Sexual Harm Crisis Support Service for Young People: Research to Inform Service Design

Dr Lesley Campbell

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ACKNOWLEDGMENTS

Sexual harm is a pervasive social problem in New Zealand, particularly for young people. Despite the fact that it is a requirement of Article 39 of the United Nations Convention on the Rights of the Child (1989) to provide adequate services for young people who have experienced sexual harm, so far there seems to be a paucity of services at the point of crisis specifically for them. Within this context uncovering the critical ingredients for designing a sexual assault crisis support service that has the potential to achieve positive outcomes for young people has been informed by the incredibly generous and insightful contributions of 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 harm crisis support service for young people. Especial thanks go to the young people who gave of their expertise to co-design this service. Your voices brought depth, authenticity and realism to this research endeavour.

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

Finally, I would like to thank Aviva who provided me with the opportunity to conduct this research to inform the design of an evidence-based sexual harm crisis support service for young people.

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Executive Summary

Across international jurisdictions and New Zealand, it is widely evidenced that young people are disproportionately affected by sexual harm and those with existing vulnerabilities (disability, socioeconomic disadvantage, mental health issues, and previous experience of abuse) are likely to be at increased risk. Yet despite this evidence, there appears to be a shortfall in provision of sexual harm crisis support services specifically. This is of concern because young people engage with services in quite a different manner to adults and children and they require services that are developmentally appropriate.

It is within this context Aviva commissioned an independent research and evaluation company, Lebern and Associates, to assemble an empirical and experiential evidence base to contribute to the design and implementation of a sexual harm crisis support service for young people in Canterbury. A proactive research design, enhanced with a theory of change, was selected for the research project. A mixed methods approach was adopted using in-depth interviews, document review and a literature review. Using the Framework Model, the qualitative data was collated in a thematic framework and interpreted and synthesised into general understandings. This data and the empirical evidence were triangulated to enhance the internal validity of the findings.

Services for Young People: What is Working Well, Not Working Well and Gaps

Despite the fact that there are youth-specific sexual harm services in some places across New Zealand, most service options are for adults, for children or provide general support for youth on a range of issues. Within Canterbury there is only one specialist sexual harm service that offers assistance for youth, but they also offer interventions for adults and children.

Respondents noted some of the success factors currently operating across the sexual violence sector including a greater understanding across multiple disciplines about the effects of trauma and the necessity to intervene early to prevent exacerbating the negative impacts. In Canterbury they identified 298 Youth Health as a best practice example of providing services for youth. Young people regard it as a trusted service. It delivers multiple different types of service (medical, psychosocial etc.) under one roof and it has the flexibility to allow youth to access it episodically. Youth respondents noted a number of generalist services stating that they had been helpful because they were youth friendly, socially and physically accessible and that they referred them to the right services at the right time.

Of their concerns about the current sexual violence sector, the respondents observed that there were workforce capacity issues; lack of government funding specifically for youth; and that there were inconsistencies in identifying and responding to sexual harm by government agencies. Moreover, they commented that there was a lack of accommodation options for young people who experienced sexual harm; inequality of access to sexual harm services for Māori, Pasifika, young people from CALD communities, young people from the Rainbow Community, disabled youth and young men.

Gaps in sexual violence crisis support services for youth was noted together with a lack of integrated planning and service delivery. Other gaps in services identified included inaccessibility of identifying suitable services online and lack of choice.

Needs

The needs of a young person who has experienced sexual harm are dependent on a range of factors involving their previous experiences, their level of development, the current vulnerabilities and strengths in their environment and the circumstances of the sexual harm. Hence, any assessment of need should be holistic as every aspect of their lives will be affected and such assessments need to be reviewed periodically to assess any changes in developmental or psychological issues. Provision of services need to be tailored to meet the individualised needs of a young person. The needs most often noted by the respondents were needs associated with the trauma response (feeling helpless, out of control, judged); psychological needs; and needs for information and advocacy. Other needs mentioned included physiological needs; safety needs; and accompaniment needs. In addition, there were often relationships needs such as needing to build a system of support or dealing with relationships when there was intrafamilial sexual harm.

Accessibility

The barriers to accessing a sexual harm crisis support service for young people included:

- Lack of awareness of helping services and how to approach them
- Shame, guilt, embarrassment and fear of not being believed
- Fear that services will breach their confidentiality and privacy
- Stigma associated with sexual violence
- Convenience including only being available during business hours; lack of responses from services when contacted; and lack of money or transport to access services
- Fear of retribution from the person who committed the sexual harm

- Lack of compassion from those working within the Health and Criminal Justice systems

Suggestions for maximising service accessibility included communicating to young people about the benefits of accessing a sexual harm crisis support service; providing choice about the way the young person engages with services – social media, telephone, online or face-to-face; providing a youth-focused organisational culture; joining up the system so that there is no wrong door; offering services at times and locations that are suitable to young people; and funding more youth services.

To encourage equity of access to a sexual harm crisis support service for underrepresented groups the respondents offered a range of strategies comprising collaborating with agencies who work with diverse groups; using culturally appropriate approaches and promotional materials; and employing staff who identify with diverse groups and who adopt a holistic, whānau/family-centred approach.

Practice and Approaches

The empirical and experiential evidence suggests that a sexual assault crisis support service should deliver both primary prevention services as well as tertiary prevention services. This is to ensure that the young person has a consistent and trusted agency and worker to engage with.

The primary prevention services include psychoeducation to increase knowledge and understanding among young people and their families about sexual harm, consent, gender stereotypes, date rape drugs, dating violence, risk reduction/prevention, assertive responses, rape myths, impact of trauma and healthy relationships, together with help seeking and appropriate ways to support a young person who has experienced sexual harm. A number of factors have been found to increase their effectiveness including:

- Comprehensive coverage of the subject matter
- Teaching methods are intensive, long-term and interactive
- Content is relevant to young people's lives
- Content includes information about health relationships
- Content includes what to do if a person has been sexually harmed.

The tertiary prevention services include providing information and advice, advocacy, crisis social work services, crisis counselling, accompaniment, establishing a system of support for

the young person and navigation of, referral to and integrated planning of other psychosocial services.

If these services are to be effective, they need to be delivered in a timely, developmentally appropriate, individualised and youth-centred manner – timely to ensure that the young person's situation does not deteriorate; developmentally appropriate by ensuring that the young person's emotional, cognitive and psychomotor development is taken into account when supporting them; individualised to ensure that it is tailored to meet the specific needs and circumstances of the young person; and youth-centred to ensure the youth is believed, safe and in control, for example, they are given choices and full information with which to make decisions.

The services need to be trauma-informed and use trauma models of practice that ensure the worker and the young person's system of support understand the wide-ranging impact of this trauma and to build the strengths of the young person within the context of their system of support. Various forms of trauma-focused cognitive-behavioural therapy, psychological first aid and crisis counselling have been found to be helpful in this context. Moreover, services need to be delivered with cultural competence – an awareness of one's own culture and knowledge and skills to work with young people of different cultures. Services also need to be delivered in a flexible manner, for example understanding that young people may wish to access services as and when they need them.

A significant protective factor identified by the empirical and experiential evidence base was gleaning the support of a trusting adult for a young person who has experienced sexual harm. Offering support to a parent or other trusted adult by, for example giving them some psychoeducation, helps the young person reduce the emotional intensity of their post-sexual harm experience.

Such crisis services could be a number of months in length and provide engagement and stabilisation services to provide emotional, social and physical safety, establish a family system around the young person, as well as establish routines such as eating, sleeping and going to school. A crisis service can also support and prepare young people for when they are ready for, or a long-term trauma counselling service is available.

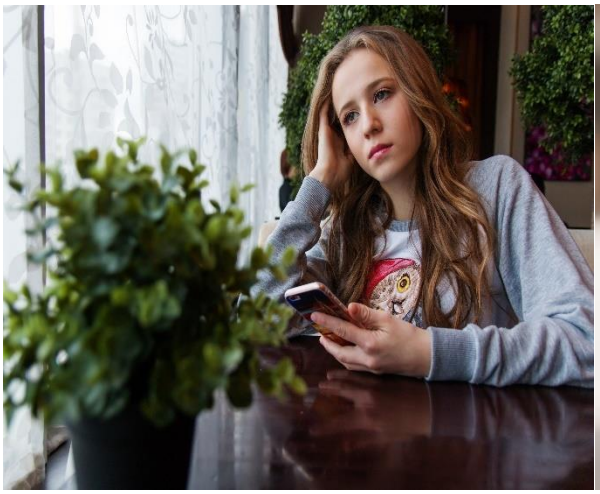
Infrastructure Requirements

The infrastructure requirements that underpin an effective sexual harm crisis support service include housing the service within a youth centre that provides a number of youth-related

activities and services; ensuring that the organisation housing the services is trauma informed and socially and physically accessible; that partnerships are formed with local iwi and Kaupapa Māori agencies and with a range of diverse communities to ensure services are responsive and integrated; and involve youth in the design and implementation of the service.

Most importantly employ staff who are qualified, trusted and highly skilled and who have a commitment to working with young people, adopt a developmental approach and who understood youth development and the underpinning principles; use trauma-informed practice which was grounded in creating safety, promoting control and empowerment and self-care; are culturally competent; and have a good knowledge of the system of psychosocial support.

Develop a sustainable sexual harm crisis support service by accessing a diverse array of funding sources; implement employee wellbeing policies and practices; develop and implement an outcome monitoring framework; implementing a stakeholder engagement plan with which to ensure stakeholder ownership of the service; have policies and procedures to guide the agency in legal and ethical matters; and undertake an annual SWOT analysis that facilitates adaptability to changes in the internal and external environments.



Part One: Introduction and Context

Introduction

Across international jurisdictions and New Zealand, it is widely evidenced that young people are disproportionately affected by sexual harm and those with existing vulnerabilities (disability, socioeconomic disadvantage, mental health issues, and previous experience of abuse) are likely to be at increased risk (McDowell et al., 2013; Khadr & Herbert, 2011; Holmes & Sher, 2013). [1]

Young people exposed to sexual harm are at risk of adverse physical, psychological, behavioural and sexual impacts (Maniglio, 2009). Blanco et al., (2015) has found that exposure to sexual harm changes the neurological brain structures which makes young people more likely to experience anxiety, depression, substance abuse and other psychological and behavioural issues. These researchers amongst others have advocated for young people who experience sexual harm to access trauma-based sexual harm crisis support early (Blanco et al., 2015; Ko et al., 2008; Veenema et al., 2015).

A 2018 formative evaluation report noted that sexual harm crisis support services are provided after an incident of sexual harm or a crisis event (an event that triggers the trauma of sexual harm experienced in the past) [2]and use a trauma-informed approach. Such services provide callout support, advocacy, crisis social work, crisis counselling, advice, information, and links or referral to services (Malatest International, 2018).

Providers described the different client pathways through their services Source: Malatest International (2018)
• Support through the crisis event only, although providers also said that some who received support through the crisis event would come back later for additional support • Support through police and justice system processes

[1] In New Zealand the age range for young people is generally from 12-24 years (Ministry for Youth Development, 2009). For the purposes of this report young people include those who are in the age range of 13-25 years.

[2] Crisis is not defined by the actual event, but by the person's response (and the response of their family/whānau/community) to that event. A victim/survivor may still be considered in crisis if the event is historical, as crisis episodes can be triggered by events later in a victim's/survivor's life.

- Holistic and non-specialised social work and counselling support for refuge, housing, entitlements and other needs
- Specialist trauma and sexual violence social work support
- Support to engage with and receive specialist counselling, either from Accident Compensation Commission (ACC) or other specialist trauma counsellors
- Support for people while they waited for specialist support or for those who did not qualify to for ACC services.

Context

In 2018 the Joint Venture for Family Violence and Sexual Violence was established to bring government agencies together to work in new ways to reduce family violence, sexual violence and violence within whānau. Its role is to lead, integrate and provide support for everyone involved, to ensure an effective, whole-of-government response to family violence and sexual violence.

In the prelude to the establishment of the Joint Venture, the Ministry of Social Development was tasked with the responsibility of leading a Sexual Violence Ministerial Work programme. The aim of this work programme was to ensure the sustainability of the sexual violence sector. A 2016 consultation process developed a service framework for the crisis sexual harm sector that included a vision, agreement on a definition of crisis support, agreement on the elements of a sexual harm crisis support service, and agreement on the length of service.

Service Framework for Crisis Sexual Harm Support Services

Vision

Sexual violence crisis support services that are accessible and readily available to those affected by sexual harm/violence wherever and whenever they need them and that those services are culturally responsive and based on good practice

Definition of Crisis

Crisis is defined as the person's internal response/trauma to that event and not limited to a timeframe and/or a 'one off' intervention. Therefore, crisis can arise at the point of victimisation, or can be triggered by events later in a victim's / survivor's life.

Elements of a Sexual Harm Crisis Support Service (SHCSS)

- *Advocacy*: supporting victims/survivors to communicate and seek appropriate support with other agencies, such as: mental health services, General Practices (GPs), employers, Work and Income New Zealand (WINZ), Police, Accident Compensation Corporation (ACC), Immigration New Zealand or lawyers.
- *Therapy focused support*: Integrated services for sensitive claims (ISSC) are the most appropriate service to deliver therapy-focused support long-term, but SHCSS providers are required to have this capability internally if they do not have links with the ISSC. It is also a critical function of support in the earlier stages of recovery and an on-going need during recovery, as victims/survivors make steps to recovery and may experience setbacks.
- *Psycho-education*: is focused on providing victims/survivors with the tools that they can use to manage their recovery.
- *Support to "navigate" the system*: tailored support by managing referrals and helping the victim / survivor understand their needs and what supports are available to them. A function of navigating is also liaising with appropriate agencies and accessing the necessary supports.
- *Family and whānau support*: trauma processing support for those supporting the victim/survivor can be vital for the recovery of the victim / survivor, especially for Māori. Psycho-education is also important for family and whānau when supporting the victim / survivor and knowing how to respond to disclosures and triggers supportively.

- *Survival needs*: providing practical support at the time it is needed. It can include safety planning and goal setting, or meeting basic needs such as access to food, housing and budgeting.
- *Psychosocial support through the criminal justice system*: preparing the victim / survivor for court or justice proceedings and liaising and advocating on their behalf (this can also be provided as part of crisis support).
- *Group support*: creating a 'therapeutic community' with other victims / survivors e.g., male survivors peer support group.

Additional support, providers felt post-crisis support could be complimented by:

- *Prevention*: debunking rape myths, providing targeted prevention programmes, education, and training in schools and the community.

Length of Engagement

The length of engagement varies and depends on the support required and the support available. If a victim/survivor requires long-term support but is not eligible to access ISSC, then the SHCSS could be required to 'hold' the person for months or years.

Long waitlists for ISSC in some locations will also impact the length of engagement required in post-crisis care and recovery through SHCSS. Additionally, some victims/survivors require practical support alongside long-term counselling support through ISSC.

This timeframe varies significantly, but there was general agreement that there is a need for at least between 6-12 sessions of post-crisis care and recovery support.

Short-term Outcomes

- Empower victims / survivors
- Adequately support them back to independence, or to engage in additional supports

Source: Ministry of Social Development (2017:13). *Sexual Violence Crisis Support Services: Service Development Consultation Document.* Wellington: Ministry of Social Development

Despite this work there now appears to be a shortfall in provision of sexual harm crisis support services for young people (Beres, 2013). Allnock et al., (2009) observed that services for young people are either subsumed into adult sexual harm crisis support services or into services that cater for a wide range of mental health issues. These authors and

McPhillips et al., (2009) note that young people engage with services in quite a different manner to adults, *often having more short-term interactions and …* they require services that are developmentally appropriate.

In addition to this gap in sexual harm crisis support services for young people, a 2017 Ministry of Social Development consultation report noted that Greater Christchurch was a very high-risk region and was likely to need an increase in sexual harm crisis support capacity (MSD, 2017:56).

Within this context Aviva commissioned an independent research project to provide an empirical and experiential evidence base to support the design and implementation of a sexual harm crisis support service for young people in Canterbury.

Part Two: Research Methodology

Research Purpose and Key Questions

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 a sustainable sexual harm crisis support service in Canterbury for young people aged between 13 and 25 years. 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). [3]

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

Table 1: Key Research Questions

Key Research Questions
The key research questions are: ➢ Q1 – What is currently being delivered for young people who experience sexual harm and where are the gaps in the delivery of crisis response services for youth aged 13-25 years? ➢ Q2 – What is currently working well and what is currently not working well in the delivery of a crisis response service for young people who experience sexual harm? ➢ Q3 – What is the extent and nature of the diverse needs amongst the defined target population for an exemplary sexual harm crisis support service for young people? ➢ Q4 - What are the barriers to accessing a crisis response service for young people who have experienced sexual harm and how can these barriers be overcome? ➢ Q5 - What research-proven practices and approaches can be applied to the investment, co-design and delivery of an effective model of crisis support service for young people who have experienced sexual harm?

[3] 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.

- Q6 – What are the infrastructure requirements required to support a model of service for young people who have experienced sexual harm, including workforce training and development?

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 harm crisis 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 stakeholders including young people and professionals who are engaged in providing sexual harm support services or who deliver policies and programmes that interact with such sexual harm support services.

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 harm crisis support service. Owen (2001) observes that this assessment is fundamental to decisions made by service delivery agencies. [4]

- Synthesizing what is known in the existing research and grey literature about models, approaches and practices associated with sexual harm crisis support services for young people 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."

[4] 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."

- Reviewing ways in which sexual harm crisis support interventions for young people 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 crisis sexual harm support service for young people this research has adopted three key lenses with which to collect the 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 harm crisis support service for young people 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 a sexual harm crisis support service for young people 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, including young people, who had experienced sexual harm and those 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. [5] This qualitative experiential knowledge was collected via in-depth

[5] 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.

interviews with identified key respondents who brought a diverse range of perspectives to the research – for example, perspectives from young people who had experienced sexual harm, policy managers, programme delivery managers, programme delivery professionals and para-professionals and those whose cross-sector services may intersect with a sexual harm crisis support service for young people (Pawson, Boaz, Grayson, Long & Barnes, 2003).

Research Design, Methods and Procedures

The research study adopted multiple methods design in order to maximise the comprehensiveness of the information collected to answer the research questions (Brazier et al., 2008; Flyvbjerg, 2011; Merriam, 2009; Stake, 2006; Yin, 2014). The principal 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 and zoom 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, 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) and increased the internal validity of the research (Stake, 1995).

Enhancing the Design with Theory of Change

The basic design for the research to inform the design of a sexual harm crisis support service for young people was further enhanced by including an additional feature: the use of an intervention logic model that included both implementation theory and a service theory.

In combination, the development of implementation and service theories comprising this service's intervention logic add value by respectively:

- 'Surfacing' and making explicit the activities involved in the service – the implementation theory; and,

- Discovering the 'how' and 'why' the various mechanisms of change within the service result in the desired outcomes – the service theory.

In summary, implementation and service theories form the basis for enhancing an understanding about what impacts might occur and how and why. Thus, the research findings aimed to make more explicit our knowledge about the mechanisms of change operating within a sexual harm crisis support service for young people. This offered the potential to not only benefit this service and any future endeavours to replicate the service in other contexts, but also provided the opportunity to uncover the conditions that enabled its success (Wiess, 1995; Wiess, 1997). [6]

Table 2: Research Methods and Procedures

Research Method	Procedures
Interviews with professionals (30)	Individual and group face-to-face, Zoom and telephone interviews were held during March and April 2021 with national and local respondents who were providing services to young people who had been sexually harmed. These respondents were purposefully selected on the basis that they possessed a body of knowledge, experience and diversity of experiences on crisis sexual harm services for young people. All respondents were sent an information sheet and consent form before participating in an interview. [7] Structured data collection instruments were used to guide these key respondent interviews. The interview schedules included mostly open-ended questions. Interview schedules

[6] Baccuhus, L., Aston, G., Murray, S., Vitolas, C. and P. Jordan (2008). *Evaluation of an Innovative Multi-agency Domestic Violence Service at Guy's and St. Thomas' NHS Foundation Trust.* London: King's College, University of London.
Weiss C. (1995) Nothing as practical as good theory: exploring theory-based evaluation for comprehensive community initiatives for children and families. In Connell AC, Kubisch L, Schorr B, Weiss CH. (Eds), *New approaches to evaluating community initiatives: volume 1, concepts, methods and contexts*. Washington DC: Aspen Institute.
Weiss C. (1997) How can theory-based evaluation make greater headway? *Evaluation Review* 21: 501–24.
[7] Elements of informed consent included in the Respondent Consent Form and the Research Information Sheet included: identification of the researcher; identification of the agency managing the co-design of 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).

	were 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). All those who participated in the research received letters of thanks.
Interviews with young people (4)	Face-to-face interviews were undertaken with young people aged between 19 and 23 years who had experienced sexual harm. These interviews were undertaken by Sexual Assault Support Service Canterbury (SASSC) staff in order to provide immediate support for the respondents if they were triggered by the research interview questions. Structured data collection instruments were used to guide these key respondent interviews. The interview schedules included mostly open-ended questions and questions that used Likert scales. [8]
Literature review	The literature review involved a systematic search for and review of international and New Zealand published and unpublished research and evaluation studies. Research literature 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, the internet was searched using Google Scholar and Google Books search engines for additional literature. The review was not exhaustive of all available data sources, as this could not be achieved in the timeframe and the resources available for the research. In addition, the

[8] The interview questions were developed in conjunction with staff from the Aviva Sexual Assault Support Service Canterbury to ensure that the language used was appropriate for young people.

	literature review only included studies that involved young people with experiences of sexual harm. Combinations of relevant terms were used to source the literature for the review including: 'sexual harm and young people/adolescents/teens;' 'effective crisis sexual harm programmes and young people/adolescents/teens'; 'sexual harm statistics and young people/adolescents/teens'; 'crisis sexual harms programmes for young people and outcomes;' 'needs and young people and sexual violence; 'evidence base and sexual harm and teens;' 'success factors and crisis programmes for young people and sexual assault;'; and 'evaluation and crisis sexual harm programmes for young people.' The review describes common or divergent findings across empirical studies and this information is presented in thematic form around the following categories: • Prevalence • Risk and protective factors • Impacts • Maximising access • Programmes • Approaches • Infrastructure

Data Analysis

The Framework approach was used to manage and analyse the data from the key respondent interviews. This approach involved familiarisation, identifying a thematic framework, indexing and grouping. The organised data was interpreted and synthesised into general conclusions and understandings (Pope et al., 2000; Sheikh et al., 2009). These results were complemented with examples that described each different response grouping, including the use of quotes.

Ethical Considerations

This research recognised that there are potential risks associated with any study carried out within the sexual violence sector and was committed to put in place adequate precautions to maintain the safety of all those involved. To counter some of the ethical issues that may have arisen as a result of this research project a number of preventative measures were put in place.

Informed Consent: All potential respondents were advised in the information sheet of the purpose, nature and possible benefits of the research so they could exercise choice about whether to be involved or not. Informed consent was sought from all potential respondents. The research 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 was respected. In addition, respondents were invited to ask questions at any time.

Freedom to Withdraw: Participation in this research 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 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 was kept in a locked file. Information collected from particular individuals has been collated and presented in aggregate form. At no time is there to 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 pressure to ignore evidence or suppress negative results. To counter this ethical issue, the research was conducted without bias and the results have been disseminated in a sensitive manner.

Storage and Use of Data: Data collected during the course of the research has been securely stored by the researcher to ensure the material is only used for the purpose for which it was gathered. Respondents have been advised that the data is to be used for the purpose of gathering information to inform the design of a sexual harm crisis support service for young people aged between 13-25 years.

Promises to Supply Information Fulfilled: All requests by individual respondents for copies of their interview notes have been met.

Wellbeing of Respondents: The research may have exposed 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. All young people who participated in the research were offered support.

Guided by Internationally Recognised Ethical Standards for Evaluation: The research was conducted in a 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 evaluations 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

Defining Sexual Harm and Consent

Sexual harm is the act of coercing another person to engage in sexual behaviour without their consent. It includes both physical, emotional and/or psychological force (WHO, 2002). It can range from harassment to rape (Cascardi & Avery-Leaf, 2003).

> *Sexual assault is a comprehensive term that includes any forced or inappropriate sexual activity. Sexual assault includes a situation in which there is sexual contact with or without penetration that occurs because of physical force or psychological coercion or without consent, including situations in which the victim would be unable to consent because of intoxication, inability to understand the consequences of his or her actions, misperceptions because of age, and/or other incapacities* (Kaufman, 2008).

Consent is required when two people agree to take part in sexual activity. Without consent from both people, sexual activity is illegal. In New Zealand, you must be over 16 years of age to consent to sexual activity. [9]

Prevalence

Young people's experiences of sexual harm in New Zealand

Mayhew and Reilly (2007) reported that young people are at high risk of sexual harm, with the age group 15 – 24 years being at the highest risk of sexual violence of any age group. Twelve per cent of women aged 15-24 years reported at least one unwanted sexual harm incident in 2005, compared with four per cent of women overall.

