[71] The Interim Report of the Social Services Select Committee from the inquiry into the funding of specialist sexual violence social services listed similar funding and workforce issues to those identified by New Philanthropy Capital (2011). Identified issues included "There is a lack of stable funding for specialist sexual violence social services—all the submissions said that services are under-funded and are struggling to meet demand. Many services are relying on unpaid work and volunteers to support service delivery, and this is not sustainable in the long term. Funding arrangements are disjointed and ad hoc, and an overarching comprehensive strategy is needed to guide the Government in purchasing services. Funding limitations at times mean organisations are not always able to deliver on their commitment to be client-focussed, holistic, wrap-around, and family- or whānau-friendly, as per the sector's standards for best practice. The impact on staff working in the sector under difficult conditions (Social Services Select Committee, 2014).

evaluation; and, ensuring that the annual budget is tied to outcomes (Centre for Substance Abuse Treatment, 2008).

9.4.3 Sustained Workforce

Hellman and House (2010) argue that the sustainability of the sexual violence sector workforce should be a critical concern for those who deliver services within this sector. Moreover, they maintain that while there is some guidance in the literature, more is required to understand ways in which organisational management can support staff to continue working within a sector that previous research has shown to be psychologically stressful (Wasco, Campbell & Clark, 2002).

Penner (2002) states that a sustained workforce can be defined as the continued membership of effective and committed individuals; and other commentators state that this means securing and retaining a workforce with the necessary knowledge and skills (Johnson et al., 2004: Kelly, L. & Dubois, L., 2008; Padgett, Bekemeier & Berkowitz, 2005; Mancini & Marek, 2004; New Philanthropy Capital, 2011).

In order to support a sustained workforce, researchers have identified a number of strategies that organisations can integrate into their recruitment, training and management practices. For example, Omoto and Snyder (1995, 2002) have found that recruiting people who are motivated to service and have a 'helping personality,' and providing them with a supportive work environment, are all factors linked to satisfaction and duration of service. More recently, Hellman and House (2010) found that providing a supportive workplace environment and monthly training meetings were the most significant correlates to the commitment and intent to remain in service amongst those who work within the sexual violence sector.

9.4.4 Policies, Procedures and Sustainability

Strong management through the development and implementation of robust policies and procedures is also regarded as a mark of a sustainable service (Johnson et al., 2004; New Philanthropy Capital, 2011). Moreover, Beery, Senter, Cheadle, Greenwald, Pearson & Brosseau (2005) and others (Johnson et al., 2004; Mancini &

Marek, 2004) maintain that organisations need to ensure their policies and procedures align with funders' requirements and that are maintained with integrity.

For those designing a sexual assault support service, there are a multitude of service standards that have been developed across international jurisdictions that provide good practice guidance about the array of policies and procedures required to support sustainable services. These guidelines include examples of service principles and values; organisational management standards; guidance on strategy and governance; guidance on working with service users/tangata whaiora; guidance on protecting service users/tangata whaiora and staff/volunteers; guidance concerning working with diversity and ensuring equality and access; and guidance on organisational development matters. [72]

9.4.5 Responsive to the External Environment and Sustainability

Many commentators in the literature link service sustainability to the host organisation's ability to be adaptive and respond to the changing socio-political factors in the external environment and the changing needs of the community within which the service is located (Beery, Senter, Cheadle, Greenwald, Pearson & Brosseau, 2005; Mancini & Marek, 2004; Shediac-Rizkallah & Bone, 1998).

9.4.6 Demonstrating Results and Sustainability

Demonstrating results is another key element in service sustainability (Goodman & Steckler, 1989; Mancini & Marek, 2004; New Philanthropy Capital, 2011).

[72] Examples of service standards from a range of international jurisdictions include:

Kelly, L. & Dubois, L. (2008) *Combating Violence Against Women: Minimum Standards for Support Services.* Strasburg: Directorate General of Human Rights and Legal Affairs, Council of Europe.

Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C. & Danilkewich, A. (2008) *Handbook of Sensitive Practices for Health Care Professionals: Lessons from Adult Survivors of Childhood Sexual Abuse.* Ottawa: Public Health Agency of Canada.

Rape Crisis National Service Standards: Summary Information for Partners, Funders and Commissioners. London and Glasgow: Rape Crisis (England and Wales) and Rape Crisis Scotland.

In the current service environment that emphasizes evidence-based best practices, funders are increasingly looking to purchase services that are based on the best available evidence and that address the diverse needs of people who have been sexually assaulted, recently or in the past (Macy, Giattina, Sangster, Crosby & Montijo, 2009). Decker and Naugle (2009) advise that optimal service strategies can be identified by combining the sexual assault and trauma intervention literature. Moreover, these authors suggest that sexual assault support services be conceptualised as a form of early intervention and support service for those affected by sexual violence. Quixley (2010) and others (Decker and Naugle, 2009; Henderson, 2012; British Columbia Ministry of Public Safety and Solicitor General, 2007) draw attention to the body of research that provides clear evidence about the elements of a sexual assault services that positively contribute to outcomes sought.

Current Evidence on Service Elements that Positively Contribute to Outcomes

Several studies have identified elements of sexual assault support services' approaches and practices that positively contribute to the outcomes sought. These identified service approaches and practices include:

- Being seen as competent
- Providing support (both physical and emotional)
- Providing acceptance
- Being nonjudgmental
- Providing validation of feelings and experience
- Being present and available
- Not rushing the client
- Listening
- Giving clear information
- Providing a safe environment

(Draucker, 1992, Draucker & Stern, 2000; Edmond, Sloan and McCarty, 2004; Ericksen, Dudley, McIntosh, Ritch, Shumay and Simpson, 2002; Gallop, McCay, Guha, & Khan, 1999; Glaister & Abel, 2001; Hall, 2000; Harned, 2005; Kondora, 1993; Konradi, 1996; Logan, Evans, Stevenson & Jordon, 2005; Mills & Daniluk,

2002; Phillips & Daniluk, 2004; Rhodes & Hutchinson, 1994; Smith & Kelly, 2001; Tyagi, 2001; Wood & Rennie, 1994).

Current Evidence on Attributes of the Worker/Client Relationship that Positively Contribute to Outcomes

In addition to these identified practices and approaches that contribute to desired outcomes from the provision of sexual assault support services, other studies identified attributes of the client/worker relationship that contribute to results. These identified attributes of the professional relationship included:

- Gentle
- Treated clients as individuals with unique needs
- Really listened
- Considered the type of sexual violence experienced by each client
- Did not tell clients what to do
- Made clients feel worthy
- Built up clients' self confidence
- Told clients no one deserves abuse
- Helped clients deal with powerful emotions
- Took active steps to help clients during difficult times

(Alaggia, 2004; Draucker, 1992, 1999a, 1999b; Draucker & Stern, 2000; Edmond, Sloan & McCarty, 2004; Gallop et al., 1999; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Phillips & Daniluk, 2004; Symes, 2000; Tyagi, 2001).

Current Evidence of the Results Achieved by Sexual Assault Support Services

While Resnick, Acierno, Kilpatrick and Holmes (2005) and others (Petrak, 2002; Zweig & Burt, 2002; Zweig, Burt & Van Ness, 2004) observe that there is a paucity of research that describes the impact of sexual assault support services, a few evaluation studies have been published that provide some promising indications about the results achieved by such services for service users. These results either

relate to aspects of the recovery of victims/survivors or increased access to other services.

Results related to the recovery of victims/survivors and reported in the literature include:

- Positive behavioural changes, such as decreases in self-harming

- Coping changes, such as increased ability to be spontaneous, and decreased minimization or denial of problems

- Increased functioning, such as an increased ability to accomplish tasks of daily living, both at work and home, and an increased sense of personal agency

- Mood changes included decreased experiences of depression, anxiety, feelings of guilt, and overwhelming, unmanageable, and undesired emotions

- Self-esteem changes, such as the ability to view oneself as having an identity and worth beyond being a survivor of sexual violence.
  (Edmond et al., 2004; Ericksen, Dudley, McIntosh, Ritch, Shumay & Simpson, 2002; Hall, 2000; Mills & Daniluk, 2002; Phillips & Daniluk, 2004; Wing & Oertle, 1999).

Other studies report outcomes related to increased access to health and criminal justice services. For example, a study carried out by Campbell (2006) found that victim/survivors who were supported by an advocate were more likely to receive a range of medical services (for example, information on STDs and HIV; receive prophylactic treatment for STDs; tested for pregnancy; receive emergency contraception to prevent pregnancy); and services from the police (for example, more likely to have a police report taken; and, more likely to have their case investigated further). Another study established a link between improved criminal justice outcomes and having receipt of services from a sexual assault support service (Campbell, Bybee, Ford & Patterson, 2009:12). For example, these findings

suggested that people who received support services were better able to participate in the criminal justice process because "*victims can give more detailed statements to law enforcement, remember more information, and can otherwise engage more fully with the investigation when they are not so traumatised and have adequate support*."

Developing Frameworks for Measuring Outcomes

Weiss (1998) states that during service design, stakeholders should draw on research and experiential knowledge to develop a theory of change – a description of the way in which inputs and activities of the proposed service contribute to the outcomes sought. Moreover, an articulation of the outcomes sought and the service elements that appear to contribute to those results enables service designers to build a monitoring framework for collecting and collating pertinent data for reporting purposes. [73]

Two principal assumptions need to be acknowledged before embarking on the development of a framework for measuring the results of a sexual assault support service. First, a sexual assault support service is one of a range of responses to the issue of sexual violence (CASA-Forum, 2014). Many authors believe that in order to make a significant impact on the problem of sexual violence an integrated, cross-sector portfolio of primary, secondary and tertiary prevention interventions needs to be designed and implemented. For example, Palmer and Crawford (2001) describe a continuum of service responses that include prevention, community awareness and information and referral services (primary prevention services); support services and early intervention services (secondary prevention services); and, crisis response and management services and intensive intervention services (tertiary prevention services). Moreover, CASA-Forum (2014) argue that a person's journey of healing can be influenced by a community's success in addressing the gender, cultural,

[73] The Rape Crisis National Service Standards for England, Wales and Scotland recommend that organisations articulate service outcomes that are meaningful to users and to funders/commissioners; monitor progress towards service user outcomes and use monitoring methods which give opportunities for service users to express themselves in their own words; use the results of outcomes monitoring to inform service development; monitor its achievement of success criteria, regularly analyse the monitoring information and improve services as a result; and, disseminate reports about service performance to relevant parties to an agreed timescale (Rape Crisis England and Wales and Rape Crisis Scotland, 2012:13).

social, economic and class inequalities that are causal factors leading to the perpetration of sexual violence; as well as providing services that reflect an understanding of the causes and consequences of sexual violence and that are accessible, effective and delivered to consistent standards of quality.

Second, referencing Herman's (1992:155) description of recovery from sexual violence, Sullivan and Coats (2000) argue that evaluating the impact of a sexual assault support service cannot draw on traditional evaluation methods, such as pre- and post-service testing. Rather, they advise that the design of an outcome framework needs to recognise that the process of healing from sexual assault is a cyclical and complicated process that is unique for each individual. Moreover, they advise designers of such outcome frameworks to select outcomes and indicators that are pertinent to the particular efforts of a service's location in the primary, secondary and tertiary continuum of responses to sexual violence. For example, in the context of developing a results-based framework for a sexual assault support service, outcomes might be selected that relate to victims'/survivors' experiences of safety (e.g. protection from self-harm; safe accommodation; connected to natural resources for practical and emotional support) and empowerment (i.e. enhanced choice and control in their lives).

In line with the advice from Weiss (1998) noted previously, Fraser, Richman, Galinsky and Day (2009) and others ((Carroll & Nuro, 2002; Saunders, Berliner & Hanson, 2004) advise that those responsible for developing frameworks for measuring the results of the efforts of a sexual assault support service should define the service's goal(s); identify the key inputs; identify the key outputs; and identify the key outcomes

Examples of sexual assault support service goals sourced from the literature include:

- The primary goal of a sexual assault support service is to lessen the victims'/survivors' trauma by empowering them through the provision of information and facilitation of choice and control (CASA-Forum, 2014)

- Those affected by sexual violence will have a quality support service intervention available to them 24 hours a day 7 days a week (Sullivan & Coats, 2000)

- To provide victims/survivors, and others affected by sexual violence, with appropriate telephone-based and accompaniment interventions, support, information, referrals and options to help effectively address their presenting needs (Brusch-Armondariz, Bell, DiNitto & Neff, 2003).

- Improved health through the provision of emotional support (Golding, Wilsnack & Cooper, 2002; Macy et al., 2011)

- Enhanced resilience through the provision of social support from providers, family and friends (Carlson, McNutt, Choi & Rose, 2002) [74]

- Enhanced safety through safety planning (Lindhorst, Nurius & Macy, 2005; Roberts & Roberts, 2002)

- Empowerment through the provision of information about the effects of violence and trauma (Gilbert, 1994; McDermott & Garofalo, 2004; Roberts & Roberts, 2002; Tutty & Rothery, 2002; White Krees, Trippany & Nolan, 2003)

In addition to specifying service goals, Sullivan and Coats (2000) state that the designers of a sexual assault support service should describe the outcomes that can be achieved by the service within the immediate term; the way in which such immediate term outcomes will lead to longer-term outcomes; and, what interventions carried out in certain ways are most likely to bring about such results. Such 'programme theories,' they argue should be developed by synthesising existing

[74] (Ullman, 1996) notes that this social support needs to be appropriate to the context of a trauma event, as his study found that negative social reactions from family and friends exacerbated the situation for those who had experienced a sexual assault.

evidence from theory and practice within the sexual violence field. While the literature predominantly identifies "trained staff" as the key input for a sexual assault support service, the National Sexual Assault Coalition Resource Sharing project and the National Sexual Violence Resource Centre (2013) and others (Busch-Armondariz et al., 2003; CASA-Forum, 2014; Palmer & Crawford, 2001; Sullivan & Coats, 2000) have identified a range of evidence-based interventions and outcomes for such services.

Table 16 provides some examples of interventions carried out in the name of a sexual assault support service and immediate and long-term outcomes.

Table 16: Elements of a Sexual Assault Support Service and Outcomes

Elements of Sexual Assault Support Service Programme Theory	Examples of Immediate- and Long-Term Outcomes
Interventions	• 24/7 availability • Education about medical options • Medical accompaniment and advocacy during forensic examination and medical care • Education about justice and safety options • Legal accompaniment and advocacy during reporting and through prosecution • Referrals to other service providers that can support survivors (e.g. therapist; social services; housing; legal aid) • Support for significant others, including provision of information and referral to services
Immediate Outcomes	• Accessible and client-centred services that meet clients' needs for onward referral to appropriate services in the immediate aftermath of a sexual assault or historic case • Increased client satisfaction with sexual assault

	service • Equity of access to accessible 24/7 support service regardless of age, gender or sexual orientation • Received factual information about sexual assault and sexual assault recovery • Victims/survivors feel emotionally supported • Victims/survivors understand the recovery process • Victims/survivors receive referrals to appropriate services • A reduction in secondary victimisation by the health care system and the criminal justice system
Long-term outcomes	• Survivors received emotional support from the workers • Survivors received information about medical and legal systems that enabled them to make informed choices and decisions • Survivors have safety plans in place

By way of illustration, Table 17 provides an example of a programme logic model adapted from those developed by the Sexual Assault Services in Texas (Busch-Armondariz et al., 2003). This illustrative model links a service purpose (for example: the purpose of the sexual assault support service is to provide support, accompaniment and advocacy to victims/survivors and their significant others in order to provide information, referrals and facilitate empowerment), inputs, activities, outputs and outcomes. [75]

[75] The purpose statement describes why the service is delivered and what needs it meets. The inputs are the resources necessary to achieve the purpose. The activities are the actions that are undertaken to achieve the purpose. The outputs are the quantifiable deliverables, such as counts. The outcomes describe the desired effectiveness of the service for the victim/survivor and/or their significant others.

Table 17: Illustrative Programme Logic Model for a Sexual Assault Support Service

Elements of Programme Logic Model	Illustrative Outcomes, Outputs, Activities and Inputs
Outcomes	➢ Victim/survivor and significant others are aware of options and available resources ➢ Victim/survivor and significant others begin to consider choices and make informed decisions ➢ Victim/survivor and significant others feel supported
Outputs	⇧ ➢ Volume of individuals served by 24/7 support line ➢ Volume of victims/survivors accompanied ➢ Volume of family and/or significant others accompanied ➢ Volume of accompaniments by type of accompaniment ➢ Volume of support worker hours ➢ Victim/survivor and significant others demographic data
Activities	⇧ ➢ Assess and assist with immediate and basic needs, including safety, transportation and clothes

	➢ Provide preparation and information about what to expect ➢ Provide referrals to assist with additional needs ➢ Offer support, active listening and empathy ➢ Accompany victim/survivor and significant others during medical, law enforcement and/or judicial proceedings ➢ Provide preparation for, and information about, what to expect of proceedings ➢ Advocate on behalf of victim/survivor and significant others when appropriate
Inputs	 ➢ Trained staff

10. Contribution of Sexual Assault Support Services to the System of Response to Sexual Violence

10.1 Primary, Secondary and Tertiary Prevention Continuum

In order to provide an optimal and comprehensive strategy for reducing and ultimately eliminating sexual violence, commentators in the literature argue that interventions should target the individual-, interpersonal-, community- and societal-level factors that influence its occurrence (Dahlberg & Krug, 2002; Jewkes, Sen, & Garcia-Moreno, 2002). Such targeted interventions, they argue, would enable risk factors to be modified and protective factors to be built and sustained across a four-level ecological model. For example, Powell, Mercy, Crosby, Dahlberg and Simon

(1999) suggest adopting counselling, therapy and educational interventions to address individual-level influences such as beliefs that support sexual violence; family therapy, parenting programmes and bystander skill development to address inter-personal relationship influences, such as those that shape people's behaviours and experiences; and, legal and policy interventions to address community-level and societal influences, such as societal norms that promote gender inequality.

Moreover, the World Health Organization and London School of Hygiene and Tropical Medicine, (2010) and others (Centres for Disease Control and Prevention, 2004; Neame & Heenan, 2003; Urbis Keys Young, 2004) maintain that a strategy of sexual violence interventions should include temporal considerations along a continuum of primary, secondary and tertiary prevention.

Primary prevention programmes are implemented before sexual violence has occurred and aim to prevent victimisation. Mullick, Teffo-Menziwa, Williams and Jina (2010) suggest primary prevention programmes target known risk factors such as parenting practices, substance abuse, social norms and gender inequality.

Secondary prevention interventions include responses immediately after the sexual violence has occurred and seek to prevent further harm and re-offending. Loots, Dartnall and Jewkes (2011) include health (for example, medical and forensic services), criminal justice (for example, police reporting and follow up procedures and providing the victim/survivor with legal resources and court preparedness support) and social services (for example, addressing safety, support, advocacy and counselling needs requested by those who experience sexual violence) as secondary prevention strategies.

Tertiary prevention interventions include long-term responses, such as counselling for victims/survivors and sex offender treatment interventions (Centres for Disease Control and Prevention, 2004).

With reference to secondary and tertiary prevention interventions, Olle (2005) states that cognisance needs to be given to both the crisis and long-term needs of those who experience sexual violence and that people may require different types of service at different times on their respective journeys to wellbeing . Such service types might include acute or crisis responses, for example support services during forensic/medical examination and police interviewing; services to meet short-term needs, for example referral to mental health and other social services and support for court preparation and appearances; services to address longer-term needs, for example counselling to manage post-traumatic stress disorder effects; and, services that may be required when people report historic sexual violence and/or to assist people to deal with the consequences of a sexual assault that may surface many years after the event.

10.2 Challenges within the Current Landscape

10.2.1 Securing Excellence in Commissioning Sexual Assault Support Services: Emerging Issues and Inquiry Recommendations

In 2013 the National Health Service England released guidelines for commissioning services for those who experience sexual violence. This guidance outlined various sectors' and groups' [76] responsibilities for ensuring "seamless commissioning and service delivery across pathways for victims/survivors of sexual violence so that integration between different providers is achieved in the care journeys victims take" (NHS England & Department of Health, 2013). In 2015 the All-Party Parliamentary Group conducted an inquiry into domestic and sexual violence (Inquiry) (Hawkins & Taylor, 2015). The Inquiry found that during the intervening two-year period less than fifty percent of independent specialist sexual violence services had been funded by the health sector or health-commissioned services. Rather, a focus on cost

[76] Within the context of this guidance for devolved commissioning, the NHS England was directed to engage with Local Authorities, Police Forces, Police Crime Commissioners, Public Health, Clinical Commissioning Groups and others to ensure victims/survivors had easy access to any services they may require (SARCs; specialist sexual violence services; sexual health clinics; police sympathy suites; etc) (NHS England & Department of Health, 2013).

cutting measures, lack of accurate data on the prevalence of sexual violence (that is, reference was only made to police data despite the fact that many victims/survivors do not report their experiences of sexual violence to the police), and lack of engagement with the specialist sexual violence sector had led to misunderstandings about victims'/survivors' need for specialist services to ensure access, responsiveness and effectiveness. Hawkins and Taylor (2015) note that there had been a preference for funding services that were delivered by non-specialist sexual violence organisations; mixed gender services – that is, services were funded that served both men and women, which then created a barrier for some women accessing services; and organisations that were one-stop-shops providing both domestic and sexual violence services.

The Inquiry offered a number of recommendations to Government including: adopting a needs-led and client-centred (rather than risk-led or a criminal-justice-outcomes led) basis for commissioning and funding services – a recommendation that was influenced by the Inquiry's survey finding that "survivors ... were almost unanimous on the importance of staff having distinct specialist sexual violence training. Many testified to the inadequacy of more general training or generic services when dealing with the complexities of issues arising as a result of sexual violence and sexual abuse" (Hawkins & Taylor, 2015:15). Other recommendations included: Government assuming central accountability for the provision of specialist sexual violence services, as well as national accountability for ensuring a joined-up, cross sector responsibility for addressing sexual violence; development of sustainable and secure funding models; and increased access to high-quality data on sexual violence.

10.2.2 Sexual Assault Referral Centres and Non-Government Specialist Sexual Violence Services: Choosing One, or the Other, or Both

In 2007 the Home Office released the Cross-Government Action Plan on Sexual Violence and Abuse – a Plan that recognised the need to increase access to support and services for those who experience sexual violence (Home Office, 2007). This

recognition was further emphasised in 2011(HM Government, 2011) and has resulted in the establishment of Sexual Assault Referral Centres (SARC) in many regions across the United Kingdom. Yet despite the intention to increase the range of services available for victims/survivors of sexual violence (that is both SARCs and non-government, independent specialist sexual violence services), Hawkins and Taylor (2015:38) found that in recent times funding "allocated to sexual violence ... disproportionately prioritised Sexual Assault Referral Centres and services aligned with the Criminal Justice System ... (such as the services delivered by the) Independent Sexual Violence Advisors." A similar observation was noted in a study undertaken by Robinson & Hudson (2011).