A survey of a representative sample of 8,500 New Zealand secondary students found that 14% had had unwanted sexual contact with 16–18-year-olds (16.2%) reporting slightly higher rates than 12–15-year-olds (14%). [10] Nearly eighteen percent (17.6%) of Māori

[9] Source: https://www.healthnavigator.org.nz/health-a-z/s/sexual-assault/

[10] Unwanted sexual contact refers to being touched sexually or being made to do sexual things they did not want to (Youth 2000 Survey).

students and 21.8% of Pasifika students reported unwanted sexual contact (Clark et al., 2015). Of those who had experienced sexual harm, 36.7% described their last unwanted sexual harm incident as 'pretty bad' or really 'bad/terrible.' The majority of the incidents were committed by a boyfriend, girlfriend (40.1%) or friend (29.8%), with 13.6% committed by a relative and 2.8% by a parent. 44% stated that they were 14 years or older when the first unwanted sexual harm occurred.

Disclosing the unwanted sexual harm was reported by 43.1% of those who had experienced sexual harm. The majority told a friend (69%) followed by a parent (37.9%). [11]

Image based sexual harm

14.6% of students in this survey reported receiving unwanted sexual material via mobile phone or the internet in the last 12 months and these students were three times as likely to report having an unwanted sexual harm experience.

A study undertaken by Netsafe (2017) reported that 3% of the young people surveyed had shared intimate images online of someone else without their consent. In 2018 Netsafe undertook another study and found that those aged between 18-29 years were the most common group to share intimate sexual content online without the person's permission.

Image based sexual harm is the most common criminal offence charged under the Harmful Digital Communications Act since its implementation. [12]

Oranga Tamariki substantiated sexual harm

Oranga Tamariki also reports statistics concerning sexual abuse. For example, table 3 shows the number of substantiated sexual abuse findings from 2013 to 2017. [13]

Table 3: Total substantiated findings of sexual abuse [14]

Type of abuse finding	F2013	F2014	F2015	F2016	F2017
Sexual abuse	1,459	1,329	1,275	1,167	1,038

[11] 14.4% of students who had experienced sexual harm told a school counsellor and 7.2% told a teacher (Clark et al., 2015).
[12] Source: https//www.nzherald.co.nz/nz/news/artice.cfm?c_id=6&objectid=11888945
[13] Source: https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/findings.html#Downloadthelatestnationalandlocalleveldata3
[14] Note: A finding of abuse or neglect was made after an investigation or assessment was completed by Oranga Tamariki and abuse or neglect was substantiated. A child or young person might have had more than one finding as a result of an assessment or investigation, or might have had more than one assessment or investigation in the reporting period.

Table 4 below shows the number of distinct children and young people (i.e., each child or young person is counted only once in the period) with substantiated sexual abuse findings.

Table 4: Distinct children and young people with a substantiated sexual abuse finding [15]

Distinct children and young people by the type of abuse finding	F2013	F2014	F2015	F2016	F2017
Sexual abuse	1,423	1,294	1,231	1,136	1,010

Women's refuge

During 2019/20, 6% of women who stayed in women's refuges were aged under 20 years (Women's Refuge Annual Report 2020). During 2018/19 16% of women who stayed in women's refuges were aged under 20 years (Women's Refuge Annual Report 2019).

Young people's experiences of sexual harm worldwide

Nearly 1 in 3 adolescent girls globally report that their first sexual experience occurred under coercion (WHO, 2010). Likewise, Stoltenborgh et al., (2011) estimated that one out of every young person worldwide stated that they had been sexually harmed.

International studies report a diversity of rates (15% to 78%) of incidents of sexual harm experienced by young people (Kanin & Parcell, 1977; Rapaport & Burkhard, 1984; Muehlenhard & Lindon, 1987; Koss, 1988). Commentators in the literature maintain that, in part, this diversity reflects a definitional problem. For example, in the Meuhlenhard & Lindon (1987) study 15% of the sample experienced rape, whilst 78% had experienced an unwanted sexual activity.

The US National Intimate Partner and Sexual Violence Survey found that rates of sexual harm were high among young people aged between 11 and 18 years (Black et al., 2011). In the same survey one in three young people who had experienced rape experienced their first rape aged between 11 and 17 years (Smith et al., 2017).

Rennison (2001) reported that among high school aged young people, the highest rates of sexual harm occurred with females aged between 13 and 18 years. Studies have shown that the risk of experiencing sexual harm increases with age, (Finkelhor, Shattuck, Turner, & Hamby, 2014; Kloppen, Haugland, Svedin, Mæhle, & Breivik, 2016; Radford et al., 2013)

[15] Note: A child or young person might have had more than one type of finding as a result of an assessment or investigation, or may have had more than one assessment or investigation in the reporting period. A child with more than one type of finding is counted in each finding type thus the total number of distinct children and young people does not equal the sum of all the types.

probably due to a significant proportion of assaults that occur within the peer context. For example, the US Bureau of Statistics found that women aged between 16 and 19 years were four times more likely than the general population to report sexual harm (Department of Justice, 1997).

Studies of young people attending tertiary education in the US have also found high rates of sexual harm (Belknap & Erez, 1995; Fisher et al., 2000; Koss et al., 1987). For example, Wilcox et al., (2006) and Abbey et al., (2006) have found that one in four university women have experienced rape or attempted rape.

Centres for Disease Control (2013) estimated that 1 in 5 adolescent males experience sexual violence before they are 18 years old. In a US study of secondary school students 15% of females and 4.4% of males stated they had experienced sexual harm from a dating partner (Bergman, 1992).

The US National Intimate Partner and Sexual Violence Survey of children and young people aged 0 to 17 years, found that there was a mix of males and females (54.4%) who committed the sexual harm against young men. Almost half of the males reported being abused by males, and a little more than 10% of females reported being abused by a female. The finding of female offending against boys is consistent with other surveys conducted in the United States (e.g., Dube et al., 2005; Ybarra & Mitchell, 2013). Easton et al., (2014) writes that stigma concerning 'homosexual behaviour' and being subject to sexual harm by females can delay young men's disclosure of the sexual harm for years or even decades.

In the United Kingdom about 1 in 20 young people have been sexually harmed. A National Society for the Prevention of Cruelty to Children (NSPCC) study asked 2,275 children aged 11-17 about their experiences of sexual harm (Radford et al., 2011). 4.8% of 11- to 17-year-olds (7.0% of girls and 2.6% of boys) reported experiencing contact sexual abuse, as defined by the criminal law, at some point in their lives. The proportion of children who reported experiencing any form of sexual abuse, including non-contact abuse (such as flashing or saying sexual things), is much higher. 16.5% of 11- to 17-year-olds had experienced any form of sexual harm, including non-contact abuse, at some point in their lives.

Oppression and sexual harm of young people

The Pennsylvania Coalition Against Rape noted that oppression (racism, classism, hetero-sexism, ableism, etc) is one of the root causes of sexual violence. For example, young

people who belong to the Rainbow Community and /or are disabled are more likely to experience sexual violence. [16]

A New Zealand study of transgendered and non-binary people's experiences found that 32% had sex against their will since they were 13 years old. Additionally, 47% reported that someone had tried to have sex with them against their will since they were 13 years old. [17]

29.9% of lesbian or bisexual teenage girls stated they had been forced to have sexual intercourse	25.5% of gay or bisexual teenage boys stated they had been forced to have sexual intercourse.

Source: Lindley & Walsemann (2015)

Previous research has shown that young people with disabilities have greater risk of experiencing sexual harm than those without experience of disability. Moreover, studies suggest that youth with disabilities are abused for extended periods of time and are at greater risk of abuse by multiple different people (Plummer and Findley, 2012). The risk of sexual harm has been attributed to a number of situations, including increased risk of isolation, dependency as a result of disability, difficulties identifying and naming disability related abuse, and cultural/societal barriers.

Mueller-Johnson et al., (2014), using data from a Switzerland national school study of 6,749 (5.1% identified as having a physical disability) young people with an average age of 15 years, found nearly half the girls and nearly a third of the young men had experienced non-contact sexual harm.

25.95% of teenage girls with a physical disability have experienced contact sexual harm	Over 18.50% teenage boys with a physical disability have experienced contact sexual harm
48.11% of teenage girls with a physical disability have experienced non-contact sexual harm	31.76% teenage boys with a physical disability have experienced non-contact sexual harm

Source: Mueller-Johnson et al., (2014)

[16] Source: https://pcar.org/about-sexual-violence/oppression-sexual-violence
[17] Adolescent Sexual Harm Conference 2020 (25 November 2020). Auckland City Hospital, Marian Davis Library Building, Auckland.

Risk Factors

Vicary et al., (1995) maintained that adolescents' youth and inexperience make them vulnerable to sexual harm, especially for those under 15 years. Table 5 notes some of the factors identified in the literature that make young people vulnerable to sexual harm.

Table 5: Risk Factors Associated with Sexual Harm for Young People

Risk Factor	
Family/whānau	• Being alienated from family and/or being part of a dysfunctional family where the young person is not well supervised and has a need for positive attention (Ageton, 1983; Finkelhor & Baron, 1986; Finkelhor et al., 1990; Fassler et al., 2005)
Dating behaviour	• Using coercive strategies such as making promises that are not kept, continued physical attempts, verbal threats and physical force (Christopher, 1988; Koss & Oros, 1982)
Sexual history	• Earlier age of sexual activity and more sexually active same-sex friends were significant predictors of unwanted sexual activity by dates/boyfriends. (Vicary et al., 1995).
Peer relations	• Poorer perceived relationships with peers were a significant predictor of sexual harm among young people (Vicary et al., 1995) • Bullied (Fontes et al., 2017)
Behavioural Factors	• Used illicit drugs and/or alcohol and had friends who used them (Fontes et al., 2017) and alcohol and drug use during a relationship with an acquaintance (Meuhlenhard & Linton, 1987). • Young people may not identify a situation as rape, especially when incidents occurred in a social setting and without a great deal of force (Glaresso et al., 1979)

	• Access to pornography online (Owens, 2012)
Psychological status	• Poor self-image was a risk factor associated with sexual harm (Stets & Pirog-Good, 1989). Vicary et al. (1995) suggested that young people might be more likely to accept unwanted sexual advances in order to keep and/or please a boyfriend. • Depression (Vicary et al., 1995)
Socio economic factors	• Less intention to go further in their education (Fontes et al., 2017)

Individual and Societal Impacts

There are a number of models in the literature to explain the causative factors associated with the impacts of sexual harm for young people. Finkelhor and Browne (1985) identified four factors that underpin such impacts: traumatic sexualisation which impacts a young person's sexuality; betrayal which impacts a young person's level of trust in others; disempowerment which impacts a young person's self-efficacy, vulnerability and fear; and stigmatisation which impacts the young person's feelings of guilt, shame and reduced self-esteem (Browne & Finkelhor, 1985, 1986; Finkelhor & Browne, 1985). While this model is largely accepted, Conte (1990) argued that not every young person experience all of the factors and the extent of experiencing such factors is variable.

Newberger and DeVos (1988) established an alternative model to explain the impacts of sexual harm on young people. Their model involves three elements: 'social cognition', which is the way in which the young person appraises the sexual harm incident, for example whether the harm was in some way their fault; 'environmental sensitivity' which is the interactions that the young person receives from others such as family members, Police and/or employees of sexual violence agencies; and the young person's emotional- (e.g., levels of distress) and behavioural (e.g., aggression, achievement) functioning. Alterations in any one of the elements can influence alterations in the others.

While the evidence that links these causative factors to the impacts experienced by young people has yet to be demonstrated, understanding the potential contributing factors may be useful for providers of services (Hecht & Hansen, 1999).

Impacts for the Individual [18]

post-traumatic stress disorder		
substance abuse	**eating disorders**	**sleep disturbances**
low self-esteem	**depression**	**anxiety**
consider / attempt suicide		

Research studies demonstrate the impact of sexual harm for young people, both those attending tertiary education and training and those who are school aged. For example, Amar and Gennaro (2005) have found that the psychological and somatic sequelae of sexual harm experienced by students attending tertiary education include negatively altered self-schemas, disordered eating, chronic pain, anxiety, depression and Post Traumatic Stress Disorder (PTSD) as well as issues with work, family and relationships (Kaura & Lohman, 2007; Koss et al., 1994).

For high-school aged young people the consequences of sexual harm include feelings of guilt and shame, depression, anxiety, PTSD, sleep disturbances, eating disorders, alcohol, use and suicidality (Raj et al., 2006; Silverman et al., 2001; Ackard & Neumark-Sztainer, 2002).

The literature is extensive regarding the consequences of sexual harm experienced by young people and includes mental health, medical, psychological, behavioural, socio-economic and sexual issues.

Mental health impacts

The association between experiencing sexual harm and subsequent mental health conditions is statistically significant and includes conditions such as:

[18] The Centre for School Mental Health Assistance (2002: 4) has identified a range of age associated reactions to trauma. For young people aged between 12-17 years the following reactions have been identified: *withdrawal, isolation, somatic complaints (e.g., nausea, headaches, chills), depression/sadness, agitation or decreased energy level, antisocial behaviour, poor school performance, sleep and/or eating disturbance, irresponsibility, risky behaviour, alcohol and other drug use, diminished bids for autonomy, decreased interest in social activities, conflict with parents, concentration problems*.

- Increased depression (Kendall-Tackett et al., 1993; Danielson et al., 2005; Jejeebhoy & Bott, 2003; Kaufman, 2008; Holmes & Sher, 2013; Martz et al., 2016; Kilpatrick et al., 2003)
- Increased anxiety disorders (Andrews et al., 2004; Gilbert et al., 2009; Marshall, 2016; Jejeebhoy & Bott, 2003)
- Increased conduct/anti-social personality disorders
- Dissociation symptoms (Herbert et al., 2013)
- Externalising behaviour problems for example conduct disorder and delinquency (Ferguson et al., 2008)
- Greater number of PTSD symptoms (Kilpatrick et al., 2003). In fact, a meta-analysis of adolescents who experienced sexual harm showed that 57% had experienced PTSD (Nooner et al., 2012). There are conflicting views in the literature about whether younger and older young people are more likely to experience PTSD. For example, a study undertaken by Nooner et al., (2012) found that given their less mature emotional, cognitive and social capacities meant that PTSD was more prevalent among younger youth. Whereas other studies have found that older youth are more likely to experience symptoms of PTSD given their larger exposure to adverse events, including trauma (Herbert et al., 2013).
- Substance use disorders (Nickel et al., 2004; Kendler et al, 2000; Kilpatrick et al., 2000)
- Self-ham and suicidality (Noll et al., 2003; Anderson et al., 2014; Jejeebhoy & Bott, 2003; Brabant et al., 2012; Martin et al., 2004; Kaufman, 2008; Holmes & Sher, 2013; Martz et al., 2016) [19]

Estimates suggest that exposure to sexual harm accounts for 13.1% of these conditions (Ferguson et al., 2008:11).

Psychological impacts

- Lower self-esteem (Andrews et al., 2004; Gilbert et al., 2009; Turner et al., 2010)
- Lower life satisfaction (Ferguson et al., 2013)
- More likely to feel alone (Fontes et al., 2017).

[19] Ferguson et al. (2008); Ferguson et al. (2013)

Socio-economic impacts

Less likely to continue school and university (Frothingham et al., 2000) and poor academic performance (Macmillan & Hagan, 2004; Holmes & Sher, 2013; Martz et al., 2016). 9.7% missed school.

- More likely to have no friends (Fontes et al., 2017)

Medical impacts

- Higher rates of doctor and hospital contact for physical illnesses (Ferguson et al., 2013)
- More likely to experience insomnia (Fontes et al., 2017)
- 9.7% were injured during the incident of sexual harm and 11.5% received medical treatment.
- Pregnancy, abortion and increased risk of sexually transmitted infections (STI) (Noll et al., 2009; Krug et al., 2002; United Nations Children's Fund, 2014; Silverman et al., 2001; Decker et al., 2014)

Sexual impacts

- Higher rates of sexual risk-taking behaviours, including failure to use condoms (Krug et al., 2002; United Nations Children's Fund, 2014; Ferguson et al., 2013; Lang et al., 2011; Fernet et al., 2012; Kaufman, 2008)
- Impact of sexual harm for males and females is different e.g., less of an effect on male's sexual functioning than for females (Dunlop et al., 2015; Najman et al., 2005)

The literature suggests that a considerable portion of the impact of sexual harm stems from shame, stigma, and inappropriate sexual socialization (Finkelhor & Browne, 1985; Kennedy & Prock, 2018; Mckenzie & Botts, 2018; Kaufman, 2008).

These individual impacts should be taken into account when planning support and services for young people who experience sexual harm (Ferguson et al., 2013)

Impacts for Society

The consequences of sexual harm to young people are not only felt by the individual but also by society. In the UK, it has been estimated that the annual cost of teenager sexual abuse is 3.2 billion euros. This includes costs associated with medical treatment, the legal system and loss of productivity and future earnings (Saied-Tessier, 2014; Fang et al., 2012; Barrett et al., 2014).

In the US, Delisi et al., (2010) estimated that the cost of each rape as $151,423.00 and Miller et al., (1996) stated that the annual costs associated with rape was $127 billion.

In Budget 2016 the New Zealand Government appropriated $45.89 million over four years to deliver sexual violence services. Of this appropriation $12 million per annum was allocated to sexual harm crisis support services which delivered 24/7 callout for advocacy and support, crisis counselling and crisis social work support (Family and Community Services Team Ministry of Social Development, 2019).

Neuroscience: What it tells us about providing sexual harm services?

Research shows that the brain of a young person is about 80% developed and is not fully integrated until mid- to late-twenties (Jenson & Nutt, 2015). [20] Under extreme stress a young person's brain is particularly vulnerable because of the release of chemicals such as cortisol, epinephrine and *β*-endorphins. The brain stops integrating the young person's experiences. Jenson and Nutt (2015) have found that experiences of trauma impact the young person's brain in more damaging ways than adults. For example, Fisher & Pfeifer (2011) have found that experiencing trauma reduces the brain matter in male adolescents in the areas of impulse control and in female adolescents in areas connected with depression.

The implications of this knowledge about dissociation [21] and hypervigilance [22]of a young person who has experienced sexual harm means that providers of crisis services must be aware of the following:

[20] Under normal circumstances the brain is constantly integrating cognitive, emotional, sensations and knowledge. In the developing brain, it is still creating the neural pathways that will ultimately result in seamless integration.

[21] Dissociation can result in impaired emotional regulation, emotional numbing and inappropriate emotional responses

[22] Hypervigilance can result in the young person being unable to modulate their level of arousal i.e., unable to calm themselves down. Sometimes the young person may engage in unhelpful behaviours (substance abuse, hurting their bodies, risk-taking behaviours) to get some temporary relief from hyperarousal.

- Young people may find it harder to forge trusting relationships because they have experienced unsafe relationships
- Young people may be described as over reactive
- Young people may display what others may consider as inappropriate emotions and behaviour
- Young people may be triggered by events in the environment
- Young people may be diagnosed as having hyperactivity or oppositional defiance
- Young people may appear to not focus
- Young people may appear to be hypervigilant to stimuli that others cannot pick up
- Young people may dissociate i.e., find it difficult to recall the trauma

NCTSN (2008:4) and others have discovered that the impact of trauma delays the development process in the brain …

> *that would normally enable them to better consider the consequences of their behaviour, to make more realistic appraisals of danger and safety, to modify daily behaviour to meet long-term goals, and to make increased use of abstract thinking for academic learning and problem solving.*

Such consequences result in enhanced risk-taking behaviour, living for today, poor school performance, lack of energy to maintain relationships with peers and making poor choices.

The American Psychological Association (2011) state that providers of services should encourage young people to adopt healthier coping mechanisms, such as establishing routines, if a young person presents with eating disorders, substance abuse and self-mutilation as survival mechanisms. Moreover, the National Institute of Mental Health (2017) advises service providers to be alert to the warning signs of suicide.

More especially, service providers should ensure that young people who experience sexual harm have access to at least one caring adult who can provide a protective effect.

Reporting sexual harm: What it tells us about providing crisis sexual harm services?

Sexual harm is often not reported for many years, if at all. The Centre for Disease Control (2000) have reflected that sexual harm that occurs within the context of teen dating is often referred to as the ‘hidden crime.’ Mayhew and Riley (2007) stated that despite sexual harm being the fifth most common crime, it is the least commonly reported to the Police. The New

Zealand Ministry of Justice (2009) reported that only 10% of sexual harm incidents are reported to the Police.

While reporting to the Police is uncommon, disclosing to others is also infrequent (National Sexual Violence Research Centre, 2015). A New Zealand health and wellbeing survey of young people in school years 9-13 revealed that only 39.9% of individuals had disclosed the sexual harm to anybody else (Clark et al., 2015).

In the US, Gewirtz-Meydan and Finkelhor (2020) analysis of the National Survey of Children's Exposure to Violence (NatSCEV) data found that only 31.0% of incidences of sexual harm were reported to parents among the 10–17 years age-group, only 33.7% were reported to other adults, and 66.3% did not disclose to a parent or another adult. Nineteen percent of cases were reported to the police. Similar findings have been found in other studies (Alaggia et al., 2017; Easton et al., 2014; Morrison, Bruce, & Wilson, 2018; Sivagurunathan, Orchard, MacDermid, & Evans, 2019; London et al., 2005; Fontes et al., 2017). Gewirtz-Meydan and Finkelhor (2020) suggested that there was a need for making child protection and police involvement more adolescent-friendly and providing educators and health professionals with guidance about ways in which to ensure adolescents feel confident that they will receive a supportive response if they disclose.

Studies have found differences in male and female reporting, with males telling someone else years and even decades after the sexual harm occurred (Easton et al., 2014; O'Leary and Barber, 2008).

Understanding the reasons why young people tend not to disclose a sexual harm incident can be helpful for providers of crisis services to create a safe environment in which the young person feels comfortable to talk about it. Young people's reasons for not disclosing described in the research literature include:

- Fear of not being believed, especially if the person who committed the sexual harm is somebody, they know
- Not understanding that the sexual harm is a crime
- Shame
- Embarrassment
- Not want others to know
- Fear of being blamed, for causing the incident by what they were wearing or that they had consumed alcohol and/or drugs, rather than focusing on the lack of consent
- Fear of punishment from parents, (for example being out after curfew) or reprisal from the person who committed the sexual harm, or being ostracised by their friends

- Avoiding the emotional pain of talking about the sexual harm
- Fear that the sexual harm will not remain confidential
- Wanting to handle the situation on their own and not worry their parents
- Traumatic reactions such as shock, confused and not remembering the details of the sexual harm (Fisher et al., 2000; Abbey et al., 2001; Whitman, 2007)

The National Child Traumatic Stress Network [23] state that if a young person decides to disclose their sexual harm that the benefits include access to medical assistance, access to psychosocial evidence-based interventions that assist with healing and prevent the long-term detrimental impacts, as well as access to legal redress.

Protective factors: What it tells us about providing crisis sexual harm services?

Drawing on previous research Casey et al (2009) and Beres (2017) have proposed an ecological model to describe protective factors for sexual harm. [24] These factors have been shown to have moderate or strong association with improved wellbeing of young people who have experienced sexual harm and can be used as measures for tracking progress of interventions (Daigneault et al, (2007; Berkowitz et al., 2010; Williams & Nelson-Gardell, 2012). The protective factors have been organised into individual-, relationship- and community-levels.

[23] Source: https://www.nctsn.org/sites/default/files/resources/fact-sheet/why_dont_they_tell_teens_and_sexual_assault_disclosure.pdf
[24] The majority of these studies focused on young people over the age of 12 years.

Individual	• **Sense of purpose** is associated with reduced substance abuse and anti-social conduct, and improvements in externalising and internalising behaviour and performance at school • **Self-efficacy** is associated with improvements in internalising behaviours • **Self-regulation skills** associated with reduction in mental health issues, and reduction in stress and anxiety • **Problem-solving skills** associated with enhanced performance at school and positive internalising and externalising behaviours • **Relational skills** associated with an ability to perform effectively in social situations • **Involvement in activities** (connectedness to school) is associated with reductions in negative behaviours • **Success at school** (Williams & Nelson-Gardell, 2012; Berkowitz et al., 2010; Chandy et al., 1996; Daigneault et al., 2007; Banyard & Cross, 2008; Vagi et al., 2013)
Relationship	• **Parenting competencies** are associated with reductions in internalising and externalising behaviours and reductions in substance abuse • **Parental wellbeing** • **Strong relationships with family/whānau** • **Positive peers** are associated with reduced substance abuse, anti-social behaviours and suicide and increased school performance (Williams & Nelson- Gardell, 2012; Perkins & Jones, 2004; Banyard & Cross, 2008; Vagi et al., 2013)
Community	• **Positive school environment** is associated with reductions in substance abuse and anti-social behaviours • **Positive neighbourhood environment** is associated with increased resilience • **Stable living environment** is associated with increased success at school, higher levels of attachment and reduced internalising behaviour (Croft et al., 2007)

Ratliff et al (2020) have presented a range of protective and compensatory experiences (PACEs) that increase the resilience and protect young people who have experienced

sexual harm from physical and mental illness. These authors have identified ten PACEs including:

- Parent unconditional love
- Spending time with a best friend
- Helping others
- Being active in a social group
- Having a mentor outside of the family
- Living in a safe and secure home
- Having opportunities to learn
- Having a hobby
- Playing sports
- Having routines and fair rules at home

Recognising that young people who have experienced sexual harm may have trouble regulating their emotions, Ratliff et al., (2020) advised caregivers to help young people to identify and label their emotions.

Barriers to accessing a sexual harm service

The literature notes that many adolescents do not access services (Jackson, 2002; Woodley et al., 2013). Moreover, the barriers to accessing services are many and varied including:

- Fear of retribution (Jackson, 2002; Selim et al., 2013)
- Lack of knowledge about existing services (Jackson, 2002)
- Uncertainty about the professionals, including a reluctance to talk to adults (Jackson, 2002; Woodley et al., 2013).
- Fear they will be blamed for the sexual harm (Woodley et al., 2013)

Selim et al., (2013) noted that social stigma was a barrier for young people seeking help. Such stigma was experienced by young women as well as young men. For young women who experience sexual harm, *restrictive gender norms* result in feelings of shame and guilt. For young men who have experienced sexual harm the stigma is compounded by homophobia and by traditional expectations of masculinity (Together for Girls, 2017; United Nations Children's Fund, 2014; Selim et al., 2013).

Maximising access to sexual harm services

Fleming et al., (2007) noted that many young people who experience sexual harm are not accessing services and supports (National Sexual Violence Resource Centre, 2018). [25] The Wisconsin Coalition Against Sexual Assault (2011) noted the reasons for this such as fear of formal system and retribution; lack of trust due to past experiences; concerns about not being understood; concerns about accessibility and lack of knowledge about local services.

The Ending Violence Association of British Columbia (EVABC) (2016) found additional reasons why young people do not access sexual harm services. First, young people may think that services were only available for adult women. Second, young people may think that they can only access services with their parent's permission. Third, young people may be concerned that they will be rebuked by their family. Fourth, the young person may fear being subjected to having their independence curtailed. Fifth, young people from some cultures who have been sexually harmed may find themselves the source of disgrace by their families.

The literature details a number of themes concerning ways in which organisations can enhance the accessibility of crisis sexual harm services for young people. These themes are outlined in Table 6.

Table 6: Enhancing the Accessibility of Crisis Sexual Harm Services

Enhancing the Accessibility of Crisis Sexual Harm Services
Barriers to Accessing Help
20% of young women and 9% of young men report unwanted sexual experiences (MSD, 2017). • Barriers to seeking help included: • shifting the blame to the victim of sexual harm • lack of support • negative reactions to disclosure • feelings of shame and guilt • attempting to maintain the status quo

[25] Source: Lifespan: Sexual violence in youth. Retrieved from: **https://www.nsvrc.org/lifespan-sexual-violence-against-youth-young-people**

• perceived lack of confidentiality and privacy (Diemer et al., 2018; Cheng et al., 1993; Lemaigre et al., 2017; Foster 2014)	
Strategies for Enhancing Access	
Accessibility Themes	
Structure	• Youth involved in governance, management and frontline services (Diaz et al., 2004) • Involvement of youth in service evaluation and decision-making processes in order to increase youth participation (Whitman, 2007) • Incorporate diversity throughout governance, management and frontline workers as well as in policies, protocols and practices (Weeks, 2001) • Conduct focus groups with underserved populations such as young people with disabilities, young people from the Rainbow Community etc to identify needs and barriers to service (Wisconsin Coalition Against Sexual Assault, 2011)
Youth friendly location **Youth friendly environment**	**Youth friendly location** • Youth one-stop shops allow young people to access sexual harm services without the stigma of others knowing. Provides an integrated and youth-specific model of care which increases access by youth, particularly those who have higher need (MacFarlane, Harris, Michael & Jakob, 2009; Allnock et al., 2009) • Service facilities being located centrally and close to public transport and other areas of interest to youth

	Youth-friendly environment • Posters, art and reading materials that are attractive to young people • Using colour schemes and decor that are interesting and mature (Whitman, 2007; Diaz et al., 2004)
People	• Strive to employ staff who reflect the demographics of the local community • Provide employees with cultural competency training • Use cultural consultants to advise • Employ an equity worker to engage with various community organisations to enhance access (Weeks, 2001) • Interact with young people in a welcoming manner and show respect and genuine concern. If young people feel that service providers are treating them with disrespect and indifference, they are not likely to engage with interventions (Whitman, 2007; Diaz eta l., 2004) • Be aware of the power differential and be relaxed and laid back • Take time to build trusting relationships by keeping promises and being clear about confidentiality and its limitations • Listen and not give advice unless it was asked for

	• Be non-judgmental and not stereotype young people • Have some understanding of young people's culture • Be able to relate to young people • Have self-knowledge by being aware of boundaries and biases • Be well prepared for sessions with a young person but also be flexible (Allnock et al., 2009; Diaz et al., 2004)
	A trusted person was someone the young person respected and trusted with whom young people … • Perceived as reliable, competent, honest and open. • Are willing to be vulnerable with and whom they believe will have their wellbeing at heart • Receive support, reassurance, and practical assistance in a low-key, direct and mutual manner (Mayer, Davis, & Schoorman, 1995; Tschannen-Moran & Hoy, 2000; Meltzer et al., 2016) • Engaged to coordinate services as having to receive many services can re-traumatise a young person. (Ullman & Townsend, 2007; Allnock et al., 2009; Liang et al., 2008; Ahrens et al., 2011; Munson et al., 2010)

Information and communication	• Outreach within schools is required as young people generally have limited awareness and knowledge of services that provide support for young people who have experienced sexual harm • Undertake outreach campaigns to educate young people about the dynamics of teen victimisation and places to go for help (Bureau of Justice, 2006; Smith et al., 2004) • Use a range of media including TV (both adverts and programme content); community radio; billboards; buses; leaflets, particularly in GP's surgeries and libraries; and on the doors of public toilets. These media all offered the opportunity to obtain information anonymously, which is very important to young people (Allnock et al., 2009) • Young people's perceptions of whom services appear to be targeted at influenced their decision making about approaching them. For example, if services do not appear to target young people, they are unlikely to access them.
Service delivery mechanisms	• Face to face, web forums, phone and email (Allnock et al., 2009) • Provide confidential spaces such as contacting 0800 line, talking to a worker online, sending an email or posting on the message board were important for young people concerned about sexual harm, so that feelings and options could be explored

	• Have systems in place to facilitate 24 hour on-call access to counsellors • Youth-friendly opening hours to accommodate study and work commitments • A strong emphasis on privacy and confidentiality for clients so that trust in the service is established • Automated text reminders for appointments
Services	• A range of services is provided with the ability to refer to secondary or tertiary services as required. • Individual needs of young people being identified and services being 'wrapped around' or integrated in a seamless and coordinated way. • Youth workers provide active support to link young people in to the services they require. • Services being available at little or no cost to the client. • Some services being able to offer recreational and other facilities, such as computers with internet access or an indoor skate ramp. • Services offer a variety of innovative programmes and workshops related to art, music, dance, personal health, esteem building and sexual diversity which attract a diverse range of young people into the service and enable them to be linked into other services they may require

	• Young people being supported when transitioning to other / adult services
Partnerships	• Collaborate with schools, families and the community in which young people reside because the more systems involved in assisting the young person the more likely they are to be successful (Diaz et al., 2004) • Implement an outreach and community development project to build relationships with specific communities e.g., CALD communities, Pasifika community, disability community, Rainbow Community etc. (Weeks, 2001) • Personalised referrals are more effective in improving access by ensuring that young people are linked to, and receive, the right service from the most appropriate agency. • Referrals made in partnership with the client are also strengths based and assist in building the young person's confidence in self-advocacy.

The principle of substantive equality recognises that a 'one size fits all' model of service delivery is not effective in meeting the needs of a diverse community, particularly when coupled with the fact that the impacts of sexual harm are individual and diverse.

Ullman & Townsend, (2007) commented that *issues with racism, ableism, homophobia and transphobia can deter young people from seeking help*. Moreover, they advise that in providing services to young people who experience sexual harm, it is important to understand and respect the diversity of cultures and communities that young people identify with.

A number of evaluation and research projects have identified a number of additional strategies to enhance the access of Māori, Pasifika, young people with disabilities, young people from the Rainbow Community and young people with refugee and migrant backgrounds (Wharewera-Mika & McPhillips, 2016; Ending Violence Association of BC,

2016; Gohir, 2013; Rajan & Waru, 2020; NASASV, 2015; Cram, Pihama & Karehana, 1999; Du Mont et al., 2017; Tamatea et al., 2016). These strategies are outlined in Table 7.

Table 7: Strategies for Enhancing Equitable Service Access

Barriers to Accessing Help for Māori

The likelihood of sexual harm is nearly twice as high as the general population [26]

Maori young people face enhanced barriers to accessing services related to health literacy, values and culture; fear of experiencing racism, victim blaming and prejudice; and geographic isolation (Du Mont et al., 2017; Tamatea et al., 2016)

Strategies for Enhancing Access for Māori

Māori Young People

- Te Tiriti partnership created
- Engage with local kaumatua and iwi
- Referrals received by mainstream services are referred to Kaupapa Māori services or if there is not a crisis sexual support service in the region then refer to a Māori therapist
- Employees are culturally competent i.e., they are conversant with Te Reo Māori and tikanga
- Engage with cultural advisors and Kaupapa Māori services
- Recognise the central place that whānau have in supporting a young person who has experienced sexual harm and provide support for them

Pasifika young people

Barriers to Accessing Help for Pasifika Young People

Although the prevalence of sexual harm among Pasifika youth is unknown a Youth 2000 study found that 29% females and 19% males reported having unwanted sexual contact.

[26] Source: Statistics of Sexual Abuse NZ – **https://www.sash.co.nz/information/statistics-sexual-abuse** ; Pihama et al., 2016)

43% females and 37% males told someone. Barriers to accessing services included not wanting to make a fuss, cost, not comfortable, fear and lack of privacy (Mila-Schaaf et al., 2008).

Strategies for Enhancing Access for Pasifika Young People

Pasifika young people

Koloto (2003) found that Pasifika young people prefer to access support from their families, friends and church.

- Access Pasifika support people and services with both cultural and professional competence
- Cultural competence including recognising the diversity of Pasifika ethnic identities and an understanding of Pasifika values, such as including family early in the process, the importance of spirituality and the role of the church
- Access Pasifika workers who speak the young person's language
- Collaborate with "by Pasifika for Pasifika' service providers (Koloto, 2003)

LGBTQIA+ Communities

Barriers to Accessing Help for Young People from the Rainbow Community

50% of transgender young people experienced sexual harm some time in their lives (Stotzer, 2009; Stotzer et al., 2013)

Barriers to seeking support included fear of 'outing' themselves; fear that the person who hears about the sexual harm will be unresponsive; shame and embarrassment; not being believed; high incidence of depression, alcohol and drug issues and poverty; discomfort at

using a service that has no history of being open or does not appear inclusive (Ending Violence Association of British Columbia, 2016a)

Strategies for Enhancing Access for Young People from Rainbow Communities

LGBTQIA+ Communities

- Mirror the language of those who experience sexual harm
- Explain confidentiality policies and respect the right of each person to let the organisations know about their sexuality and gender identity
- Establish and maintain relationships with the Rainbow Community who have the knowledge
- Collaborate with the Rainbow Community to provide resources that are appropriate to those who identify as LGBTQIA+
- Train employees in sexuality and gender diversity
- Create a welcoming environment – one that celebrates gender and sexuality diversity
- Create inclusive intake forms that are appropriate for LGBTQIA+ communities

Young Men

Barriers to Accessing Help for Young Men

Berelowitz et al., (2012) commented that professionals are failing to identify sexual harm among young men and consequently there is a failure to provide them with appropriate

support services. Homophobic attitudes and a culture of 'hyper-masculinity' make seeking help difficult for young men. McNaughton Nicholls et al., (2014) and others (Easton et al., 2014; Brayley et al., 2014) found that the main reasons why men do not seek help include experiences of discriminatory social attitudes; primary prevention focused on females; negative emotions (shame, embarrassment, self-blame; disgust, anger); and gender differences in emotional responses (e.g., young men tend to be emotionally isolated/lacking communication skills to talk about sexual harm).

Strategies for Enhancing Access for Young Men

Young Men

- Believe men when they disclose
- Training for all employees in the needs of men
- Create a male-friendly reception area using appropriate posters and relevant information
- Strengthen interagency connections, processes and communication with agencies that provide services for men

Young people with disabilities

Barriers to Accessing Help for Young People with Disabilities

Young people with disabilities are 3.1 times as likely to experience sexual harm (Sullivan & Knutson, 2000).

Young people with a developmental disability are at increased risk of sexual harm. In the United States young people aged between 12 and 15 years with disabilities had 2.5 times the rates of sexual harm compared to youth without disabilities. Moreover, young people aged between 16 and 19 years with disabilities had three times the rates of sexual harm compared to youth without disabilities (Harrell, 2012). Davis (2016) reported that young people with disabilities are more vulnerable to sexual harm because of a decreased ability to resist the perpetrator, an expectation of increased compliance, an increased tolerance

of physical intrusion, dependence upon others for physical care and in some cases a limited means of communicating (Brownlie et al., 2007).

Institute (1994) has identified a number of factors that might influence a young person with a disability to disclose a sexual harm incident. These factors include: whether the young person understands that sexual harm has occurred; whether the young person can communicate to others about the incident; whether the young person has a trustworthy person to tell; and whether the young person believes they will be believed.

Franklin et al., (2015) discovered that young people with learning disabilities faced a number of barriers to accessing the help they need. These barriers included a lack of appropriately trained professionals able to identify when a person with a learning disability has experienced sexual harm; lack of coordination of sexual harm services and services for people with disabilities; and not knowing what has happened to them is sexual harm.

Strategies for Enhancing Access for Young People with Disabilities

Young people with disabilities

- Provide a range of communication resources including access to the NZ Sign Language interpreters, communication boards and other communication assistive devices for meetings
- Provide information in easy read formats, NZ sign language and on an accessible website
- Provide office space that complies with universal design principles that enables access for people who experience physical, mobility, visual, hearing and/or cognitive disabilities
- Provide a mobility care park
- Situate office space in proximity of public transport

- Work collaboratively with disabled persons organisations. For example, work with those who have knowledge about the deaf culture

Young People from Refugee and Migrant Backgrounds

Barriers to Accessing Help for Young People from CALD Communities

Gohir, (2013) found that the reason why young people – aged between 16-18 years - from CALD communities do not disclose and access sexual harm support services include blackmail connected to shame and dishonour; emotional attachment; fear of violence; not being believed and getting into trouble; and not believing they are victims.

Shama (2019) reported that reasons for not seeking help for experiences of sexual violence included lack of culturally safe, aware and competent services; the risk of revictimizing young people by not responding appropriately; language barriers; lack of confidentiality with the professional interpreters; and lack of understanding of ethnic groups.

Strategies for Enhancing Access for Young People from CALD Communities

Young people from CALD Communities

- Work collaboratively with a range of culturally and linguistically diverse communities, including providing information. These communities can help with understanding the cultural norms that affect the young person's and their family's perception of sexual harm (Weeks, 2001)

- Use the preferred language of the young person and engage professional interpreters (Fontes & Tishelman, 2016)

- Provide workforce development in cultural and religious needs

- Recruit people from CALD communities

• Develop appropriate resources in different languages • Apply a trauma-informed approach which includes using strengths-based style to promote healing; create an inclusive environment; promote trusting relationships; ask for permission to discuss the sexual harm incident; recognise the impact of the trauma on the developing brain; utilise a two-generation approach to intervention as caregivers can be a protective factor; advocate (Miller et al., 2019).	

Evidence-based crisis services for young people who have experienced sexual harm

Introduction

Beres (2017) notes that there are very few crisis sexual support services for young people in New Zealand. Currently when young people disclose a sexual harm incident to a service it is likely that this service will mainly focus on adults or provide a broad range of services for young people.

Klugman et al., (2014) stated that crisis sexual assault services that support young people who have experienced sexual harm should in the first instance (within 72 hours) facilitate their access to the following services:

- Medical services that provide pregnancy screening and emergency contraception; contraceptive counselling and services; STI testing and post-exposure prophylaxis; and medical treatment for injuries.
- Psychosocial counselling and social work support
- Referral to legal redress.

Gavril et al., (2012) and others (Breslau, 2009) argue that follow up after the initial support should occur within 1-2 weeks. This follow-up service should provide an assessment of the young person's mental health functioning (as they are at high risk of PTSD and other post-

trauma disorders), referrals to counselling and appropriate referrals to social services as needed. Khadr et al., (2018) urged sexual assault services to provide holistic support for young people addressing such needs as deprivation, special education needs and psychiatric comorbidity.

Backe (2018) wrote that key roles for a crisis sexual harm service should be crisis intervention (disclosure, assistance with services, navigating police reporting, medical checks, brief tele-counselling), short-term counselling and community education.

The evidence suggests that providing first-line services to young people who have been sexually harmed need to be both adolescent-centred and gender sensitive (Campbell et al., 2013; Funston, 2013; Jones et al., 2010; Backe, 2018). Analysis of over 22 studies elucidated some common needs noted by young people and their families following an incident of sexual harm. These needs included:

- Providing age-appropriate information, explanation and timely support about what interventions will be offered to them, whether the sexual harm needs to be reported to the relevant care and protection agency etc. (Campbell et al., 2013; Collings, 2011; Davies & Seymour, 2001; Davies et al., 2001; Du Mont et al., 2016; Jones et al., (2007)

- Inquiring about the young person's worries or concerns and needs, and answering all questions 19

- Taking actions to enhance the young person's safety and minimize harms, including those of disclosure and the likelihood of the harm continuing, where possible

- Attending to them in a timely way and in accordance with the young person's needs and wishes (e.g., triaging where necessary to avoid long waiting times, but without rushing them) (Davies et al., 2001; Du Mont et al., 2016, 2014; Rohrs, 2011; Wangamati et al., 2016; Watkeys et al., 2008)

- Prioritizing immediate medical needs and first-line support

- Providing emotional and practical support (such as encouraging good sleep hygiene, nutritious eating, regular exercise and engaging with support system) by facilitating access to psychosocial support (including referrals to counselling, social services, child protection services, police and legal services if appropriate) for the young

person and their non-offending caregivers (Copeland et al., 2003; Campbell et al., 2013; Denis et al., 2016; Du Mont et al., 2016; Jones et al., 2010; Rosenthal et al., 2003; Runyn et al., 2014; Wangamati et al., 2016)

- Privacy (including visual and auditory privacy) and confidentiality (Du Mont et al., 2014; Rohrs, 2011; Wangamati et al., 2016)

- Making the environment and manner in which care is being provided appropriate to age, as well as sensitive to the needs of those who might face discrimination

- Appreciating the young person's autonomy (Campbell et al., 2013; Collings, 2011; Davies et al., 2001; Du Mont et al., 2016; Wangamati et al., 2016)

- Non-judgemental responses that demonstrate to the young person that they are believed and are not blamed for the sexual harm (Campbell et al., 2013; Collings, 2011; Du Mont et al., 2016; Jones et al., 2010)

- Acting in the best interests of the young person

- Active, respectful listening to the information provided by the young person

- Prioritising the assessment of medical and psychological needs

- Operating in a youth-friendly environment (Jones et al., 2007)

- Engage care givers to provide support to young people by empowering them with information to understand possible symptoms and/or behaviours that the young person may show in the coming days and months and when to seek further help (Broaddus-Shea et al., 2019).

For adolescents who have experienced sexual harm such psychological first aid should be offered for at least one month after the incident.

Given that previous research has shown that young people are disproportionately affected by sexual harm, especially those with pre-existing vulnerabilities, [27] a holistic and

[27] Pre-existing vulnerabilities could include disability, socioeconomic disadvantage, mental health issues

comprehensive package of support may well be required (Khadr et al., 2011; Holmes & Sher, 2013; Vesina & Herbert, 2007). Moreover, establishing and maintaining links between crisis sexual assault service for youth and youth mental health services is likely to be advantageous. For example, studies have found an association between pre-existing psychopathology, not accessing social support and low social support and higher likelihood of psychiatric disorders following sexual harm (Darves-Bornoz et al., 1998; Khadr et al., 2018)

Early intervention [28]

Early intervention with young people who have experienced sexual harm can decrease the likelihood of post-traumatic disorders and can reduce the distress experienced by them during the days and weeks following the incident (Berkowitz et al., 2011; Denson et al., 2007; Kassam-Adams & Winston, 2004; Blanco et al., 2015; Ko et al., 2008; Veenema et al., 2015).

Early intervention programmes often include:

- Elements of cognitive-behavioural therapy (e.g., trauma narrative, some kind of exposure, training in coping skills)
- Involve the caregiver
- Psychoeducation (e.g., likely outcomes of trauma; use of effective coping skills; how to decide whether further support is needed and where to find that support)

Despite the usefulness of early intervention there are very few models available to address the trauma of sexual harm. Moreover, there is not a strong evidence base available on early interventions with young people (Kramer & Landolt, 2011). Those that appear in the literature include:

- Psychological First Aid
- The Child and Family Traumatic Stress Intervention
- Crisis Intervention
- Trauma-Focused Cognitive Behavioural Therapy
- Integrated Treatment of Complex Trauma for Adolescents
- Adjunct Trauma Treatments
- Preventative Programmes

[28] A review of evidence-based longer-term interventions for young people can be found in Landolt & Kenardy (2015) Evidence-Based Treatments for Children and Adolescents in Schnyder, U. & Cloitre, M. (eds.) *Evidence-based Treatments for Trauma-related Psychological Disorders: A Practical Guide for Clinicians.* Switzerland: Springer International Publishing.

- Group Programmes

Psychological First Aid

Providers of a crisis sexual assault service should apply psychological first aid (PFA) with young people who have experienced sexual harm. The literature states that applying PFA within the first days and weeks of the sexual assault is important. This is because youth are especially vulnerable since the trauma can disrupt their developmental trajectories and/or they may remain silent to protect their caregivers from worry (Cieslak & Henretig, 2003; Pynoos & Nader, 1988; Silverman & La Greca, 2002; McDermott & Plamer, 1999; Schonfeld, 2002). Moreover, Kar (2009:1) commented that without PFA young people are vulnerable to experiencing *acute stress reactions, adjustment disorders, depression, panic disorder and PTSD.*

Raphael (1986) maintains that providing Psychological First Aid achieves the following purposes:

- Increased adaptive functioning
- Increasing self-efficacy / control
- Facilitating access to longer-term support
- Facilitating social reintegration

Psychological First Aid is a structured way of helping that seeks to support short- and long-term adaptive functioning. It includes a number of actions including:

- **Contact and engagement**: To respond to contacts initiated by the young person, or to initiate contacts in a non-intrusive, compassionate, and helpful manner. Frank & Frank (1998) advise workers not to argue, not to confront and to find something to agree upon.
- **Safety and comfort**: To enhance immediate and ongoing safety, and provide physical and emotional comfort
- **Stabilisation**: To calm and orient emotionally overwhelmed or disoriented young people.
- **Information gathering**: To identify immediate needs and concerns (e.g., medical needs, food, water, shelter, etc.), gather additional information, and tailor Psychological First Aid interventions. Everly and Flynn (2006) have suggested a number of interventions that could be used: Empathetic listening; stress management techniques such as cognitive reframing, problem solving, suggestions concerning

interpersonal support; reassurance to reduce anxiety; and providing psychosocial information to aid normalising and to foster resilience and self-efficacy.

- **Practical assistance**: To offer practical help to young people in addressing immediate needs and concerns.
- **Connection with Social Supports:** To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources.
- **Information on coping supports**: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning
- **Linkage to collaborative services**: To link young people with available services needed at the time or in the future.

Ruzek et al., (2007) have integrated available research about working with youth in a crisis situation into guidance for delivering PFA. In particular, these authors maintain that providing support to the young person's care givers is one of the most effective ways of helping to alleviate their distress (Norris, Friedman & Watson, 2002; Pynoos & Nader, 1988). For example,

- Providing them with strategies to keep the young person safe, such as keeping them near calm adults and peers.
- Focus gaining information about the development impacts the sexual harm experience has on the young person, such as performance at school
- Providing information on coping, such as how post-traumatic reactions manifest themselves in the young person's behaviour and how to respond to such behaviours

While Ruzek et al., (2007) stated that delivering PFA to the young person's caregivers is a priority, talking to young people directly is also regarded as respectful of their efforts to progress towards independence. Using developmentally appropriate language, discussing ways in which to seek help and ways in which to discuss feelings and needs are some of the strategies suggested for use by the PFA worker.

While there is little outcome data regarding the effectiveness of PFA those who have received it find it useful and would recommend it to others (Hambrick et al., 2013; Dieltjens et al., 2014).

Child and family traumatic stress intervention

The youth and family traumatic stress intervention is an evidenced based programme designed for implementation between crisis intervention and longer-term counselling for sexual harm. The target group is young people aged between 7 and 18 years and is facilitated over five sessions involving:

- Holding separate meetings with the young person and their caregiver to gather information about the traumatic stress as well as providing information about the effects of trauma and common traumatic stress symptoms

- Holding a joint session with the young person and their caregiver to compare their individual understandings about the young person's post-traumatic experiences. This provides an opportunity to clarify for the young person and their caregiver that the behaviours identified are traumatic stress symptoms.

- Further joint sessions work on highlighting the benefits of communicating; acknowledging existing strengths in the support provided; and highlighting the way in which the shared understanding about the traumatic stress symptoms enhances the connection between the family members (Berkowitz et al., 2011).