In order to more fully understand the contribution that SARCs and non-government, independent specialist sexual violence services make to the system of support for victims/survivors in England and Wales Robinson and Hudson (2011) examined the operations of these two types of services delivered in different settings.

Findings from this study showed that the settings respectively for SARCs and non-government sexual violence services affected the types of referrals received. For example, SARCs received the majority of their referrals from criminal justice sources, such as the police – a situation probably influenced by the fact that this sector provides much of their funding. Moreover, SARCs' clients were younger, more likely to have experienced a recent sexual assault, and such assaults were mostly committed by strangers or acquaintances and carried out in public places. In comparison, the non-government sector sexual violence services received their referrals from a range of sources, and significantly, received twice as many self-referrals than received by SARCs – a situation that the researchers believed may have been influenced by people's perceptions that such services are independent of the criminal justice system. [77] Of the characteristics of the clients who accessed the non-government services, there were more people presenting with historic

[77] Hawkins and Taylor (2015) noted that the 2013 UK Ministry of justice data showed that 85% of victims/survivors do not report to the police.

experiences of sexual violence; [78] and more were victimised in domestic settings by a family member, partner or ex-partner.

Whilst the respective characteristics of the clients presenting at SARCs and non-government sexual violence services were different, respondents from both settings recognised that multi-agency partnerships were critical to enabling victims/survivors to access the various types of services required to meet their diverse presenting needs. Interestingly, this research noted that such partnerships were more easily facilitated in the multi-agency one-stop-shop settings in which SARCs were located. Moreover, respondents believed that SARCs were better placed in community, rather than statutory settings, as such placement increased access for victims/survivors.

In light of the funding challenges faced by non-government sexual violence service providers noted earlier, this research recommended supporting "these two different, yet complementary (services) ... given the diverse array of sexual violence victims (Robinson & Hudson, 2011:515). Moreover, they further recommend that:

> *"(SARCs and non-government sexual violence services) represent the minimum that should be available to victims living in every area ... the service needs of sexual violence victims in any local area will be diverse, and indeed could change over time for the same victim. A comprehensive strategy that is truly victim-focused will include many types of support (e.g. advocacy, counselling, criminal justice advice, practical assistance, medical attention, etc.), offered in varied locations (e.g. residential, police, medical), by different personnel (e.g. ISVAs, counsellors, specialist police, forensic medical examiners, etc.)"* (Robinson & Hudson, 2011:531).

10.2.3 The Intersection of Domestic Violence and Sexual Violence

Winters (2008) notes that intimate partner sexual violence (IPSV) is the place where the movements to end and address domestic and sexual violence intersect; and

[78] Two thirds of Rape Crisis' adult service users seek support for sexual violence perpetrated two or more years ago (Rape Crisis England and Wales annual Ministry of justice monitoring returns as reported in Hawkins and Taylor, 2015).

McOrmond-Plummer (2008:7) states that IPSV is both domestic violence and sexual violence "with some distinctive features, [79] the recognition of which are crucial if survivors are to be aided effectively."

Duncan and Western (2011) note that the context within which this intersection occurs is somewhat complex. For example, while domestic violence and sexual assault services may share common philosophies (for example, violence is understood through cultural, economic, structural and feminist lenses) and principles and offer some similar services (for example, information, support, advocacy and referral; support groups; community and professional education), such services are prioritised and delivered in different ways (Duncan & Western, 2011; McOrmond-Plummer, Levy-Peck & Easteal, 2014). These authors explain:

> *"Practice priorities reflect the separate evolution of the domestic/family violence and sexual assault service provision and current funding agreements. For example, a domestic violence service may focus on particular issues such as housing, the need to obtain court orders and other issues of immediate safety and security. It may not provide crisis counselling or trauma counselling, which is more likely to be provided by a sexual assault service"* (Duncan & Western, 2011:8).

While commentators in the literature generally agree that those working across the sexual violence and domestic violence sectors may share some common underlying principles, they also recognise the specialist nature of the services and approaches used by each.

[79] The literature has described some of the issues that differentiate the experiences of IPSV victims/survivors from others who experience sexual violence. Finkelhor and Yllo (1985) found that IPSV victims/survivors experience a longer-lasting trauma largely due to lack of recognition and unwillingness to disclose the experience. Myhill and Allen (2002) found higher levels of physical injury among those who experience partner rape, as well as a higher incidence of multiple sexual assaults. Adams (1995) found that many who experience marital rape are advised by friends and family 'to put up with it.' McOrmond-Plummer (2008) comments that many who experience IPSV are financially dependent on the person who commits the sexual assault; may require assistance to enhance their safety (for example, court orders); and may have difficulty defining the offence as a sexual assault.

This observation has to some extent played out in the debate concerning the pros and cons of stand-alone sexual violence services, stand-alone domestic violence services and/or integrated domestic and sexual violence services. Of the benefits of stand-alone sexual violence services, commentators argue that such services are able to focus one hundred percent of their time on the issue of sexual violence, which in turn enables staff to develop expertise in serving clients, conducting community outreach and education, and working as consultants with allied professionals. Moreover, the name of such services often alludes to sexual violence which facilitates access for victims/survivors as well as assisting with bringing needed attention to the issue of sexual violence within communities (Mathews, 2006; Schmisek, 2006).

For those who comment on proposals to merge sexual and domestic violence services, commentators state that care needs to be taken to emphasise common values, beliefs and attitudes about combating all forms of violence, as well as ensuring that there is equity in terms of resources devoted to addressing issues of sexual and domestic violence (Sloan, 2006). Moreover, Mathews (2006) states that such merges need to ensure the community is educated about that fact that the target client group for the service includes those who experience sexual violence, those who experience domestic violence, and those who experience both forms of victimisation.

While such structural- and service-level debates continue both in the literature and across sectors and communities, many advocate for more coordination across the systems that serve victims/survivors of sexual and domestic violence (Bennice & Ressick, 2003; Heenan, 2004; McOrmond-Plummer, Levy-Peck & Easteal, 2014; Yllo, 1999). This is particularly pertinent for those who experience IPSV. For example, Heenan (2004) comments that the siloed focus of domestic violence and sexual violence services creates uncertainty for both professionals and those experiencing IPSV about which service to access to gain support. Duncan and Western (2011:10) and others (McOrmond-Plummer, 2008; Winters, 2008) note that "a focus on crisis responses within family violence organisations might run the risk of

a woman's experience of IPSV being 'silenced' or 'placed behind other needs'". Moreover, they observe that many professionals lack the confidence to specifically ask clients about IPSV, despite the fact that research has shown that people want professionals to ask about the possibility of sexual violence (Parkinson, 2008); and in the event that clients do disclose experiences of IPSV, they experience the assistance they receive as inconsistent and fragmented with multiple workers and little coordination amongst them – a situation that Duncan and Western (2011) observe results in service gaps such as "failing to offer referrals" to the appropriate source of help.

In order to address such issues commentators in the literature advocate for an integrated, cross-sectors' response that includes:

- Organisational policies that support practitioners to ask clients about the possibility of IPSV during intake interviews

- Maximise referral options and pathways for those experiencing IPSV by clarifying the roles and services offered respectively by sexual violence and family violence services and how this information could be made available to clients and/or potential clients

- Develop procedures for family violence and sexual violence workers to engage in secondary consultations

- Provide multidisciplinary cross-training on IPSV for family violence workers and other professionals working within the health and other sectors (Duncan & Western, 2011; Levy-Peck, 2014)

Winters (2008:10) summarises the strategies that promise to provide those experiencing IPSV with a more integrated response from domestic violence and sexual violence services:

> *"Counsellors and advocates working in domestic violence programs must learn how the experience of sexualised violence impacts efforts to build safety for*

survivors of domestic violence. Counsellors and advocates within rape crisis centres must learn how the risk for ongoing physical violence impacts efforts to seek justice and address healing. Educators and trainers must know how to deepen the analysis of these issues in the context of prevention and professional training. Policy developers must include strategies that address the complexity of these issues. Finally, organisations must implement concrete strategies that promote integrated safety, healing, advocacy and prevention."

11. Arguments for Investing in Responses for Victims/Survivors of Sexual Violence

11.1 The Financial and Social Costs of Sexual Violence

Research into the costs of sexual violence to the community conducted by the World Health Organisation (WHO, 1997 vol. 8) [80] commented that the 'the costs to society are tremendous' and Quixley (2010:14) warns that "the potential economic cost of failing to address sexual abuse is frightening."

A Budget 2014 Information Release prepared by the New Zealand Treasury estimated that the total cost of sexual violence in this country in 2012 was $1.8 billion – an estimate based on an assumption that the costs of sexual violence is 0.85% of New Zealand's GDP (The Treasury, 2014). [81] Moreover, an earlier analysis of the cost of crime in New Zealand noted that while sexual offending comprises only 1% of all crime, it is the most expensive crime per incident. With reference to 2003/2004 crime data, actual expenditure of public service (financial costs), and the social costs borne by the private sector Roper and Thompson (2006) stated that the total cost of sexual violence in that year was $1,192 million and the cost per sexual violence

[80] The World Health Organisation (2002a) considered a range of costs including health costs (for example, treating physical injury and treating psychological issues); systemic costs such as investigation and legal costs; rehabilitation programmes for perpetrators; social service costs, such as child protection services; and costs associated with reduced productivity and employment.

[81] Estimates of the cost of sexual violence in other international jurisdictions have been published by Centres for Disease Control and prevention (2003); Cohen and Miller (1998); Dubourg, Hamed and Thorns, 2005; Miller, Cohen and Rossman (1993); Minnesota Department of Health (2007); National Alliance to End Sexual Violence (2011); United States Department of Justice (1994); and the Illinois Coalition against Sexual Assault (2002)

offence was $72,130.00 (Roper, & Thompson, 2006:3). [82] These researchers observed that a significant proportion of the cost of sexual violence was borne by the private sector, [83] compared to that borne by the public sector.

This observation offered by Roper and Thompson (2006) is supported by other studies in the literature which suggest that the largest proportion of the costs of sexual violence is born by individuals who experience sexual assault, their family/whānau and friends and the communities within which they reside (Olle, 2005). For example, Mayhew and Adkins (2003) and others (Dubourg, Hamed & Thorns, 2005; Miller, Cohen & Wiersema, 1996; Morrison, Quadara & Boyde, 2007; Post, Mezey, Maxwell & Wibert, 2002) note that such 'private' costs include loss of earnings; loss of quality of life; pain and suffering; medical costs; and, counselling costs. [84] More particularly:

- Sexual abuse has a negative impact on children's educational attainment (MacMillan, 2000), later job performance (Anda et al., 2004) and earnings (MacMillan, 2000)

[82] Roper and Thompson's (2006) analysis included costs borne by the public sector (core justice sector agencies, such as Police, Courts, Corrections, Child Youth and Family, Crown Law Office – a net total of $177 million; and the Health Sector - $34 million) and the private sector (for example, lost work output and intangible costs that reflect the impact on victims'/survivors' quality of life through the physical and emotional impacts of sexual violence - $981 million).

[83] Roper and Thompson (2006) note that the private costs of sexual violence include non-profit agencies dealing with the consequences of sexual violence, however their report does not identify such costs separately.

[84] The National Council to Reduce Violence Against Women and Their Children (2009) noted that the costs of violence, including sexual violence. These costs related to pain, suffering and premature mortality; public and private health costs; production costs, such as the loss of actual earnings and future earning capacity; consumption-related costs, such as the costs of moving; second generation costs, such as the costs of child protection services and increased juvenile and adult crime; police, incarceration, court costs; costs of primary, secondary and tertiary prevention services; and, transfer costs, such as the payment of government benefits.

- Sexual violence victims/survivors experience reduced income in adulthood as a result of victimisation in adolescent, with a lifetime income loss of $241,600.00 (MacMillan, 2000)

- Sexual violence interferes with victims'/survivors' ability to work (Lyon, 2002). For example, Ellis, Atkeson and Calhoun (1993) found that 50% of their study's participants resigned or were forced to leave their employment in the year following the sexual violence incident as a result of the severity of their reactions.

Some studies predict that, in the future, the cost of sexual violence will disproportionately result from the sexual assault of certain identified population groups including young women; those residing in rural areas; those from refugee and migrants communities; those with disabilities; and, those from indigenous groups (National Council to Reduce Violence Against Women and Their Children, 2009).

11.2 Reasons for Investing in Responses for Victims/Survivors of Sexual Violence

11.2.1 Cost Savings

While Day, McKenna and Bowlus (2005) conclude that the economic costing literature demonstrates that the whole of society pays for the cost of sexual violence, the National Alliance to End Sexual Violence (2011) argues that investing in appropriate interventions can mitigate such costs and consequences of sexual violence. There is currently a paucity of studies that examine the cost savings that can be made by implementing responses to sexual violence. However, the National Alliance to End Sexual Violence (2011) reports a reduction in societal costs within the United States as a result of implementing the various mandates encapsulated within the Violence Against Women Act 1994 (Act) – mandates that include grant programmes that provide financial support for sexual assault services. Clark, Biddle and Martin (2002) state that the net benefit of this Act is $16.4 billion; that $14.8 billion in victimisation costs were averted by the Act which cost $1.6 billion to

implement; and at an individual level, the estimated cost is $15.50 per person, yet there were savings of $159 associated with averted victimisation costs.

Moreover, in the United Kingdom the Women's Resource Centre (2011) wrote:

> *"The total value created by Women and Girls Network (West London Rape Crisis) has been calculated as £3,773,917. The total investment into these services has been calculated as £749,844. Therefore the final SROI ratio shows that for every £1 invested into WGN, £5 of social value is generated to service users, their families, wider society and the State over five years."*

Yet despite this emerging evidence that there is likely to be a significant social return on an investment in programmes and services that address sexual violence, a number of studies across international jurisdictions indicate that many such services do not have adequate financial resources to meet the demand (Baxter, 1992; National Alliance to End Sexual Violence, 2011; Office of the Status of Women, 1998). For example, the results of a 2010 survey of six hundred and forty-four rape crisis centres in the United States found: 56% of had been forced to reduce staff in the previous year; 25% had waiting lists for services; 66% had reduced primary prevention efforts because of funding losses; 60% indicated they needed four full-time staff to meet the demand; and 93% of their employees were paid less than $40,000.00 a year (National Alliance to End Sexual Violence, 2011). In New Zealand similar demand/supply and financial resourcing issues were identified among the key issues experienced by this country's Sexual Violence Sector and reported to the Social Services Select Committee (Social Services Select Committee, 2014).

Olle (2005) and others (Laing & Bobic, 2002; Lee, 2001; Vichealth, 2004) argue that it is "false economy to under-fund specialist services to victims/survivors." It is noted that a recent progress briefing paper for the Cabinet Social Policy Committee indicated that work is currently underway to "develop and approach for service purchasing and planning to support good quality and sustainable (sexual violence) service" (Ministry of Social Development, July 2015).

11.2.2 Improved Outcomes

Lonsway (2011) notes that research has consistently demonstrated that sexual assault support services facilitate victim recovery and increase access to other services. Davis, Lurigio and Herman (2013) agree that studies have found positive results for victims/survivors of sexual violence who receive such services. Moreover, these commentators note that while many of these studies have incorporated pre- and post service measures of outcomes for victims/survivors, others have incorporated both pre- and post service measures and comparison groups of victims/survivors who had not received services - the inclusion of both of these criterion adding to the methodological rigour of such studies.

For example, Campbell (2006) compared the psychological functioning of victims across a number of measures and found that people who had received sexual assault support services were less likely to report feeling bad about themselves (60% compared to 83%); feeling guilty (59% compared to 81%); or feeling depressed (53% compared to 88%) than victims/survivors who had not received such services. Similarly, Allen, Bybee and Sullivan (2004) found that women who engaged with victim advocacy services had fewer depressive symptoms at follow-up and were better able to acquire social support than the control group.

Moreover, studies have also found that when victims/survivors receive support from sexual assault support services during medical and criminal justice procedures, in the longer-term they experience less psychological distress, physical health problems, sexual risk-taking behaviours, guilt and depression.

In addition to these wellbeing outcomes, studies have found that when victims/survivors receive sexual assault support services there are improved criminal justice outcomes. For example, Campbell, Bybee, Ford and Patterson (2009:121) found that victims/survivors who had the support of sexual assault support services could “give more detailed statements to law enforcement, remember more information, and can otherwise engage more fully with the investigation when they

are not so traumatised and have adequate support." Such circumstances increased prosecution rates.

Taken together, the findings from these and other studies suggest that sexual assault support services produce beneficial results.

11.2.3 Contribution to New Zealand's Mandate to Meet International Obligations and Government Priorities

There is a strategic fit between an investment in the sexual assault support services and a range of Government priority result areas and plans including: Better Public Services; Children's Action Plan; Youth Crime Action Plan; and the Ministry of Social Development's Investing in Services for Outcomes and Community Investment Strategy. [85]

Moreover, New Zealand is a signatory to a range of international resolutions and conventions that require this country to address sexual violence in a systemic manner. [86] For example, article 1 (c) of the United Nations General Assembly Resolution 62/134 (eliminating rape and other forms of sexual violence in all their manifestations, including in conflict and related situations) obligates member states to:

> *"Provide victims with access to appropriate health care, including sexual and reproductive health care, psychological care and trauma counselling, as well as to rehabilitation, social reintegration and, as appropriate, effective and sufficient compensation, in accordance with relevant international and national law."*

[85] Retrieved from: Better Public Services http://www.ssc.govt.nz/better-public-services; Children's Action Plan http://childrensactionplan.govt.nz/; Youth Crime Action Plan http://www.justice.govt.nz/publications/global-publications/y/youth-crime-action-plan-full-report; Investing in Services for Outcomes http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-services-for-outcomes/; and Community Investment Strategy https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/community-investment-strategy/index.html.

[86] See section 1 of this report for a list of the international instruments that relate to responses that seek to address sexual violence.

Moreover, New Zealand's obligations, under the United Nations Convention on the Rights of the Child 1989, also require a multi-level prevention strategy (primary, secondary and tertiary prevention) and a range of physical and psychosocial responses for children and young people affected by sexual violence. [87]

The provision of sexual assault support services is a critical element of meeting such international obligations and government priorities.

11.2.4 Sexual Assault Support Services Offer a Value Proposition

The National Alliance to End Sexual Violence (2011) argues that without sexual assault support services victims/survivors are less likely to receive critical services (such as referrals to community-based services) and more likely to experience secondary victimisation – both of which have been linked to increased psychological distress; increased physical health issues; increased incidents of sexual risk-taking behaviours; increased experiences of self blame, guilt and depression; and a reluctance to seek further assistance (for example, counselling). In summary, the evidence suggests that increasing access to sexual assault support services contributes to the prevention of complex, long-term health and mental health problems for victims/survivors (Lovett, Regan & Kelly, 2004; The World Health Organisation, 2002).

[87] The relevant Articles within the United Nations Convention on the Rights of the Child 1989 include:
Article 19 (1) "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."
Article 39 "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child."

Lovett et al. (2004:75-76) agree that sexual assault support services have demonstrated their value by "limiting the damage and impacts of sexual violence." Moreover, these researchers also maintain that such services contribute to "addressing the justice gap, especially the aim of increasing confidence in the criminal justice system and decreasing attrition ... (as well as) delivering on procedural justice." Of the issue of attrition, Kelly, Lovett and Regan (2005) note that many who experience sexual violence either do not report such incidents to the police and/or withdraw early from the investigation. Moreover, these researchers observe that there is a low rate of arrest, prosecution and conviction for those who commit sexual violence offences. The evidence suggests that engagement with sexual assault support services can contribute to mitigating such attrition and contribute to achieving more satisfactory outcomes for the criminal justice system.

Of the value of sexual assault services in delivering procedural justice, Konradi (2003) and Lovett et al. (2004) believe that such services treat victims/survivors with respect and dignity – treatment that they believe is an element of procedural justice, and which studies have shown reduce negative outcomes for victims/survivors, even in circumstances where those who use sexual violence are acquitted in court.

QUALITATIVE FINDINGS

12. Determining the Demand for a Sexual Assault Service for Canterbury

12.1 The Challenge of Gaining an Accurate Picture of the Target Client Population

Gaining a picture of the potential target population for a sexual assault support service for Canterbury proved challenging. Respondents described sexual violence as a "*hidden issue*" and that many people chose "*not to disclose to anyone*."

> *"It's hard to know how many people have experienced sexual violence in New Zealand let alone in Canterbury ... and there are some pockets of people in the population where the incidence of sexual violence is unknown ... disabled people in residential settings, elderly, young people and CALD communities."*

> *"There's only a 9% reporting rate New Zealand wide."*

> *"David Ferguson's Canterbury-based study showed, for child sexual assault, there is about 10.2% rate of disclosure for pre-18 unwanted sexual touching."*

They offered a myriad of reasons for the 'hidden nature' and "*infrequent reporting"* of incidents of sexual violence to agencies, such as the Police or Child Youth and Family. These reasons included societal beliefs and assumptions about sexual relationships, sexual norms and gender roles; feelings of shame and not wanting others to know; fear that they will not be believed, and/or they will be blamed, and/or that they will be ostracised from their families and communities; and, not realising that sexual violence is a crime.

> "*People don't come forward and don't report it because when they do they are not believed, not enough evidence to go to court ... the shame that the person gets away with it ... not believed ... helps to add to low self esteem."*

> *"Difficult to engage men in a patriarchal system that doesn't allow men to be victims ... if men are victims then weak and not fit model of what men are supposed to be."*

Many respondents reported that if people did disclose their experiences of sexual violence to others, it was more likely that they would tell a family member or friend; and, a few reported that people may initiate conversations about their experiences of sexual assault within the context of receiving other types of services and supports such as whilst attending *"women's support groups"* or *"parenting programmes."* In both instances, respondents believed it was unlikely that such disclosures would result in reporting to the Police or Child Youth and Family.