The sessions partially focus on helping the caregiver to manage their distress. This is important because exposure to their parents' stress and upset can result in negative post-traumatic experiences and impact the young person's healing process (Elliott & Carnes, 2001). Increasing the support of families following a young person's sexual harm is a primary goal of child and family traumatic stress interventions. Previous research has shown that such support helps the young person's emotional and behavioural adjustment follow a traumatic experience (Caffo & Belaise, 2005; Elliot & Carnes, 2001; Fjermestad et al., 2009; Tyler, 2002).

Two strategies for working with caregivers achieve more positive outcomes for the young person. First, increase the communication between the caregiver and the young person about the traumatic stress symptoms and provide them with the tools to cope with such symptoms. Second, provide help with external stressors that might impede the families' engagement with the intervention. In the short-term it reduces feelings of helplessness and loss of control. In the medium term the intervention has reduced PTSD symptoms and anxiety as well as PTSD diagnoses (Berkowitz et al., 2011).

Crisis Intervention

The responses that young people and their caregivers receive from a crisis intervention service can play an important role in their recovery (Danielson & Holmes, 2004). The crisis phase for young people and their families begins at the disclosure of the sexual harm incident and will continue and intensify through the investigative and litigation process if crisis support is not provided. McCubbin and McCubbin (1987) stated that crisis develop when a young person and their family discover that it does not have the ability to cope effectively with certain life situations. Haugaard & Reppucci (1988) stated that few families or young people who are faced with sexual harm have ever had to resolve a situation with similar emotional and legal consequences. Most people, therefore, would not have developed coping strategies that can be used when the sexual harm is revealed.

Gomes-Schwartz et al. (1988) found that the greater the delay between the time young people and their families were referred to a crisis intervention and the time they received treatment, the less likely they were to benefit from the intervention.

Crisis intervention seeks to mitigate the social and psychological effects of the sexual harm. Crisis intervention strategies include restoring the young person's sense of equilibrium, providing information and providing coping strategies (Centre for School Mental Health Assistance, 2002). This involves connecting the young person to a trusted person to provide safety; to return the young person to the present, such as returning to daily routines; to encourage emotional expression, such as reflecting their feelings; and help young people to understand what might happen next (Sandoval, 1985, 2000; Shaw, 2000).

A study of Sexual Assault Nurse Examiner (SANE) / Sexual Assault Response Team (SART) interventions [29] noted that crisis intervention services are often the first point of formal contact with young people after a sexual harm incident and that the provision of evidence-based practices, including manaakitanga, can provide *a safety net for teens* (Danielson & Holmes, 2004: 387). Campbell et al., (2011) found that providing a crisis service in a non-judgemental manner and with compassion increased the young person's willingness to tell their story. Moreover, being given options about whether or not to

[29] Sexual Assault Nurse Examiner (SANE) programmes are staffed by specially trained forensic nurses who provide 24-hours-a-day, first response crisis intervention and medical forensic exams for child, adolescent, and adult sexual assault/abuse victims (Department of Justice, 2004; Ledray, 1999). Second, many SANE programmes operate as part of Sexual Assault Response Teams (SART), which are multidisciplinary community efforts that bring together police officers, detectives, prosecutors, doctors, nurses/SANEs, victim advocates, and crisis intervention counselors to coordinate and improve the community-wide response to rape (Barkhurst et al., 2002; DOJ, 2004; Hutson, 2002; Littel, 2001).

participate in a medical examination and continue with the criminal justice process resulted in an increased engagement with these services.

Armsworth (1989) reported that young people who had experienced sexual harm rated highly the crisis help they received and found that validation of the incident, advocacy, empathetic understanding, and the absence of contempt were the most helpful attributes.

Trauma-Focused Cognitive Behavioural Therapy

Saywitz et al., (2000) noted that trauma-focused cognitive behavioural therapy has proved useful to young people who have experienced sexual harm. Weiner et al., (2009) and others (Deblinger et al., 2011) have advised that this is the strongest treatment model for young people who have experienced the trauma of sexual harm. A number of meta-analyses have provided evidence of the effectiveness of cognitive behavioural programmes to improve the psychosocial functioning of young people (Macdonald et al., 2012; Arellano et al., 2014).

The target group for trauma-focused cognitive behavioural therapy is 3–18-year-olds who have experienced sexual harm. It has been used effectively with a variety of ethnic groups.

Essential components of trauma-focused cognitive behavioural therapy comprise psychoeducation about trauma; a parenting component; relaxation skills; affective modulation skills; cognitive coping by connecting thoughts, feelings and behaviours; trauma narrative and processing; mastery of trauma reminders; and enhancing safety and the future developmental trajectory.

Such studies demonstrate a number of outcomes for young people including decreased PTSD symptoms, decreased anxiety, reduced depression, reduced feelings of embarrassment, improved interpersonal trust, improved social competence and reduced behavioural issues (Cohen et al., 2004; Cohen et al., 2005).

Integrative Treatment of Complex Trauma for Adolescents (ITCT)

ITCT is a developmentally appropriate and culturally adapted treatment for 12–21-year-olds. The intervention can include multiple modes for example, cognitive therapy, exposure therapy, mindfulness skill development, affect regulation, trigger management, relationships, and psychoeducation. The relationship with the worker is a crucial aspect of this intervention with safety and trust being necessary components.

Outcomes from this intervention include reduced anxiety, depression, anger, post-traumatic stress and dissociation (Briere & Lanktree, 2012; Lanktree & Briere, 2013).

Adjunctive Trauma Treatments

Edmond et al., (2020) noted that there is emerging evidence for the effectiveness of a range of adjunctive trauma treatments for young people who have experienced sexual harm. These treatments involve art and play therapy as well as approaches that make mind-body connections such as mindfulness, somatic experiencing and sensorimotor therapy.

Prevention Programmes

The National Sexual Violence Resource Centre (2014) stated that providing an opportunity for young people to understand healthy relationships, consent, boundaries and how to engage safely in sexual behaviours empowers young people to seek support when they need it. They argue that prevention programmes help young people to make informed decisions and recognise sexual harm and to seek help and support when it occurs.

In the United States of America, a number of sexual victimisation prevention programmes have been developed for high schools and tertiary institutions. Examples of such programmes include Men Can Stop Rape, Together Against Acquaintance Rape, The Safe Dates Programme and the Community Awareness Rape Education Programme. The American College of Obstetricians and Gynaecologists (2000) have identified a number of common factors about such programmes that might contribute to their effectiveness including:

- Comprehensive coverage of the subject matter
- Teaching methods are intensive, long-term and interactive
- Content is relevant to young people's lives
- Content includes information about healthy relationships
- Content includes what to do if a person has been sexually harmed.

Outcomes recorded from such programmes include increased clarity about defining sexual harm; increased knowledge about risk-reduction strategies and knowledge about where to seek help and support from service providers (Foshee et al., 2000; Wright, Akers & Rita, 2000).

Cocciolone et al., (nd) described ten Rape and Sexual Assault Prevention Education programmes facilitated in Michigan from 2003 to 2005. The target group was 13–18-year-olds who were attending middle and high school. The content of these programmes included sexual harassment, sexual assault, gender stereotypes, self-esteem, date rape drugs, dating violence, bullying, risk reduction/prevention, assertive responses, rape myths, healthy relationships and local resources. Outcomes reported included increased knowledge

of sexual assault resources and intolerance of sexual violence. Two of the programmes also measured behaviour change (e.g., before I go out with someone, I decide what I will and won't do).

Fontes et al., (2017) reports on a number of prevention programmes provided in schools. These authors maintain that such programmes are important because some young people may not have the support of their families and the school becomes their only source of safety and care. Outcomes reported from such programmes include less guilt and victimisation; increased disclosure; greater understanding about sexual violence and strategies to manage at-risk situations (Taal & Edelaar, 1997; MacMillan et al., 2009; Walsh et al., 2015; Finkelhor & Dunne, 2013)

Smothers and Smothers (2011) reported on findings from a preventative programme that not only targeted young people but also the systems (family/whānau, schools) that shape them. They used role plays as a way of immersing the young people in the content of the programme together with providing the programme over a longer period of time – both factors which contributed to its effectiveness. The outcomes reported from this programme included increase knowledge about self-protection and healthy relationships.

Prevention programmes for caregivers of young people have also been successful at giving them the skills to support their children after an incident of sexual harm (Herbert et al., 2002; Kenny, 2009; Self-Brown et al., 2008)

Group Programmes

Group therapy sessions have been found to be effective in reducing depression, anxiety and PTSD (Habigzang et al., 2009).

Effective Approaches to Working with Young People Who Have Experienced Sexual Harm

The literature describes a number of good practice approaches to working with young people. These approaches include:

- Young People- Centred
- Trauma-Informed
- Providing Familial and Peer Support

Young People Centred

Cascardi & Avery-Leaf (2003) advised that effective interventions for young people include those that they perceive are directly relevant to their own experiences. The literature described a number of young people-centred practices when working with youth who have experienced sexual harm. These included the worker:

- Building rapport with the young person by asking open-ended questions about themselves (Campbell et al., 2011). This rapport building facilitates the young person feeling comfortable to share information about the sexual harm incident (Ahern et al, 2014; Hershkowitz et al., 2006; Hershkowitz, 2009; Jones et al., 2010; Katz, 2015)

- Providing information about when it might be useful to seek support and information about available services (Jackson, 2002; Woodley et al., 2013). Moreover, WHO (2017) commented that information should be given to caregivers about possible behaviours displayed by the young person following the sexual harm so that they know when to seek further assistance.

- Offer services in a way that respects the young person's culture (Woodley et al., 2013)

- Offering clear age-appropriate information and explanation about what to expect during the initial response, the next steps and follow-up services provided (Campbell et al., 2011; Campbell et al., 2013; Collings, 2011; Davies & Seymour, 2001; Davies et al., 2001; Du Mont, Macdonald, Kosa, & Smith, 2016; Jones, Cross, Walsh, & Simone, 2007; WHO, 2017). Several studies have documented the distress experienced by a young person about not knowing what to expect following an incident of sexual harm. Moreover, these studies commented that young people liked full information so that they could exercise choice and control about what happened to them (Marks et al., 2009; Collings, 2011; Davies et al., 2001; Wangamati et al., 2016; Eruera & Dobbs, 2010; Jackson, 2002; Woodley et al., 2013).

- Offering timely support without long wait times (Davies et al., 2001; Du Mont et al., 2016, 2014; Ro¨hrs, 2011; Wangamati et al., 2016; Watkeys, Price, Upton, & Maddocks, 2008; WHO, 2017)

- Offering explanations about confidentiality and privacy (Du Mont et al., 2014; Ro¨hrs, 2011; Wangamati et al., 2016; Jackson, 2002; Woodley et al., 2013; Eruera & Dobbs, 2010)

- Respect for young person's autonomy and wants, including no pressure to disclose information or undergo procedures (Campbell et al., 2013; Collings, 2011; Davies et al., 2001; Du Mont et al., 2016; Wangamati et al., 2016; WHO, 2017)

- Non-judgemental responses that indicate that the young person is believed, that the sexual harm is not their fault and that they have acted appropriately in disclosing it. Several studies reported the importance of not placing any blame on the young person, particularly if they stated that alcohol and drug use preceded the incidence of sexual harm (Campbell et al., 2011; Campbell et al., 2013; Collings, 2011; Crawford-Jakubiak et al., 2017; Du Mont et al., 2016; Jones et al., 2010; WHO, 2017)

- Responses that prioritise the young person's safety and minimise harm (Collings, 2011; Palusci, Cox, Shatz, & Schultze, 2006; WHO, 2017)

- Active and respectful listening to the information that the young person wants to share (Campbell et al., 2013; Du Mont et al., 2016; Jones et al., 2010; WHO, 2017)

- Being patient and providing the young person with choices (Campbell et al., 2011). Given that the young person is growing their autonomy and the lack of control that often accompanies an experience of sexual harm, Sutton and Dixon (1986) state that the young person may resist help. Lundquist and Hansen (1998) advised workers to be empathetic, involve the young person in the selection of goals and actions, advocate for the young person and involve the young person's system of support (e.g., school counsellors).

- Psychosocial support for both the young person and their caregiver as well as minimising the need to go to multiple different locations for assistance (Campbell et al., 2013; Du Mont et al., 2016; Jones et al., 2010; Rosenthal, Feiring, & Taska, 2003; WHO, 2017)

- Resources for the caregiver that ensure that they have the capability to support the young person emotionally (Campbell et al., 2013; Du Mont et al., 2016; Runyon, Spandorfer, & Schroeder, 2014; Sowmya, Seshadri, Srinath, Girimaji, & Sagar, 2016; Wangamati et al., 2016; Woodley et al., 2013; Eruera, 2015)

- A youth-friendly environment – an environment in which young people congregate and which is accessible by public transport and accessible using technology (Jones et al., 2010; Beres, 2017; WHO, 2017). For example, Crawford-Jakubiak et al., (2017) reported that providing such environments encourages the young person to describe a clear history of what happened, access medical services and engage in counselling.

  Moreover, a study undertaken by Krause-Parello and Friedmann (2014) found that young people found having therapy dogs in the office helped to reduce their stress.

- Inquiring and assessment of psychosocial concerns and needs of the young person (including those unrelated to the sexual harm), answering any questions and prioritise the interventions (Denis et al., 2016; Girardet et al., 2006; Ro¨hrs, 2011; Sowmya et al., 2016; WHO, 2017)

Trauma-informed

In designing a sexual support service for young people, it is important to minimise the risk of re-traumatisation (Knight, 2015). Introducing trauma-informed practice is one way of countering this risk (Azeem et al., 2011; Chandler, 2008; Domino et al., 2006; Gatz et al., 2007; Greenwald et al., 2012; Messina et al., 2014; Morrissey et al., 2005; Weissbecker and Clark, 2007).

Elements of a trauma-Informed service Source: adapted from Sweeney et al., 2016		
	Operationalising elements	**Experience of young person**
Recognition of trauma	• Recognise the signs & impact of trauma • To avoid re-traumatising the young person, sensitively ask	Feeling validated, safe and hopeful

	them if any trauma has happened to them	
Avoid re-traumatising	• Practices and power differentials between the worker & the young person can result in re-traumatising both (i.e., workers suffering secondary trauma) • Be transparent	Feeling in control
Cultural, historical & gender contexts	• Acknowledge the trauma of colonialism • Culturally and gender appropriate services • Recognise individual identities	Unique identity recognised
Trustworthy and transparent	• Being transparent about what you are doing and why	They do what they say they will do
Collaboration & mutuality	• Understand the power imbalance between staff and survivors • All relationships based on mutuality, respect, trust, connection and hope.	Hope that through the worker/young person relationship healing can begin
Empowerment, choice and control	• Use strengths-based approaches • Support young person to take control of their	Young person feels empowered

	lives and develop self-advocacy	
Safety	• Create a work environment that is physically, psychologically, socially, morally and culturally safe	Young person feels physically, emotionally and socially safe
Partner with young person	• Co-design services • Peer support programmes are introduced	Young person feels the mutuality in relationships
Pathways to services based on trauma models	• Develop relationships with evidence based, trauma-specific services	Young person feels confident about being referred to services

Studies have shown that working with young people in a trauma-informed manner can reduce post-traumatic stress symptoms and general mental health symptoms, increase coping skills, improve physical health, improved engagement and retention in service interventions.

Familial and Peer Support

Since a number of studies have found that a high percentage of young people who experience sexual harm are likely to disclose to peers, having their support is a factor contributing to positive outcomes (Priebe & Svedin, 2008). Nelis and Rae (2009) found that young people with a secure attachment to their peers were less likely to be depressed and anxious.

Campbell et al. (2011) found that young people generally disclose their experience of sexual harm to their peers, then to an adult (mostly their mothers) and then to the system of response (e.g., sexual violence sector, including Police, medical assistance and sexual help support agencies). These researchers stated that making decisions about when, how and to whom they disclose is important to maintaining their control over their situation – a factor

which not only characterises their developmental stage when they are wanting independence and autonomy, but also in the context of their 'loss of control' during the sexual harm.

Elliot and Carnes (2001) and other researchers have found that supportive parents have a positive influence on the short- and long-term outcomes of young people who experience sexual harm (Lovett, 2004; Rosenthal et al., 2003; Norris et al., 2002; Hecht & Hansen, 1999; Pynoos & Nadar, 1988). This support can involve 'not taking over.' Rather providing the time and space for the adolescent to make their own decisions about, for example, whether to report the sexual harm to the Police. Ruzek et al., (2007) have found a number of strategies that help caregivers support their young person. Such strategies included making sure that people near the young person are calm, providing emotional stabilisation, providing practical aid to families and providing information about the way in which trauma impacts on young people. In a twelve-month follow up study undertaken by Rosenthal et al., (2003) found that young people who had supportive parents experienced less depression and higher self-esteem.

Positive relationships with siblings can also have a positive impact on outcomes for youth who experience sexual harm. A metanalysis undertaken in 2013 found that having supportive siblings is linked to having less internalised and externalised behaviour problems (Buist et al., 2013). These authors argue that such supportive relationships promote emotional regulation strategies.

Infrastructure Requirements

The literature provides some guidance about the infrastructure requirements for providing services to young people who have experienced sexual harm. This guidance included:

- Principles Underpinning the Service
- Delivery of High-Quality Services
- Effective Systems and Governance

Principles Underpinning the Service

Campbell et al., (2013) and others (Funston, 2013; Jones et al., 2010) have noted the values and preferences of young people who receive sexual harm services. These preference and values include providing information, explanation and timely support; respecting confidentiality and privacy; respecting the autonomy and wishes of the young person; receiving a non-judgemental and validating response that communicated belief in the young

person's account; acting in the best interests of the young person; careful and respectful listening of the young person's and their caregivers' accounts; prioritizing assessment of medical and psychological needs and support; and providing a youth-friendly environment. In addition, to drawing on feedback from young people about what they value about sexual harm services, Allnock et al., (2009) makes reference to Article 39 of the United Nations Convention on the Rights of the Child (1989) guided the development of principles that should underpin the provision of services for young people who experience sexual harm.

The WHO (2017) identified a number of principles including:

- **Best Interests of the young person** including provider actions to provide safety, offer non-judgemental and empathetic responses to disclosure, and promote the confidentiality of information (e.g., storing securely, informing the young person if there are obligations to report to the care and protection agency) and privacy in the delivering services and supports.
- **Evolving capacity of the young person** to make decisions about the support they will receive depending on their age and developmental stage. This involves providers of sexual harm services to provide information that is tailored to the young person's age, ethnicity, sexual orientation, disability and socio-economic status using appropriate language. Moreover, they must, in most cases, seek the consent of the young person regarding decisions and actions taken regardless of the legal age of consent; respect the autonomy to give information and receive services; and be offered choices.
- **Non-discrimination** in which providers need to take into account the inequalities that can impact some groups (i.e., indigenous peoples; disability; LGBTI; culturally and linguistically diverse groups) access to services
- **Participation** in which providers need to provide the opportunity for young people to have input into the decisions that affect them as well as participate in the design and implementation of services that they are involved in (WHO, 2017).

Huriwai and Baker (2016) stated that core Māori principles and values are universally applicable to the care, support and respect of young people who have experienced sexual harm. Moreover, they advocated for the use of Māori models of care and principles when delivering a service for young people. [30]The principles underpinning a Kaupapa Māori approach to delivering a sexual harm service include:

[30] The Maori models of care noted included Te Whare Tapa Whā (Durie, 1994); Te Wheke (Pere, 2014); and Tihei-wā Mauri Ora (Piripi & Body, 2010).

- **Tino Rangatiratanga:** The principle of self-determination which allows Māori to make decisions about their aspirations for their lives
- **Taonga Tuku Iho:** A principle that considers Māori ways of knowing, doing and understanding the world are valid in their own right
- **Kia piki ake i ngā raruraru o te kainga:** This principle asserts the need to assist in the alleviation of disadvantages experienced by Māori communities.
- **Whānau:** This principle is at the core of Kaupapa Māori. It acknowledges the relationships that Māori have to one another and to the world around them. Whānau, and the process of whakawhanaungatanga are key elements of Māori society and culture.
- **Kaupapa:** This principle refers to the collective vision, aspiration and purpose of Māori communities.
- **Manaakitanga:** Hospitality and caring for others through aroha, respect and sharing of food.
- **Wairuatanga:** The belief that there is a spiritual dimension to people's lives often expressed through their connection with their maunga (mountain), their awa (river), their marae and their tūpuna (ancestors).
- **Whakapapa:** Family tree.
- **Ata:** This principle relates to the building and nurturing of relationships
- **Te Tiriti o Waitangi:** This principle defines the relationship between Māori and the Crown in New Zealand. It affirms both the tangata whenua status of whānau, hapū and iwi in New Zealand, and their rights of citizenship (Pihama, 2001; Pōhatu, 2005).

Delivery of High-Quality Services

Trauma-informed organisation

Treisman (2017) wrote 'moving towards becoming more trauma-informed and trauma responsive provides an organisation with a lens, a framework, a guide and a language to consider and reflect on their purpose, principles, mission, vision, values, practices … This creates a sense of identity, meaning and connection. [31]

Lane et al., (2011) proposed building a trauma-informed organisation with reference to a number of principles including:

[31] Source: Adversity, Culturally, Trauma-Informed, Infused, & Responsive Organisations & Systems | Safe Hands Thinking Minds

- Understanding trauma by taking the perspective of young people who have been traumatised in designing and implementing such services
- Safety and autonomy in which the young person has the autonomy and control to make informed choices. This principle also includes providing an emotionally safe environment in which the young person is free to express themselves.
- Hospitality and inclusiveness in which the young person feels welcomed and respected. The organisation embraces the diversity of ways that people find it meaningful to engage with the services. It also addresses the power dynamics that may exist between the young person and the provider of services. It does this by forming relationships that are mutual so as to minimise the possibility of retraumatising the young person.
- Accessible in the broadest sense, for example, creating an accessible physical and people environment

According to SAMHSA (2014) an agency that is trauma informed:

- Realises the widespread impact of trauma and understands potential paths for recovery
- Recognises the signs and symptoms of trauma in young people, their families and employees
- Resists re-traumatisation
- Responds by fully integrating knowledge about trauma into policies, procedures and practices

Hales et al. (2019) found that applying the trauma-informed principles (safety, trustworthiness, peer support, collaboration, empowerment and responsiveness or cultural considerations) improved employee satisfaction, safety and transparency within the organisations and brough positive changes to policies, procedures and practices (SAMHSA, 2014).

Culturally Competent Agency

If a crisis sexual harm support service agency delivers a youth centred response and contribute to the healing of young people, it must display a commitment to integrating cultural competence into its policies and procedures, its written materials and any evaluation of its services. The Wisconsin Coalition Against Sexual Violence (2011) provide some examples of such organisational cultural competence. These examples included using the young person's language, providing professional interpreters and having a zero tolerance for discrimination.

Olavarria et al., (2009) noted that the main goal of a culturally competent organisation was to tailor its services to resonate with the perspective of each young person, so that they may be served effectively. They define a culture of diversity as embracing race, ethnicity, language, cultural practices, religious beliefs, values, gender, sexuality, age, ability, socioeconomic status, political views, geographic location, lifestyle and living conditions.

Suarez-Balcazar, et al.'s (2011) model of a culturally competent agency described three necessary factors: (1) developing cultural awareness/knowledge of differences, specific practices, people's experiences of oppression and marginalisation, discrimination, and becoming aware of one's own cultural biases. (2) developing the cultural skills in professional practice to modify, adapt and improve service delivery. (3) organisational context/support for multicultural practice and the demonstrated commitment to developing cultural competency across the organisation.

Shama (2019) suggested some principles to underpin a new service that supports young people who have experienced sexual harm and who are from a range of ethnic communities. These principles include respect for cultural and ethnic diversity; client driven; holistic, professional and innovative; advocating for change; safety is paramount; and community grounded.

The National Standards of Practice for Services Against Sexual Violence (2015) described two main best practice elements for a culturally competent service:

- Has a comprehensive and integrated framework to improve its cultural competency at all levels including: a continual process of research, engagement, learning, planning, action, reflection, and evaluation
- Seeks the input of diverse cultural groups to its planning and evaluation.

Integrated Service Delivery [32]

Wharewera-Mika and McPhillips (2016) have identified that providing a wraparound service requires a youth sexual harm crisis support service to have collaborative relationships with a range of providers of psychosocial services as well as those working within the Health and Criminal Justice Systems. For the young person this means that they build a trusting relationship with one person who provides support throughout their journey of healing.

[32] Ministry of Social Development (2017) discussed integration within and across services. The across services response involved the whole-of-system integration (i.e., prevention, early intervention, crisis response and long-term recovery) as well as an appropriate cross-sector response to sexual violence.

Appropriate Staffing

As a specialist response to young people who have experienced sexual harm, the National Association of Services Against Sexual Violence (NASASV) (2015) maintained that the workforce needed to be tertiary qualified, have at least 3 years counselling experience and be registered with a professional association.