> *"Can get the numbers of those who disclose to the Police and Child Youth and Family, but those numbers don't reflect all those that disclose ... people are more likely to tell a friend or talk about it in a support group."*

Many of those interviewed, referred to published statistics about the prevalence of sexual violence in New Zealand. Although they cautioned about the accuracy of these national statistics, they commented that the rate of sexual violence in a region such as Canterbury was likely to "*mirror what we see nationally."*

> *"Research tells us that 1 in 3 women and 1 in 6 men have experienced sexual violence, but I am concerned about the accuracy of this data because of the way they ask the survey questions and some people ... elders and people with disabilities don't have the language to say what happened to them."*

> *"Research says 1 in 3 girls and 1 to 8-10 boys in New Zealand ... interesting because no New Zealand research specifically related to prevalence of sexual violence for men ... in Australia and America its 1 in 6 for boys. I think it's the same for boys as it is for girls."*

From a Canterbury perspective, other respondents working across Health, Child and Family, and Family Violence Sectors offered estimates of the prevalence of sexual violence within the context of their work and some described "*the hand-in-glove nature of family violence and sexual violence."*

"In our agency, 60% of the women who seek family violence services would have sexual violence somewhere within their situation ... could be historical, either personal or sibling's experience of sexual violence as a child or an adult, could be current experience of sexual violence either within the relationship or have a child that has experienced sexual abuse."

"Within intimate partner violence lot of clients have history of child sexual abuse and this impacts on their ability to form healthy relationships."

"With perpetrators of family violence frequently see sexual assault as part of family violence."

"About 25% of my caseload at Child Youth and Family would involve sexual-abuse-related incidents. These vary from a woman ringing to say my Dad sexually abused me and he is having unsupervised access to my niece to disclosures of sexual abuse. A lot of women in their 30s and 40s notify against their parents ... historic, but have reached the stage where they have the confidence to talk about it."

"68% of cases we work with at the hospital have some history of child sexual abuse."

In addition to these perspectives another respondent observed that *"ACC claims are part of the picture of prevalence ... about 19% of what happens. A third of all claims come from Canterbury and the region is the fourth highest in New Zealand for the size of the population."* Two respondents noted that use of specialist sexual violence services by members of the target client population may be linked to the presence of services in regions and the degree of awareness about such services by them.

"The need for sexual violence services is everywhere in New Zealand, but the use of services depends on the number of NGOs in a region. Where there is a higher concentration of sexual violence services in a region, there are higher numbers of people using services."

"Build it and they will come. There is benefit in having a service available ... reflects a societal norm for seeking help especially when people are clear about where they can get that help and they know the service runs a good shop. A number of clients say the existence of a service means they know

they can ring up ... normalises for people that they can get help when they are ready to receive it."

12.2 Estimating the Demand for a Sexual Assault Support Service for Canterbury

Despite the lack of precision in terms of predicting the exact size of the potential client target population for a sexual assault support service for Canterbury, a number of respondents offered previous reporting period data that may assist with providing an estimate of the demand for such services. For example, one element of a sexual assault support service involves supporting people whilst they participate in 'scoping interviews' with the Police and forensic / medical examinations following reports of sexual violence incidents. Moreover, a number of respondents from sexual assault support services throughout New Zealand reported that such service provision is initiated by a referral from the Police. This data has the potential to not only offer an estimate about the level of demand for a sexual assault support service, but also may provide clues about the nature of the sexual violence (historic or recent sexual violence) and some elements of the demographics of this target client group.

"The Canterbury Police deal with around 300-350 sexual assault files each year ... pretty stable over a number of years. These files range from historic cases of sexual assault that occurred as children or when people were younger ... can be up to 40 years ago to 6 months ago, to current rapes or sexual assaults. All are referred to DSAC for evidential examination for recent cases, and for historic cases a health check ... not all want to go, so they receive about 150 cases each year." [88]

In addition to this Canterbury data, administrative records from other regions also assist with building a picture of the demand for a sexual assault support service. Although it is acknowledged that not all people who experience sexual assault report such incidents to the Police, in Wellington the sexual assault support service receives about 120 referrals from the Police each year to provide support for those

[88] DSAC is the acronym for Doctors for Sexual Abuse Care. The Cambridge Clinic (DSAC Canterbury Limited) provides medical services for anyone in Canterbury or the West Coast who has been sexually assaulted whether recently or in the past (Retrieved from: http://mherc.org.nz/directory/all-listings-alphabetical/cambridge-clinic-dsac-canterbury-ltd).

participating in Police interviews and forensic/medical examinations. In this region such services are mainly provided to those who have experienced recent sexual assaults. In Auckland, a similar service receives about 600 such Police referrals.

In addition to this element of the sexual assault support services in Wellington and Auckland, such services also include telephone help line services; face-to-face support; and, support for people as they participate in court cases. The Auckland administrative data suggests that the 24/7 telephone service receives about 1,300 calls each year; the number of court-support services is about 100; and, there are about 100 face-to-face support engagements with people. The Wellington crisis service reported that it receives *"500 plus inquiries about various matters associated with sexual violence each year."* In addition to this more aggregated data, a crisis support team worker estimated that over a year she would receive "*100 telephone calls from people about sexual violence matters and attend about three after-hours Police/forensic callouts each month."*

Data concerning the level of demand and type of service offered by the after-hours service provided by the Sexual Assault Support Service Canterbury was also sourced during the focus group with of a sample of six of that service's volunteers. Table 18 illustrates the level and type of these services along with demographic information about the clients who received these services during the period October 2014 to April 2015. Note that this sample of respondents included individuals with a range of experiences from those with many years experience to those who were still in training.

Table 18: Illustrative Examples of Volunteers' Experiences of Delivering the After Hours Sexual Assault Support Service Canterbury Service

Respondents	Examples of Volunteers' Service Experiences
1	*"12-13 callouts to the Clinic to support a wide variety of people including a child of 2½, males, 13 year old girl and mature women ... 1 callout to support a person with a Police Statement ... 2-3 phone calls from the Police and from people wanting information."*
2	*"Still in training ... 1 Police callout to support 20 year old female ... 2-3 telephone calls requiring information ... want to know about what services available for them; contact numbers of services; what the DSAC process involves; people just wanting someone to listen to them."*
3	*"2 callout to support people through Police statements ... 1 Cambridge Clinic callout ... one telephone call wanting information about a referral for free counselling."*
4	*"3 callouts to the Cambridge Clinic ... all females – 2 teenagers aged 16 and 19 years, and lady in mid 40s. Attended 2 Police Statements with a male and a female, and another one where there wasn't enough evidence to prosecute and the client had to decide whether they wanted the Police to take it further and do a full investigation ... number of phone calls ... one had contacted the service before and wanted to follow up as now ready for counselling ... another whose daughter had been repeatedly sexually assaulted and wanted to know what to do ... others from Victim Support and the Police."*
5	*"Over 12 callouts to support 3 males and the rest females ... lot of calls from the Police ... person wanting to know what to do to approach woman who they suspected had been sexually violated ... advised them to let her know they were there to help ... followed this up with pamphlets about SASSC and how to*

	choose the right counsellor ... invited them to contact the service if they need more advice ... lots of calls wanting general information about sexual violence."
6	*"3 Police callouts ... 2 interviews and 1 to ask person to stop using Facebook as interfering with their investigation."*

Apart from comments about the level and type of services delivered by sexual assault support services, respondents also reflected on whether demand for service changed in response to particular times within the calendar year, community events, and/or media reports. There was some variation in terms of the respondents' advice about this issue. While most reported that generally there were no peaks and troughs in numbers of clients accessing service throughout the year nor a surge in demand around the Christmas period, they were divided in their experiences of demand for service following significant community events or in response to media reports or awareness raising initiatives, such as the "*Louise Nicolas story on TV*." Some noted that such events or media releases made no impact on the number of referrals to a sexual assault support service, whilst others had experienced the opposite impact on service demand. Comments from two respondents illustrate these varying experiences of service demand: [89]

[89] A partial explanation for the lack of immediate demand for service may be found within previous research which indicates that "*most people who have been sexually assaulted do not seek professional help immediately ... most do not seek support during the first two-four weeks following the sexual assault ... one community-based service has found that the common presentation time is 12 months after an assault ... another ... found that even people who chose not to report their assault typically take 3-6 months before recognising the full impact of the sexual assault ..." (Quixley, 2010: 24).*

In addition, research indicates that an individual's reaction to emotional trauma is complex and difficult to predict. Some will seek professional support, whilst others will manage the trauma themselves or within the context of their own natural supports. For example, McFarlane and Yehuda (1996) state that a person's age, past exposure to trauma, social support, culture, family psychiatric history and general emotional functioning are some of the variables related to individual response to trauma. In addition, McFarlane & de Girolamo, (1996) add that the emotional and physical proximity to actual danger, degree of perceived personal control, the length of exposure to trauma, the reaction of others to the trauma, and the source of the trauma (e.g., abuse from *parent, abuse from stranger, random personal violence) also impact an individual's reaction to trauma.*

"*They just keep trickling in at a steady rate throughout the year."*

"After the St John of God and the Kaitaia inquiries were in the media the inquiries kept coming in."

"A TV programme about sexual violence can trigger people's own experience and this might be when they need help."

13. Presenting Needs and Impetus and Timing of Help Seeking

Almost without exception, those interviewed were of the view that meeting the presenting needs of those who have experienced sexual violence has layers of complexity. It is a unique journey during which clients might move in and out of the helping system. Moreover, each client's journey impacts on, and is impacted by, their system of natural supports as well as the structures and belief system operating within the wider society.

Respondents noted that part of the complexity is due to the uniqueness of each person's experience of the trauma of sexual violence; that the experience is different across different life stages – child, adolescent and adult; and, the journey to wellness is far from linear. Rather, the journey involves "*dipping their toe in and out of the helping process*" and at each step clients will present with different needs.

"The impacts of the trauma are variable ... some people are activated and distressed, but a lot shut down, lot of avoidance ... some look asymptomatic, but have a lot of need. The situation is not static. It's variable across time ... can look fine and then triggered, have escalation and things get very messy. They could have gone back to avoidance by the time they seek help ... help needs to be offered straight away."

"There is variability of experiences and need across ages, whether they are a child or adult and whether the presentation is acute or historic."

"When a child has been sexually abused, the presenting needs are along a continuum. At one end the family might just need information about what to expect, but generally they have a strong skill base and are resilient. At the other end of the continuum you have 'unprotective' parents ... mental health issues, family violence, budgeting and accommodation issues, child discloses and they do nothing about it."

"Impacts on the developmental stages, especially adolescence when they get to know how broken they are ... happened when they were seven ... yucky what uncle did, pleased its stopped ... get to 12 and really understand what uncle did to them ... resonance of that is huge."

Respondents noted that those who experience sexual violence have "*immediate, intermediate and long-term needs"* – needs that are triggered by either a recent or historic sexual assault and that require a *"strong front door when they do disclose."* Several respondents explain the events that result in clients presenting for service and the requirement for services to respond immediately and in a tailored manner:

"People come because something has happened to them. The need is the event or level of readiness for service, rather than because of symptomatology."

"During the day people are active ... have jobs and don't need support so much. It's in the middle of the night when they are triggered ... have flashbacks that services need to be accessible. The 24/7 element of the service is important."

"Some people don't report and want to put it behind them as quickly as possible and then come back months/years later ... things have changed and what clients ask for has changed."

14. The Nature of a Sexual Assault Support Service for Canterbury

14.1 The Overall Focus and Approach

Respondents recognised that sexual assault support services are the 'front door' for those who have experienced sexual violence and are seeking support and service in the immediate and intermediate phases of the journey to wellbeing. However, they believed that such services needed to be couched within a continuum of service that

includes primary prevention initiatives to "*change the norms within communities so that help seeking is enhanced,"* and long-term therapy and counselling.

This 'front door' requires a comprehensive package of responses that takes account of *"acute and historic crisis needs."* Moreover, this package of responses needs to be inclusive of "child-focused," "adolescent-focused" and "adult-focused" approaches; client-centred and delivered within the context of a cross-sector team of specialist services (includes medical and forensic services, police services, court services and statutory child, youth and family services); and include elements of a 'social work' service (for example, advocacy and brokerage interventions) for the victim/survivor and their system of 'natural supports.' According to respondents, this immediate and intermediate response to sexual violence needs to:

- ***Address the physical and psychological safety needs of victims/survivors***

> *"A safe environment needs to be created in order to prevent a stress response being triggered."*
>
> *"Make sure they are safe from further stress; that they are safe from the offender ... that they have a safe place to go to after the forensic exam."*
>
> *"Work with the doctors so they get all their medical needs met."*
>
> *"Need to help people access medical assistance so their physical needs are met."*

- ***Reduce the Impact of the Trauma*** [90]

> *"Assistance needs to be given in a way to minimise the impact of the trauma ... minimise damage to the brain ... not make things worse ... introduce*

[90] Briere & Scott (2006) suggest that the immediate response to acute trauma should include assessing the person's immediate emergency needs including their physical and psychological needs, social needs and ensure they are safe from further trauma. In addition, people should be provided with support and information; connected with social resources; and avoid de-briefing or exposure techniques.

yourself as a person without reminding them where you are from ... provide support for the person, but not get into clinical assessment or ask them about the incident ... could be re-traumatised."

"Psychological first aid is the immediate response to a trauma event ... presentation is so individualised and it's all bound up with the rest of the story ... who the offender was, what happened before the event. The response is tied to the trauma model and brain functioning, although not all people with experience of sexual assault have PSTD ... not functioning in the thinking part of the brain, so need to make things as predictable as possible, give people as much control of their environment as possible ... know what happen next ... offer simple information ... protective factors that prevent further harm."

"Be aware of the way you are around people who have experienced a traumatic event ...read the situation as this dictates how you respond yourself ... speak slowly, not a lot of detail. Need to understand the space they are in ... and that will influence the way you are with them. Looks like a cup of tea and a hand hold, but the decisions about what the delivery looks like for each person is influenced by layers of detail and understanding about sexual trauma. Response could be practical. Some may say 'get away from me', and so think about what else can be done to shore the person up, for example who in the person's system may need support?"

"You need to have the knowledge that you don't ask about what happened. It's not our job to do an assessment beyond what is present, as that can re-traumatise people. If they want to talk, then that's fine, but if they are not ready to talk and you question them then that can re-traumatise ... as a support person you don't need to know what happened."

"Support them to hold their boundaries ... contain them ... if this not done then more harm than good can occur."

- ***Be client centred***

"Service needs to be separate from the police ... some people are intimidated by them. Let them know you are there to support them so they know they have an ally in the room."

"Sometimes others want to tell them what to do ... ACC, police, medical staff, court staff, friends, family, society ... need someone independent of all these, whose on their side so they can make decisions about what they need to do for themselves ... for example, pace the medical procedures ... slow down the court process."

- ***Empower and facilitate victims/survivors to gain control***

  "Need to give the control back to the client ... empower them as the power and control has been taken away."

  "Clients face a lot of stigma and have to deal with the stereotypes held by society and reported in the media. For people who have been raped, society tends to blame them ... people hold this view in a strong way after a sexual assault and they begin to self blame ... Did I do something to invite this to happen? Was my dress too short? They think it only happened to them. Takes away the power ... gross disempowerment ... relationships change because they respond to others differently, hold the secret because of the stigma."

  "Need to give control back to the person, as the sexual assault has taken away their power and their sense of control."

  "People need assistance with managing relationships so not pushed and pulled by others."

- ***Be information rich***

  "The person providing the support needs to be knowledgeable about the tasks of forensics, medicals, prosecution matters and how they proceed."

  "People need to access information so they know what their options are and can make decisions that are best for them."

  "People need to know things are predictable. They need information about what is going to happen next ... provide them with the bones of what is going to happen."

  "Decide not to go to the Police: support them to work out their options by providing them with information so they can know what they may need to do next."

- ***Facilitate navigation and easy access to diverse cross-sector services and supports***

  "You have to be knowledgeable about the system."

"People require longer-term support to access mental health services, budget advice, help to ensure there is a great match between the person and the ACC counsellor."

"Sometimes it's about preventing the re-abuse of the child ... get perpetrator into STOP."

- ***Work with Family/Whānau and Friends***

"Having support within their own social network and family is critical ... make sure clients are connected with them after the sexual violation."

"Lot of sexual violence happens in families ... need to manage responses of family and friends so they are helpful for the person ... no blaming, no shock/horror reactions."

"Can have between 8-9 people with the victim ... all have different personalities and reactions to the situation ... have to be able to gauge the situation for each and provide support ... helps the client even if they prefer to be on their own."

"The child will be distressed and be grieving, and find the parents won't be coping either ... worker needs to support all three people."

14.2 Key Elements of the Intervention

The majority of respondents emphasised that the elements of a sexual assault support service should take account of the needs of those with recent experiences of sexual assault; those with historic experiences of sexual assault; as well as the ongoing needs of both groups. In addition, they advised that a sexual assault support service should also focus on meeting the needs of those within each victim's/survivor's natural environment, for example, family/whānau and friends.

Respondents identified two principal intervention strategies for a sexual assault support service. The identified interventions were:

- Support
- Advocacy

However, within the context of these two principal elements of intervention, they identified a range of delivery mechanisms that they argued could be packaged as a "*specified number of sessions, say four to six, that could be used flexibly by either the victim or their family at the front end of the person's help-seeking engagement."* This package, they believed, would ensure support services were responsive to each victim's/survivor's individual healing journey and the 'in-and-out-of-service' patterns often associated with such journeys.

14.2.1 Support: Range of Service Delivery Mechanisms

Of the support intervention strategy, respondents suggested several mechanisms for delivery – mechanisms that they believed would support the principle of 'client choice' and thereby enhance responsiveness.

> *"Client choice is paramount. It's best to have available a combination of ways to deliver the service. This is based on the principle that the service should fit the person, not the person having to fit the service".*

Respondents identified several service delivery mechanisms for the support element of a sexual assault support service including:

- ***24/7 telephone support***: The majority of respondents advocated for the provision of a 24/7 telephone support line which they variously noted could include a brief intervention, such as provision of information; active listening; brokerage to other services; coping strategy suggestions; and/or callout to support forensic examinations and/or police interviews.

> *"Access to be able to ring up 24/7 is important."*

> *"People call for all sorts of reasons ... information about how to access a counsellor; parents worried about their child's behaviour and wanting to know what to do; being triggered in the middle of the night ..."*

"Mum rang ... teenager was ripping room apart, cutting, self destruction ... found it hard to cope ... wanted advice about what to do."

"We get a lot of calls from the police wanting someone to provide support during a medical examination and interviews."

"Often people go one to two years before they ring someone to talk about the sexual violence ... need to be able to respond in those circumstances ... often in the middle of the night that problems flare up. Some people want advice about the consequences of the assault, like contracting sexually transmitted diseases ..."

"Callers might need information about medical stuff, like what to do when they are not able to sleep. Some want advice about whether to continue routines at school and work ... other just need to talk after flashbacks."

- ***Face-to-Face Support***: The respondents commented that a sexual assault support service should offer face-to-face support, although they had varying views about its exact nature of this service delivery option. All respondents stated that the sexual assault support service should provide face-to-face support at forensic/medical examinations and police interviews; and, support during the police investigation and prosecution processes as well as any subsequent court proceedings. Many respondents believed ongoing face-to-face support should be an option provided by a sexual assault support service. They stated that this face-to-face support could focus on providing "*a social-work-type of service that included problem-solving, working out coping strategies, and brokerage to services to meet practical needs*." A few respondents noted that family/whānau support groups and peer support groups should be delivered under the auspice of a sexual assault support service. Respondents' comments illustrate the operation of these face-to-face support service options:

Respondents' comments about face-to-face support at forensic/medical examinations and police interviews
"Provide support during police statements, police outcomes from investigation meetings." *"This (support during forensic examination) could involve social work tasks like: 'Where are the clients going to sleep tonight? Who is going to support them? How do they get a new set of clothes? ... practical things."* *"Vast majority of clients want support ... cup of tea; distraction talking; debrief after the forensic examination; know what happens next; and what their options are."*

Respondents' comments about face-to-face support during court procedures
"Go with clients to court ... While some of the counsellors will attend court with clients, many people chose not to engage with counselling, but still end up in court ... could be years latter but someone with specialist knowledge needs to be available to support people in court." *"Provide support at court ... work with clients to prepare them for court and support them through the court process. This is different from the court victim advisors who focus on the court process, proceedings and trail stuff."* [91] [92]

[91] Victim Support is an independent society that provides a 24/7 community response to help victims of serious crime and trauma. This service provides emotional and practical support, information, referral to other support services and advocacy for the rights of victims (www.victimsupport.org.nz).

The Court Victim Advisors advise witnesses about when and where they need to be at court; arrange for a visit to the courtroom beforehand to see what the courtroom looks like and what to expect; and, at the victim's request can organise particular arrangements with the judge, such as providing evidence from behind a screen or via closed circuit television (http://www.justice.govt.nz/publications/publications-archived/2010/victim-information-summary/being-a-witness).

[92] When asked about the roles carried out by the Victim Support Workers, the Court Victim Advisors and the way in which the court support provided by the sexual assault support service complements these services, respondents stated that Victim Support Workers lack the specialist skills required to support those who have experienced a sexual assault and the Court Victim Advisors' role was focused specifically on "*preparatory aspects of the court process and this did not include attendance at the trial*." One respondent explained the support provided by a worker from a sexual assault support service during court proceedings:

Respondents' comments about ongoing face-to-face support

"There is continuity of care between supporting person in crisis situation and then subsequently providing practical support. Supporting people during a crisis helps build an alliance. This alliance between worker and client is critical for people who have had a trauma experience ... they find it hard to trust people."

"Ongoing sessions would offer people more help ... explore what they want to do next ... could be helping them contact the police if they haven't done that before ... it's a problem-solving process to assist the client achieve their goals ... could focus on containment."

"Ongoing face-to-face could be used to work with family members ... caregivers of children who have been sexually assaulted and they don't know what to do or how to access a long-term therapist. Could be partner who is angry and needs support ... explore what their situation might be like living with a survivor ... what options could they take up. The waiting list is long to get into therapy and so the service could provide someone for survivors to talk to ... meet that need while they are waiting. But need to be careful that the service gets the focus and timing of this right ... don't want to disrupt the therapy process where people have to tell their stories twice."

"Could offer short-term intervention, but it would need to be grounded in helping people deal with the other things going on in their lives ... often people in a rocky place, but not get into the specialist sexual violence counselling area."

"Provide support for all the immediate issues ... support person through the police investigation, support to access housing, benefits ... It's the specific action-focused stuff they could help the client work out, for example offering someone with a learning disability tool to deal with situations that might arise in the community ... prevention of sexual violence."

"Sometimes people don't turn up to appointments ... good to have support to enable that to happen."