A 2017 Ministry of Social Development Service Development Consultation report and others (Woody & Beldin, 2012) outlined the skills, knowledge and attributes required for the sexual harm workforce. These competencies included empowering, approachable, self-aware, empathetic, non-judgemental, knowledge of trauma and its affects, a team player and an ability to function in an integrative manner across sector and across discipline, and to engage with others in a culturally safe way (i.e., recognise their own culture and how that affects the young people with whom they are working. Additionally, the Family Violence, Sexual Violence and within Whanau Workforce Capability Framework [33] specifies that workers need to follow legislative requirements (e.g., requirements of the Oranga Tamariki Act, the Privacy Act, the Health and Safety Act, etc.); follow indigenous models of practice; and an ability to work with young people from culturally and linguistically diverse communities.

Similarly, to Sweeney and Taggart (2018) the 2017 Ministry of Social Development report recognised the importance of empathetic relational practice. Relational practice involves respectful, compassionate, and authentically interested inquiry into the experiences of a young person. Sweeney and Taggart (2018) noted that engaging young people so that they receive support from a crisis support service may be challenging (e.g., rejecting help) – a symptom of the underlying trauma – and Khadr et al., (2018) noted that workers needed expertise in supporting young people with high levels of complexity and vulnerability. To facilitate the helping relationship, patience is needed so that the young person can build trust which is a key element of trauma work (Sweeney and Taggart, 2018).

[33] Source: Workforce Capability Framework | New Zealand Ministry of Justice

Location

There are a variety of places to house a crisis sexual harm support service including in a general practice or health centre, in a neighbourhood house, in a school, in a multi-agency complex, in a youth centre or in an outreach facility (WHO, 2002). [34]

Grefe (2011) maintained that a crisis sexual harm support service for young people should be located within a school environment where they are every day and where the school psychologist engages and retains the young person in receiving support. However, Winnard et al., (2005) noted that not all young people attend school. In their study Woodley et al., (2013) found that young people agreed that an ideal physical location for school students would be at a school and for those not at school, a youth centre was the preferred option. The Māori students in their study were less sure about locating a service within a school setting because of confidentiality issues, but were inclined to favour a youth-focused facility or a whānau house.

Skype or internet-based services were preferred by many of the respondents in Woodley et al's., (2013) study, particularly by the students who identified as Chinese and Korean.

The Ministry of Health and Communio (2009) found that young people prefer to access help via a youth centre with multiple different services and recreational services because there was increased privacy.

Effective Systems and Governance

Wellbeing of Sexual Harm Workers

Good practice in the literature suggests that one of the most important elements of a sexual harm support services infrastructure is to take care of the agency's staff.

Esaki & Larkin (2013) found that levels of trauma are higher among staff in the sexual violence sector. [35] Hindle and Morgan (2006) stated that the emotional impact of working with people who have experienced sexual harm can negatively affect the workers' relationships with family and friends. In light of these observations organisations delivering

[34] Woodley et al., (2013) found that the students in their study did not support locating a sexual harm support service within a general practice because they mostly visited such venues with their families.

[35] This experienced of trauma is known as vicarious trauma. Pearlman and Saakvitae (1995) define vicarious trauma as the emotional residue experienced by sexual harm workers as a result of hearing trauma survivors' stories. This emotional residue might be experienced by the worker in various ways including intrusive reactions such as experiencing nightmares; avoidance reactions such as being numb to clients' trauma; and hyperarousal reactions such as difficulty concentrating

sexual harm services have a responsibility to protect the psychological as well as the physical safety of their employees by providing a supportive work environment and putting in place appropriate policies and procedures.

Sexual harm organisations can put in place a number of strategies to counter the emotional and traumatic risk associated with this type of work. First, Wasco and Campbell (2002) recommended that caseload management is one way to maintain the wellbeing of employees. This involves limiting the number of cases that each employee has, providing diversity within the clients (i.e., working with children, adolescents and adults), and working across multiple levels (i.e., community education, training, research and counselling).

Second, Bell et al., (2003) state that the organisation needs to provide both clinical and administrative supervision for each of its workers. They state that clinical supervision should be provided by a senior person with whom the worker can trust and speak openly about their worries and fears (Bernard & Goodyear, 1992; O'Donovan et al., 2011).

Third, Bell et al., (2003) recognise the importance of providing social support within the organisation. This support can take a number of forms including critical incident debriefing (a method of processing a traumatic event) with a peer; peer group case conferencing, clinical seminars or professional reading groups; and providing opportunities for social support among the members of the team.

Fourth, providing a level of homeliness and comfort within the work environment by encouraging employees to have personally meaningful items in their offices and by providing a comfortable break room (Pearlman and Saakvitae, 1995; Bell et al., 2004).

Fifth, in order to work safely and sustainably employees need to engage in reflective practice (particularly in relation to their own relationship to interpersonal trauma) and on-going professional development (Taggart, 2018). WHO (2017) state that such training needs to focus on assessment and providing adolescent-centred support as well as on countering gender inequality, stigmatising young people based on their sexual orientation or gender identity or blaming the young person. Bober and Regehr (2006) maintained that training improves the employees' feelings of effectiveness and may reduce the likelihood of burnout and vicarious trauma.

Last, providing a workplace culture that encourages employees to take care of themselves by making self-care as part of the agency's mission; by educating them about protective factors to counter vicarious trauma; by encouraging flexible working hours; actively involving employee in providing suggestions about ways in which to provide a supportive environment

and decisions affecting staff; and discussing positive aspects of the work such as celebrating achievements with clients (Wasco & Campbell, 2002).

Governance

Bradfield and Nyland (2002) argued that any organisation that is delivering a sexual harm crisis support service for youth needs to have a structure and systems that deliver on the stated principles and purpose for the service. This included:

- Having sufficient policies and practices focused on delivering a quality service for young people
- Having risk management strategies in place to facilitate the wellbeing, health and safety of its staff
- Having transparent communication systems
- Having lines of accountability clearly articulated
- Being responsive to relevant legislation and codes of professional practice
- Ensuring that all staff have the resources and support to carry out their roles

Evaluation

For the management of the sexual harm crisis support service to remain sustainable and appropriate the necessary resources needed to support the service an evidence base needs to be gathered about the impact of the service on the young people it provides services with and their family/whānau. Klein (2000) stated that data needs to be collected that informs stakeholders about whether the service is reaching the target group, about the quality of the service and the outcomes achieved. Gavin (2004) states that youth self-report is a moderate or highly sensitive and specific measure and should be used to assist with quality improvement.

The New Zealand Ministry of Social Development (2021) advised providers of sexual harm crisis support services to develop a monitoring framework that aligns with their Results Measurement Framework. The data collected answers three questions: How much? How well? and Is anyone better off? [36]

[36] This document includes a client feedback form which was supplied by Catherine Buckley, Bay of Plenty Sexual Assault Support Service.

Other infrastructure requirements

The evidence in the literature suggests a number of strategies that organisations can put in place to facilitate an enabling and supportive environment for employees who work with young people who have experienced sexual harm and the clients they work with.

- Adequate staffing and adequate resources, including funding, to ensure timely provision of services
- Providing clinical specialists to provide advice and prevent professional isolation – strategies known to prevent burnout and support vicarious trauma
- Establish multidisciplinary team to enhance coordination
- Establish a policy and procedure for managing reports of concern
- Providing support for caregivers to prevent burnout
- Develop monitoring tools to collect outcome data (Cangwa & Pather, 2008; Funston, 2013; Greaney & Ryan, 1998; Bechtel et al., 2008; Edinburgh et al., 2008)

Sustainability: Understanding the Success Factors

Heady, Kail and Yeowart (2011:3) define sustainability as *the extent to which 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

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 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.

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. [37]

[37] 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

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 evaluation; and, ensuring that the annual budget is tied to outcomes (Centre for Substance Abuse Treatment, 2008).

Sustained Workforce

Hellman and House (2010) argue that the sustainability of the sexual harm 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

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).

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 harm sector.

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 harm crisis 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. [38]

[38] 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.

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).

Demonstrating Results and Sustainability

Demonstrating results is another key element in service sustainability (Goodman & Steckler, 1989; Mancini & Marek, 2004; New Philanthropy Capital, 2011).

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 harmed, 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 harm and trauma intervention literature. Moreover, these authors suggest that sexual harm crisis 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 harm crisis services that positively contribute to outcomes sought.

Part Four: Qualitative Findings

Psychosocial needs of young people who experience sexual harm

The respondents were asked to describe the presenting psychosocial needs of young people who had experienced sexual harm. Most importantly, they emphasised that each young person's response to sexual harm is individualised and depends on their previous experience and their current development level. These varying responses resulted in differing presenting needs.

> *All incidents have meaning and dynamics around that person so needs are based on a case-by-case basis. Raped at party … have secure attachment, good relationships, good sense of self … freaked out but reach out for support because got good messages that reinforced sense of self as a good person that something shitty happened to. Reach out as not ashamed, access support quickly; had an intense experience but have anchors that are healthy.*
>
> *Same scenario but have healthy dose of shame, attachment issues, peer group who says it's your fault, stoned or pissed at the time, self-blame … quite different needs* (professional respondent).

Moreover, the respondents advised that as a result of *every area of life* (being) *affected by sexual harm (job, no money, drugs and alcohol, relationships*) that a holistic assessment of need be undertaken. Moreover, some respondents stated that often a *range of other things are happening in an adolescent's life that need attention* as well as the needs arising from the experience of sexual harm.

> *… crisis support to deal with things other than sexual violence … join up the dots* (professional respondent)
>
> *At times victims use porn as a way of trying to understand their abuse experience … sometimes victims harming others as a way of trying to process and understand their abuse experience* (professional respondent)

The needs identified fell into a number of categories including physiological, safety, psychological, accompaniment, information and advocacy, trauma response and relationships. Of those noted, the needs associated with trauma response, information and advocacy and relationships were most frequently noted by the professional respondents.

Needs Identified by Professional Respondents	Professional Respondent Comments
Physiological needs such as accommodation, financial assistance, clothing	• *… poverty, housing* • *Access to supports …accommodation, basic needs* • *Not have any money to get to therapy, go to the Police … not know they can claim that back*
Safety needs	• *Protection … know how not to let it happen again … physically moving to a safe space or emotionally moving* • *Immediate safety … other young people in the house … make sure they are not exposed to the offender … liaise with the Police and OT* • *Ensure physical safety … system around the young person is as safe as possible*
Psychological needs such as anxiety, isolation, anger, self-harm and suicidality and PTSD	• *… disengage from school and friends … isolated* • *… meeting friends to overcome isolation*
Accompaniment needs, for example support at the medical / forensic examination and at interviews with the Police	• *… explaining the medical procedures and the Police process, not understand the justice system* • *Accompaniment to Cambridge Clinic …* • *Need to ensure that the person has the correct information and assistance about emergency contraception and STI … get a free sexual health assessment*
Information and advocacy needs	• *… make calls, fill out victim support forms …up to $500 to spend on petrol, accommodation, clothes* • *Contacting professional e.g., when haven't heard about the case from the*

	Police will ring the detective involved to get an update • *Needing guidance on what to do … help with moving accommodation … how to navigate being near perpetrator … practical things … connect with counsellors*
Trauma response experience as threat to life; shock; feelings of helplessness and out of control; self-blame;[39] not believed; judged [40]	• *Stabilisation … looking at what needs to be put in place to get things going in life … going back to school, keep friendships going, sleeping and eating well* • *… self-blame* • *… ashamed* • *Change of attitude in society … provide training and giving way more support to families.* • *Somatisation of physical symptoms being tied into the trauma loop. A medical lens can go on a physical hunt and overlook the message or the trauma that is presenting as physical symptoms.*

Assistance with relationships was another theme that featured frequently among the respondents. This theme included a range of scenarios including:

- Understanding what constitutes a relationship involving sexual harm

> *Sexual harm is prevalent with young people, so need to work on inappropriate relationships … violent relationships, controlling relationships, abusive relationships … and define what sexual harm is as a lot of them are not aware. Desperate need to engage them in programmes such as 'Loves Me Love Me Not' and health classes in schools where they learn about what a healthy relationship is … many miss out on attending these programmes* (professional respondent).
>
> .

[39] Hammerslough, J., (2014). Guilt, Self-Blame and Shame, in Katz, L. (Ed.) *Warrior Renew*. New York: Springer Publishing

[40] Baum, Cohen & Zhukov (2018) describe the effects of a rape culture on whether those who experience sexual harm are believed.

- Relationships where the sexual harm was intra-familial

> *Dynamics within the whānau … perpetrator living at home … love my Dad even though I know what he is doing is wrong. Mum loves Dad … now it's out in the open I feel guilty* (professional respondent).
>
> *Split families … girl stays at home and boy is removed … financial struggle for family and how do they manage their emotions. Lot of families have moved to New Zealand and do not have extended families to go to* (professional respondent).

- Involving a family member or adult in supporting the young person, especially if they are aged 13-17 years

> *Daughter and Mum presented to service and the Mum said you're the first service to come back to me with information … privacy stuff and left out of plans for young person. What you've got to do is agree with the young person what you're going to tell parents because they have to be part of the team … train them up to be a good member of the team … don't know what they are saying is doing harm because nobody has told them* (professional respondent).
>
> *Effect families a lot … girls feel they are not cared for enough* (professional respondent).

- Provide assistance for members of families who have also experienced historical sexual harm

> *Often brings up past sexual harm for parents … relive what happened to them … provide care for parents* (professional respondent).

Youth Respondents' Views about Need

The youth respondents also identified information and advocacy as a high priority need with *information about the feelings and behaviours associated with sexual violence, referral to counsellors and other services* and *support to work with the Police* among the needs they identified.

Moreover, the youth respondents identified a number of psychological needs that they experienced including *behavioural issues and being labelled as a problem; anxiety; coping with negative emotions;* and *struggling with their mental health.*

Assistance with their trauma response was another need identified by the youth respondents including their need for *empathy, reassurance and that I was going to be alright.* Two other young people stated that they just *wanted to hide away* and needed *time to process my thoughts.*

Of the need to find assistance with relationships the youth respondents noted that three of the four had told their mothers (one of whom was told by her partner about one and half years after it happened and they had since not found an opportunity to talk about the sexual harm) while the fourth had not told her parents. [41] Of the three whose parents had been told, one stated that *they had had a neutral response and hadn't since talked about it;* one said that they *had talked to anyone who would listen … lot of people have since left me;* and one stated that her mother *had empowered her* but she had *never identified that she had any needs.* Of the youth respondent who had not told her family, they reflected that they wished their *siblings had been told so that they could defend me at school with all the rumours going around.*

The current system of response for young people

The professional respondents were asked to identify the services currently available for youth aged between 13-25 years who had experienced sexual harm. They identified services at national and regional levels as well as those available in Christchurch.

Respondent Identified National, Regional and Christchurch Services which provide services for young people who experience sexual harm	
Overarching	Te Ohaakii a Hine – National Network Ending Sexual Violence Together – support direct service providers

[41] Note that two of the youth respondents who had told their mothers reported that they had not been supportive (i.e., not talked about it again).

National [42]	Youthline -generalist service with youth perspective Accident Compensation Corporation sensitive claims Shakti Youth – empower youth; understand what works well in terms of engaging youth within their communities; sexual violence from a family member Safe to Talk (24 hr service) 0800 044 334) – receive calls from young people, provide immediate help and link them to more comprehensive support. Oranga Tamariki New Zealand Police Health Information website
Christchurch	298 Youth Health – *provide a safe space without judgement, accepted (for YP who experience) chronic effects of abuse … recall, reset and restore … so they don't have to continue as a victim … engages holds them and lets them go* School counsellors Family Planning Sexual Assault Support Service Canterbury Cambridge Clinic Sexual Health Clinic ACC counsellors General Practices (GPs) Victim Support Mana Ake and Leading Lights (support for intermediate students)

[42] While these services were the only ones identified by the respondents, more national services for young people who experience sexual harm can be found at the following links https://www.wellstop.org.nz/links-to-other-agencies-and-resources.html; https://www.healthnavigator.org.nz/health-a-z/s/sexual-assault/

	Society of Youth Health Practitioners – multidisciplinary teams set up for special needs students by Resource Teachers Learning and Behaviour Presbyterian Support Upper South Island Youth Parent payment Student Health Centre counsellors Oranga Tamariki Police Schools Gateway Clinics START Shakti Ethnic Women Support Male Survivors Qtopia Te Puna Oranga
New Zealand regions [43]	Shama Ethnic Women's Trust, Hamilton Auckland HELP SASH (Sexual Abuse Support and Healing): SASH: www.saats-link.nz INP Medical Clinic has teams of specialist doctors and nurses based in Nelson and Blenheim who provide medical care and examinations for survivors of sexual abuse and sexual assault for the top of the South Island.

Youth Identified Services

The youth respondents also identified services for young people who experience sexual harm. The most frequently mentioned services were START, ACC and Sexual Assault Support Service Canterbury (SASSC).

[43] While these were the regional services for young people who have experienced sexual harm noted by the respondents more regional services can be located at the following link https://sexualabuse.org.nz/resources/find-sexual-assault-support-near-you/

ACC amazing at their job … go to counselling when you want to … flexible with options (youth respondent)

ACC really safe, government funded and well-funded, protect confidentiality, easily accessible … got to therapist really quickly and sorted the paper work very efficiently (youth respondent).

Like START as a service … great job with a number of people on site so that you can easily change counsellors (youth respondent).

Other services noted by the youth respondents included Purapura Whetu, Princess Margaret, Hillmorton, Cambridge Clinic and the school counsellor.

All of them feel safe and are used. Had positive experiences (youth respondent)

The most helpful services were described by youth as those who referred them to other services that met their self-identified needs, those which were youth-centred and youth friendly and those which were physically and socially accessible.

Good that the Police asked me whether they could give my name to SASSC to get in touch with me … only way I knew to access a service. Police asked me rather than pushing services on me (youth respondent).

Services that re accessible both physically and socially (youth respondent)

Having services located on metro bus routes (youth respondent)

Youth specific services (youth respondent)

Most helpful if service asks youth what they need (youth respondent)

The youth respondents commented that most unhelpful ways in which services were delivered to young people included situations where they could not find any services online to access and when they were not given choices about which services they accessed.

… don't promote and educate people about services. The only time I knew about services was when I was referred to them … really daunting … Why am I here? It's the worse experience (youth respondent).

Made me feel helpless when I couldn't find services (youth respondent)

When services are pushed onto youth (youth respondent)

Trying to push me a certain way … the process should be decided by the youth (youth respondent)

What's working well

Respondents commented on some aspects of the system of support for young people who have experienced sexual harm that are currently working well. First, they noted that professionals are more aware of the effects of this traumatic experience and are more aware

of the importance of early support and intervention. Moreover, across the broader system there was a culture being created *that it's OK to talk about it.*

> *For those who refer victims there is an awareness of the need to support victims, knowledge that they need to be safe, awareness that the key thing is providing support* (professional respondent)

> *More training in terms of trauma informed care and adverse experiences … Looking underneath the presenting behaviours … higher level of suspicion … asking the right questions, ACEs questionnaire* (professional respondent). [44]

> *The MeToo Campaign is beginning to lift the taboo associated with sexual harm and providing an avenue to seek help* (professional respondent).

They also noted the accessibility of the ACC Sensitive Claims process.

> *Process of getting ACC counselling is easy … not have to be current sexual harm, not have to report to the Police, can go through your GP to access it* (professional respondent)

Finally, they stated that the features of a local youth service, 298 Youth Health, offered an accessible and responsive model of service for young people.

> *298 Youth Health is a perfect model … trust built, episodic option for young people … one stop shop that delivers to a continuum of needs … such variety of needs for those between 13 and 25 years (crisis, long-term recovery and medical on site) a multiple access point … in and out and no one knows* (professional respondent)

What's not working well

Of the aspects of the system of support that is not working so well for young people, the respondents identified included:

Workforce and service capacity: Insufficient workforce capacity (e.g., *nurses, school counsellors, ACC counsellors*) was identified as a major issue confronting the sexual harm system of response for young people.

> *Not many people want to work with young people …* (professional respondent)

> *Getting them into ACC counselling … shortage of counsellors and waitlists* (professional respondent)

> *Not getting to ACC counsellors in a timely manner – waitlist … so busy and not do it as the whole of their job. When do see them after 1-2 months wait, then significant time lapses between therapy sessions. Can refer to* (generalist) *counsellor but not*

[44] The Adverse Childhood Experiences questionnaire can be found at the following link: https://www.apa.org/pubs/books/adverse-protective-childhood-experiences-sample-chapter.pdf

specialists in this area and only a stop gap measure. Unless we can get them into counselling early there are not a lot of services for young people to connect (professional respondent).

This insufficient capacity across the system of support for young people had a number of consequences including *putting pressure on the mental health system; therapist burnout from not having enough time away from providing services;* and creating waitlists.

> *The Joint Venture is dealing with the waitlist problem … brave step to ask for help and then to have to wait is a barrier for youth needing help. With the aging workforce … hard to get people into the sector and then to balance that with other private work … creates a professional burden. Need to get tertiary providers to create a career path* (professional respondent)

> *Need to deal with wait times … with sexual harm a young person is ready to access help then they have to wait several months by that time their thinking has changed about accessing support or their needs have changed* (professional respondent). [45]

Government funding: Some respondents believed that there were gaps in government funding which resulted in services that were inaccessible or not responsive to young people's needs. In addition, some of the respondents noted that there was insufficient government funding invested in primary prevention *to prevent sexual harm happening in the first place.*

> *Piecemeal approach … split contracting between MSD and OT in 2017 with not all MSD contracts funding services for under 18-year-olds* (professional respondent)

> *ACC funding … youth's needs don't fit the ACC framework They come to us with relationship issues, not want long therapy. They want to engage when they want to … least intrusive. Need flexibility with services for young people to meet their needs rather than the funders' needs i.e., come in and out of services* (professional respondent)

> *ACC … fund whānau only if young person is involved with counselling. The caregiver often needs more help than the young person. Young people want to be out in the community finding their own edge and own safety* (professional respondent)

Inconsistent approaches: Practice inconsistency was another aspect of the system that respondents reported did not work well. They reported inconsistencies in the way that the Police and Oranga Tamariki investigated non-familial sexual harm, inconsistencies among Oranga Tamariki staff about what is defined as sexual violence and inconsistencies among Police in the way in which teen date rape is investigated. Moreover, some who worked with young people did not take account of the early- middle- and late-developmental stages of

[45] Consequences noted in the literature of waiting for services include increased harm, prolonged distress, increased anxiety among family members, decreased motivation to address issues and fragmented service delivery (Anderson et al., 2003; Centre on the Developing Child Harvard University, 2008; Guralnick, 1997; Postl, 2006; Brown et al., 2002; MacKillop et al., 1996; Hicks & Hickman, 1994; Schraeder & Reid, 2014).

young people. [46] Reportedly there were also inconsistencies about whether parental consent to access services was needed for 13–16-year-olds.

> *Inconsistency in working with young people … not seen as a specialist role with developmental needs considered … rather treated as adults* (professional respondent)
>
> *Inconsistency in approach to non-familial sexual harm … confusion about where the investigation sits … Police and/or Oranga Tamariki* (professional respondent)
>
> *Oranga Tamariki … huge inconsistencies about what is considered sexual violence … have similar cases and one site operates in one way and another site operates in another way … Oranga Tamariki not trained well in this area* (professional respondent).
>
> *Whether the youth have to have the consent of their parents before they participate in services. Need to have sound clinical training and knowledge … and guidelines as parents can be a protective factor … provide safety or not great support. Easier when youth is over 16 years* (professional respondent)
>
> *Police do not know how to deal with teen date rape … what is serious and what is not serious* (professional respondent).

Respite accommodation: Tending to the physiological needs of young people after an experience of sexual harm was not always carried out. For example, accessing emergency accommodation for young people was considered a major problem in many parts of New Zealand.

> *Young person assaulted … not safe for them to go home … need a place where they feel safe, nurtured and can rest … hostels only place and full of older men* (professional respondent).
>
> *Government has provided a couple of organisations for homeless kids but not enough* (professional respondent).
>
> *Disclosed sexual abuse and not in a position to work through the trauma as have high immediate needs* (professional respondent).

Accessing help and support: Despite the benefit of accessing medical and psychosocial services as a result of disclosing, many young people chose not to disclose or to disclose sometime after their experience of sexual harm. There are many reasons for not disclosing including not being believed, shame, fear of reprisal and the limits of confidentiality.

[46] Source: http://www.amchp.org/programsandtopics/AdolescentHealth/projects/Pages/AdolescentDevelopment.aspx#:~:text=Researchers%20suggest%20adolescence%20undergo%20three,and%20late%20adolescence%2Fyoung%20adulthood.&text=Early%20Adolescence%20occurs%20between%20ages%2010%2D14.

> *After experiencing sexual violence reaching out for help is a significant step for a young person … disclosing that to someone else they always think will I be believed?* (professional respondent)

Additionally, respondents reported difficulties accessing help by young people who have experienced sexual harm.

> *Health inequality across NZ … the struggle young people have accessing health services in some parts of New Zealand. If young people happen to access INP or an outreach service at their school they get a better service than if they went to their GP – barriers include people knowing them, cost, having credit on their phones … and only having 2 family planning services in* (our city) *means that many young people cannot access help… transport is challenging for youth* (professional respondent)

Gaps in services for youth

Most respondents agreed that there was a lack of specialist crisis and trauma support services for young people and workers especially trained to work with them.