"Court case could be a year after the sexual assault and the worker has relationship with the person ... prepare them so they are ready for court ... ready to tell their story, ... lot of people don't have counsellors but still go to court ... and clients tell us that it is important to them to have them at court, as they know how distressed I was on the night of the assault."

Respondents' comments about face-to-face support groups
"There is a long wait till people get into counselling ... could offer peer support programme ... someone to talk to ... talk about what to expect at different points in the journey ... how to navigate the journey." *"Could offer support groups for families ... Mums and Dads."*

14.2.2 Advocacy: Specific and General

Respondents stated that a sexual assault support service should offer both specific and general advocacy. Specific advocacy related to that offered to victims/survivors during forensic and/or medical examinations. General advocacy related to that offered to victims/survivors to assist with managing workplace, financial and other arrangements.

> *"They need to support people to navigate justice matters and medical matters and make sure they are attended to."*
>
> *"Need to include the advocacy element when things are not flowing ... able to fight with them in their corner."*
>
> *"Advocacy skills important ... negotiate with work places if people don't want to go to work ... make sure people have access to financial support."*

14.2.3 Primary Prevention

In addition to the support and advocacy elements of a sexual assault support service, some respondents argued that there was a role for this service (in conjunction with other sexual violence sector specialists) to contribute to primary prevention work. Respondents stated that the purpose of this role was to reduce the incidence of sexual violence and increase help seeking by providing education to various community groups, including children and young people within the school

environment and service and hospitality workers. In addition, respondents noted that this primary prevention work provided balance for workers involved in secondary and tertiary prevention work – a balance that mitigated, to some extent, the risk of stress and burnout for employees working within the sexual violence sector.

> *"Agency needs to take a system-wide approach ... include social justice and social change focus, as well as crisis and therapy services. If the agency only works at the bottom of the river it will struggle to swim and get the survivor to the bank and it's likely that sexual violence won't end. Working up river is where we need to be to succeed in raising the bar for effective political and community responses to sexual violence."*

> *"The prevention/education work supports the clinical work ... do better because we do both."*

> *"Half the (crisis) team are involved with prevention/education work in partnership with other agencies."*

15. Principles and Values

Respondents were invited to consider the key principles and values that might underpin the structural and service delivery arrangements for a sexual assault support service. The key underpinning principles identified included: [93]

- **Victim/Survivor- and Family-Centred With Deep Understanding of the Impact of Sexual Violence**

The majority of respondents believed that a sexual assault support service should demonstrate an appropriate and informed approach that is victim/survivor-centred and recognises and understands the dynamics and impact of sexual violence, within an equalities and human rights framework.

> *"A flexible service that is responsive to clients' needs."*

[93] The principles are listed in descending order of the frequency with which respondents mentioned them, with the principles with the highest number of responses at the top of the list.

"Service needs to help and understand sexual violence within the complexity of the social environment ... feminist perspective that sexual violence is an issue of male violence against men and women and includes notions of what masculinity is within society ... Also involves issues of social justice, social equity and fairness ... need to consider factors that provide the conditions for sexual violence to prevail."

"*Client-centred, like the paramountcy principle for children"* [94]

"Client is at the centre ... survivor is paramount. Don't have to tell me, because I know what you are here for. It's about you, not me. What can I do to support you? What do you need us to help you with, and if you don't know let's talk about it and see what's going on in your life ... if it's alcohol or drugs let's look at that. If you go to a counsellor they look at the alcohol and drugs, different from the focus of a service that works with people who were sexually violated as children."

"Service committed to victims"

"Recognises that sexual violence has a ripple effect in families/whānau and within the communities within which the survivor lives."

"Not just primary victim that suffers, but also their system suffers."

- **Diversity is Respected and Fair Access to Services**

Respondents noted that a sexual assault support service must respect the diversity of service users; positively engage in anti-discriminatory practices; and support and assist service users to access services on an equitable basis.

"Respectful of difference in all sorts of descriptions"

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94 This re*spondent used the analogy of the child being paramount within the context of the Children, Young Persons and Their Families Act.*

Welfare and interests of child or young person paramount

- In all matters relating to the administration or application of this Act (other than Parts 4 and 5 and sections 351 to 360), the welfare and interests of the child or young person shall be the first and paramount consideration, having regard to the principles set out in sections 5 and 13.

"Service needs to be inclusive"

"Service needs to be available to all people ... disability"

"Equity ... ensure people affected by sexual violence have access to high quality services."

- **Respect, Manaaki and Safety**

Respondents commented that a sexual assault support service must ensure that both clients and staff/volunteers are engaged with respect and manaaki and are safe.

"Warm, calming and friendly service"

"Manaaki is how people need to be treated ...looked after, genuinely cared for, shown respect and kindness."

"*Service delivered within auspice of care for harm done"*

"Focus on safety and help."

- **Empowerment, Participation and Partnership**

Some respondents stated that a sexual assault support service needs to promote empowerment, self help and partnership working to enable service users to take control of their lives and make informed decisions about the delivery of services for them.

"Service should value empowering clients."

"Service needs to provide a space where people feel empowered to make their own choices and they are supported and believed in that way. It's how you hold the person, in a shared and respectful but bounded relationship. Knowing that you don't let the victim, perpetrator, rescuer dynamics play out ... not rescue or punish ... 'they're ringing too much' ... 'why didn't they do what I told them to do?' The aim is to establish power. You have to hold an

equal relationship and do everything in that way, and not be afraid to name the power dynamics if they emerge."

- **Collaboration**

A few respondents mentioned that a sexual assault support service should operate within a context of relevant within-agency and inter-agency cooperation, collaboration and coordinated service delivery.

"Collaboration at all levels is critical for the service to be effective."

"The service has to work with the police and the medical people and other specialist agencies to do the work. Because sexual violence services are not resourced to provide all of these services, it has to enable the person to build relationships and to engage with other agencies outside the service. It does this by facilitating the person being attached to a worker that helps and supports them ... enables them to regain trust and communication within relationships."

- **Accountability**

A few respondents stated that a sexual assault support service should ensure that their clients receive a high quality service that is focused on continuously improving and is delivered by appropriately skilled staff

"Real focus on staff professional development and learning."

"Service that uses its learnings."

"High levels of professionalism ... skilled, knowledgeable, accessible to people ... not suits and clinical."

- **Treaty-Based Relationships**

A few respondents commented that a sexual assault support service should recognise the Treaty of Waitangi as the founding document of Aotearoa/New Zealand

"Treaty based ... underpinned by framework"

- **Hope and Recovery**

  "Believe that people can recover and healing is possible."

  "Give hope ... recognise this is a temporary time ... help them to see the bigger picture ... show there is potential to heal by the workers role modelling that themselves."

- **Holistic and Wellbeing Focus**

  "The service needs to take a holistic approach ... provide for the overall wellbeing of the person ... meet their safety and basic needs."

  "Enhance wellbeing for victims of sexual violence."

- **Challenge Social Tolerance of Sexual Violence**

One respondent noted that a sexual assault support service should challenge society's tolerance for sexual violence in all its work, and hold a core belief that it is preventable.

"No condoning of sexual violence of any form."

16. Access and Responsiveness: Strategies for Enhancement

16.1 Language, Promotion and Access

Client-centred practice was highlighted by the respondents as one of the priority principles underpinning the structure and service delivery of a sexual assault support service. This foundational principle was also reflected in respondents' advice about ways in which the design of this service could facilitate access and responsiveness for victims/survivors. Respondents reflected on the way in which mechanisms for access and responsiveness could best meet the circumstances and needs of those seeking help concerning sexual violence. For example, respondents commented that the "*public persona of the sexual assault support service"* should communicate messages that are inclusive of the diverse sexual violence experiences of the target

client population – that is, people are able to recognise that the service is the right one for them; and, they have confidence initiating contact with the service because service provision will be conducted in a way that empowers them, enables them to regain and maintain control and choice, assures them of their privacy, and meets their information needs.

Respondents suggested 'recognition' and 'confidence' messages, for the target client population for the sexual assault support service, could be delivered through a range of mechanisms – mechanisms such as the name of the service; the use of 'person-first' and inclusive language in all promotional materials; and, the inclusion of descriptors and visual representations that enable people to recognise themselves as members of the service's target population.

Of the services name, respondents advised that it needed to reflect its mission.

> *"Need to name the service for what it is, so people know what it is and what it does. The name needs to enable people to identify the service whether they have experienced sexual assault or sexual abuse. Needs to be appealing and accessible, but at the same time describe what the service does."*

> *"There are lots of perspectives about identifying a sexual violence service: secret and respecting people's privacy; not being ashamed of what it is; and, everything in between ... need to name it and be clear about what the service is, so there is no confusion."*

Respondents also recognised that the language in a service's promotional materials can exclude people from accessing service. For example, people may exclude themselves from service if words, such as 'victim,' 'rape' and 'crisis,' are used. Instead, respondents suggested using person-first language.

> *"The use of language does impact on clients' ability to engage and accept support from a service ... If you say you are from a 'victim service,' then people might think it's not for them because they don't identify themselves as victims."*

"There are a lot of people sitting at home who have never told anyone. Traditionally Rape Crisis and Women's Refuge were the brands that people knew to go to if they had concerns about sexual things, but these names are off putting for some people. A lot of women don't see rape as the thing that happened to them ... people think of rape as being dragged off into the bushes ... crisis word not mean anything for people who have historical experiences of sexual assault ... think crisis belongs to other people's experiences."

"Victim is a very western concept. CALD people do not think about themselves as victims because of the taboos in their cultures ... may feel that way, but not think that way."

"Language needs to reflect the reality of the different experiences people have ... avoid crisis, as excludes people with historical experiences of sexual assault ... survivor and victim – avoid both terms on a website. Better to talk about the client ... 'people who have experienced sexual violence' and 'service that provides support for people who have experienced sexual violence. It's language that communicates person-centred help and support. This language is more mainstream and less stigmatising."

"Need to use language that puts the person before the act."

"Use people-first language and use language that meets people where they are in the three stages of recovery from the trauma." [95]

In addition to the use of 'people-first' language, respondents' experiences of working with people from various groups within the community suggested that some people exclude themselves from service because service descriptions do not reflect their particular life circumstances. To counter this issue, respondents recommended the service's promotional materials include scenarios so people recognise their experience as sexual violence.

"Language on the website needs to be inclusive so people's various experiences of sexual assault are not discounted ... there are some grey areas for people ... husband held me down and forced me to have sex ... may

[95] The respondent referred to the three stages of the trauma recovery process developed by Judith Herman: establishing safety, retelling the story of the traumatic act, and reconnecting with others (Herman, J., 1998).

not be seen as sexual violence. Information on the website needs to give people information about what is OK and what is not OK."

"Important to describe different forms of sexual violence so that people can name it ... know woman in lesbian relationship who experienced sexual violence and thought that her experience wouldn't be validated as thought people would think this only happened between men and women ... similar assumptions about men in gay relationships."

"Pictures in the promotional materials need to be representative of, and reflect, the diverse makeup of the community ... not just pictures of Māori and Pākehā."

Respondents also recognised that those who experience sexual violence value service and support that is empowering and provides them with choice and control at all stages of their engagement. In addition, recipients of service want assurance that their privacy and need for confidentiality are respected.

"How the service is promoted is important ...ensure people understand it is free, confidential, and there are interpreters available."

"Tell people about the flexible ways they can engage with services ... a lot have anxiety that they will lose control when they engage with service ... get on a treadmill and the next thing they will be in court ... need to build understanding that engaging with the criminal justice system can lead to a lot of different circumstances .. OK just to ring anonymously to sound us out about a situation and that they have choice about what happens ... people want to keep control."

Respondents advised the use of a range of methods for promoting a new sexual assault support service including the design and distribution of resource materials translated into a range of languages; participation in community events and expos; and, engagement with the media.

"Raising awareness is important ... brochures that describe the service need to be available at primary health and tertiary education institutions, on Health Pathways, and be at expos ... need 088 number."

"Promotion is critical ... attend community events, develop purse cards with service's contact details, get service on calendars and wall planners. The promotional materials need to reference all other key providers involved in the crisis sexual violence response ... Police, DSAC. Use the media to explain the service."

"Need to identify key population groups within the community and translate all resources into the different languages."

16.2 Information Communication Technology and Access

There was particular recognition of the potential client target population group's use of information, communication technology and therefore its role in enhancing the accessibility of the sexual assault support service. The interactional nature of many forms of this technology was believed to be well matched to the journey of those affected by sexual violence – a journey that involved different forms of help seeking at different times.

"Phone line, texting, 0800 number, online ... all make the service visible and accessible."

"Use of the internet has increased and most people will use it to look for services to engage with ... they look at websites to see what services offer. Some clients want links to websites."

"The service's website needs to be accessible to all groups ... Be Accessible can provide advice about fonts, use of sign language and videos for those who are unable to read."

"Technology has helped access ... use of Facebook to get information about services ... lot of clients use text messaging."

"Needs to be a single point of access that anyone can call if they have concerns about sexual violence ... if people want to dip their toe in to get information ... could be concerned parent or someone who thinks they are at risk of harming others to find out what to do (like STOPITNOW phone line) ... more in line with people's experiences of needing different things at different times, and the fact that they come in and out of help seeking. This would create a filter mechanism to triage people into face-to-face meetings with

sexual assault support services that would explore the different options for people."

16.3 Community Engagement and Access

Maximising the accessibility of a sexual assault support service was, according to the respondents, an activity that required constant and ongoing attention. They reflected on the "*hidden nature of sexual violence services"* and *"the number of people who have no idea who we are."* In order to raise awareness of the service amongst community and professional groups, respondents suggested that the service become involved in health promotion programmes; engage and build relationships with services that might be potential referring agents; and, engage in public debate about issues in the media and/or participation in national and pertinent campaigns.

"Accessing service is a needs-based thing ... people don't care until they are faced with the issue and then they find out about it. So needs constant push and marketing as I run into people all the time who say they have never heard of the service."

"Police and others, who run into people needing help, need to know. Lot of referrals come through the police ... so up-skilling them and other possible referral sources about what the service offers and how it works and how they can connect to the service."

"It's important to identify a network of connections and establish relationships with services that work with different groups ... women's refuge, Māori women's refuge, local marae, disability, Shakti, ... get understanding about the services they offer and what you offer so referrals are appropriate."

"Residential services may not notice the signs of sexual abuse ... by raising awareness, it will increase the chance of building a practice culture that knows what the signs of sexual assault are and knows how to report it."

"I think you have to work at both the system change level and the service level on any issues that create barriers for people. Not just address issues with the person who is impacted, but also need health promotion. This is more important for CALD communities. They have not grown up in New Zealand and don't know about the system that has been developed in this country to

address issues. Health Information Provider Programme ... learn about topics and what is provided in the communities ... sexual violence is part of one of the modules ... goes to a lot of families with refugee backgrounds ... need different approach for migrants. The information people get offers the potential for behaviour change ... through knowledge and skill acquisition ... it's the whole thing about people learning together about something that could be threatening if not delivered in that way. The knowledge they learn flows into other areas of their lives ... how to access support, and then they tell other members of their families."

"Carry out outreach education about sexual violence to communities to build their capability about where to get support ... a bridge to communities. This could involve identifying a coalition of champions with expertise throughout New Zealand and inviting them to train their local network of providers who have access to different communities and can get the information to them... for example, Shakti."

"The community doesn't really know about sexual violence services, how to identify sexual violence, or how to help. New service needs to raise its profile in the community ... comment on national campaigns like 'Who Are You? or comment on things that are reported in the media like Roast Busters incident."

16.4 Enhancing Access and Responsiveness for Diverse Groups: Collaboration is the Answer

Respondents were invited to offer their views about whether the design of a sexual assault support service should target clients from particular groups within communities, or all population groups. [96] They were unanimously of the view that specialist sexual assault support services for each of the diverse population, demographic and/or social history groups was not possible because the level of demand from each of these groups would not warrant separate services for each. While they recognised that client choice was an important consideration and that in order to meet that requirement each region required separate specialised sexual

[96] Respondents were invited to consider a range of groups that may be affected by sexual violence and noted in the research literature including: historic/recent sexual assault; family/acquaintance/stranger sexual assault; children/young people/adults; elders; gay/lesbian/bisexual/transgender; Māori; Pacifica; people with refugee or migrant backgrounds; people with disabilities; prisoners; sex workers; gang members; those with religious affiliations.

violence services for Māori, children and young people and men, they believed that "*one recognised point of entry was preferable."* [97]

> *"There are not enough numbers to have specialist services for all different population groups, apart from Kaupapa Māori, child and male specialists ... different things are needed for children and adults. These three have specialist knowledge and skills to work with those groups. It becomes too split up if there are special services for each group."*
>
> *"Not possible to employ service providers of every persuasion with sexual violence expertise."*
>
> *"Apart from children and young people, who need to be separate as this is a specialised area ... count them out, for all other groups there needs to be one point of contact for a specialised sexual violence service that provides support."*
>
> *"Never going to get the numbers, better to think about the service from an all-comers perspective ... need a single funnel for all people to come through and back up for variable populations. Need to do special things for different groups, but not separate services ... need good relationships with experts in relevant areas and join their expertise with your expertise."*

In order to enhance the sexual assault support service's accessibility and responsiveness to diverse groups, the respondents believed that this service would be required to exert considerable effort to connect with other agencies, particularly those with specialist knowledge and skill for working with 'hard-to-reach' groups. To

[97] Respondents identified the Christchurch-based sexual assault support services available for Maori, children and young people and men. Those identified were:

Te Puna Oranga: "*We are Kaupapa Māori, committed to tautokouwhanau oranga through the process of holistic healing. Māori sexual abuse healing, abuse prevention education, Māori youth & whānau advocacy services provided"* (Retrieved from: http://www.tepunaoranga.co.nz).

Child and Family Safety Service, Canterbury District Health Board (A description of this service is located in the Appendix and retrieved from: http://www.cdhb.health.nz/Hospitals-Services/Child-Health/childrens-departments-units/Pages/default.aspx).

Male Survivors of Sexual Abuse Trust: *"All MSSAT organisations offer one to one, peer and group support for survivors and their significant others"* (Retrieved from: http://survivor.org.nz).

this end, they advised that the service needed to be grounded in a collaborative paradigm. Essentially, this paradigm would include the development of a way of working that involves concentric circles of joint effort, with those operating in the centre having more intense engagement and shared responsibilities than those operating in the outer circles.

> *"Develop map of engagement and differentiate key partners from others. Need list of who the service works with, why and specifically how. Develop meaningful reasons for engagements and how work together ... respect, common purpose, what you want to achieve and the objectives ... also need client pathway and information sharing protocols. Fundamental to working together is to keep abreast of others' activities and directions."*

Respondents envisaged layers of collaborative arrangements *"that would streamline services for the victims following their contact with the police and health sector so that they receive all the different types of support they need through a recognised point of entry"* including:

- Collaborative arrangements between those responsible for forensic examination and immediate medical care, those responsible for the immediate 'crisis' support intervention, and the police

- Collaboration between the mainstream sexual assault support service, the child and family sexual assault support team, the region's Kaupapa Māori organisation and the men's sexual assault peer support service

- Collaboration between the mainstream sexual assault support service and those with specialist knowledge about working with identified target client population sub-groups such as elders, the gay/lesbian/bisexual/transgender community, the Prostitutes Collective, those working with Pacific Peoples, those working with the culturally and linguistically diverse communities, those working in the Disability Sector, and those working within residential settings

The level of engagement, between a sexual assault support service and these various partners, and the type of collaborative models adopted will depend on the level of intensity of service and responsibilities required to meet client-centred goals. One respondent's comments illustrate the thoughts of others concerning the need to define where on the continuum of collaborative strategies each of the three collaborative arrangements best sits.

> *"Need to explore the continuum of collaboration and define what this means for different aspects of the work ... high-level working or core interactions around clients ... need conscious discussion around what collaboration means."*

For example, many respondents noted the critical importance of the collaborative working arrangements of the Police, the Doctors for Sexual Abuse Care and the sexual assault support service, and the need for a tripartite agreement that outlined the roles and responsibilities of the three parties. [98] Such agreements defined each of the parties' responsibilities concerning meeting attendance; information sharing; learning from each other to enhance the responsiveness of service to those who have experienced sexual assault; and, risk management. Various respondents' comments describe this tripartite response and the way in which it is operationalised.

[98] In the third monitoring report on the response of the New Zealand Police to the Commission of Inquiry into Police Conduct, the Office of the Auditor General outlined the three types of support that need to be available for adult sexual assault complainants including crisis support by specialist providers; the Sexual Abuse and Treatment Service (SAATS) which is jointly funded by the Accident Compensation Corporation, the Ministry of Health and the Police through contracts with the district health boards and managed by ACC as the lead funder; and, victim safety and offender accountability support facilities which are safe facilities that the police provide for examining and interviewing complainants and ensuring that investigations are carried out properly. These three types of support rely on cooperative relationships with support agencies. Collectively they are called the "tripartite" response.

This same report described the roles of the SAATS. SAATS is a medical forensic service providing triage, assessment, treatment, and referral services for all victims of sexual abuse. It is designed to provide: a 24-hour, 7-days a week service; timely medical triage by a medical specialist or nurse with training in sexual abuse care; expert medical assessment, sexual health advice, and treatment that meets health, injury, and forensic needs; referral to, and co-ordination with, other services, such as the New Zealand Police, Child Youth and Family, and crisis support agencies, in a timely manner; and follow-up treatment, treatment that is provided in a suitable environment, and treatment that meets forensic requirements (Controller and Auditor General, 2012:25).

"A local level agreement developed that facilitates meetings with police, medical and support service representatives ... able to discuss points from different perspectives, share understandings, inform each other when there has been a media exposure regarding sexual violence. It's about building good relationships, so that it's OK to challenge ... successful when you don't bulldoze people and maintain communication."

"The tripartite agreement between the police, medical and crisis support service is required to manage the relationships with confidence. It needs to be supported by professional structures within each organisation ... a level playing field. Would include the means with which to address problems when they arise ... would reflect the professionalism and structure in each service ... way staff are trained, supported and managed."

"Police, forensic and crisis support meet regularly ... talk about what seen, where things are at ... share information from all perspectives. People need to have good records, understand their role and be prepared for meetings to make this effective. They need to be attended by professionals and clinicians to achieve a level of professionalism ... all worked out in tripartite arrangement that includes agreement to not use names, just initials; destroy progress papers before leave the meetings – not take papers back to agencies, procedure for when things are not going well."

"Regular meetings with DSAC, police and sexual assault support service guided by simple MOU ... meetings involve connecting about cases, any issues that have arisen, what is required, any complaints about response ... provides what is needed for the victims ... really victim focused."