> *Need a dedicated youth team of crisis workers trained to work with young people* (professional respondent)

> *Services not designed with young people in mind … Auckland HELP research … need to provide in a prevention and support space* (professional respondent)

> *Need to set up a specialist centre for trauma. Had a Mum come in here with teenage daughter … become withdrawn … eventually broke down and told her Mum two years after it happened … taken to lots of services GP, Hillmorton, Psych Services … none of them got anywhere with her … don't know how to deal with trauma. They only know how to deal with mental health and they couldn't address her problems with drugs* (professional respondent).

Moreover, some of the respondents believed that the system was not set up to support victims and that more was needed to give those who experience sexual harm confidence to disclose their experience.

> *Peer to peer youth sexual harm … Family Group Conferences are geared towards the harmful person and do not take account of the victim's needs. This is a practice issue and Oranga Tamariki needs to support the person harmed to go through the process* (professional respondent)

> *Limited support for young people … making a sexual harm complaint involves complicated systems and processes. The system is not set up for victims … mistrust in the Criminal Justice System and people in power are scary for young people* (professional respondent).

More particularly, respondents commented that there was a gap in services for young men who had experienced sexual harm.

> *Young men who have been harmed are not legally raped and there is extra shame if men have been sexually harmed … gap in services for vulnerable men* (professional respondent)

An emerging service gap identified by a few of the respondents was the increasing incidence of revenge porn that was not covered by the Crimes Act and therefore not covered by the ACC Sensitive Claims process. [47]

> *A case of a woman who had broken up with her husband … He had posted explicit sexual material of her that she had not known about … experienced PTSD … need to update the ACC Act and the Digital Harms Act* (professional respondent).

The youth respondents noted the following gaps in services including:

- Support for males who experience sexual harm
- Support for young people who are *going through the Police system*
- Integration of services for young people
- The relationship gap between staff who are older and young people
  > *Some counsellors are very old … hard to relate to them technologically and socially … have different views … conservative* (youth respondent).

Barriers to access

A number of barriers to help seeking by young people were identified by the respondents.

These included:

- Lack of knowledge and awareness of services
- Shame, guilt, embarrassment and not being believed [48]
- Breaching confidentiality and privacy
- Stigma
- Convenience
- Retribution
- Lack of compassion

[47] ACC Sensitive Claims are only accessible to people who have experienced sexual harm categorised in Schedule 3 of the Crimes Act 1961.

[48] On the Intensity of Experiencing Feelings of Shame in Mental Disorders. Annette Kämmerer in *Psychotherapie, Psychosomatik, Medizinische Psychologie,* Vol. 60, No. 7, pages 262–270; July 2010. Tracking the Trajectory of Shame, Guilt, and Pride across the Life Span. Ulrich Orth et al. in *Journal of Personality and Social Psychology,* Vol. 99, No. 6, pages 1061–1071; December 2010.

Lack of knowledge and awareness of services

Both the professional and youth respondents identified that lack of knowledge about helping services for those who experience sexual harm is a significant barrier to accessing supports. The reasons for not knowing what to do if a person experiences or is told about an incident of sexual harm included lack of education, inaccessibility of online information and lack of life skills among young people who have not previously referred themselves to services and not previously had the experience of attending a service appointment.

> *There is a gap between child and adult services … most services are structured for adults, but young people need the life skills to be able to refer themselves to services; know what it's like to access a service …* (professional respondent)
>
> *Knowing what supports are available … and making the call* (youth respondent)
> *Inexperience going for help … Unknown experience … hardest thing is to get them to go for the first time … Are they going to judge me? Who's going to be there? I haven't experienced this before. 16–18-year-olds not been to counselling before. What's it going to look like? If I need to tell someone about the sexual harm what is that going to look like?* (professional respondent)
>
> *Not enough people are educated in how to help someone … how to deal with emotions … how to deescalate a situation* (youth respondent)
>
> *Not knowing that seeing a counsellor can help themselves* (youth respondent)
>
> *Not very easy … because not know about services … google and find that services are very niche … for Māori, Pasifika, low income, DV … none of them fitted with my circumstances* (youth respondent)
>
> *Wish I had known about the medical examination …* (youth respondent)

Shame, guilt, embarrassment and not being believed

Feelings of shame, guilt, embarrassment and not being believed and / or being judged were also identified as major reasons for not accessing support services. [49] Professionals noted that adolescents feel shame more intensely than adults do and that this is a function of their personality and identity development. They believed that young people are expected to conform to all manner of norms that define their place in society and that their uncertainty as to how to deal with these external expectations may make them quicker to feel shame.

Guilt is also known to preclude young people from accessing support and services – guilt about behaviours such as leaving their home without their parent's permission or guilt that they were drinking alcohol.

[49] Shame refers to one's negative emotion about one's sense of self. Guilt is one's negative emotion about one's behaviours (Manion, J. (2002). The moral relevance of shame. *American Philosophical Quarterly*, 39, 73-90)

While believing young people when they disclose their experience of sexual harm enables them to feel validated and supported, many young people perceive that their account of the incident will be questioned (by Police, by parents, by community). The respondents stated that not disclosing to anyone is a survival mechanism for young people.

> *Self-blame and mind games are why youth don't come for help … societal messages don't help either* (professional respondent).

> *Lot of shame … alcohol consumed … drinking and drugging before 18 years and fear of prosecution … fear of people not believing them and others finding out* (professional respondent)

> *Not disclose because of guilt, shame, fear and embarrassment, not being believed, trauma of talking about it* (professional respondent)

> *Scared they will not be believed … self-doubt that their experience was sexual harm. SHARMA believes that sexual harm has been normalised within this country* (professional respondent)

> *Shame, silenced, fear and whakama* (professional respondent)

> *Police not believe them and not do anything about it* (youth respondent)

> *When vulnerable, feel rejected or shamed by them telling you you're not eligible for the services they provide (youth respondent*)

Breaching confidentiality and privacy

The risk of breaching the confidentiality and privacy of their information is another reason why young people do not disclose their sexual harm and get help. *Fear of retaliation* from the person who harmed them, fear of experiencing stigma and harassment from their peers and fear of their parents finding out were the reasons offered by the respondents for not taking the risk of privacy breaches.

> *Think their parents will be told … many won't go to CAF because they know their parents will be told* (professional respondent)

> *Fear of confidentiality breaches … everybody will know and call me a slut if I show up at a service* (youth respondent)

> *Not going to the GP because the receptionist knows who the young person is* (professional respondent)

> *Not want to leave school to go for support as stigmatising … a privacy issue* (professional respondent)

Fear of running into someone they know (youth respondent)

Stigma

A few of the professional respondents commented that young people who experience sexual harm who perceive themselves as stigmatized (due to their status as a sexual assault victim) will be less likely to seek support.

There are a lot of rape myths within society (professional respondent)

This was particularly associated with Māori, Pasifika and young people from culturally and linguistically diverse groups.

Some groups struggle with the idea of going to counselling … Pasifika, Māori refugees … (youth respondent)

Difficulty accessing support because of the stigma associated with getting help (professional respondent)

Convenience

Some of the professionals and youth respondents noted that the lack of availability of the support at convenient times, lack of response by services, lack of money and lack of transport were also barriers to help seeking. Moreover, the extensive paper work associated with accessing help can also be a barrier to accessing help.

Once they've decided they want help now … crisis response not always available … weekends (professional respondent)

*ACC paperwork a nightmare (*youth respondent)

Location … counsellor located far away from them … need to be aware of taxi chits via ACC … time of day … need to be available at any time as some services only open during office hours. Young people want services when they are ready to receive them (professional respondent).

*Money … couldn't afford to pay for counselling … not worth the money as there are lots of different types of counselling and some of them don't work (*young person)

*Getting in contact … not a phone person … emailed a lot of places and they never replied after 4 years (*young person)

Some young people won't use their computers to access support because they fear their parents will find out (professional respondent).

Retribution

Some of the youth respondents stated that they did not contact the Police because they feared that the person who sexually harmed them would seek vengeance.

> *The reason I put off talking to the Police was because I was scared of my rapist … knew where I lived … terrified … enraged talking about him, get angry and come to my house. I wish I knew that the Police were confidential* (youth respondent).

Lack of compassion

All of the youth respondents reported a lack of care and concern by the police, court and medical examiner for them as young people who had experienced sexual harm. They believed that such experiences made others reticent to approach these and other services for assistance.

> *Police, court, medical … cold, emotionally unintelligent places where they do not know how to deal with victims in a caring manner. Not have best interests of youth in mind* (professional respondent).

> *Police trying to get the facts they can be too pushy when they ask questions. Interviewed by a man … felt very vulnerable … felt very confronting* (youth respondent).

> *Medical examiners just took my clothes off and started touching me. Need to respect boundaries … ask for permission before touching you* (youth respondent).

To counter the adverse experiences of these young people, the youth respondents recommended that the youth crisis response service remain *independent* of the Police, court and the forensic/medical examiners, but at the same time develop relationships with these services so that they can advocate on behalf of young people.

Maximising the accessibility of a service for youth who have experienced sexual harm

Communication

The respondents all noted that more was needed to provide information to young people to answer their questions about: What is sexual harm? What is consent? What services are available for whom? What are the benefits of accessing helping services?

> *Hearing the voice of the other side … health literacy is poor … need information to address fear of help and what happen next* (professional respondent)

They advised that using *social media … TikTok, Instagram … rather than websites* was the preferred communication source for young people. Moreover, communication needed to include *age- and gender-appropriate messages that relate to them … simple, use slang.*

> *Getting messages out … promotion in a gentle way e.g., information about Safe to Talk; information about what is sexual harm … most people think it is rape, brutal and committed by strangers, but it can also be about the subtle, insidious kind of sexual harm like sexual harassment. If people knew more about it, then they'd identify that they needed to talk to someone* (professional respondent)
>
> *More access to ACC's Mates and Dates … session 4 is about help seeking* (professional respondent)
>
> *Reaching out to employers by putting a flyer into work places to let them know about the services available* (youth respondent)

In addition, respondents noted that *phone calls and online services give easy access and means someone is protected as not being face to face …'easy-to-hide' kinds of services are good.*

The youth respondents recommended giving information to peers *that showed them how to help someone experiencing intense emotions … how to de-escalate a situation* (youth respondent).

They also suggested using text messaging as *it feels more instant than emails when I'm reaching out for help* (youth respondent). In addition, they suggested that communications be written in a way that is accessible to a range of genders and ethnicities.

> *Make sure that the information is not specific to Māori, Pacific Peoples … refer to sexual assault and what it's about so that anybody can access it … female, male, gender diverse* (youth respondent).

Organisational culture

Many respondents noted that a youth-friendly organisational culture improved the accessibility for young people who have experienced sexual harm. Such a culture would be designed by young people, include a youth-friendly environment and most importantly be a safe physical and psychological place for both young people and the staff who work there. A cross-discipline team would be available to assist young people – a team that holds similar values, ways of thinking and responding and which takes a holistic approach that *caters to all of their needs*.

… young people direct it and help set it up, one person driving it preferably a teen, doctor, nurse, counsellor and youth worker, everybody on the same wavelength as a team to create an environment that is safe (not feel judged, feel people listen to you and take you seriously) (professional respondent)

Create a safe, private place for people to disclose and ask for help … meet young people's needs; feel heard; be protected; staff know what to do; have a therapeutic relationship with the professional (young people friendly environment; genuine, empathetic, trustworthy and non-judgemental staff) … it's about the staff attitudes. Knowing that if you tell someone they will deal with it … confidential (professional respondent).

There is a physically accessibility and safe place to access but also people need to be empowered to access … knowing what has happened to them is sexual harm (professional respondent).

Educate professionals about the process … that sexual assault care needs to be holistic (professional respondent).

Building a system of support

Respondents also talked about the importance of building cross-sector relationships so that there is no wrong door to access support for a young person who has experienced sexual harm.

Community of stakeholders around the young person e.g., school counsellors … the relational space (professional respondent)

Have youth centres know about the crisis youth sexual violence support service (professional respondent)

Convenient

The youth respondents noted that young people need money to access support services which they stated needed to be *easy to access and not too far away.* They also recommended that sexual harm services needed to be *known about, but included in an umbrella of different types of support services to protect young people's privacy.*

Funding more youth services

Finally, a few respondents mentioned that more services needed to be funded by the Ministry of Social Development and the Ministry of Health to ensure that young people can access them. This was particularly noted for rural communities and large cities.

Equity of access and inclusion for diverse communities

The literature suggests that access to supports for indigenous, disabled and members of the Rainbow Community is poor. The respondents were asked about how equity of access to support services for youth who have experienced sexual harm can be improved for these groups.

Collaboration

Building relationships and working collaboratively, with communities and non-government agencies who specialise in working with diverse groups, was considered a key strategy for improving equity of access. This collaborative practice involves providing wraparound services that include services that meet the cultural and other needs of young people whilst they are accessing specialist sexual harm services. Some of the respondents described how young people might access their communities' services and then after a period of time disclose that they have experienced sexual harm.

> *Building relationships … know who in the community is best to offer the service for whānau … whānaungatanga* (professional respondent)
>
> *No wrong door … pick them up from other services … children access other services and takes 3-4 years before they disclose, they have been sexually abused* (professional respondent)
>
> *Marginalised communities … Rainbow have support within their own communities so best to partner with them. They feel safe within their own identity … strong online support groups. Reputation spread everywhere. Be proactive and put up a Rainbow flag in service's office* (professional respondent).
>
> *Work with Rainbow communities; work with Pacific churches, Et Tu Pasifika, Pasifika youth workers* (professional respondent)
>
> *Engage with Te Puna Oranga – waitlist for ACC counselling but will take people on their general counselling services – go out to the home and awhi the families* (professional respondent)
> *Can have individual services that refer to a Māori Health model or within a mainstream service have visibility that they are connected to other Māori, Pasifika etc services as not everyone wants to go to a Māori service but they want to feel safe* (professional respondent)
>
> *Work with support worker from Rainbow youth and come to us for therapy* (professional respondent)

Getting more wraparound and people willing to work together … work with others to get a plan of action … not being territorial about your path … what best for young person about who's working with them when (professional respondent)

Diversity of staff

Employing a team of staff who identify with a range of cultures was the second most frequently noted way to improve equity of access for diverse groups. *Seeing someone you recognise in the service* was regarded as an important element of improving the access of diverse groups.

Predominantly see New Zealand European people at services – need more Māori, Pasifika and CALD workers (professional respondent)
Having people in the service … visible Māori, Pasifika, Rainbow … not see many refugees within mainstream services (professional respondent)

Practice approach

Some of the respondents believed that a culturally competent approach was important to improving the equity of access for young people. In particular they understood this to mean that workers recognise that their culture and values influence their interactions with young people and that they need to build a respectful and understanding relationship with each of them.

Accessible by including a caring process … flexibility by going to people who are challenged with accessing services (professional respondent)

Clinician understand the impact of their beliefs on diverse groups of people and create a nurturing relationship (professional respondent)

Need to read the client in front of you … lengthy appointments … need time (professional respondent)

Cultural support (professional respondent)

In addition, the respondents recommended providing outreach to facilitate young people's access to support services.

Outreach to young people via the New Zealand Prostitutes Collective, City Mission, Hagley High, Te Puna Wai … remember invited into their space and need to build trust (professional respondent)

Moreover, recognising that specialist services are unlikely to be available in every part of New Zealand, a few of the respondents suggested using technology to provide advice and services from one region to another.

> *One region might be able to support capability issues in another region. The important thing in crisis support work is to make sure that the advice given about a particular group is correct and given by experts … Health Pathways, Shakti and TOAH-NNEST all have resources on their websites* (professional respondent)

Promotion

A few respondents suggested promoting the sexual harm crisis support service using culturally appropriate promotional materials.

> *Focus to reach Māori and Pacific Peoples … advertisements developed by cultural advisor and Māori artist* (professional respondent)

> *Shakti have developed some great promotional videos in different languages* (professional respondent)

The youth respondents offered their views about the issues confronting diverse groups and some possible solutions to improve equity of access.

	Issues	Solutions to assist equity of access
Men	• *Men struggle to receive help … stigma … society struggles to accept that men can be sexually abused by women* • *Female dominated services … not know if taken seriously* • *Conviction rate for females is lower than for males … inequality in justice system*	• *Make welcoming* • *All Right? campaign posters … men don't have to be strong all the time and it's OK to seek help* • *Employ male staff*
Rainbow Community	• *Not trans persons responsibility to teach a service what it's like to be a trans person, asexual …*	• *Knowledge about rainbow community for staff* • *Rainbow-only support groups*

	• *Stigma … lesbian relationship … How can a woman sexually abuse another woman?*	• *Diversity of staff … someone you can relate to …being around someone who you recognise and will understand you*
Māori	• *Inequality of access*	• *Prioritise engagement with iwi, hapu and whānau in design phase* • *Holistic approach* • *Get family involved* • *Interconnect with whānau, hapu and iwi*
Pasifika peoples	• *Shut down and don't talk about it*	• *Work with churches … communities to address issues* • *Train staff in culture … collective group*
Refugees & Migrants	• *Lack of knowledge about what they have been through* • *Limited support system in New Zealand* • *Language barriers* • *Lack of knowledge about system of support*	• *Staff training about countries of origin* • *Use professional interpreters* • *Some refugees could access Shakti for women …* • *Ability to go to somewhere … a separate space … for marginalised communities as small communities … abused by husband but not access counselling because of husband's position in the community*
Disability	• *Having a support service designed for able-bodied people* • *Noise and light for people with Autism*	• *Universal design of buildings* • *Easy read* • *Supported decision making* • *Provide transport* • *Access to someone trained to work with people with Autism and can respond to their needs*

Principles/values to underpin a sexual harm crisis support service for youth [50]

The values of a service can be defined as beliefs about desirable results or actions that are explicitly or implicitly shared by members of an organization. They function as a guide to decisions and actions within a service and as such are an important element in the design of a new service.

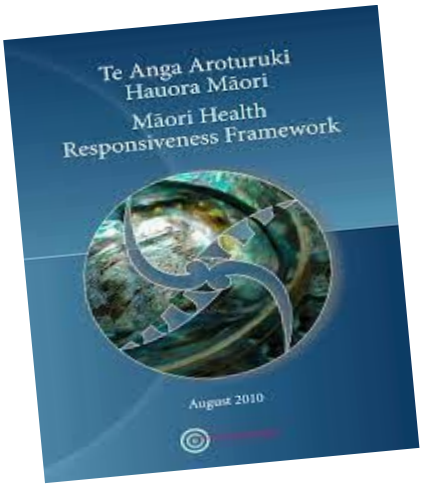
The most important values in order of frequency of response that the youth and professional respondents identified are included in the following text box.

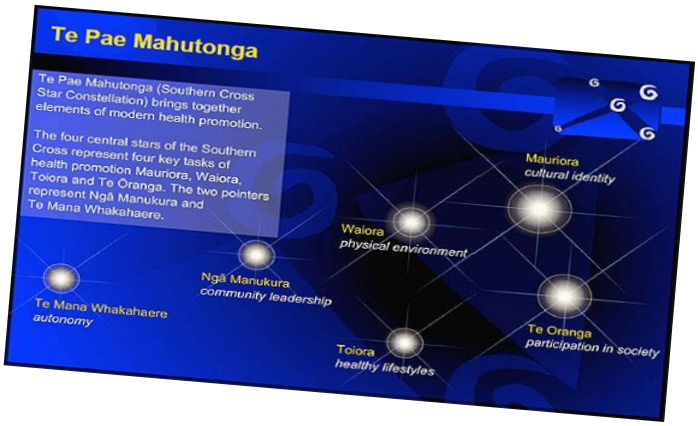
Value	Respondents Comments
Manaakitanga	• *Caring, kindness, understanding, patience* (professional respondent) • *Listening and hearing* (youth respondent) • *Non-judgemental* (youth respondent) • *Trustworthy* (professional respondent)
Diversity and inclusion	• *Culturally diverse … continuum of identity and culturally appropriate responses* (professional respondent) • *Acceptance, tolerance and celebration of diversity* (professional respondent) • *Understanding that different cultures approach services in different ways … Meihana, Te Pae Mahutonga … models embedded in the service* (professional respondent)
Best interests of youth	• *Very important … a priority as it means the service really cares about the young person and is trying to understand their situation* (youth respondent)

[50] King, L.M. (2017). Indigenous social work practice development: The contribution of manaakitanga to Mana-enhancing social work practice theory.

Self-autonomy for youth	• *Youth needs to have a solid degree of control over the situation … making decisions* (youth respondent) • *Informed decisions in the help you receive is really important … giving options and deciding what they want* (youth respondent)
Privacy and confidentiality	• *Christchurch is a small city … not getting out there if you tell someone* (youth respondent) • *Privacy very important … not share information with others for not good reasons … services have been criticised for privacy breaches* (youth respondent)
Youth centred	*Young people need to be recognised as a unique age group … evolving capacity to independence* (professional respondent)
Safe	• *Safety … physical and emotional … what do you need to lead your life* (youth respondent) • *Have one safe adult who loves them* (professional respondent) • *Calm space … safe for everybody* (professional respondent)
Participatory	*It's the reason for going to services is so you can do something that helps you. If you have no control over what you are participating in it doesn't help …. Feels like you're losing control again* (youth respondent)

Meihana models of health [51]





Other values noted by the respondents included mana enhancing, non-judgemental, aroha, whānaungatanga, gender sensitive, accessible, collaborative and references were made to the youth development principles. [52]

[51] To access these Meihana models of health click on the following link: https://www.google.com/search?rlz=1C1EJFA_enNZ771NZ772&source=univ&tbm=isch&q=meihana+model+of+health+pictures&sa=X&ved=2ahUKEwiuqZOV8K_yAhUA7HMBHVoSBEsQjJkEegQIBRAC&biw=1536&bih=754

[52] There are 6 principles: 1) youth development is shaped by the big picture 2) youth development is about young people being connected 3) youth development is based on a consistent strengths-based approach 4) youth development happens through quality relationships 5) youth development is triggered hen young people fully participate 6) youth development needs good information (sourced from: www.myd.govt.nz)

Locations: Benefits and Difficulties

While generally the professional respondents preferred to locate the sexual harm crisis support service in a 'hub' of other services, the youth respondents had mixed views about the desirability of this location. Of the benefits of the hub location, they stated that it provided a degree of anonymity and made a range of services available to young people. From the other perspective, having a hub of services within the context of a mall was difficult as *people in your local area would know you were seeking help* (youth respondent).

> *Hub where young people can drop in that incorporates other services that they can access … not focus on sexual harm and provides anonymity … like 298 Youth Health where there are youth workers, where they can meet and access a range of service to meet needs (art therapist for teens, cook something for whanau, careers advisor from Ara – a safe nurturing and helpful place where they can build skills for the future practical and resilience skills … ground floor place that is open and bright and welcoming … give sense of positivity for the future and put in place a plan that gives them the steps to get there* (professional respondent)

> *Drop-in centre, 24 hours … discrete, friendly, welcoming reception, hospitality and refreshments available … can disclose and seek immediate support with a range of paths forward. One stop shop needs to be collaborative with other agencies also* (professional respondent)

> *Torn between having a sexual harm service as part of a wellbeing centre or a standalone centre … University of Otago research has found the standalone services are most supportive …* (professional respondent)

Several of the professional respondents believed that delivering a sexual assault service in a client's home was a viable option for *some people especially immediately after an event when they may not be comfortable going out anywhere …and for people with disabilities who might find it difficult to leave the house.* However, worker safety was a concern with this option. The youth respondents on the other hand were not supportive of this location for service provision because of their reticence to disclose their sexual harm to their families.

Locating the sexual harm service within the context of a General Practice was assessed as poor or fair by the youth respondents.

> *Depends on whether you have a close relationship with your doctor or whether they are impersonal and insensitive. Not a good idea to sit in the waiting room with people who have not experienced the same things you have. Dealing with sexual harm is not just a medical issue … look at it from a holistic perspective.* (youth respondent)

> *Poor as rushed appointments, only look at the physical side and expensive* (youth respondent)

On the other hand, a few of the professional respondents believed that locating a sexual harm service within the context of a General Practice was a good idea for some young people.

> *Some of the models being introduced into GP practices might fit with this …. Nurse, doctor and having a person there to deal with cases of sexual assault … benefit of going to the doctors … nice hiding thing* (professional respondent).

> *Some would find it easier to discloses to a GP under a more medical model, others not* (professional respondent).

Locating the sexual harm crisis support service in a neighbourhood was regarded as a suitable option by a few of the professional respondents, although they believed that *transport could be a problem.* The youth informants on the other hands were very positive about this location.

> *My favourite option … good place to establish a hub that youth can just wonder in of the street … make yourself a coffee in the kitchen, sit down in the living room and chill out … nice way to make you feel comfortable* (professional respondent)

> *House – non threatening and welcoming* (youth respondent)

One professional respondent was of the view that an office was a suitable place to locate a sexual harm service.

> *Office … needs to be a reason why not deliver service in an office where you can make it homely and comfortable, offer a cup of tea* (professional respondent)

The youth respondents scored this location option fair.

Only a few professional respondents stated that delivering a sexual assault crisis support service online was a good option for young people because of the anonymity it offered them. However, they believed that it was an important option to include despite the fact that some young people may not have access to Wi-Fi. The youth respondents scored this option as fair.

> *If it was solely on line, you would not get the proper support … need personal interaction* (youth respondent)

All respondents commented that delivering a sexual assault service from a school location would not be suitable.

> *School … maybe risk of spotlight on someone …* (youth respondent)

> *School … not get good level of engagement with young person as where peers and teachers are* (professional respondent).

Range of services delivered by a sexual harm crisis support service

Ideally the respondents advised that a sexual harm crisis support service for young people would comprise of an integrated suite of services *to prevent youth having to run around to different places with different people.* This suit of services would take account of the primary prevention services delivered to youth as well as the immediate, intermediate and longer-term needs of young people who experience sexual harm. The services noted by respondents included:

- Preventative services, for examples *programmes about healthy relationships*

- Immediate crisis service involving supporting a young person who has recently experienced a sexual harm or who has been triggered some time after the incident. Services could include stabilising the young person, put a safety plan in place, accompany them to a forensic medical examination and/or a health check, accompany them to a Police interview and meeting their physiological needs (e.g., accessing the youth benefit, obtaining accommodation, etc.)

> *Warm, friendly, skilled triage process … nature of the disclosure … date rape last night, abused 3 years ago, 14-year-old who does not want to disclose to mother but has told a social worker … need a skilled team to manage many scenarios of disclosure* (professional respondent)
>
> *… immediately, do they require medical attention? … assessing their safety* (professional respondent)
>
> *Parent/caregiver support … grief, shock, minimising, triggers, distress … how to support* (professional respondent)
>
> *De-escalate … people heightened and need to bring back to a space where they are rational … hear what you are saying* (professional respondent)
>
> *Understanding that a person harmed may cope in various ways one of which is to act out, be more vulnerable* (professional respondent)

Crisis services have profound impact … three to four months can prevent PTSD … includes affect regulation, validation, settling and stabilising (professional respondent).

Wish I had had help with school … doing so poorly, facing backlash from teachers. Why are you so unfocused? Why are you not doing the work all of a sudden? Tell them on behalf of the youth within educational settings. (youth respondent)

Great if they could connect with WINZ to access disability benefit for mental health (youth respondent).

- Intermediate crisis service that involves providing social work support, building a system of support (e.g., family, peers and community) for the young person as well as providing support for the family, providing support through the police, Family Group Conference and court processes, advocacy, brief intervention, facilitate peer mentoring programmes and working collaboratively with other NGOs to provide *wraparound services.*

Support the process post harm recognising the impact on the victim and their families … often a medical examination done, pregnancy test, morning after pill, STI swabs, suppository for constipation and many intrusive processes (professional respondent)

Connect with services … work with the Police, school counsellors … connect with them on a regular basis (professional respondent)
Offer good support during the disclosure and process … Police need to have both male and female available Parent/caregiver support … grief, shock, minimising, triggers, distress … how to support (professional respondent)
For victims walking through an FGC process to have an equivalent to a victim advisor … people who have been harmed if they chose to go, no support through that process and follow up (professional respondent)

Advocacy … young person assaulted in a park and work with council to change the playground to make it safer (professional respondent)

Arrange a safe adult for the young person to talk to … parent (often not tell parents as don't want them to worry), family friend, peer, professional that the young person identifies with and who can provide appropriate support (professional respondent)

Help with getting back to school … how navigate when everybody knows … do brief intervention about going to school … important as could become socially isolated (professional respondent)

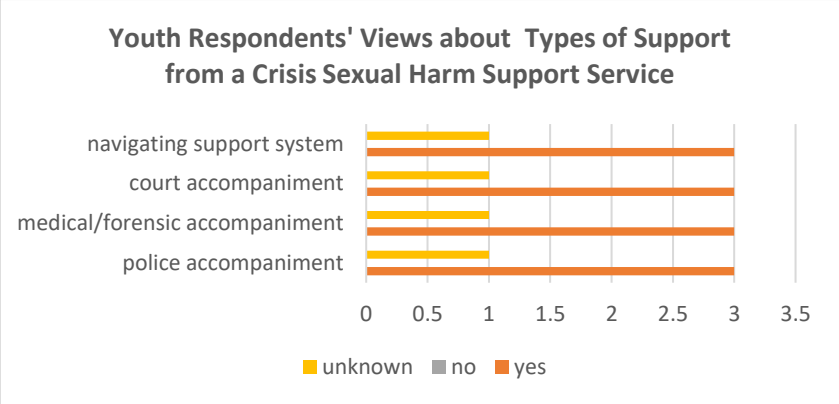
… crisis service includes young person having access to support and someone to talk to alongside equipping the parents. If you can't get them into therapy straight away, can hold them. So, shore up the family system by giving them information and education to stabilise and support the young person (professional respondent)

Build systems around the young person *could be school counsellor who engages with* young person *throughout the day and brings the* young person *to counselling* (professional respondent)

The youth respondents stated that all the services noted above *need to be in place for youth when they require them.* They were of the opinion that having one person to *guide, help and mentor them to navigate the different services* was important.

Provision of information to *help them decide whether to go to the Police or medical services* and to learn about the social services that are available to young people was considered important. Accompaniment was also considered *useful as those processes can be daunting* (youth respondent).

Chart 1 shows that most of the youth respondents wanted a sexual harm crisis support service for youth to provide accompaniment to Police interviews, medical/forensic examination and court appearance as well as navigating the support system.



Crisis intervention and longer-term therapy were highly rated by the youth respondents. With crisis intervention, the youth respondents recommended not talking about the sexual harm incident as *they needed to process it first before they were ready to talk.* All youth respondents reported that the quality of the therapy they received was effective. They highly recommended follow-up services because *mental health is not something you can fix in a year … comes in waves.*

> *Therapy for six months … feel amazing, give it a rest for six months and then something else arises … really struggles with that* (youth respondent).

Approaches and Practices

Client-centred

Most of the professional respondents and all of the youth respondents stated that client-centred approaches were essential for working with youth who have experienced sexual harm. This kind of approach involves tailoring interventions to fit with the unique needs and experiences of each young person, and beginning work from *where the young person is at*. Young people's experiences are likely to differ from each other along many socio-demographic variables such as cultural background, religion, age, gender, sexuality, and particular sub-cultural affiliations. There is also wide variability among young people according to developmental stage or maturity, and the strengths and other resources that they bring with them.

> *It is the individual that is going through the trauma … should focus on them … provide supports that they need* (professional respondent)

> *Right throughout the healing journey … individualised approach with each person … stabilising through to therapy* (professional respondent)

Make the approach more client centred than client centred (professional respondent)

Fit the individual … aware of people's cultures, situations and personal preferences (youth respondent)

Wraparound and integrated services

Most of the professional respondents and almost all of the youth respondents stated interventions for a youth's sexual harm experience must also take into account the multiple and complex needs (e.g., mental health problems, accommodation, unemployment, and problems associated with school among others) that they may present with and that multiple services may be required to address these issues. They reasoned that taking a holistic approach takes account of the multiple and interlinked determinants associated with sexual harm including psychosocial factors operating at the levels of the young person, their families, communities and whole societies. Moreover, these closely associated problems may work to reduce the young people's ability to access and engage with treatment interventions.

Holistic approach to meet all their needs … not always about the sexual harm, often other things going on for them (professional respondent)

Collaborative approach where services talk to each other (professional respondent)

Collaborative approach with other key support agencies e.g., Cambridge Clinic, not a stand-alone agency that does not work with other pre-existing agencies doing great work (professional respondent)

The other message that respondents conveyed was the need to integrate sexual harm services from primary- through to secondary- through to tertiary prevention services. They believed that this would enhance the accessibility of the client pathway to various types of short- and long-term interventions.

Outreach to accompany young people to hospital ... to the Police … need to ling aftercare to crisis counselling to therapeutic counselling … follow with the school counsellors (professional respondent)

Biggest message I want to convey is that services need to be more connected, streamlined for the young person to flow to the different types of help they might need (professional respondent).

Solution-focused therapy

Two of the professional respondents noted the utility of taking a strengths-based, solution-focused approach to working with young people who have experienced sexual harm. They believed that this approach is closely related to the client-centred and holistic approaches because the individual strengths and social assets to be worked with are individualised and dependent on each young person's situation. The aim of solution-focused therapy is to assist young people to identify and develop their coping and problem-solving skills.

Development approach

Most professional respondents noted that working with young people who have experienced sexual harm requires services that are developmentally appropriate. They described developmentally appropriate services as those that meet the unique development needs of young people and that these services need to be responsive to the ways such needs change over time as development progresses. Moreover, they commented that those who experience sexual assault *experience disruptions to the social processes that drive development* and that such disruptions need to be taken into account by the provider of services.

> *Developmentally appropriate approach that is tailored to the ages and stages reflected in those aged between 13-25 years* (professional respondent).

Flexible approach

The majority of professional respondents stated that working with young people demands a high level of flexibility and adaptability from the workers. They noted that a tailored approach was needed for each young person and that that might need to be changed over time. Moreover, there was a need for practitioners to be patient with young people who miss appointments and /or come in and out of service. In sum, working with young people may not be linear or consistent.

> *Understand their needs and wants and be flexible about how to meet the individual's and their system's needs* (professional respondent)
>
> *Flexibility is required as whatever is going on for them can change on a daily basis* (professional respondent)
>
> *The sexual harm service needs to have an elastic open door … for some it's episodic for others it's long-term … need the opportunity to come and go* (professional respondent)

Flexibility to understand that if a young person does not turn up to an appointment it's about the space, they are in … no money on the cell phone, no money for transport, received text from friends and missed the bus, moods too low … need to be patient (professional respondent)

Working with the young person's system of support

Most of the professional respondents recognised that family support was an important component of developmentally-appropriate practice. Families can play an important role in supporting young people who have experienced sexual harm.

A critical role for care givers is coregulation – providing immediate support to reduce the emotional intensity of the young person's post-sexual harm experiences. This was regarded as important for early and middle stage adolescents but may still apply to young people in late adolescence.

If immediate family members are unavailable, the potential contribution of other significant adults should be considered, for example, family friends or other social systems such as schools.

Foster good relationships with parents and educate them as they are a protective factor (professional respondent)

Developmentally young people belong in systems and the younger they are the more the system has to be thought about … young person choses their support people and wraparound them to make them feel safe. This systemic approach is aligned with Kaupapa Māori approaches (professional respondent).

If sexual harm breaks down the relationship with their family and they don't want their family involved … this is too much of a generalisation. This is why you need a clinician at the start of the process of the engagement … we know you're scared but let's work with you to get a system around you. Teens need big people in their lives and the task is to work out with them who they are … ethically and legally need to (professional respondent).

Trauma-models of practice

For most of the professional respondents, trauma-informed practice reinforced the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of young people; and of acknowledging that services can retraumatize young people by, for example, having to retell their experience of sexual harm again and again to multiple different providers of services.

They emphasised the importance of tailoring the service to meet the young person's needs rather than applying general treatment approaches. In addition, young people are more likely to engage with services that practice *manaakitanga* and that provide an approach that is *Rogerian* [53] in nature, offers a *sense of safety* and that treats young people with *gentleness* and is *welcoming*.

Key steps identified in providing a trauma informed service identified by the respondents included providing service to young people in a way that empowers them; not retraumatize young people; and building on the strengths of young people in the context of their system of support.

> *Trauma … not having to share their stories* (professional respondent)
>
> *Trauma informed support … awareness of trauma and not retraumatising for example passing from service to service and having to retell your story* (professional respondent)
>
> *Trauma informed relationships and trauma work models* (professional respondent)
>
> *Very good … immediate aftermath … dealing with the trauma, understand why all over the place, understand the physical and emotional reactions to trauma is important* (youth respondent)
>
> *Trauma and sexual harm go hands in hand … knowledge is good about the effects of trauma* (youth respondent)

Specific models of practice identified by the respondents included:

- Acceptance therapy
- Acceptance and Commitment Therapy (ACT)
- Dialectical behavioural therapy **(**DPT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Psychological First Aid
- Art therapy
- Brief intervention
- Solution-focused therapy

- [53] Rogerian or non-directive therapy is based on the idea that the client knows best. The therapist is empathetic, authentic and accepts the client as they are. Their role is to facilitate their decisions about what to discuss during each session (Stephen, 2018)

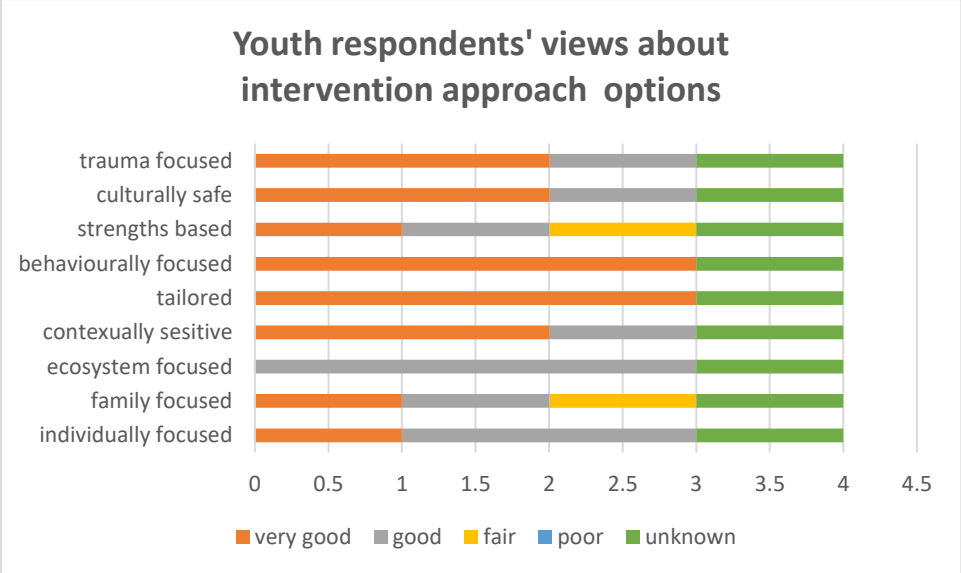
- Not just talking therapies, body centred therapies … yoga, dance, movement, art
- Family therapy

Moreover, respondents noted that approaches need to be *stabilising, not labelling, non-judgemental, relaxed* and involve *active listening* – approaches that facilitate the young person feeling accepted and which result in their being more likely to open up to the worker.

> *Not destabilise, support emotion and support resilience* (professional respondent)
>
> *Listening ear understand what they are experiencing … empathy* (professional respondent)
>
> *Non-judgemental relationships* (professional respondent)
>
> *Knowing … walk in another person's shoes … validating what a young person's life is in that space … young person can pick up judgemental attitudes from a hundred paces* (professional respondent)

Young people's views about practice and approach

The youth respondents were of the view that behaviourally-focused interventions and intervention tailored to meet their individual circumstances were the most helpful. Trauma-focused, culturally safe and contextually sensitive services were rated as very good and good. [54]



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Individually focused (intervention focused on the individual)

Frequency and Length of Service

The youth respondents were asked for their opinion about the frequency and length of service. Most of the youth respondents commented that weekly sessions were adequate for them but they recognised that some young people might want to see a service provider more often especially after a recent sexual harm.

> *Tailor to the individual. Lot of people do well with once a week … some people need to check in every day, especially when sexual harm has just happened* (youth respondent).
>
> *Weekly … prepare myself, go home and not think about the abuse all the time. If I had to go a few times each week that's all I'd be thinking about* (youth respondent).
>
> *Weekly to stay connected* (youth respondent).

Family focused (intervention with youth and their whānau consisting of psychoeducation, family communication, and problem-solving).

Eco-system focused (examining the psychological impact of sexual harm through an ecological perspective to understand how factors at multiple levels of the social ecology contribute to post-assault sequelae)

Contextually sensitive (An approach specifically designed for people with experience of sexual harm. It is grounded in the observation that contexts beyond abuse trauma, especially restrictions in psychological development stemming from growing up in an ineffective family environment, appreciably impact the adjustment of many people. Contextual therapy proposes that remediation of developmental gaps is essential to equip them to move beyond symptom reduction to the attainment of adequate social and occupational functioning).

Tailored to the individual (service individualised to meet the specific needs of an individual)

Behaviourally focused (An approach that explores how someone's thoughts and beliefs influence their actions and moods. It often focuses on a person's current problems and how to solve them. The long-term goal is to change a person's thinking and behavioural patterns to healthier ones).

Strengths-based (concentrate on the inherent strengths of individuals and their families, deploying personal strengths to aid recovery and empowerment)

Culturally safe (cultural safety seeks to achieve a better service through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing youth to determine whether an encounter with a professional is safe)

Trauma focused approach to therapy recognizes and emphasizes understanding how the traumatic experience impacts a youth's mental, behavioural, emotional, physical, and spiritual well-being

With respect to the length of service, most of the youth respondents preferred an integrated approach whereby they saw a crisis service for a period of time followed by a longer-term counselling service.

> *Dealing with the immediate crisis services should be between 3-6 months before you move on to another type of support. Sexual harm … dealing with things that pop up and trigger several years later. If I couldn't go back, I think my choices would be limited* (youth respondent).

> *How long is a piece of string … until the person is feeling better. Nobody goes back to the place they were at before the sexual harm occurred … at a point where they are at peace with themselves, got the skills to deal with it on their own and go back to service if needed. Lot of people take at least 1 year to get some substantial results* (youth respondent).

> *More than two years … sometimes I have a really bad day … the experience of trauma … It's a stop start thing. Need a long-term service with breaks … flexible to access when needed* (youth respondent).

Workforce Background and Competencies

Employing a diverse workforce of *all genders, all ethnicities and all ages* was important to those interviewed. The respondents were all of the view that a qualified workforce was necessary.

> *Psychologist, social worker, clinical nurse specialist … professionals because of the complexity of the sexual harm work* (professional respondent)

> *Qualified in the area as need to have a framework to work from … good concept of human development* (professional respondent)

They noted that it was important that the workforce *was committed to working with young people, had a good understanding of youth development* and had *experience working with people who had been harmed and experienced trauma.* In addition, respondents advised that it was necessary to employ people who were trained in crisis intervention and had the *therapeutic tools to work with young people.*

> *Clinicians with an understanding of the impact of porn, sexting and social media has on youth culture. So many blamed for sending nude photos but has no weight on harm that may occur. No means no* (professional respondent).

> *Clinicians have an understanding and awareness that the impact of the trauma is ongoing* (professional respondent)

The characteristics the respondents wanted for staff included a non-judgemental, compassionate and empathetic approach, emotionally intelligent and able to *engage with young people at their level whilst maintaining professional boundaries.*

> *Able to read a person in that particular moment so you can pitch your interaction with them … not wordy, not talking too much, not talking too clinically, intuitive knew how to act … move slowly, got down on her knees … flight and fright thing … she read it beautifully* (professional respondent).

> *Culturally competent … need to be able to work with identity, socio-demographic diversity, cultural identity, work in respectful manner … cultural awareness of refuges and migrant communities … certain views about the body … religion may underpin their thoughts and values, males higher in the hierarchy than women and acknowledging that* (professional respondent).

Knowing about the system of support was also considered important as was being a team player.

> *Knowing what services are available and knowing who to talk to* (professional respondent).

A few respondents noted employing people with lived experience as acceptable *as long as they were well down their healing journey and were not easily triggered.*

Some respondents spoke about the lack of specialist training for working in the sexual harm sector in tertiary education facilities. This issue and the fact that not every professional wants to work with people who have experienced sexual harm, meant that the pool of people available to do this work as small.

> *Lack of specialism in tertiary education and therefore not the people to draw on to recruit … use an apprenticeship model* (professional respondent).

> *Whoever is recruited needs to be retrained as there is no training pathway post-university* (professional respondent)

Youth respondents' view about workforce capability

The youth respondents had mixed views about whether qualifications were necessary for an employee working with young people who have experienced sexual harm. Whilst all

favoured working with someone with lived experience as long as their experiences did not breach professional boundaries.

> *Support me and not have their experiences impact me then it's OK* (youth respondent)

> *Lived experience … if someone has this and is now living well … able to build relationship based on what trauma does to someone. Breaks done the barriers … some people struggle with a professional being above them … lived experience closer to the same level* (youth respondent)

All believed that cultural competence and practicing with trauma models was important.

> *Everyone needs to be culturally competent … respectful of other cultures* (youth respondent)

> *Trauma-informed practice needed to deal with situations … knowing what is needed* (youth respondent)

All believed that building trusting relationships as an important competency of workers in a youth sexual harm service.

> *Trusting relationships most important attribute … not going to bond with a person if you can't trust them … personable, communicate with people, kind, helpful, empathetic* (youth respondent)

The characteristics of staff that the youth respondents noted were important to them included being a *good listener, caring, empathetic* and having *the best interests of the youth at the heart of their practice* (youth respondent).

> *Not putting words in my mouth or finishing my sentences. Give me a platform to speak freely and to be able to be heard and understood* (youth respondent).

> *Understanding my feelings and thoughts* (youth respondent)

Infrastructure

Governance

The respondents agreed that youth representation on the board of trustees was important *to hold the service accountable.* They also advised those on the governance group to model *tolerance, flexibility and have strong boundaries* for management and frontline workers and hold the vision strongly over the long term because *achieving results can take up to ten years.*

Staff

Valuing staff was of great importance to the respondents who noted the risk of employees experiencing vicarious trauma and burnout.

> *Being valued … personally thanked, given a koha. manaakitanga … having nice tea and cake in the cupboard* (professional respondent).

They suggested a number of strategies to counter these health and safety risks including:

- Providing a safe nurturing workplace environment

- Access to *regular, free supervision* and debriefing processes

  > *Provide supervision for all staff including the reception staff … hear dreadful stories day after day … keeping boundaries so that they can keep themselves safe … not getting so upset and realising that this is someone else's life and that it's your job to be there and help … debriefing within the team* (professional respondent)

- Having variety in the work and *seeing progress to maintain empathy and emotional intelligence* (professional respondent)

- Having sustainable workloads and human resources that match the service demand

  > *Time, space and resourcing for staff … if we don't do that then we burn people out* (professional respondent)

- Appropriate remuneration for the level of expertise

- On-going professional development, for example *in-service training by experienced clinicians* (professional respondent)

- Frontline workers supported by clinical and management leadership

  Not feel you're on your own … for example, don't report to Oranga Tamariki on your own. Consult with somebody first (professional respondent).

  Mandatory reporting … all people under 18 years … discuss within a multidisciplinary meeting and develop a plan and support. Not make decisions on your own (professional respondent).

Policies

Having a range of policies concerning staff health and safety, practices when working with youth, cultural practices and organisational culture were noted by respondents.

Strength-based policies … What can we do to grow? How can we provide an environment that is trusting, accepting and tolerant? (professional respondent)

Policies … pathway to making a notification to Oranga Tamariki … explain the process of making a report of concern when a young person discloses (professional respondent)

Policy about how to behave when working with youth (professional respondent)

Policies about looking after staff … giving them mental health days if they need it … (professional respondent)

Legislation, Policies & Regulations: **What a sexual harm crisis support service needs to consider?**	
The Children's Act 2014 [56]	Children's worker safety checking helps identify the small number of people who pose a risk to children. The government safety checking regulations made under the Act require all paid employees and contractors who work with children for state-funded organisations to be safety checked. The regulations also apply to people doing unpaid work with children

[56] Source: https://www.legislation.govt.nz/act/public/2014/0040/latest/whole.html

	as part of an educational or vocational training course (e.g., trainees or students).
Oranga Tamariki Act 1989 [57]	*Reports of concern for young people under 18 years* (professional respondent) *Reporting to OT … consult with somebody first … not feel like you are on your on (professional respondent)* *Information sharing* (professional respondent)
Health and Safety Act 2015 [58]	
Privacy Act 2020 [59]	The Privacy Act has 13 principles that cover the collecting, storing, using or disclosing (sharing) personal information. The Privacy Act says you can, if necessary, disclose (share) personal information to prevent or lessen a serious threat to either: • Public health or public safety; or • The life or health of that person, or of another person
Information Sharing Guidelines [60]	Oranga Tamariki Act 1989 Family Violence Act 2018

[57] Source: https://www.legislation.govt.nz/act/public/1989/0024/latest/DLM147088.html
[58] Source: https://www.legislation.govt.nz/act/public/2015/0070/latest/DLM5976660.html
[59] Source: https://www.legislation.govt.nz/act/public/2020/0031/latest/LMS23223.html
[60] Source: https://orangatamariki.govt.nz/assets/Uploads/Working-with-children/Information-sharing/Information-sharing-Guidance-OT-Act-1989.pdf

	Privacy Act 2020 *Ability for workers with consent to pass on the story between each other so the victim is not repeating the story of the abuse to mum, Police, counsellor, ACC etc* (professional respondent)
Consent to receive services [61]	*Need to have consent to engage with our service regardless of the age of the young person … parents and young person if under 17 years and young person if over 17 years* (professional respondent).
MSD Operating Procedures	
ACC Criteria for Operating	*ACC criteria for operating (number of sessions, timeframes, trained people, follow process to engage people and that we are operating within scope; if can't help person then find something else for them; safety and child protection legislation, health and safety procedures)* (professional respondent)

[61] Source: The consent of all children and young people should be sought or, if they are too young, health practitioners should find out the child's or young person's wishes and take these into account.