While respondents noted the more formal arrangements for a sexual assault support service within the context of this tripartite collaborative effort, they were also of the view that the design of this service needed to incorporate the development and ongoing maintenance of collaborative relationships with those who had strong connections and expertise with particular populations groups within the community. For them the purpose of such relationships was to enhance accuracy, access and responsiveness of service for those who had experienced sexual assault.

"The service needs to build relationships with other services so it can get a better understanding of what people from different groups might need from SASSC. This could improve accessibility to different groups. Also need to work closely with the people with the expertise as the service is delivered."

> *"Being responsive to different groups in the community is a journey, not a destination. You have to keep asking other organisations and other people about their experiences ... talk to the disability community about ways to work with a person who has an intellectual disability, about ways they can learn the signs when they might not be safe from sexual assault ... talk to the queer community about ways to make your forms and office more accessible. The main thing is to get guidance from the people who know about certain groups."*

Many respondents suggested that the sexual assault support service map the 'expert' providers of service to diverse population groups along the collaboration continuum – a continuum that includes 'coordination' across agencies for the purpose of sharing information; and, 'cooperation' across agencies for the purpose of not only exchanging information, but also contributing workforce resources to enhance service access and responsiveness for victims/survivors. In addition, some respondents advised developing memorandums of understanding with some agencies, particularly those where the sexual assault support service works with services using a 'cooperative' model of collaboration. Respondents' comments illustrate this continuum of collaborative relationships in action.

For example, respondents noted that in situations where *"cooperation between services is important ... MOUs are required to give legitimacy to the relationships and clarity about roles."* Such 'cooperative' relationships may involve supporting or building capability to deliver services to those affected by sexual violence; work to transition clients from one type of service to another; and, working in unison whilst providing support services.

> *"Create concept of sister agencies in regions ... Māori and mainstream and work together to strengthen each other."*

> *"Got referral from the police for person raped ... would be killed if she disclosed ... problematic, and so first thing do is ring Christchurch Resettlement Services ... not able to deliver sexual violence service, but could contact that service to coach them about what to be mindful of and how to do some helping."*

"Often need transition ... go with them to hand over the credibility that the client holds with service to other service. Need to have connection to other services that might be referring, that have a relationship with the different communities within the target population."

"Some clients are wary of translators because they believe that what has happened to them will become known to their community. Need to be careful about which translators are used and ensure they understand the topic and the need for privacy and confidentiality."

"Disability ... deaf people ... get interpreters in and talk to their community ... get advice about using TTY Machine iphone for deaf and hard of hearing people ... all improves access."

In addition to developing 'coordination' models of collaboration with some agencies, respondents believed that the sexual assault support service should also develop 'coordination' focused models of collaboration with other community-based services. The key purpose of this model of working together is information exchange – an exchange that ensures victims/survivors receive accurate and up-to-date information that supports their understanding of the choices available to them and their decision making about what is best for them during their journey of recovery.

"Service is part of the system and we need to know the whole story about what other services are doing ... latest changes at ACC ... relationships with other services is important so we can understand each part of the system and work as a team. This means the service can give accurate information from a knowing perspective about how the system works, and also include consumers' feedback about their experiences as part of that information. Last thing the service needs to do is to give misinformation."

"LGBT have good connections to their community ... bring them in as part of the sexual assault support service."

"Being responsive could include workers getting to know and being aware of the different groups in the community. "

"Pacifica don't have a sexual violence service for them, so need to keep challenging the service to do better with that group."

"Go into the prisons ... reach out as best as the service can within the available resources."

"Workforce needs to know about the Pegasus CALD counselling service ... counsellors with Japanese, Korean, Chinese and refugee backgrounds. Some people want support in their first language, other people don't ... people need to know the choices."

While all respondents agreed that those affected by sexual violence needed information about legal, medical, mental health, practical and social work support, counselling and other options, choices and services, one respondent was concerned about the consistency and reliability of the information gathered via 'relationship-based' connections. This respondent described a web-based information source that would be accessible to members of the community and professionals.

"*Need to move from informal connections between services to more consistent model like a sexual violence website that had links to services for both members of the community and professionals ... could include advice about accessing services, as well as advice about potential issues and how to help."*

Overall, respondents were of the view that a sexual assault support service should place emphasis on developing "purposeful" collaborative relationships of various kinds. Such relationships would involve agreeing on a set of common goals; working out responsibilities for obtaining those goals; and, then working together to achieve the goals, using the expertise and resources of each collaborator. Some respondents believed that such collaborative working should be supported by specifications within government contracts. One respondent explains this position.

"Need to identify key services that are funded by different government agencies to provide sexual violence services (police, medical/forensic, health, ACC, CYF, MSD) and develop a local level agreement about how they will operate and work together. Also need to include in contracts 10 hours of active liaison for each client to enable sexual support agency to connect with providers to support the client. This mechanism needs a strengthened accountability for the funders. Many providers just list their networks. What is needed is evidence of a purposeful LLA that outlines the shared referral pathways and the protocols for working together."

While the majority of respondents spoke about this collaborative way of working for a sexual assault support service, they recognised that this model of working takes time to build trust and understanding and during the process of relationship building can involve challenges for the parties – challenges largely concerned with the differing philosophical positions of different sectors and disciplines and the challenges of working within a competitive funding environment. Some of the respondents explain this situation.

> *"To me there is no magic about this. Collaboration is as good or as bad as the relationships are. Need to build in time for relationship building, to know and trust others, so that you know how to refer clients to get help because you know how other services work and you'll go the extra mile for people you have good relationships with."*

> *"Mixed disciplines working together, in the same space, is both difficult and useful. It's difficult because of the philosophical differences. However, if you understand each other's backgrounds and have a common purpose/philosophy like trauma informed, then you are able to work together."*

> *"Some of the challenges include being territorial ... some don't want to be involved. For example, asked general practices to include question about sexual violence in their assessment, but did not see the benefit for them. Funding can cause difficulties when an agency is seeking resources from the same funding stream ... need to hold on to that whilst maintaining the relationships. Need to have good relationship with the funder, both at the local and national levels, and be transparent about what is happening at the operational level."*

> *"Recognise that collaboration operates within a competitive environment ... call this out by saying competition is not about squashing friends and cutting each other's throats. Rather it is about getting relevance, quality services and results."*

17. Programme Theory and Outcomes

17.1 Change Mechanisms

Respondents were invited to identify the key elements within a sexual assault support service that would have the greatest potential for influencing the outcomes sought for a person who had experienced a sexual assault and those within their natural system of support. They identified a number of elements within a sexual assault support service that they believed were critical to the achievement of results including:

- Tailoring the response
- Immediacy of the response
- Independence to support client-centred response
- Empowerment focus of service elements
- Practice approach informed by normative reactions for sexual assault trauma

17.1.1 Tailoring the Service Response

Overall, they emphasised that any service response of this nature needed to be underpinned by a fundamental understanding of each individual's life context and their journey from the sexual assault incident to healing– an understanding that recognises that people who experience the trauma of sexual assault frequently move in and out of help seeking over lengthy periods of time; that they may need different types of support at different times on that journey; and, that their respective decisions to seek specialised sexual violence services and supports may depend on their personal characteristics, such as level of resilience, and their social connectedness to significant others in their natural environment. In this context the respondents argued that using an approach that was individualised and tailored to match each person's unique circumstances was one of the most significant service elements that had the potential to influence results. Moreover, they believed that a trained specialist sexual violence support workforce was required to deliver such individualised interventions.

"The experience of sexual violence involves so many variables ... who did the sexual assault; the time over which the sexual violence occurred; the characteristics of the person who experienced the sexual assault ... so the response needs to be flexible to account for this variation. It's not a one-size-fits-all intervention and that's why a service needs trained professionals who are able to assess each situation and deliver a tailored response."

"The intervention needs to be couched within the context of the time of the interaction between the person and the support service ... could be a small pocket of time and then people might not come back for a year or more. So need to hone in on a small package of things that can realistically be achieved, knowing that people might not be in a position to receive further intervention in the immediate term. They need to walk away with something."

It's a client-centred and social work task that requires flexibility to tailor the response to each person's situation ... at the immediate crisis point the worker has to be able to accurately assess what the person needs, as well as containing the family and offering them support ... family can exert an influential external force that needs to be harnessed in a way that helps the victim."

"Flexible ... service should be for however long a person needs it ... some people need more help than others. Some people have lot of supports, for example a supportive family, while others have nobody and need service for a long time, including a support service and counselling."

"The space between the event and counselling is an opportunity to continually engage with the person, keep them connected to service ... not this stop/start approach that characterises the erratic access to service amongst this group, which is unhelpful for recovery. This space is an opportunity to explore options as things come up; offer information about what to do when people are uncertain about the different experiences and circumstances that come up for them; brief interventions to assist people with practical things like access to housing ... or could just sit and be with the person in a place that they feel safe, believed and supported. Things happen in the background during the period between the event and getting to counselling and these things can create barriers to treatment. What is needed is an active waiting list where support is available for people to identify and remove the barriers so people are ready for the therapeutic process."

"Some people don't want anything. We bring our thoughts, assumptions and worldviews to the service ... but need to realise some people don't want to talk

to the police, not want help, think support and therapy is for others and a waste of time and they'll sort things out for themselves. So, it's important not to push things on people. Rather tell them we are here for them now, here is the information and let them know we are here for them in the future ... like a safety net."

17.1.2 Immediacy of Response

Respondents were also of the view that the immediacy of the sexual assault support service response was critical to the effectiveness of this intervention and advocated for this service to be available on a 24/7 basis. They referred to a key principle of crisis intervention - the importance of such services being delivered as soon as possible following a crisis because such timeliness has been shown to increase people's long-term prospects of recovery. For example, they noted the evidence base that linked the receipt of psychosocial and practical support to reductions in post traumatic stress disorder amongst victims/survivors of sexual abuse.

"Immediately following the time they decide to take formal step of disclosing, they need to get support. Outcome ... people helped to navigate the reporting process, the medical process, and engage in ongoing support. For anyone who wants to tell about a sexual assault matter, they get the support that is appropriate for them at that stage. The logic behind this is that support prevents worse outcomes later. The trauma is the trigger for the flight/fright response and support is one way to get out of that."

"A timely response is important to minimise the impact of the violent event in terms of each person's safety, wellbeing and health."

"Phone calls need to be responded to in a timely manner."

***"**Evidence shows that people need a support service to prevent them being re-traumatised."*

"If people don't get support then the impact of the sexual assault is lifelong ... Glenn Inquiry showed that if people don't get the services they need then the impact of violence is ongoing. " [99]

17.1.3 Independent: Enabling Client-Directed Experience

Having a specialised sexual violence worker whose role and responsibilities were singularly focused on the person who had experienced the sexual assault, and/or the people who had a close social connection to that person, was also regarded by respondents as key to the achievement of results. Being independent from other legal and medical services with whom the person may interact was regarded as a factor that enabled equalising of power between the person and the support worker; facilitated advocacy on behalf of the person so that all services followed the lead of the victim/survivor and responded to their self-identified needs – *"listen to what the client needs"*; and, enabled medical and legal colleagues to focus on their part of the system of response for the victim/survivor.

"Person is supported and held; focus on the person ... different from forensic staff's focus and the police's investigative focus. Family, friends and the person often see the police and doctors having a lot of power and so it helps to have someone normal who cares; being connected to someone out there after they have had a hard time during the weekend; offer family-centred care ... often they don't know what to do and so offer them strategies to try that might work. Some parents of children report back that it felt good to have someone who cared and after the contact they knew what to do."

"Good listening, micro-counselling specialist knowledge makes a difference. An ability to be both facilitative as well as directive ... The facilitative aspect involves using elements of client-centred and strengths–based models to empower the person and the worker has to have a belief that people have the ability to get through. Can also need a directive approach at times ... for example, someone might say that their child has disclosed and so they need time off school, but give them information about how it's best for children to have a routine so parents can make informed choices. We talk about four key

[99] The two Glen Inquiry reports can be retrieved from: https://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=4421 and http://www.newstalkzb.co.nz/media/5202718/embargoed-the-peoples-blueprint-final.pdf (Wilson & Webber, 2014a, 2014b).

considerations when considering sexual violence ... having control, trust, safe, and self worth ... so the work is about how to increase these. Wellbeing is about looking for ways to increase control and thinking about what that would look like for the client ... that's the client-centred part."

"People need to feel heard and listened to; they were able to do what they wanted to do, and not what they were told to do."

"People need to know they have been heard and understood in a non-judgemental way ... ability to listen is important .... give them the space to talk and not shut them down ... so easy to get into 'this is what you need to do'."

"Sometimes people do not want a support person and this creates difficulties because other professionals have to spend time offering that support."

"Advocacy is important ...if someone is unsure about something need someone there who can say something ... kind of intermediary when interacting with the police. These processes involve getting permission from the client ... need to ensure they understand what they are agreeing to and ensure they are in a position to say they don't agree ... it's about empowering the person."

"The purpose of the service is important ... put a face on the system for vulnerable people when they are being handled by the system ... it's an intermediary role ... the police say it's important – often say 'thank goodness you are here'."

17.1.4 Empowerment through Information Provision, Accompaniment and Brokerage

Respondents noted that the primary function of a sexual assault support service was to lessen each victim's/survivor's trauma by empowering them to have full choice and control over decisions and actions with respect to medical, legal, social support services, and other presenting needs and issues. They believed that the provision of information and options; accompanying them through medical examinations, police interviews, and other processes; and, providing onward referral to other services and supports in the immediate aftermath of a sexual assault, or historic case, were all elements of service that contributed to such victim/survivor empowerment.

"PTSD ... sense of autonomy and control is important. The worker's role is to empower the person to make choices, rather than spoon feeding them. It's a scaffolding approach ... provide the person with choices, back off and let them think for a while, normalise and validate their position and let them know their responses are normal within the context of the circumstances ... if you take this come-in-and-out of the person's life, then the person will feel empowered."

"Was the impact of what the person experienced at the sexual assault reduced? Informed and choices assured; heard and listened to; did what they wanted to do, not what they were told to do; well supported during court processes and Police interviews; services met overall needs; different people's access and cultural needs were met."

"Crisis support intervention includes giving basic and consistent pieces of information so clients have choices; clients have to be given options for follow-up by the support service and long-term service options; families also have to be offered support ... important that children and young peoples' parents' emotional reactions of guilt, anger and fear are managed and young person's feelings are defused."

"Most people say when they make contact 'What now? I don't know what to ask. Where do I go next? It's directing people to the right paths. We need to be very careful not to counsel or advocate for one thing over another ... more talking through the choices, how to get in touch with other agencies. The SASSC window is so small ... important to let people know who we are, why we know (referral from the police or the clinic), and what we can do for them ... usually they want knowledge about ACC counselling, and what else is available."

"Informational support ... just put the information out there and leave it. Not advice, as that is subjective and directive."

"There needs to be a victim focus so they get over the trauma of the sexual assault. Offer ways to put in place wrap-around services so that people can deal with the other issues in their lives over the long term."

17.1.5 Practice Techniques to Ameliorate Normative Reactions to Sexual Violence

According to the respondents, the effectiveness of the delivery of the various elements of a sexual assault support service depends on the practice approach, skills and knowledge of the workforce. They reiterated that the unique nature of the harms associated with sexual violence requires a specialised approach to the response – an approach that enables the victim/survivor to experience their interaction with the sexual assault support worker as trustworthy, safe, non-judgemental, empathetic, respectful and believed; and one that the worker carefully balances their level of engagement with victims/survivors with their maintenance of personal and professional boundaries. Moreover, the respondents reflected that this practice approach took account of many of the normative cognitive, emotional and social reactions of victims/survivors during the post-assault period. [100] Respondents offered a range of examples about the ways in which sexual assault support workers carry out their role that reflect this understanding of victims'/survivors' reactions following a sexual assault and that are intended to ameliorate and/or take account of such normative reactions. These examples are noted in the following text box.

[100] Common emotional reaction to sexual assault include anger; anxiety; irritability; denial; sadness; embarrassment, feeling exposed, humiliated; fear; feeling loss of control over life; helplessness; hopelessness; numbness; sense of disbelief; grief; sense of unreality; apprehension; feeling stuck; shame, guilt or self-blame; vulnerability; and, shock.

Common cognitive reactions to sexual assault include: changes in perception of the world; indecision; Am I damaged goods?; suicidal thoughts; preoccupation with safety; confusion; difficulty concentrating; I deserved it because...; What if I hadn't done...?; What will people think?; Why me?; Will others reject me?; Will they blame me?

Common social reactions to sexual assault include: difficulty getting things accomplished; difficulty/apprehension around men, or apprehension around persons having similar attributes to the perpetrator; discomfort around other people; fear of being alone; fear/nervousness in crowds; hypersensitivity when relating to others; loss of trust in self and others; and, withdrawal from people and relationships (Retrieved from: http://sapac.umich.edu/article/45 and http://www.safehorizon.org/uploads/pdfs/1386087773_After_Sexual_Assault_Bklt.pdf).

Practices to Ameliorate Normative Reactions to Trauma	Respondents' Comments
Maintaining professional boundaries ensures the safety of the worker and client; builds trust between the parties; ensures actions are in the clients' best interest	*"Workers need to have the ability to engage, but know when to pull back to maintain the boundaries ... really careful not to give your private contact details or promise to be their friend."* *"A lot of people were driven into the work because of their lived experience. What's important is the humanity of the interaction with the victim, the kindness, the genuineness ... volunteers can do just as well as others in making this human connection, but it needs to be professional. The risk is that sexual violence has always been the poor cousin ... mostly driven from the grassroots, and over the years a lot of wisdom has made good things happen. The risk, with those who have experienced sexual violence themselves, is that the intervention can be less about the client and more about what they think the client needs. To deliver a professional service, people need time to heal. They can do the work so they can live with the experience in a way that doesn't dominate who they are."*
Building and Maintaining Trust	*"People who have been sexually assaulted are afraid to tell professionals, because they are unsure about who else that professional will tell and afraid they will lose control of who knows. You have to be very sensitive about checking with the person that it's OK to talk to another service about their situation. If you are not open with people they will lose their*

	trust in you and they may never talk to anyone about it again." *"Trust is important to enable people to feel safe to go through to other services and counselling ... when they know the worker they will come to service and counselling without being pressured as they feel safe. This involves the worker providing ongoing support ... visiting them to see how they are managing and coping, providing support through a court case ... could be up to a year or more."*
Countering Feelings of Shame	*"Whenever you are working with a person you need to pay attention to what they are saying, as well as what they are not saying. They give you bits of information to see how you will react, how shocked you are. It's important not to be shocked by what they tell you, because if you do then this just feeds into their feelings of shame."*
Reducing the physiological and acute stress responses to sexual assault	*"Response immediately after person has experienced a trauma like sexual assault is to slow everything down; make the process predictable for the person so they know what will happen next by giving them information; workers need to know their stuff – where to find the forms and provide accurate information about the processes, as this gives the client confidence and has a stabilising effect. The person is in shock and hypersensitive, so the worker*

	has to be around them in a certain way to calm them down."
Responding appropriately to the cognitive effects of trauma	*"Information ... not tell too much as they won't remember it."* *"Workers need to know they can only take on a certain amount of palatable information, as they can't take in too much."*
Creating a milieu of acceptance	*"Cup of tea can make all the difference ... shows kindness and acceptance of the person."* *"The service can be described as empathetic support at point of crisis."* *"Skill and the quality of the people ... humanity and relatable skills and high level of specialist skill."* *"There needs to be a non-counsellor approach ... not a meeting for people to discuss what has happened to them ... gentleness when speak to someone, as there is sensitivity and privacy around the experience and if you are loud then frighten people away ... ability to listen is important, slow the process down. Some people say if they did not have the support and encouragement at the time of crisis they would not be able to take the next steps."*
Enhancing safety	*"There needs to be an ecological perspective to their safety. What do they need to keep safe, to reduce*

	their vulnerability ... the risk of sexual assault needs to be considered within context of work, family, their environment so that their risk of exposure to further incidents of sexual assault are minimised. It's providing the opportunity to access multiple services ... preventing further exposure to risk."

Moreover to support this specialised approach to practice, respondents noted that sexual assault support workers required a range of skills, including engagement, assessment and brokerage skills. In addition, they maintained that workers needed a sound knowledge of community resources, cross-sector business processes, and the complexities of the experience and response to incidents of sexual violence.

> *"Workers need to have a variety of practice skills ... assessment skills; knowledge of the community and the system of services; and, ability to engage with people in those community services and across multiple systems."*

> *"Workers need to know about what is available in the system or have the ability to find out ... need to be adept at getting the practical things ... access to practical things, clothes, housing needs – a place to sleep."*

> *"They have to be knowledgeable about the forensic, legal and social service processes."*

> *"Good relationships with other parties that are needed to get the job of the interventions done, like the police, the clinic .... If there is conflict and friction, this is not conducive to dealing with trauma situations. People need to know what they are doing and do this in a trouble-free environment given the nature of this shitty business."*

An example of practice offered by a sexual assault support service worker during a police scoping interview and forensic examination illustrates this service in action.

Illustrative Practice Example: Sexual Assault Support Service Worker Working with a Victim/Survivor During a Forensic Examination and a Police Scoping Statement
"At the first meeting, the person is in a state of trauma. Introduce self as a person without reminding them where you are from ... they know why they are there, and you don't have to remind them. *Have to be vigilant and gauge what is going on all the time ... half the time it's just being there ... give little bits of information. Gauging the situation is important ... enables you to respond quickly with the right response. Could be lots of family there and they all have different ways of responding to the situation ... need to be able to respond to each appropriately. You also need to be able to gauge when it's right to engage and when the person just wants to be left alone ... it's about being human, not clinical– this is the key tool for providing support.* *Important to be seen as separate from the police ... it's about bond building, as some people are intimidated by the police. Let them know you are there to support them and their experience that brought them there ... make the engagement not too intense ... they need to feel there is an ally in the room. If they have any questions and you don't know, make sure you find out. Often clients want to know what is going to happen next ... forensic exam, police scoping interview ... best to give the bones of what is going to happen ... just little bits of information.* *Important to focus on 'them, their health, their wellbeing ... give the control to the client, as their power and control has been taken away ... find ways to empower people."*

17.2 Outcomes and Frameworks for Measuring Performance

When asked to describe the outcomes from a sexual assault support service, a number of respondents observed that within the New Zealand context this was an area that required improvement. These respondents commented that performance reporting largely focused on outputs; there was a lack of agreement about outcome measures; and, many providers of service did not have the infrastructure in place to collect pertinent outcome data. Respondents' comments illustrate these observations.

> *"Stating outcomes is a big gap ... mainly outputs recorded."*

> *"The biggest challenge I see with NGOs is there is not an agreed way to measure performance. They don't record data about what people accessed the service for, or what outcomes were achieved. If this is not consistently collected, there is no way to aggregate the information and report on the results from a national programme of services. What is needed is an outcome system. This system requires services to map out the model of intervention or the intervention story, and then develop indicators around that. The RBA framework is big with MSD. Some use balanced scorecard ... doesn't matter what system people use. Whatever system is set up needs to be able to talk to other systems; and enable outcomes to be captured, as well as what services are doing to achieve those."*

A number of respondents advocated for the development of outcome frameworks that linked to purchase of service contract specifications. Moreover, they advocated for the development of outcome frameworks that described what results could be achieved by particular services that contributed to the system of response to sexual violence; the way in which those results were known to contribute to longer-term outcomes; and the rationale that explained why in certain contexts interventions delivered in certain ways were most likely to bring about immediate- and longer-term results. Two respondents' comments illustrate the perspectives of others.

> *"Outcomes need to be related to the contracts for service ... Police, MSD, ACC. Most agencies are now using the RBA framework, which includes the question: 'Who is better off?' The challenge for funders and service providers*

is to know how to change the curve. It's not just the numbers, but rather, how do we know a service is working?"

"Outcomes from crisis services should be that the person feels more informed; they are comfortable with the choices they made; they know what next steps to take."

Respondents also reflected on the challenges of developing outcome statements within the context of the varying journeys towards healing of those who experience sexual assault – journeys that may involve help seeking in the immediate and longer term; journeys that involve help seeking for particular aspects of such journeys; and journeys that may not involve help seeking from professional sources.

"The outcomes need to be thought of in terms of the diverse situations of when people would find support useful ... some want support at the forensic examination; some don't want support or opt out of support; other people want support at court; and, others want support six months after court."

"I am loathed to say the outcome (of a sexual assault support service) will be all people will then get into specialist counselling. This is not necessarily a marker of success. A lot of people deal with the support bit; then take a break, sometimes for up to ten years; and then get counselling help. Not necessarily a marker of wellbeing ... if got a lot of home support or a good friend and feel looked after ... engaging a counsellor is not the only way to make improvements ... not linear going from a to b to c. They land at a sexual assault support service, or the police, because they are at the stage of telling."

Most respondents favoured gathering outcome data that focused on the victims'/survivors' experiences of a sexual assault service. In particular, they wanted client-sourced data about whether such service experiences ameliorated the adverse impacts of sexual violence. For example, they advised that outcomes should focus on measuring changes in people's knowledge (for example, enhanced knowledge about the experience of trauma and how to respond; and enhanced knowledge about available sexual violence sector services and other services available to address their presenting needs); changes in people's feelings (for example, feelings of safety; feeling more stable); and, enhanced experiences of social connectedness and support.

"Most important to capture consumer-rated outcomes from the individuals and their families ... What tools did they get from support services that were useful? How satisfied were they with the service? What difference is there in their lives as a result of receiving the service?"

"Examples of outcomes could be immediate needs met; person's choice was respected; had offer to engage with cultural services; received assistance they needed on the day – all basic stuff. After people have received the support service ask questions like: Do you remember having someone with you today? Can you distinguish our service from others who deliver other services? Did you feel heard? Was it a survivor-led service? Did you feel you were able to make choices and felt in control?"

"Lots of young people at the clinic ... first experience of a medical examination or being with a professional ... if it's a positive experience, this will shape how they feel about contacting professionals in the future."

"More informed about services available."

"The outcomes should be about the degree to which the service enabled people to be more constrained, stabilised ... supported people's functioning by knowing their choices; and the way they used information to enhance their safety, both in terms of safety from self harm and safety from further events of sexual assault."

"The goal is people who seek it, via police when they report a sexual violence matter, get the support they find appropriate at the point of dealing with the police. The logic behind having a support service is that if people get the support at the beginning (after the sexual assault), then the evidence suggests that it frequently prevents worse outcomes later. It prevents the effects of the trauma going deeper."

"How did the service equip the person to be safe, have the right connections and supports in place so they can get through the first few weeks ... measures of social connectedness are important." [101]

[101] The Ministry of Social Development's 2010 Social Report includes six indicators to measure social connectedness in New Zealand. These are: telephone and internet access in the home, contact with family and friends, contact between young people and their parents, trust in others, loneliness, and voluntary work (Ministry of Social Development, 2010).

While the respondents agreed that victims/survivors were the preferred source of outcome data, they noted that selecting the most appropriate method of collecting such data was challenging within a crisis situation. Most preferred collecting such data using face-to-face methods, rather than paper-based methods such as the administration of client evaluation forms.

> *"Client evaluation forms should not be distributed at the point of crisis contact. People in those situations find filling out forms, like the forensic and police consent forms, a harrowing experience. What is better than filling out forms is to get direct feedback from the clients ... what did they do and say during the support process that might suggest they found the service useful ... get hug at the end or express gratitude ... ask them what the service did well?"*

18. Structural Arrangements for a Sexual Assault Support Service

Respondents were invited to consider a range of structural options for housing a sexual assault support service. They considered the following structural options:

- Included as a service within a hub of social service organisations
- Included in an organisation that delivers a multi-discipline (medical, legal, support/counselling) service to victims/survivors
- Included as a business arm of a family violence service
- Included as a business arm of a non-government organisation that specialises in providing sexual violence services for victims/survivors

18.1 Located within a Hub of Social Service Organisations

A few respondents believed that housing the sexual assault support service within a hub of social service agencies would have the advantage of improving the access to a range of health, mental health and other social services that might be required by

those who had experienced sexual violence, as well as reducing the stigma often associated with stand-alone sexual violence or sexual health services. Some of the respondents explain this position.

> *"Placed in a hub of social service agencies would make the service more accessible for transgender men and males ... seen as safe place where not identified."*

> *"Being near lots of different services would be really valuable because people who experience sexual violence often have health and mental health needs as well."*

> *"Service should be located within a hub of social services with access to a range of services ... least stigmatised structure and various types of services readily available for them."*

> *"The hub has merit because doctors would be on site and a mix of different services and helps ... opportunity to develop relationships with these services. Within this model they would have to juggle the privacy that victims/survivors need with making sure the client gets what else they need."*

18.2 Located in a Multi-Discipline Organisation

Few respondents supported housing a sexual assault support service within the context of a multi-disciplinary organisation for victims/survivors. Those that did support this option considered it in terms of either being aligned with Justice Sector services and housed within Christchurch's proposed Justice Hub, or housed with other Health Sector services within a hospital setting. Against these views, other respondents argued that large organisations comprising amalgamations of services were inefficient; and/or such structures mitigated against the independence and advocacy required by each of the services that provide a response to sexual violence. Respondent comments illustrate these opposing views.

> *"Everything together as one humongous complex organism would be too unwieldy ... talk at moment about bringing family violence, child abuse and adult sexual violence together ... not see point of that, all such different things ... little bit of cross-over, but not sufficient to create a big organisation. I prefer small teams that work efficiently ... main thing is to have strong liaison between the groups."*

"The experience from the North American model of Victim Centres is that when the medical and legal professionals are within one organisation, there is pressure on the medical profession to provide proof ... from a medical and support perspective, it's best that it is independent and that it focuses on the care of the person."

"There are three different funding streams that support police, forensic and support services. They work under different models and face different kinds of stresses."

"Te Puaruruhau is a child protection model that includes the police, Child Youth and Family and health. The model is enshrined in a children's focus, versus an adult focus. In Australia they have all the services in one place, but it wouldn't work here because New Zealand has ACC-funded counsellors in the community, and because Christchurch is too small to warrant a unit like this."

"Visited Star Ship Hospital integrated hospital system ... includes crisis stuff. There is real value in being part of the bigger story, but for people going through a sexual violence experience this might be a barrier ... like going to a sexual health clinic ... stigmatised when go through the door." [102]

18.3 Business Arm of a Family Violence Service

Respondents again had mixed views about having a sexual assault support service as part of a family violence service agency. Some respondents believed that the clients respectively of family violence services and sexual violence services presented with different needs and required different intervention approaches; and, that historically family violence services had dominated sexual violence services both

[102] Starship Paediatric Te Puaruruhau is the Auckland District Health Board health service for children and young people who have experienced abuse or neglect. This service is located in a multi-agency centre with Police and the Department of Child, Youth and Family. It's name literally means "blossoming in unity" or "as one" which reflects the bringing together of the three statutory agencies involved in specialist child abuse investigation and the common aim, which is to enhance the recovery and care of those affected by child abuse. The team offers a 24 hour urgent medical service for acute abuse cases, and carries out nursing and social work assessments for alleged physical or sexual abuse or neglect (Retrieved from: https://www.starship.org.nz/patients-and-families/directory-of-services/Te-Puaruruhau-Child-Protection/).

in terms of visibility and in terms of the funding attracted by that sector – a situation that they believed was a risk for a sexual violence sector service. On the other hand, some respondents believed that there were advantages for those clients experiencing both family violence and sexual violence in terms of accessing both types of service within one agency. However, they cautioned that the sexual assault support service would need to be marketed separately and hold its own budget and management structure. Respondents' comments on these two perspectives are noted below.

> *"There are pluses and minuses of having them together ... there is a relationship between the two ... can be different layers of the client's experience and good to have the range of skills to address these layers of experience ... the advocacy role in sexual violence is quite different ... if they are based together they need to be autonomous."*

> *"Integrating sexual violence and family violence services means clients get both types of support for these two issues. The sexual violence service needs to be marketed as having its own identity, so that people can access the service regardless of whether they have family violence or not."*

> *"In Australia they found that if a sexual violence service goes into a family violence service it disappears."*

> *"People need to understand there is a huge difference between family violence and sexual violence ... John Briere describes this well. People who are sexually violated struggle to come to terms with the healing ... Someone who has been physically assaulted can move through that easier. Sexual violence takes away sense of self ... They struggle with knowing that we are created as beings through the act of sex. Yet when sex happens to you at a young age it's not a sex act, it's power and control. The person was using them for their own gratification ... therefore your sexuality and knowledge of sex is totally distorted ... child thrown into adult world ... the effect that has on the mind is massive ... Physical stuff is terrible, but the sexual assault does huge psychological damage ... triggered."*

> *"In New Zealand you can't have a sexual violence service within a domestic violence service ... different from the U.S. where the dual agency structure can work. In New Zealand sexual violence is a poor cousin to domestic violence. Here resources are not equally distributed. While domestic*

violence and sexual violence do cross over at times, the power dynamics are different. With DV the immediate safety is important ... could be life threatening. With sexual violence you need a different way to approach safety. With sexual violence, sometimes it can be a stranger, sometimes an acquaintance ... with DV people see it. It's more visible. The consequences of sexual violence are more subtle ... different way to use power."

"Family violence and sexual violence should not be together ... some cross over, but rare. Sexual violence is so diverse in terms of victimisation, offending, location, type of offence ... vast majority not family violence matters ... putting sexual violence with family violence creates confusion ... family violence generally physical assaults and very occasionally a sexual assault."

"Integrate the 24/7 with a sexual violence service so that the voice is heard and doesn't disappear into an abscess ... when funded in a family violence agency it all goes into family violence. We have struggled to get this far."

18.4 Business Arm of a Non-Government-Organisation Specialist Sexual Violence Agency

Overall respondents offered mixed views about the advantages and challenges of each of these structural options for housing a sexual assault support service. Be this as it may, over half of the respondents interviewed were of the view that a sexual assault support service should be included in a stand-alone non-government organisation that delivers a range of primary, secondary and tertiary prevention sexual violence services. From their perspective the advantages of this integrated sexual violence services' structure were independence to advocate and focus on a wrap-around, client-centred focus for those with experience of sexual violence; and, ability to maintain a 'survivor-driven' lens amongst all who undertake immediate-, intermediate- and long-term interventions with victims/survivors. While they recognised that this model was unlikely to include the police, medical clinicians and other key service partners, they believed that this stand-alone structure could develop "*strong alliances through local level agreements"* and "*develop integrated services that privilege what is good for the clients."*

"A crisis team needs to be with an organisation that is grounded in a survivor-driven lens ...constantly need to remember why we are doing the work and be able to support the workers to do that work. This is important for enabling the conversations between practitioners that make the work easier and more effective."

"It's important to have both the crisis service and the long-term therapy service within one agency ... agency could deliver the long-term therapy itself, or via contracting specialists working in the community. This provides a wrap-around service for clients ... enter the agency via the crisis service and then therapists can pick up the clients – seamless. This structure means the agency holds the specialist sexual violence knowledge."

"Historically the drive for stand-alone sexual violence services came out of the need to prevent re-victimisation of the victim within police and medically driven processes ... need for a support worker to be the intermediary for the victim and support them through those justice and medical processes. That role is still valid even though the medical and police processes have improved markedly ... the medical process is still based on the medical model and the police process is still focused on catching the badies. The NGO model makes the most sense. The advocate role within a multi-disciplinary team would be more difficult ... independence could become compromised ... for example, if in the pocket of the police could be used as a tool for getting information about whether the complainant is telling the truth or not about the sexual violence."

"An ideal service design would be to have a purpose-built sexual violence hub with Te Puna Oranga, Male Survivors and other services for victims together ... include teaching element ... currently nowhere to train as a specialist sexual violence practitioner, only the apprenticeship model; crisis, long-term intervention, education arm going out into the community, and research unit all together. The unit would be designed as an ordinary, discrete, warm and friendly 'home' ... home matters to this client group. The crisis team needs to be joined up and located with other teams working in the sexual violence sector ... acculturated into sexual violence more deeply, get on-tap supervision. They would be the constant person as the clients take the journey of recovery ... good handover, from crisis where trust has been built, to long-term therapist."

"The ideal situation would be a key worker who had made first contact with the client ... Bring into the service and introduce to the team ... role would involve preparing clients for therapy ... The client knows that the worker has

been with them in a professional way by holding them within boundaries and making them feel safe... Clients know and trust the worker."

"Work first with the client in conjunction with the Adult Sexual Assault Team and the forensic team ... explains how the service works, what service can do for the client ... answer questions about how the system works, sounding board for the client and not in police's pockets ... give call and set up interviews ... go with them to make statements and support afterwards ... join up with ACC counsellors ... be someone who comes in and out of the person's life when they need it ... could be up to two years ... support through court processes. If down time do community liaison and education."

Moreover, many respondents argued for intra-sexual violence service structural changes. For example, they were of the view that having separate afterhours and day 'immediate response' teams was counter to a seamless journey for victims/survivors. This integration would include day-time workers taking regular and scheduled afterhours shifts – an integration that respondents believed would enhance the quality of the service because clients would engage with the same worker for support at the point of the first engagement, as well as for follow-up support services. Some of the respondents' comments describe the details of how this support team integration could be operationalised.

"Disjointed having separation between after-hours staff and day staff ... professionally isolated ... working from home and on the cell phone. Need to have integration between the two roles ... people do some day shifts and some night shifts. Also need to make strong connection between the crisis team and the greater team within the organisation (therapy team)"

"Integrated model is best ... Need to have a team of at least three social-work-trained staff to cover the day and afterhours shifts ... nine shifts afterhours ... five over night during the week and four at weekend (9am – 6pm and 6pm to 9am) ... each week take responsibility for 2 afterhours shifts. This structure fits well with the fluctuating nature of the work and provides consistency for clients."

"There is a huge issue with afterhours work ... fluctuates with varying demand. This means that while staff can be trained in the processes round the forensic/medical processes and the police's evidence-based interviews, their knowledge and practice only improves with practice and the input from those

more experienced staff ... Need to integrate the afterhours and day roles to overcome this issue."

"Have people working during the day, with shifts after hours ... reduces sense of being isolated from the work; increase staff's confidence and capability to work after hours by being able to check out with others about ways to deal with clients ... during the day take new calls and also follow up with clients seen during afterhours."

"*The after-hours staff need a certain amount of work to make the role meaningful ... a full roster. If there is too little work then the role becomes meaningless ... not called out every night ... nature of crisis work, no calls for weeks and then at other times have 3-4 callouts in a row ... The ideal is a crisis team leader and 5 funded staff who do on-call work and face-to-face support meetings and other ongoing support during the day."*

"Our workers say they could handle the afterhours as well as the 9-5pm."

19. Sexual Assault Support Service Workforce

Respondents were invited to provide advice about the qualifications, experience and attributes of the workforce required to deliver an effective sexual assault support service.

19.1 Qualifications and Experience

Those interviewed held a continuum of views about the level of professionalism and experience required by a sexual assault support service workforce. The majority believed that those who comprised this workforce should have "*life experience and been round the traps"* and *"be of sufficient maturity and have life skills to deal with the nature of the work."* However, there was less agreement about whether this workforce needed to be qualified and/or have considerable professional experience working within a human service context. About half of the respondents were of the view that the sexual assault support service workforce needed to have a human service qualification and have a number of years experience working within a

psychosocial field of practice. They argued that this depth of professionalism was required because of the specialist knowledge and skill required to work with the complexities associated victims/survivors and their families affected by sexual violence; the level of vulnerability of the target client group; and, the need for assurance of, and accountability for, the quality of service delivered within the sexual violence sector. Moreover, respondents were concerned about the significant rate of turnover of the volunteer workforce – a situation that meant "*there was little return on investment for the recruitment and training effort."* The following respondents' comments illustrate this position.

> *"In the early days of providing sexual violence services people came to the work with passion and heart ... people were offered jobs and trained on the job. That ethos has not been successful in the sexual violence sector. It's not about whether people are paid or not. Rather it is about the quality and calibre of the human beings and their capacity to do the work. Dealing with vulnerable people so there is a responsibility to put the right people in front of them."*

> *"Workers need a sound qualification and a bank of experience and credibility. They need life experience, not a new graduate."*

> *"The workforce needs to be down the track in terms of their professional development ... if not experienced, they flounder and are unable to master the complexities of the work ... not new graduates and not students. They have to have had lot of experience in other human interaction jobs ... working in sexual violence is hard stuff. (Staff who provide the sexual assault support service) need to be qualified, have a lot of experience, and be registered. It's an apprenticeship model of learning within the sexual violence sector and skills need to be well-honed. It requires people who have a well developed craft."*

> *"Employ people who have a background that relates to what the sexual assault support service staff do ... qualified in youth work, counselling."*

> **"***Avoid volunteers ... A lot of agencies use volunteers, but it's not appropriate. The service would be dealing with vulnerable people, many of whom have co-morbidity. This situation puts volunteers and survivors at risk. I see volunteers with little support, little monitoring, and little supervision."*

> *"Concerned about volunteer workforce ... have no professional code of conduct and therefore are not bound by a code of ethics. There needs to be assurance that people have professional knowledge, are clear about their role and boundaries associated with that. This is a specialised area and there needs to be qualified people."*

> *"There needs to be a professional workforce. Volunteers can only do work that doesn't require engaging clients, such as administration or child care to enhance accessibility for victims. I've found that volunteers have their own lives which they give priority to, so they are not continuously available. They are not specifically trained nor have the level of understanding needed. It's also a reality that you can't hold them accountable to the same degree as employees. There must be a professional workforce."*

From a different perspective, a small number of respondents were of the opinion that "*qualifications were not necessary."* Rather they argued that the core purpose of the role was to offer support for victims/survivors – support that did not require a professional response. For those who held this view, the critical matter was to ensure that those recruited to carry out the sexual assault support worker role understood the boundaries of their responsibilities and the position of such roles in the system of response. A respondent's comments illustrate this view.

> *"Recruit people who can stay within the boundaries of the role ... need to understand that the support role at callouts is the first step, a building block and that after this first contact the person is passed on to a professional. It's not a therapeutic relationship ... Feedback from clients indicates that there are a lot of professionals around at the point of crisis, like police and doctors; and that the volunteers are there for the person, with no other purpose but to look out for them and be there for them to support them in whatever they want. The clients are very vulnerable, and while you may want to do so much more, you can't offer something that you are not qualified to deliver."*

Still other respondents held the view that a sexual assault support service workforce may be comprised of a mix of people with professional and volunteer backgrounds and levels of experience – a diverse workforce that was appropriately matched to the varying roles undertaken by the service. Those that supported a workforce comprised of both qualified and unqualified people also supported the separation of the support role from the social work role. For example, they commented that the

service could employ qualified people to undertake 'social work role' (for example, brief intervention, brokerage etc), whilst recruiting unqualified people to undertake the support role during police statements and forensic/medical examinations. This position is described by two respondents' comments.

> *"Qualifications are important for staff who undertaken the day-time crisis work ... use social work frameworks to support clients. For those on afterhours call outs, I wouldn't expect them to be qualified. Rather prefer them to have similar experiences, like Youthline. They need to have life experience; good common sense; a beacon of calmness, not fired up to change the world."*

> *"It's always difficult to balance the need for highly skilled people, the client demand and presenting needs, and the available financial resources. Suggest mapping the different types of service types required at the front end of sexual violence services to meet identified client needs. Then decide what qualifications, skill sets and training the different workforce types require to do the job ... For example, it could be that volunteers can answer the phone, while qualified people may be needed to deliver brief interventions. Once this has been done, develop a plan of staged strategies. Start with implementing the core services required with a workforce with minimum skills sets. Then add other components to the service as other resources become available to employ qualified staff or as the initial workforce is up-skilled."*

19.2 Perspectives on Gender and 'Lived Experience'

As well as commenting on the qualifications and experience of the workforce for a sexual assault support service, the respondents also offered their perspectives on aspects of the demographic makeup of this workforce, in particular gender, and their views about employees with 'lived experience' of sexual violence.

Most respondents acknowledged that both the past and current sexual violence sector workforce included those with 'lived experience' of sexual violence. For them, decisions about whether or not to recruit people with 'lived experience' depended on each applicant's position in their healing journey and their assessment of their vulnerability for triggering, re-traumatisation and stress as a result of working with those affected by sexual violence.

"Not a black and white issue ... The sexual violence sector began its history with survivors and we need to recognise their contribution. The question rests on: How far are they from their exposure? How well are they as human beings? How robust is their ordinary life? Who they are personality wise? When recruiting, we ask people what attracted them to the position ... get disclosure and this could be a serious red flag that demonstrates that this is too close to the surface for them to do the work ... or could get the sense that they have worked through their process well. The issue is that it can pop up any time ... work with thirty-five clients and with the thirty-sixth client they hear their story. Lived experience is a management risk ... never want to say not employ people with lived experience, but wouldn't want to say have to have lived experience."

"Try to be neutral about lived experience. It's not good or bad, but rather where the person is now ... if they disclose talk to them about what they have done, what triggers them and how they manage that ... not appropriate if they are vulnerable."

"People need to have done their own work, otherwise they become overwhelmed."

"Coming to work in the sexual violence sector with lived experience requires a lot of personal work to be done, as the work is very triggering for people."

In general, the respondents reflected that the sexual assault support service workforce should, as much as possible, reflect the makeup of the community within which they were employed. This workforce composition would, they believed, enhance the accessibility of the service for those help seeking. Some of those interviewed offered their thoughts and experiences about clients' preferred choices for male or female members of staff. While they stated that clients were always offered the choice of working with a male employee or a female employee where this option was available, they observed that most clients chose a female member of staff.

"Gender matching is important."

"There is only a small number of men working in crisis ... different for counselling where the relationship between a male counsellor and male victim

is important. Try to match gender of worker with what the clients want, but most look for women workers."

"Men generally run from working in this sector, so it's mainly a female workforce. When clients are given a choice, they can go either for a male worker or a female worker, but most prefer to work with women. It would be great to have a male worker on the team for male victims, as some of them have been victimised by women ... even so, many still prefer to work with women. If you are only able to employ one worker, it's better for that person to be a woman because the quantity of clients requesting a women worker will be greater."

"Men prefer women to support them. For gay and transgender men, where else would they get the support from ... not engage with Male Survivors as they do not feel they would fit in. If the sexual assault happened within the gay community, then there are different dynamics ... the community may shut down on them ... outcasts, as not fit in elsewhere."

19.3 Competencies

Not only did respondents offer their views about the experience, qualifications, demographic makeup and 'lived experience' of the workforce for a sexual assault support service, they also offered their advice about the key competencies required to carry out this role. While respondents offered a number of suggested competencies, those that were most frequently mentioned included: analytical and conceptual thinking; technical skills appropriate for crisis and trauma-informed practice; cultural competence and understanding diversity; and, self management.

- ***Analytical and Conceptual Thinking***: The ability to take a holistic perspective; identify a range of factors or considerations that need to be taken into account when analysing a situation; and, quickly identify the central or underlying issues within complex situations.

" Staff need to bring academic rigor to the work ... a good capacity to think because of the complexity of the work ... They need to have conceptual ability and be able to work in a systemic way ... the work with the person does not

happen in isolation. There are secondary victims involved in sexual violence. There are layers of complexity as mostly it's not strangers that commit the sexual assault. Here you have an emotional connection between the victim and the person who sexually violated them. This is the complexity of the intrusion. This complexity starts at the crisis stage because family and friends are involved, and there is also a need to work across sectors. The work is systemic and staff need to have strong cognitive skills."

"Workers need to be able to think quickly ... know how to read situations, an ability to assess what's needed."

"People have to be quick thinkers in this work. You can't put people on hold. In crisis work, people ring and need you to respond and you need to be able to pick up the cues about what is happening for the person. Get call from woman who was running up her drive away from a gang who was about to rape her ... OK ring the police."

"People need to have good reflective and analytic skills ... able to assess situations under difficult situations. They also need an understanding about societal attitudes and influences that are associated with sexual violence."

"Ability to read the situation. It's always the same, but people's reactions are different."

"Analytical skills essential to be able to look at each different situation and work it out ... custodial issues, where both parents are stating different things about the risk ... need to work out are the behaviours related to the parenting style or can they be directly attributed to the sexual abuse ... understand the system and how it all fits together."

- ***Technical Skills Appropriate to Crisis and Trauma-Informed Practice***: These technical skills include understanding the protective factors, such as safety, non-judgement and supportive social connections, can ameliorate the impact of trauma; engaging with empathy; active listening; and, the ability to relate to others in an empowering way to expedite client-directed choices.

  "While the specialised skills are critical, so is having the human traits ... empathy and compassion."

  "Workers need a passion for people ... a humanity ... not judge, but rather meet people where they are at and move through the process with them."

  "Non judgemental ... a silent role that doesn't heighten the situation ... read what people need through good listening."

  "Able to relate to families, empathy, advocacy and good communication – oral and the written forms."

  "People have to hold values that align with the empowerment model ... It's power with, not power up, so that work with clients enables them to make their own choices."

- ***Cultural Competence and Understanding Diversity***: An ability to provide sexual assault support services within the context of the unique and varying cultural beliefs, attitudes, behaviours and needs of those affected by sexual violence; and, meet their needs in ways that honour and incorporate their cultural identity and experience.

  "If we ask a person at interview how they would respond to a person who was lesbian and they say 'they love gay people', then they are not the right person for this work. People have to have an understanding of diversity."

  "Regardless of the skills, profession or qualifications of the people doing the work, they have to have good skills working across cultures ... culturally competent and an ability to embrace diversity."

  "An ability to relate to people of any age and from a wide variety of backgrounds."

Cultural Competence and Working with a Trauma Informed Model: An Illustration

"The model of trauma developed in Australia is a recovery model. It focuses on people gaining control over their lives and within their family setting given that clients come from a collective world view. Be a curious inquirer ... what does gaining control over their lives mean to them?

Working with trauma is about helping people find a place where they accept what has happened to them, accept it won't go away, find a place where they can manage this ... be like a navigator. Help people create a link between the past, present and the future ... training told us that we help people to create a worldview that encapsulates their past, where they are now, and where they want to be, and link the three together. The client is at the centre of this process. It's their process. It's a partnership. We are learning about what's important to them and we teach them from what we know from our own professional skills. It's a respectful relationship of partners that's about equality where we learn from each other through the journey ... the power structure has to be addressed.

Look at the whole journey ... where they were in terms of refugee / migrant background? What brought them to New Zealand ... What was the reason for coming? Address the migration journey, experience and history? What resettlement here has been like, what issues have arisen because of the resettlement, and link them to the services they need to resettle.

There are four main components to the trauma model: respectful engagement ... creating a partnership; enabling them to take control; link past, present and future together to create a future that encapsulates their experiences; learn different ways to manage what has happened to

them ... help them to learn and introduce the therapeutic tools so they can help themselves. The most powerful element is respectful engagement. It's all about the relationship where you are connected to the person with a purpose ... If engage well, people will disclose and operating within their cultural identity is an important part of that."

- ***Self Management***: This self management competency includes the worker's ability to maintain clarity about their role; the boundaries within the client/worker relationship; as well as recognising when the needs of the clients are beyond the scope of the role and making referrals to appropriate professionals.

> *"Sexual violence is the hallmark of boundary breaking and as a population they are often described as boundary less. So an important part of any intervention is to demonstrate appropriate boundaries, because the clients will push up against them because someone has pushed theirs. Staff need to demonstrate they can keep good boundaries."*

> *"Engaging traumatised people requires people to know themselves and their boundaries to keep them and the clients safe."*

> *"Have to have an understanding of boundaries and professionalism."*

Other key attributes of the sexual assault support service workforce noted less frequently by the respondents included resilience; emotional intelligence; and, specialist knowledge.

- ***Resilience***: A few respondents commented that the sexual assault support service workers need to have resilience to manage the stress of working with those affected by sexual violence.

> **"***'There needs to be robustness in the workforce to do the work ... not fragile; have life style balance; have other interests/another life; other things matter to them."*

"Employees need to be resilient. I've seen a lot of people come and go ... high turnover as people can't handle the work."

- ***Emotional Intelligence:*** Some respondents stated that emotional intelligence was an important attribute of the sexual assault support service workforce – an ability to monitor their own emotions; an ability to monitor the feelings and emotions of those with whom they work; to be able to discriminate among their own and other's emotions and use this information to guide thinking and actions.

  "Emotional intelligence, (for example) self aware and very conscious."

  "People need to be self aware and able to reflect."

  "Emotional intelligence ... ability to read body language and understand where someone is at; workers understand the impact of their own emotions on others; and empathy and genuine compassion."

- ***Specialist and System Knowledge:*** In order to provide those affected by sexual violence with accurate information with which to inform their choices and decisions during and following their contact with the sexual assault support workforce, some respondents stated that they would be required to have knowledge about the impact of sexual violence; knowledge about trauma-specific practices; knowledge about the sexual violence sector and the responses provided by different parts of that sector; and knowledge about services provided by other sectors.

  "People need to have knowledge about trauma-informed models of practice."

  "They need knowledge of the system and the sexual violence sector. They also need generic skills and knowledge in trauma and sexual violence and a willingness to learn more."

  "Knowledge and understanding of sexual violence; and understanding the processes so workers can answer questions about what will happen next."

20. Supporting Factors in the Internal Environment

Respondents offered an array of advice about ways in which the environment and infrastructure within the host agency could support the effective implementation of a sexual assault support service. This advice included:

- Trauma-informed agency culture
- Induction and ongoing training
- Administrative and professional supervision
- Accountability for service quality and results

20.1 Trauma-Informed Agency Culture

Some respondents advised the agency hosting the sexual assault support service to develop a trauma-informed culture. Organisational cultures of this nature apply the principles of trauma-informed practice to all aspects of the infrastructure that support its employees to deliver the service – principles such as ensuring the safety of the workforce by putting in place support and care policies and procedures that counter stress, assure confidentiality, and maintain psychological and physical wellbeing; building trust through the development of clear role descriptions and communicating clear expectations about the boundaries of the associated employee responsibilities; providing staff with control over their work with clients within the margins of organisational policies and procedures; building relevance through continuous learning; and, supporting collaboration by adopting a partnership approach to service delivery. Respondents' comments illustrate this trauma-informed culture in action.

- ***Principle of Safety***

> *"The organisational needs to have a trauma-informed culture and resources applied to team building and team care ... having fun. This helps to counter the toxicity that can develop amongst people who work in the sexual violence area."*

"The agency needs to put in place mechanisms that give staff the opportunity to talk about the dilemmas that come up - confidentiality issues, ethical issues, boundary issues and collegial issues. With those on a support line this could be access to someone who can debrief with them straight away ... access to external supervision and access to internal and cultural supervision."

"It's easy for staff to burn out ... no one works full time and you have to pour lots of dollars into looking after people. A lot of work time effort and dollars goes into looking after people who do this work so they don't fall over. The fiscal argument is that you need a return on investment, so there is a fine line between having to look after staff and knowing this is costly."

"To prevent burnout, services need to make sure staff leave work at work."

"In this type of work there is the risk of vicarious trauma. A lot of the work is done from people's homes. They are isolated. In these situations, all staff need individual supervision ... about focusing on self care and the processes needed to keep themselves and clients safe. There needs to be a team clinical discussion and accountable, clinical management."

- ***Principle of Trust***

"The roles of the team, the team leader and the team manager have to be well defined."

"There needs to be things put in place so that staff take care of themselves ... clear role descriptions; administrative support. The agency needs to emphasise self awareness for staff ... knowing the limits of their capabilities to take on more work. Sometimes people do more than they should ... take on lots of shifts and this leads to burnout."

- ***Principle of Control***

"The organisation has to balance a culture of openness with some rules and boundaries that ensure staff and clients are safe ... enable staff to have a say about things, but someone needs to lead with kindness and judiciousness. Sexual violence services are working with a vulnerable client group ... staff have a lot of autonomy within their practice ... in the room alone with people,

so need to make sure this autonomy is balanced with rules and boundaries to keep all safe."

- ***Principle of Relevance***

"Everyone needs a training plan and time for professional development at work. While most of the training for workers in the sexual violence sector is overseas, organisations have a responsibility to provide training so employees' practice keeps up to date with new practices and theories."

"Professional development is really important. I see a lot of dysfunction in this sector because people are not getting the professional development support they need to do the work. It really comes down to funding and resources ... agencies have to prioritise releasing their staff for training so they keep energised and effective."

- ***Principle of Collaboration***

"There needs to be a willingness to taking a team approach in providing the best service to the victim and having knowledge about the roles others play ... police, doctor, nurse."

20.2 Induction and Ongoing Training

Respondents noted the importance of employee induction and ongoing training for the sexual assault support service workforce. They reflected that such elements of professional development equipped staff with the knowledge and skills necessary for them to be effective in their work with those affected by sexual violence.

"Induction is very important. Even if people are experienced counsellors, they need space to observe different situations within the work, for example support service calls. What is done, or said, in the context of providing a sexual violence service is so different from other types of service. It's also important to observe them in the work and get them used to receiving feedback and being observed. Give them lots of readings and ask them how that impacted on them."

"A good induction is critical and needs to include the philosophy of practice and an understanding of the values that underpin the service."

"It's important to train people in the fundamental aspects of the cause and effects of sexual violence; trauma-informed work with people who have experienced sexual violence; management of conflict ... people are often angry and direct that at you; and, ensure the trainers provide accurate information about the processes and procedures of the work. I am concerned that the training is crammed into the first two weeks and then people are put on the phone rosters."

"Crisis support workers need to be appropriately trained. There needs to be a basic understanding of crisis intervention; be clear about the role of the crisis support worker during the forensic medical examinations ... providing support during medical, if client wants them present and afterwards; have a basic understanding of forensic evidence collection and the need to avoid accidental contamination ... tie hair back, avoid flowing clothes, check before offering tea or coffee; know how to advise people about the options if contacted by phone; and, ability to respond to a wide range of scenarios, including providing support to relatives/supporters as well as the victim when needed."

20.3 Administrative and Professional Supervision

Respondents advised designers of a sexual assault support service to provide ongoing support, supervision and clinical consultation to maintain practice standards and continuously enhance the quality and effectiveness of the service. They suggested that the organisation hosting the service put in place a range of team and individual forms of supervision (debriefing immediately after service delivery; administrative supervision provided by the organisation's team leaders; and clinical supervision provided by a senior clinician external to the organisation).

"Supervision for the after-hours team includes monthly group supervision and external supervision with one of the contracted counsellors; and, administrative supervision on the alternate fortnights. The daytime team have individual and group supervision; external cultural supervision and supervision for those working with children and their families."

"Supervision is critical for good practice and the workers also need time to debrief after each call out."

"After each callout they need to be called by their supervisor. What you would look for is self reflection about what they noticed and the questions they ask about their practice. They also need to attend an administrative meeting, where workers bring their cases and reflect as a group about what worked well and what they were not confident about ... input from their peers."

"People need organisational supervision; team supervision to discuss difficult cases; clinical supervision with an external supervisor to discuss how the work is affecting them ... things come up for workers like weird dreams ... affects their sex life."

Respondents recommended that organisations hosting a sexual assault support service have a clinical supervisor on site with the team of workers. The role of this clinical supervisor would include observing practice; and being available to assist with challenging situations. They noted that it was important for clinical and administrative supervisors to be clear about their roles, responsibilities and accountabilities, including clarity about the way in which the two roles would interact to manage performance issues. In addition, they stated that it was helpful to match the content and style of supervision with the level of experience of the different members of the service delivery team.

"There needs to be clarity around the roles of clinical supervision and administrative supervision in relation to the performance appraisals. This is where the bottom line of accountability is, if things go wrong. Staff and the supervisor need to be on the same site ... able to observe and see the day-to-day practice, not just what is reported. Supervisors need to be able to make an active contribution to the work in staff meetings, clinical meetings and one-to-one sessions; and, staff need constant access to clinical guidance when things come up about practice."

"There are two models of supervision arrangements. The administrative and clinical supervision can be delivered by one person ... sometimes challenging to mix performance issues with supporting staff in their self care. If administrative and clinical supervision are separated, you need to make sure the external supervisor knows what the challenges are and can raise issues about practice in an assertive way. For example, if a person is not timely with

their handovers, then the response needs to be about working out a solution, not asking people how they feel about that."

"Supervision ... the irregularity of the work ... sometimes go for four months with no call outs and so supervision could be a waste of time as nothing to get feedback about. The high turnover of staff means that often the peer supervision sessions focus on imparting new knowledge to the new people and so there is not much learning."

20.4 Accountability for Service Quality and Performance

Respondents offered their thoughts about ways in which to include accountability and performance into the design of a sexual assault support service. First, they considered it was necessary to plan and implement the service in a way that maximises productivity and/or efficiency. Although their experience would suggest that there is an irregular pattern of demand for the service, they suggested using data to assess the level of need for the service within the community; drawing on data from other like services to calculate annual levels of demand; and, then calculating the workforce numbers required to address the need and met the demand. Essentially, this would provide the basis for demonstrating accountability for efficiency.

"The service needs to have a robust plan and budget. It needs to be able to demonstrate the demand for the service and the level of need in their community ... then you can work out the size of the workforce and the kind of structure required."

"For the role to be meaningful there has to be sufficient work and staff have to have lots of slots on the roster. The work is changeable ... not call outs every night ... sometimes a worker could go weeks without a call out and then have three or four in a row. The optimum number would be five funded positions."

Second, the respondents recommended that the service designers set quality standards by developing a range of policies and procedures that meet regulatory

requirements and good practice guidelines for the purposes of benchmarking. [103] In addition, they advised the development of processes with which to assess and report whether such standards had been met.

> *"More is required to ensure quality and accountability for standards ... clearer vision , principles, kaupapa to shape the work; clearer policies around the professionalism of messages on answer phones; clearer expectations about the number of shifts people have to take on when they become volunteers; more clarity about the expectations of the role and what that entails; more ongoing training."*

> *"Funders need to have assurance that the workforce has sufficient experience and qualifications to do the work to quality standards, that supervision is provided and that there is ongoing professional development and up-skilling. This can be assured by staff belonging to a professional body and having to work under a code of conduct."*

Table 19 includes a variety of documents in the regulatory environment that respondents identified as critical reference material for the development of the policies and procedures for a sexual assault support service.

Table 19: Pertinent Reference Documents in the Regulatory Environment for Designing Sexual Assault Support Service Policies and Procedures

Reference Documents in the Regulatory Environment	Respondents' Comments
Children Young Persons and Their Families Act, 1989 [104]	
Crimes Act, 1961 [105]	

[103] One respondent recommended that the designers of the sexual assault support service refer to: McPhillips, K. (2009) *Mainstream Crisis Support Services responding to Sexual Violence Perpetrated Against Adults: Good Practice Project Round 1.* Wellington: Taskforce for Action on Sexual Violence. Retrieved from: http://www.justice.govt.nz/policy/supporting-victims/taskforce-for-action-on-sexual-violence/documents/Good%20practice%20Round%20One%2014%20December%202009MOJ.pdf

[104] Retrieved from: http://www.legislation.govt.nz/act/public/1989/0024/latest/DLM147088.html

[105] Retrieved from: http://www.legislation.govt.nz/act/public/1961/0043/latest/DLM327382.html Pertinent sections in this Act that relate to sexual crimes are sections 127-144.

	"Crimes Act gives definitions of sexual assault etc." *"Look at to understand why a person was prosecuted under one section and not another."*
Solicitor-General's Prosecution Guidelines, July 2013 [106]	*"This is helpful to know why the Police cannot proceed to court with certain cases of sexual violence ... not meet the evidence requirements."*
Health and Disability Commission Code of Rights [107]	*Health and Disability Code of Rights so people can address issues through a complaints procedure."* *"Code of Rights ... children have separate rights."*
Health and Safety at Work Act, 2015 [108]	*"Employers need to understand their responsibilities in relation to employee stress. This work is not for everyone ... being on-call workers can be a major stress for people and when stress becomes significant, they can be triggered from a work-related call. How people and the organisation carries that responsibility is important to consider."*
Privacy Act 1993 [109]	"*Privacy Act requirements provide guidance for sharing information."*

[106] Retrieved from: http://www.crownlaw.govt.nz/uploads/prosecution_guidelines_2013.pdf

[107] Retrieved from: http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full)

[108] Retrieved from: http://www.legislation.govt.nz/act/public/2015/0070/latest/DLM5976660.html

[109] Retrieved from: http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM296639.html

	"Important to have information sharing agreements that comply with the Privacy Act. Police share everything which reflects the high degree of trust in the relationship. Service needs to be clear about what information it shares ... need client's consent. Service also needs to be clear with clients that CYF can access files as part of the requirements of the funding agreement with them ... limits confidentiality." *"Privacy Act to guide the development of the consent forms. They are needed so the service can do the medical support and the other work with the client. The consent form identifies the agencies that can be contacted."*
Tripartite Response [110]	*"The Adult Sexual Assault Investigation Guidelines and the OAG report outline the types of support that need to be available when someone reports a sexual assault to the police. This support includes specialist sexual violence services, DSAC and safe places to interview victims. Each region needs to have a tripartite agreement between the police, the crisis support service and the DSAC doctors."* *"There needs to be good relationships between the tripartite partners ... sexual assault support services provide invaluable support by bridging*

[110] Retrieved from: http://www.oag.govt.nz/2012/police-conduct/part3.htm

	the spaces between police, forensic assessment, family/friends, and the people who have been assaulted."
Vulnerable Children's Act, 2014 [111]	"*Refer to the contents of the White Paper for Vulnerable Children and requirements under the Vulnerable Children's Act ... vetting and screening of staff and child abuse policy and reporting requirements. People are complex ... need to ask a lot of questions before reporting to CYF or the Police ... some people ring anonymously as they want to check out issues associated with a child at risk ... grey areas for people about whether to report or not. When it's a really serious issue, this is really easy to make a decision to report. In other cases the greyness makes this really difficult."*

Third, respondents advised collecting outcome data with which to demonstrate accountability for effectiveness.

> *"The service has to be able to demonstrate results to attract government funding."*

21. Supporting Factors in the External Environment

Respondents identified a number of factors in the external environment that they believed should be considered by the designers of a sexual assault support service. These identified factors mainly related to pertinent international and national

[111] Retrieved from: (http://www.legislation.govt.nz/act/public/2014/0040/latest/DLM5501618.html)

legislation and policies, although a few respondents advised the service to look for emerging workforce development opportunities that might support the human resource policies and procedures that support the sexual assault support service.

Factors in the external environment that respondents believed should be considered when designing a sexual assault support service included:

- United Nations Human Rights Council Universal Periodic Review [112]

> *"Look at the UNHR review. It has 100 recommendations about human rights in the universal periodic review concerning violence."*

- Better Public Services: Results for New Zealanders and Strategic Priorities of Key Government Agencies

- Accident Compensation Corporation Sensitive Claims Service

> *"There has been massive changes within ACC ... now support packages for people who have experienced sexual abuse or assault, counselling is free and people are covered for longer and are able to enter and exit counselling at any time ... families can also get help without having to pay."*

- Law Commission: 2015 Proposals for Better Supporting Victims/Survivors Of Sexual Violence through The Criminal Process

> *"Amy Adams has asked the Law Commission to review the recommendations of the 2009 report. The outcome of this review could bring changes to the sexual violence sector. The impact of the court process impacts on the number of people who decide to report a sexual assault to the Police. At present the burden of proof lies with the survivor ... have to prove they didn't give consent. This needs to shift to the perpetrator to describe how they went about getting consent from the person. They are also considering a judge-only, with two specialist members of the jury with specialist sexual violence training, involved in the court proceeding ... at present the juries tend to reflect*

[112] More information about New Zealand's Periodic Review is located at http://mfat.govt.nz/Foreign-Relations/1-Global-Issues/Human-Rights/Universal-Periodic-Review/index.php

the stereotypes about sexual violence within the community ... also an independent attorney for the victim ... now the Crown represents the State, not the survivor. Could also include specialist victim advisors and payment for staff who support the survivor at court ... considering whether evidence can be presented before the court proceedings ... what actually happened so that the survivor doesn't have to repeat the story ... often re-traumatised. Look at all these things and consider whether there needs to be any changes in the legislation."

- Government's Response to the New Zealand Productivity Commission's Report: More Effective Social Services [113]

> *"The future of services will depend of the Government's response to the Productivity Commission's report about social services and this will provide direction for what will happen in the NGO sector in the future. We have to ask the question: Have we got the right services in different areas across New Zealand and are they doing the right things?"*

- National Sexual Violence Helpline and information Portal: A Proposal

Two respondents stated that they believed the New Zealand Government was considering the feasibility of providing a national single point of entry for anyone seeking information about sexual violence.

> "*There is concern across the country about the inconsistency of information being given to clients. One solution on the table at present is the development of a national helpline, where people can ring to get consistent advice from appropriately skilled staff who could then direct people to local services."*

- Sexual Violence Workforce Qualifications

A few respondents stated that there was no qualification currently available in New Zealand for those interested in working within the sexual violence sector. They advised the designers of a sexual assault support service to watch for any

[113] New Productivity Commission (April 2015) *More Effective Social Services: Draft Report.* Wellington: New Zealand Productivity Commission Te Komihuna Whai Hua o Aotearoa. Retrieved from: http://www.productivity.govt.nz/sites/default/files/social-services-draft-report.pdf

opportunities that arise concerning the publication of regulations and/or availability of specialist sexual violence workforce qualifications.

> *"There are no workforce frameworks in New Zealand to provide a regulatory framework for the sexual violence sector profession ... these are helpful for deciding who can and is appropriate to deliver a sexual violence service ... provides the basis for what to pay people and the expectations of the service, such as the need to offer supervision."*

> *"To get some consistency about the knowledge and skill base of the workforce for crisis services, Careerforce needs to develop a qualification that all people have to have ... would provide a benchmark and some consistency of competence across this workforce."*

22. Sustainability

Respondents were asked to provide their advice about ways in which a sexual assault support service could ensure its sustainability over the longer term. They commented that sustainability is dependent on a number of factors including:

- Funding
- Stakeholder engagement
- Sustainable workforce
- Demonstrating Outcomes

22.1 Funding

Most respondents stated that securing a multi-year contract that includes full-cost recovery, was critical for sustainability. They noted costs should be calculated for a number of out years; should be based on a calculation of anticipated service demand; and cover both the direct and indirect costs of implementing the sexual assault support service. In particular, they noted that the direct costs should include a budget that covered the salaries of a highly competent team of employees. Moreover, respondents suggested that financial sustainability, including possible funding sources, should be considered during the design of the service; and that

such financial planning needed to considered in terms of the resources required to achieve the service's mission and deliver an evidence-based intervention.

> *"Ability to access core funding that fully funds the service is critical for sustainability ... get high-trust contract over a number of years ... develop a three-year plan that provides assurance for the funding bodies to be confident about investing in the service. This requires an understanding about the projected demand and then mapping a forecast for out years. The history of lurching from year to year with funding is a recipe for burnout."*

> *"The funding agent needs to undertake to fund one service for a long time ... contract for six months or a year means services are not sustainable ... too much work to justify existence. All the services that work with the sexual assault support service need it to be stable, as it's disruptive and confusing for clients and service partners when services stop and start. Ideally provide a good service, fund for five years, and provide annual reports to show what services have been provided."*

> *"Costing a service that is future proofed cannot be based on what it has cost in the past because there was a lot of donated time historically. The aim is to estimate the demand for the service based on the population of Christchurch ... can't imagine having less than three staff to do a 24/7 roster and there needs to be backup. What's important for the clients is to be available. Could have staff providing counselling for certain days and on the callout roster on other days ... has to be thought of in terms of qualified people on full salaries. The take home message about a sustainable budget is that it needs to cover salaries for staff who are competent and of good calibre."*

> *"The service has to be credible with the funders. It has to have data about need for the service and demonstrate that the service is based on current evidence about good practice."*

> *"There is potential for funding from ACC, if the service included a brief intervention."*

22.2 Stakeholder Engagement

For respondents stakeholder engagement not only provided an avenue for promoting the sexual assault support service across sectors and services and garnering support for it, but it also facilitated the development of seamless pathways for victims/survivors to access other services they may need. Some of the respondents'

comments illustrate the way in which stakeholder engagement contributes to sustainability by building cross-sector support, as well as having benefits at an operational level for clients.

> *"Engagement is vital to sustainability. As the service engages with stakeholders, it needs to actively put forward suggestions and possibilities that help others. In this way stakeholders will be reminded of the service and talk positively about it. For the clients' sake realising that the sexual violence is not all that is going on in their lives, so it's our duty to know what else is available for them, what other helps could be brought into their lives so we don't duplicate effort. The service needs to be positioned and interact with the child and family sector; the social services sector; and the sexual violence sector, both locally and nationally. So in making the connections for the clients, it also makes a difference to a service's sustainability."*

> *"Sustainability depends on being linked to the broader social service sector. Specialist services should not be arrogant. Rather, they need to see that everyone has a part to play to support their client group. The service should not keep people in a box, but rather widen their experience of support and a service. This broad experience can only be achieved if the service adopts a model of practice where staff work across sectors and work together."*

> *"Being part of the broader sector is important. Representatives from the service need to be regular attendees at meetings and actively contribute to projects others are working on. By doing this people don't forget your service's key agenda – you become the face that promotes the needs of the clients you serve. This is about making connections on behalf of your client group and other things will come out of that ... like connecting clients, who work with you and perceive you as credible and trustworthy, with other sources of helping. These face-to-face relationships are critical to engaging clients ... one service can broker to another."*

22.3 Sustainable Workforce

In recognising the critical role that employees play in achieving desired outcomes for victims/survivors, the respondents stated that personnel management was a critical factor in not only maintaining an engaged, competent and productive workforce, but also critical for service sustainability. They suggested a range of human resource and organisational development strategies that would contribute to the productivity and effectiveness of the workforce employed to deliver a sexual assault support service. Such strategies focused on creating a warm, nurturing and personalised

workplace environment; creating an organisational culture that values teamwork and is responsive to staff's need for work and home balance; and providing professional development opportunities. The respondents' comments provide more detail about the way in which such strategies work in practice.

> *"The wellbeing of staff is critical to sustainability."*

> *"Workforce sustainability is about caring for staff , providing a level of nurture and managing their caseloads. What staff say matters to them is the physical environment ... highly personalised rooms to work in and space for the tools of the trade ... rooms need to be set up for working with clients. They need spaces to work that are safe, warm, good light, because clients are vulnerable and fragile and they need to come to an environment that is nurturing, kindly, and accessible for people with disabilities. The agency culture needs to be relaxed, with warm relationships and fun because a lot of what staff are dealing with is black. It needs to be flexible and respect people's commitments to their families. For professional staff, they need extension and to work in a learning environment."*

> *"Workforce sustainability requires ongoing training; providing staff with a sense of progression both in terms of their role and their salaries. Ideally the members of a crisis team need to be with each other ... critical for those who work after hours. They can't be remote from the organisation. A crisis service has to be accessible 24/7. More seamless for the clients if the daytime team and the night time team were one and the same ... daytime people on call after hours. Also need a backup for this team in the form of a service coordinator role. When employ staff communicate that this is the expectation."*

> *"To provide best practice for clients there needs to be one team providing call-out support services and business hours support services ... a critical support for this team would be a coordinator role that provides backup. This kind of model would enhance the sustainability of the workforce."*

> *"The sexual assault support service needs to be embedded in a larger specialised sexual violence service agency. This workforce needs a sense of belonging and to be supported by other professionals. There is a risk if you have a workforce that's only responding to the sporadic demand for service and staff working from home."*

"Sustaining the workforce is about having a good management structure to provide support for staff, treat them well and take a flexible style of leadership; providing training and supervision; and, for more experienced staff giving them more autonomy. What's important is having all the people working in this area together and then providing a supporting structure around them. If any of them are having a tough time, then the team is there to assist."

"The culture of the organisation helps workforce sustainability ... work as a team to support each other and the clients. Also good professional development helps staff be the best in the field of their expertise."

22.4 Demonstrating Outcomes

Implementing an evidenced-based service that is able to demonstrate that it achieves outcomes is critical to service sustainability. Two respondents illustrate the way in which a service should be designed to achieve outcomes and thereby remain sustainable.

"Adopt a more for less approach ... consider the core elements of the service required to match what we know about the clients' journey. For example we know that we have to tailor services for each client and services have to be able to respond to the length of their individual journeys – a kind of as long as it takes model. These core elements need to be based on best practice that we know from the evidence are likely to produce outcomes. So the service needs to be set up to meet the episodic nature of help seeking of the client group – can be managed by employing a mix of full-time and fee-for-service staff."

"The service has to prove its worth by demonstrating outcomes ... outcome data is essential to put a service in a good position with purchase-of-service contracting bodies. If a service achieves results, then more people will access it and this will ensure its sustainability."

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Appendix

Appendix 1-A: Sample Letter of Introduction for Respondents

Dear,

Research to Inform Design of Future Sexual Assault Support Service for Canterbury

I am writing to seek your assistance with an independent research project that will assemble an empirical and experiential evidence base to inform the design, development, implementation and operation of a sustainable sexual assault support service in Canterbury.

In July 2014 SafeCare, a 24-hour crisis response service for victims of rape and sexual assault in Canterbury, was wound up when the Monarch Centre closed. In order to maintain access to this critical service, Aviva and START has been working in partnership to deliver the service. Known as the Sexual Assault Support Service Canterbury (SASSC), the service is hosted by Aviva, whilst START provides specialist oversight, guidance and supervision. Funded by the Ministry of Social Development, this interim service has been contracted to run from July 2014 to July 2015.

As a critical next step, , Aviva and START have asked Dr Lesley Campbell to undertake independent research to provide an evidence base to support future decisions about this service, its form and operation. The research involves conducting a literature review and key stakeholder interviews with people who use, or are involved in providing services for those who have experienced a sexual assault and so may have an interest in co-designing this sexual assault support service. As a key stakeholder in the local sexual assault response system you and your agency have been identified as important research participants.

Collecting Information and Opinion

The purpose of this letter is to invite you to participate in an interview with Lesley during April 2015. Each interview is expected to take about an hour and, with your consent, will be digitally-taped. The interview questions will focus on gaining your experiences of current responses for people who have experienced sexual assault, as well as your views about various aspects of the design of a sustainable and future-focused sexual assault support service for Canterbury. Lesley will make contact with you, as a recommended participant, during the next few weeks to ask you if you would be willing to be interviewed and, if so, arrange a suitable time for this to occur.

Ethical Implications of the Evaluation

We have considered the ethical implications of undertaking this research and have put in place the following strategies. The anonymity of those interviewed will be maintained. Information collected from individuals will be collated and presented in the research report in a way that protects each person's identity. As the principal researcher, Dr Lesley Campbell will be the only person who will have access to the information that could identify particular individuals and this information will be securely stored to ensure it is only used for the purpose for which it was gathered. Lesley will send you a copy of the notes taken at the interview with you, on request.

Thank you for considering taking part in this research. Your experiences of current responses for those who have experienced sexual assault and opinions about the design of Canterbury's future sexual assault support service will provide a valuable source of information to support service design decisions. An information sheet is attached for your reference.

If you would like any more information, or have any questions that you would like to talk through, please do not hesitate to call or email me.

Yours sincerely,

Appendix 1-B: Sample Respondent Information Sheet

Aviva, START and Lebern and Associates
Research to Inform the Design of a Sexual Assault Support Service for Canterbury

PARTICIPANT INFORMATION SHEET

1) What is the research project about?

In July 2014 SafeCare, a 24-hour crisis response service for victims of rape and sexual assault in Canterbury, was wound up when the Monarch Centre closed. In order to maintain access to this critical service, Aviva and START has been working in partnership to deliver the service. Known as the Sexual Assault Support Service Canterbury (SASSC), the service is hosted by Aviva, whilst START provides specialist oversight, guidance and supervision. Funded by the Ministry of Social Development, this interim service has been contracted to run from July 2014 to July 2015.

This research project has been commissioned by Aviva and START, to assemble an empirical and experiential evidence base that will inform future investment and operational decisions about the design, development and implementation of an exemplary and sustainable model of service for the Sexual Assault Support Service in Canterbury.

2) Who is carrying out the research project?

The research project is being carried out by an independent researcher from Lebern and Associates. The researcher's name is Dr Lesley Campbell. She can be contacted at camfam1@slingshot.co.nz.

3) What does the research project involve?

The research project involves exploring what is known in the existing literature about sexual assault support services and approaches that achieve maximum effect; and, engaging key stakeholders and agencies to ascertain their views about the future design of a sustainable and effective sexual assault support service.

The research study involves participating in an interview. Each interview will explore your experiences of, and opinions about, 'best practice' sexual assault support services. If you agree, the interview will be digitally-taped. If you wish, a copy of the information you provide that is included in the research report will be provided to you and you may make corrections or changes.

4) How much of my time will participation in the research take?

Participating in an interview is expected to take about one hour. However, it could take more or less depending on how much you have to say.

5) Can I withdraw from the research?

Participating in the research is completely voluntary. You are not under any obligation to participate. If you do decide to participate, and change your mind, you can withdraw from the research at any time before, during or after the interview. There will be no negative consequences, whatever your decision about participation.

6) Will anyone else know about the information given by people interviewed for the research?

The anonymity of those interviewed for the research will be maintained.

All aspects of the research will be strictly confidential. The researcher will be the only person with access to any information that could identify particular individuals and

this information will be securely stored to ensure it is only used for the purposes for which it was collected. Only the researcher has access to this.

There may be publications and reports from the research, but information collected from individuals will be collated and presented in a way that protects people's identity, unless individual participants give their permission to be identified.

7) What will be the benefits of participating in the research project?

The research will have benefits for people with experience of sexual assault, the family and friends that support them, and those who work within the Sexual Violence sector. It will increase our knowledge and understanding about success factors associated with what works and what's helpful for people who have been sexually assaulted, their families, friends and professional supports.

8) Can I tell other people about the research?

You can tell other people about the research and if they wish to obtain further information they could contact Nicola Woodward, Chief Executive Officer, Aviva on 027 2450255 or Nicola@avivafamilies.org.nz; and/or, Maggy Tai Rakena, Manager, START on 021 025 34425 or maggy@starthealing.org.

9) What if I require further information or have any concerns?

If you require further information, or have concerns about, the research please contact Nicola Woodward, Chief Executive Officer, Aviva on 027 2450255 or Nicola@avivafamilies.org.nz; or, Maggy Tai Rakena, Manager, START on 021 025 34425 or maggy@starthealing.org

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This information sheet is for you to keep

Appendix 1-C: Sample Respondent Consent Form

Consent Form
Research on Sexual Assault Support Service for Canterbury

I have read the information sheet for this research; and, understand the nature of the research and why I have been asked to take part in it.

I have been given the opportunity to discuss and ask questions about the research and have had them answered to my satisfaction. I understand that:

- I do not have to take part if I do not want to
- I can withdraw my participation and information provided at any time without affecting my relationship with the researcher, the service or Aviva now or in the future
- My name will not appear with anything I say for this research project
- This consent form and what I say will be stored safely
- The findings from this research will be used to inform decisions and actions associated with designing and implementing a sustainable sexual assault support service for Canterbury
- The interviews will be digitally-taped so that the researcher can accurately record my comments
- A transcript of my interview will be available from the researcher on request

I understand this consent form and am happy to take part

Name: _____

Signed: _____

Date: _____

Appendix 1-D: Sample Questionnaire for Respondents

Interview Questionnaire

Demographics

Name of participant: Designation:

Interview Date & Time: Interview duration:

Section 1: Respondent and their Agency's Role in the Sexual Violence Sector

1. Can you describe your role within your agency?
2. Can you describe your agency's role within the context of the Sexual Violence Sector?

Section 2: Design of Service Elements

Anticipated Demand for Service and Presenting Needs of the Service's Target Client Population

3. In your experience what is the prevalence of sexual assault in NZ? Canterbury? in any 12-month period? What percentage of this group of people report such assaults? Of those who report, what percentage might access a sexual assault support service?
4. If we think about those who have experienced a sexual assault and the families/whanau and others who support them, can you identify the sorts of presenting needs that a sexual assault support service might assist with?

Accessibility

5. If we are thinking about designing SASSC in a way that maximises accessibility, do you have any advice about ways to do that?
6. From your perspective, do you think it's best to provide a SASSC that targets particular population groups, or all population groups? Do you have any reasons for your preference?

7. Can you provide any advice about the most appropriate way for this service to engage with the following groups of people and their situations to ensure the service is accessible and responsive?
    a. Historical / recent sexual assault
    b. Family/acquaintance/stranger assault
    c. Men/Women
    d. Children/Young people/ elders
    e. Gay/lesbian/bisexual/transgender
    f. Maori, Pacific Peoples, CALD – refugees/migrants
    g. Disability
    h. Prisoners
    i. Sex workers
    j. Gang membership
    k. Religious affiliations

Structure

8. The literature identifies a number of different ways in which to position a sexual assault support service (hosted by a stand-alone NGO; part of a multi-discipline team comprising legal and medical services; part of a domestic violence service; part of a hub of social services agencies). From your experience, do you have any views about the benefits or challenges associated with these possible structures? Advice about the best way to structure the Canterbury sexual assault support service?
    - What are the similarities and differences in the models of service/ approaches offered within the Family Violence and the Sexual Violence Sectors? Where are the boundaries between the services delivered by these two Sectors? If we are thinking about providing a responsive service for those who experience sexual assault, which of these models of service should be given priority?

Principles

9. In your view what principles/values might underpin a sexual assault support service?

Legal/Regulatory Frameworks

10. Are there any legal, regulatory or policy frameworks that need to be taken into account when designing the sexual assault support service for Canterbury? In your experience, what is the best way to operationalise these frameworks within this context?

Service Elements

11. In your view what range of services and supports should SASSC deliver?
    - Should SASSC operate at the service level as well as at the system level (i.e. engaging in system change through education and awareness raising)?
12. If we think about the range of agencies that those who have experienced a sexual assault interact with (e.g. Police, medical/forensic services, specialist counselling services, courts), what, if any role do you think a sexual assault support service might have in these different contexts?

Coordination/Collaboration

13. In terms of the design of SASSC, how might this service best collaborate with your service (i.e. medical, police, court, counselling, etc)? Any benefits? Any challenges?

Outcomes and Performance Monitoring

14. In your view, what outcomes might SASSC seek to achieve or contribute to?
15. If we think about the cause and effect relationships between activities and results, what elements of SASSC have the greatest potential to contribute to the achievement of these outcomes?
16. The SASSC service will need to develop a performance monitoring framework for accountability purposes. Do you have any advice about the sort of performance measures that this service should include in that framework?

Workforce

17. If we think about the workforce required to deliver a sexual assault support service, do you have any advice about the competencies and/or background required to competently carry out the role?
    - Core competencies and attributes
    - Volunteers vs those with human service qualifications
    - Professional disciplines
    - Gender? Ethnicity?

- Lived experience?

Infrastructure

18. What organisational factors do you think need to be considered to maximise the success of a sexual assault support service?

Section 3: Sustainability

19. Do you have any advice about ways in which to ensure the service is sustainable over the longer term?

Section 4: Summary and Conclusion

20. Do you have any other advice about the design of SASSC that we haven't discussed that you would like to comment on?

Thank you for your participation

Appendix 2

Crimes Act 1961 (Source: Wellington Community Law, 2011)

Section 128: Sexual violation defined

(1) Sexual violation is the act of a person who –

(a) rapes another person; or

(b) has unlawful sexual connection with another person.

(2) Person A rapes person B if person A has sexual connection with person B, effected by the penetration of person B's genitalia by person A's penis, –

(a) without person B's consent to the connection; and

(b) without believing on reasonable grounds that person B consents to the connection.

(3) Person A has unlawful sexual connection with person B if person A has sexual connection with person B –

(a) without person B's consent to the connection; and

(b) without believing on reasonable grounds that person B consents to the connection.

(4) One person may be convicted of the sexual violation of another person at a time when they were married to each other

Section 2: interpretation

sexual connection means –

(a) connection effected by the introduction into the genitalia or anus of one person, otherwise than for genuine medical purposes, of –

(i) a part of the body of another person; or

(ii) an object held or manipulated by another person; or

(b) connection between the mouth or tongue of one person and a part of another person's genitalia or anus; or

(c) the continuation of connection of a kind described in paragraph (a) or paragraph (b)

Section 128A: Allowing sexual activity does not amount to consent in some circumstances

(1) A person does not consent to sexual activity just because he or she does not protest or offer physical resistance to the activity.

(2) A person does not consent to sexual activity if he or she allows the activity because of –

(a) force applied to him or her or some other person; or

(b) the threat (express or implied) of the application of force to him or her or some other person; or

(c) the fear of the application of force to him or her or some other person.

(3) A person does not consent to sexual activity if the activity occurs while he or she is asleep or unconscious.

(4) A person does not consent to sexual activity if the activity occurs while he or she is so affected by alcohol or some other drug that he or she cannot consent or refuse to consent to the activity.

(5) A person does not consent to sexual activity if the activity occurs while he or she is affected by an intellectual, mental, or physical condition or impairment of such a nature and degree that he or she cannot consent or refuse to consent to the activity.

(6) One person does not consent to sexual activity with another person if he or she allows the sexual activity because he or she is mistaken about who the other person is.

(7) A person does not consent to an act of sexual activity if he or she allows the act because he or she is mistaken about its nature and quality.

(8) This section does not limit the circumstances in which a person does not consent to sexual activity.

(9) For the purposes of this section, –

allows includes acquiesces in, submits to, participates in, and **undertakes sexual activity**, in relation to a person, means –

(a) sexual connection with the person; or

(b) the doing on the person of an indecent act that, without the person's consent, would be an indecent assault of the person.