Young people aged 16 or over have the same rights as adults to consent to treatment. There are situations when a health practitioner finds that a child or young person aged under 16 years has the understanding and maturity to form a balanced judgement about the proposed treatment and then the child or young person can be treated without parental consent. If the child or young person does not have such understanding, parental consent must be secured before treatment is given. Retrieved from: https://www.kidshealth.org.nz/principle-7-children-young-people-need-information

The youth respondents were asked to reflect on information sharing amongst agencies. They were all of the view that the *benefits outweighed the negatives,* for example not having to retell the details of their sexual harm, as long as information security was tight.

> *Sharing information can be good … someone working with youth knows exactly what the person has told them rather than relying on their memory. Switch over a service … not want to discuss the trauma again … if it's written down it can be shared with other agencies* (youth respondent).
>
> *Having information written down means that the agencies have listened and heard what I've said* (youth respondent).

Outcomes

The respondents were asked to identify the outcomes that might be achieved for young people who attended a sexual harm crisis support service. The professional respondents noted the short-, medium- and long-term outcomes that may be achieved from delivering a sexual harm crisis support service for youth. These outcomes are noted in Table 8.

Table 8: Outcomes Identified by Professional Respondents

Short-term outcomes	Medium-term outcomes	Long-term outcomes
• Experienced confidentiality & privacy • Engaged in service • Voice heard & understood • Felt accepted • Stabilised • Safe • Physiological needs met • Feel validated & believed • Understand Police investigation processes • Understand the forensic & medical check processes	• Needs fulfilled • Positive whānau, peer and community relationships • Ready for & participating in long-term therapy • Whānau coping & supportive • Positive & trusting experiences with social services • Resume everyday activities	• Reduced revictimization • Reduced suicide rates • Reduced rates of self-harming • Engaged in education, training or employment • Reduced substance abuse • Create your own family • Experiencing healthy relationships • Positive life functioning & wellbeing • Less frequent memories of trauma • Feel safe, confident & powerful

The success factors identified by the professional respondents that result in such outcomes included:

- Working with staff who are non-judgemental, accepting, flexible and who take a positive youth development approach
- A long-term (1-2 years) relationship with a counsellor who sustains the young person and develops their strengths.

The short-, medium- and long-term outcomes for youth who participate in a youth sexual harm crisis support service identified by the youth respondents are outlined in Table 9.

Table 9: Outcomes Identified by Youth Respondents

Immediate outcomes	Intermediate outcomes	Long-term outcomes
• Improved understanding of consent • Improved understanding about the red flags of an unhealthy relationship and the green flags of a healthy relationship • Feeling safe • Improved understanding about reactions after a trauma • Understand how to manage the symptoms of psychological trauma • Understanding about how the brain works after a trauma	• Higher rates of conviction for those who commit sexual harm • Knowledge about how to feel better • Improved self-worth • Return to school with an understanding about how to support the young person • Knowledge of how to access help	• Personal closure • Empowered • Feeling safe from the person who caused the sexual harm • Find employment, return to study, get a hobby • Inner peace & calm

The success factors identified by the youth respondents that contribute to the achievement of such outcomes included:

- Developing a trusting relationship in which the young person feels listened to and heard [62]

[62] The youth respondents reflected that it was difficult for them to trust others after their experience of sexual harm as *their relationships of trust had been compromised* (youth respondent).

- Providing therapy and support group services that assist the young person with their emotional and mental health and with their relationships
- Providing services that advocate for young people within the school system, to access the Sexual Health Clinic and to access a WINZ disability allowance
- Providing education programmes to help young people understand what is an unhealthy relationship? What is consent? etc.
- Deliver services in a flexible manner … *as and when people need it not for a certain amount of time* and at times when youth are available … *a lot of people can't afford to take time off work*

Sustainability

Respondents were asked to identify the factors they thought were important to ensure the sustainability of the new sexual harm crisis support service for young people. They identified three factors: human resources, funding, and drawing on the target group's expertise in designing the service.

Human resources

The most important factor in sustaining the service identified by the respondents was looking after the health, safety and wellbeing of the employees who delivered the service.

> *Good quality employment conditions* (professional respondent)
>
> *The most significant tool is the human being … so chose well, look after them, realistic workloads and time to do the work, debrief … have a team approach when things get thorny* (professional respondent)
>
> *An onerous job … scratching the underbelly, harsh stories … not full time as high-trauma contact, workloads to match* (professional respondent)
>
> *Value staff … look after them … give them decent wages … provide supervision … look after their wellbeing* (professional respondent)

Funding

The second most frequently identified factor that respondents believed contributed to service sustainability was for organisations to access a viable level of diverse funding sources to enable them to operate a high-quality service.

Not be reliant on government funding … get diverse funding sources (professional respondent)

Co-design with target group

The final factor associated with service sustainability was to have young people involved in the service's design and to use the youth development principles as the foundation for all management and clinical decisions.

Young people involved in the development of the service and base the service on youth development principles (professional respondent).

Part Five: Pulling It All Together with a Theory of Change

Unpacking the Outcomes and Success Factors

A programme theory has been developed for the sexual harm crisis support service for young people that explains how the necessary preconditions (i.e., the resources and aspects of the intervention) are understood to contribute to a chain of results that produce the intended impacts. This programme theory has been developed using the respondents' views together with the empirical evidence about the factors that contribute to the short and intermediate outcomes.

Long-term Outcomes

The New Zealand Ministry of Social Development (2017) described the ultimate outcomes that a sexual harm crisis support service contributes to in their intervention logic model. These outcomes included:

- Safe, attentive and responsive communities of care
- Healthier youth, families and whānau, and more vibrant communities
- Decrease in sexual harm within communities and an increase in youth wellbeing
- Reduction in costs of sexual harm impacts on NZ society.

Working backwards from these ultimate outcomes, the long-term outcomes that the empirical and experiential data indicated could be achieved from a sexual harm crisis support service included:

- Reduced revictimization
- Reduced psychiatric disorders such as reduced rates of self-harming, reduced suicide, reduced substance abuse and reduced PTSD symptoms such as anxiety and depression
- Healthy relationships with family, peers and community
- Re-integration into positive life functioning such as returning to employment, returning to study, getting a hobby
- Personal closure which includes feeling safe, calm, an inner peace, empowered and uniting the trauma into the young person's life

Intermediate Outcomes

The intermediate outcomes identified by the respondents included:

- Increased coping skills such as breathing and relaxation exercises and mindfulness
- Increased knowledge about how to access help
- Increased levels of connection to support systems (family, peers, community)
- Stabilised including more regulated (to allow relational and cognitive experiences to impact), increased feelings of emotional, psychological and physical safety, returning to life routines (sleeping, eating, school, interacting with peer group)
- Increased readiness for long-term trauma therapy
- Improved engagement and retention in helping services which is facilitated by building trusting and positive experiences with the sexual harm crisis support service

Short-term Outcomes

Short-term outcomes identified in the literature and by the respondents included:

- Increased participation in medical and criminal justice systems through understanding the forensic and Police processes
- Increased participation in integrated psychosocial services as a result of receiving crisis services from a worker who gained the young person's interpersonal trust, who responded in a youth-centric, developmentally appropriate manner and with integrity and who was not judgemental
- Increased feelings of control
- Increased access to protective factors such as having a supportive and trusting adult to assist the young person
- Increased understanding about the impacts of trauma through receiving psychoeducation

Inputs

The inputs which are some of the preconditions for an effective sexual harm crisis support service include:

- Qualified, trusted & highly skilled workers: Such workers have a commitment to working with young people, adopted a developmental approach and who understood youth development and the underpinning principles; used trauma-informed practice which was grounded in creating safety, promoting control and empowerment and

self-care; were culturally competent (an ability to interact effectively with young people of different cultures); and have a good knowledge of the system of psychosocial support

- Trauma informed organisation that promotes physical and interpersonal safety; that employs transparent decision-making practices; that applies mutuality to level power differences between employees and young people; that empowers young people by recognising their strengths; that maximises opportunities to exercise choice and control; that promotes inclusiveness and addresses issues of inequality; and that performs as a learning organisation
- Accessible services as a result of providing an adolescent friendly and inclusive environment; manaakitanga; diversity incorporated throughout structure, policies & practice; located in youth one-stop-shop situation that is centrally located & near public transport; and able to be accessed via multi-modal forms of communication (text; phone; Zoom & Skype)
- Family system supported
- Partnerships to deliver integrated services
- Youth involved in design and implementation (governance, management & delivery of services)
- Develop a sustainable service by accessing a diverse array of funding sources; implanting employee wellbeing policies and practices; developing and implementing an outcome monitoring framework; implementing a stakeholder engagement plan with which to ensure stakeholder ownership of the service; and undertaking an annual SWOT analysis that facilitates adaptability to changes in the internal and external environments.

Activities

The empirical and experiential evidence suggests that a sexual assault crisis support service should deliver both primary prevention services as well as tertiary prevention services. This is to ensure that the young person has a consistent and trusted agency and worker to engage with. The primary prevention services include psychoeducation to increase knowledge and understanding among young people and their families about sexual harm, consent, impact of trauma and healthy relationships, together with help seeking and appropriate ways to support a young person who has experienced sexual harm. The tertiary prevention services include providing information and advice, advocacy, crisis social work

services, crisis counselling, accompaniment, establishing a system of support for the young person and navigation of, referral to and integrated planning of other psychosocial services.

If these services are to be effective, they need to be delivered in a timely, developmentally appropriate, individualised and youth-centred manner – timely to ensure that the young person's situation does not deteriorate; developmentally appropriate by ensuring that the young person's emotional, cognitive and psychomotor development is taken into account when supporting them; individualised to ensure that it is tailored to meet the specific needs and circumstances of the young person; and youth-centred to ensure the youth' is believed, safe and in control, for example, they are given choices and full information with which to make decisions. The services need to be trauma-informed and use trauma models of practice that ensure the worker and the young person's system of support understand the wide-ranging impact of this trauma and to build the strengths of the young person within the context of their system of support. Various forms of trauma-focused cognitive-behavioural therapy have been found to be helpful in this context. Moreover, services need to be delivered with cultural competence – an awareness of one's own culture and knowledge and skills to work with young people of different cultures. Services also need to be delivered in a flexible manner, for example understanding that young people may wish to access services as and when they need them.

Another protective factor identified by the empirical and experiential evidence base was gleaning the support of a trusting adult for a young person who has experienced sexual harm. Offering support to a parent or other trusted adult by for example giving them some psychoeducation helps the young person reduce the emotional intensity of their post-sexual harm experience.

Such crisis services could be a number of months in length and provide engagement and stabilisation services to provide emotional, social and physical safety, establish a family system around the young person, as well as establish routines such as eating, sleeping and going to school. A crisis service can also support and prepare young people for when they are ready for, or a long-term trauma counselling service is available.

Figure 3: Theory of Change

Ultimate Outcomes [63]

- Safe, attentive and responsive communities of care
- Healthier youth, families and whānau, and more vibrant communities
- Decrease in sexual harm within communities and an increase in youth wellbeing
- Reduction in costs of sexual harm impacts on NZ society.

Problem statement: young people who have experienced sexual harm are at risk of adverse physical, psychological, behavioural and sexual impacts

Inputs	Activities	Short-term Outcomes	Medium-term Outcomes	Long-term Outcomes
		Outcomes for young people		
Qualified & highly skilled workers Young people aged 13-25 years Supportive family systems Accessible agency & services Trauma-informed & culturally competent agency Diversity incorporated throughout structure,	Deliver primary prevention programmes to young people & their whānau	• Reduced normalisation of sexual harm • Increased awareness of actions to take if you or someone else is sexually harmed • Increased knowledge of risk-reduction strategies • Increased understanding of consent • Improved understandings about the red flags of an unhealthy relationship • Increased knowledge about help seeking	• Healthy relationships • Early disclosures and more immediate positive responses to youth experiencing sexual harm • Enhanced community awareness and pro-social responding to sexual harm.	

[63] Source: Ministry of Social Development (2017)

policies & practice Partnerships to deliver integrated services Youth involved in design & implementation of services Sustainable		• Increased disclosure		
	Deliver timely, development & age appropriate, trauma informed trauma specific & culturally competent services Two-generation approach to intervention Build relationships with diverse stakeholder to enable integrated services	• Increased participation in medical, forensic, criminal justice & psychosocial services • Increased feelings of control • Increased access to protective factors • Increased understanding of impacts of trauma	• Increased coping skills • Increased access to helping services • Increased connection to support systems • Stabilised • Increased readiness for long-term therapy • Improved service engagement and retention • Reduced long-term impacts for youth and greater resiliency/productivity • Increased self-esteem/efficacy and restoration of mana.	• Reduced revictimization • Reduced psychiatric disorders • Healthy relationships • Re-integration into positive life functioning • Personal closure

This theory of change provides a visual representation of the outcomes of a sexual harm crisis support service for young people and the way in which the results will be achieved. It can be used for a variety of purpose including service planning, as a communication tool that captures the complexity of delivering the service and the performance story; and a blueprint for measuring indicators of success and as the basis for reports to funders and governance groups.

In the light of this theory of change for a sexual assault crisis support service the following recommendations are offered:

I. Select qualified and highly skilled employees who are committed to working with youth in a youth development, developmentally appropriate, trauma informed and family systems manner. They must be compassionate, empathetic and non-judgemental, have strong interpersonal relationship skills, be culturally competent and be flexible and adaptable
II. Deliver the service from a centrally located youth centre which offers a range of activities and services for youth as well as offering services via technology – both of which have been found to protect the privacy and confidentiality of young people

III. Deliver primary prevention and tertiary prevention services to provide a trusted and consistent agency for young people to access as well as providing a balanced workload for workers to prevent vicarious trauma and burnout.

IV. Provide sexual harm support services for a number of months and deliver engagement and stabilisation services. These services are intended to provide emotional, social and physical safety and meet those needs, establish a family system around the young person, establish routines and prepare the young people for when they are ready for, or a long-term trauma counselling service is available.

V. Structure the service in a way that is tight as well as loose – loose to address the flexible approach taken by young people (adaptable) and tight in terms of providing services that only engage and stabilise the young person without entering into long-term trauma therapy

VI. Tailor the service and information to meet the developmental stages of the diverse range (age, gender, ethnicity, diversity of environmental circumstances etc.) of young people accessing the service

VII. Utilise research-informed models of practice such as psychological first aid, crisis counselling, trauma informed cognitive behavioural counselling, strengths-based counselling

VIII. Explore ways in which the sexual assault crisis support service can include Te Ao Māori and Te Reo in the delivery of services; reflect the bicultural nature and diversity of cultures within New Zealand; and include cultural competency and cultural safety professional development opportunities for staff.

IX. Develop a trauma informed and culturally competent organisation to support the sexual harm crisis support service

X. Develop a service that is accessible for young people by providing a youth friendly, welcoming and inclusive environment – a service that incorporates manaakitanga

XI. Include family or an adult support system for all young people especially for those in their early and mid-teens

XII. Establish and maintain partnerships with a range of psychosocial services especially those with whom there is often inequality of services access and responsiveness

XIII. Involve youth in the design and implementation of the sexual harm crisis support service (governance, management & delivery of services)

XIV. Enhance the sustainable of the service by accessing a diverse array of funding sources; implement employee welling policies and practices; develop an outcome monitoring framework; develop and implement a stakeholder engagement plan with which to ensure stakeholder ownership of the service; and undertake an annual SWOT analysis that facilitates adaptability to changes in the internal and external environments.

XV. Undertake a longitudinal research and evaluation project as part of the ongoing programme that considers the longer-term psychosocial outcomes from the implementation of a sexual harm support services. The detrimental impacts of sexual harm warrants gathering evidence about its impact on the psychosocial and economic outcomes for young people as well as outcomes for their whānau and their communities.

References

Abbey, A., Zawacki, T., Buck, P., Clinton, M., & Mcauslan, P. (2001). Alcohol and sexual assault. *Alcohol Research and Health, 25*(1), 43.

Abbey, A., Parkhill, M.R., BeShears, R., Clinton-Sherrod, A.M., & Zawacki, T. (2006). Cross-sectional predictors of sexual assault perpetration in a community sample of single African American and Caucasian men. *Aggressive Behaviour.* 32:54–67. doi:10.1002/ab.20107.

Ackard, D.M. & Neumark-Sztainer, D. (2002). Date violence and date rape among adolescents: Associations with disordered eating behaviours and psychological health. *Child Abuse Neglect, 26*(5): 455-73. DOI: 10.1016/s0145-2134(02)00322-8

Ageton, S. (1983). *Sexual assault among adolescents.* Lexington, Mass: Lexington Books.

Ahern, E. C., Hershkowitz, I., Lamb, M. E., Blasbalg, U., & Winstanley, A. (2014). Support and reluctance in the pre-substantive phase of alleged child abuse victim investigative interviews: Revised versus standard NICHD protocols. *Behavioural Sciences and the Law, 32*(6), 762–774. https://doi.org/10.1002/bsl.2149

Ahrens, K. R., DuBois, D. L., Garrison, M., Spencer, R., Richardson, L. P., Lozano, P. (2011). Qualitative exploration of relationships with important non-parental adults in the lives of youth in foster care. *Children and Youth Services Review, 33*, 1012-1023.

Alaggia, R., Collin-Vézina, D., & Lateef, R. (2017). Facilitators and barriers to child sexual abuse (CSA) disclosures. *Trauma, Violence, & Abuse152483801769731*. https://doi.org/10.1177/1524838017697312.

Allnock, D., Bunting, L., Price, A., Morgan-Klein, N., Ellis, J., Radford, L. & Stafford, A. (2009). *Sexual abuse and therapeutic services for children and young people: The gap between provision and need.* London: NSPCC

Altarum Institute (2009). *Literature review: Defining sustainability of Federal Programs based on the experiences of the Department of Health and Human Services Office on women's multidisciplinary health models for women.* Paper prepared for the U.S. Department of Health and Human Services, Office of Women's Health. Ann Abor, MI: Altarum Institute.

Amar, A., & Gennaro, S. (2005). Dating violence in college women: Associated physical injury, healthcare usage, and mental health symptoms. *Journal of Nursing Research, 54*(4): 235-42. Doi 10.1097/00006199-200507000-00005.

American College of Obstetricians and Gynaecologists (2001). Adult manifestation of childhood sexual abuse, number 259, July 2000. *Int J Gynaecology Obstetricians 74*(3):311-20. doi: 10.1016/s0020-7292(01)00491-x.

American Psychological Association (APA). (2011). *Resilience for teens: Got bounce?* Retrieved from http://www.apa.org/helpcenter/bounce.aspx

Anderson, L. M., Hayden, B. M., & Tomasula, J. L. (2014). Sexual assault, overweight, and suicide attempts in U.S. adolescents. *Suicide and Life-Threatening Behaviour, 45*, 529-540. doi:10.1111/sltb.12148

Anderson, L.M., Shinn. C., Fullilove, M.T., et al. (2003). The effectiveness of early childhood development programs. A systematic review. *Am J Prev Med,* 24:32-46.

Andrews, G., Corry, J., Slade, T., Issakidis, C., & Swanston, H. (2004). *Child sexual abuse. Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors.* Geneva: WHO. Vol. 2

Arellano, M.A.R., Lyman, D.R., Jobe-Shields, L., George, P., Dougherty, R.H., Daniels, A.S., & Delphin-Rittmon, M.E. (2014). Trauma-focused cognitive-behavioural therapy for children and adolescents: Assessing the evidence. *Psychiatr Serv,* 65(5):591-602.

Armsworth, M.W. (1989). Therapy of incest survivors: Abuse or support? *Child Abuse Neglect, 13*(4):549-62. doi: 10.1016/0145-2134(89)90059-8.

Azeem, M.W., Aujla, A., Rammerth, M., Jones, R.B. et al., (2011). Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital. *Journal of Child and Adolescent Psychiatric Nursing 24*(1):11-5. DOI: 10.1111/j.1744-6171.2010.00262.x

Baccuhus, L., Aston, G., Murray, S., Vitolas, C. and P. Jordan (2008). *Evaluation of an Innovative Multi-agency Domestic Violence Service at Guy's and St. Thomas' NHS Foundation Trust.* London: King's College, University of London.

Backe, E. L. (2018). A crisis of care: The politics and therapeutics of a rape crisis hotline. *Medical Anthropology Quarterly, 32*(4), 463–480. https://doi.org/10.1111/maq.12463

Banyard, V. L. & Cross, C. (2008). Variables in Ecological Context. *Violence Against Women* 14, 998–1013.

Barkhurst, P., Fowler, H., Siadal, I., & Vokes, S. (2002). *Attorney general's sexual assault task force: Sexual assault response team (SART) handbook (Version I).* Retrieved from: http://www.oregonsatf.org/documents/PDFVersionofSARTHandbook.pdf.

Barrett, A., Kamiya, Y., & O'Sullivan, V. (2014). Childhood sexual abuse and later-life economic consequences. *Journal of Behavioural and Experimental Economics,* 53:10-16.

Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. *Journal of Transcultural Nursing, 13*(2), 145-152.

Bechtel K, Ryan E, Gallagher D. (2008). Impact of sexual assault nurse examiners on the evaluation of sexual assault in a paediatric emergency department. *Pediatr Emerg Care. 24*(7):442–7. doi:10.1097/PEC.0b013e31817de11d

Beery, W.L., Senter, S., Cheadle, A., Greenwald, H.P., Pearson, D., Brosseau, R., et al. (2005). Evaluating the legacy of community health initiatives: A conceptual framework and example from the California Wellness Foundation's Health Improvement Initiative. *American Journal of Evaluation*, *26*: 150-165.

Belknap, J. & Erez, E. (1995). The Victimization of women on college campuses: Courtship violence, date rape, and sexual harassment, (156-178). In *Campus Crime: Legal, Social, and Policy Perspectives* (B. S. Fisher and I. Sloan, John J., Eds.). Springfield, Illinois: Charles C. Thomas Publisher.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organisational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Services, 84*(4), 463–470

Beres, M.A., Senn, C.Y., & McCaw, J. (2013). Navigating Ambivalence: How Heterosexual Young Adults Make Sense of Desire Differences. *Journal of Sex Research*, DOI: 10.1080/00224499.2013.792327

Beres, M. (2017). *Preventing adolescent relationship abuse and promoting healthy relationships*. Issues Paper 12. Auckland: The New Zealand Family Violence Clearing House.

Bergman, L. (1983). Dating violence among high-school-students. *Social Work,* 37:21–27.

Bergman, L. (1992). Dating Violence among High School Students. *Social Work, 37*(1): 21-27. https://doi.org/10.1093/sw/37.1.21

Berkowitz, S. J., Stover, C. S., & Marans, S. R. (2010). The child and family traumatic stress intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*. Retrieved from http://www.med.upenn.edu/ traumaresponse/documents/cftsi.pub.pdf.

Berkowitz, S.J., Stover, C.S., & Marans, S.R. (2011). The child and family traumatic stress intervention: secondary prevention for youth at risk of developing PTSD. *J Child Psychol Psychiatry,* 52: 676-685. DOI: 10.1111/j.1469-7610.2010.02321.x

Berelowitz, S., Firmin, C., Edwards, G., & Gulyurtlu, S. (2012). *I thought I was the only one. The only one in the world. The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups: Interim report*. London: The Office of the Children's Commissioner in England.

Bernard, J.M. & Goodyear, R.K. (1992). Fundamentals of Clinical Supervision. *Counsellor, 31*(3): 175-178. https://doi.org/10.1002/j.1556-6978.1992.tb00158.x

Breslau, N. (2009). The epidemiology of trauma, PTSD, and other post trauma disorders. *Trauma Violence Abuse*, *10*(3):198–210

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T. ,…Stevens, M. R. (2011). *National Intimate Partner and Sexual Violence Survey: 2010 summary report.* Retrieved from the Centres for Disease Control and Prevention, National Center for Injury Prevention and Control: https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

Blanco, L., Nydegger, L. A., Camarillo, G., Trinidad, D. R., Schramm, E., & Ames, S. L. (2015). Neurological changes in brain structure and functions among individuals with a history of childhood sexual abuse: A review. *Neuroscience & Biobehavioural Reviews, 57*, 63–69.

Bloom, S.L. (2020). The Impact of Trauma on Development and Well-being. In Ginsburg, K.R., & Itasca, M.Z. (Eds.) *Reaching Teens: Strengths-based, Trauma-sensitive, Resilience-Building Communication Strategies Rooted in Positive Youth Development*. Second Edition. Elk Grove Village, United States: American Academy of Paediatrics.

Bober, T, Regehr, C. (2006). Strategies for Reducing Secondary or Vicarious Trauma. *Brief Treatment and Crisis Intervention*, 6:1.

Brabant, M-E, Hébert, M., & Chagnon, F. (2012). Les symptômes dépressifs, les idéations et les tentatives suicidaires chez les adolescents ayant vécu une agression sexuelle. In: Hébert M, Cyr M, Tourigny M, organizadores. L'agression sexuelle envers les enfants. Tome II. Québec: Presses de l'Université du Québec; p. 55-89.

Bradfield and Nyland (2002). *Management Support Unit. 'Information Sheet 1: Good Governance'*. Australia: NCOSS.

Brannigan, R., Schackman, B. R., Falco, M., & Millman, R. B. (2004). The quality of highly regarded adolescent substance abuse treatment programs. *Archives of Paediatric and Adolescent Medicine, 158*, 904-909.

Brayley, H., Cockbain, E., & Gibson, K. (2014). *Rapid evidence assessment – the sexual exploitation of boys and young men*. Barnardo's, London.

Breslau, N. (2009). The epidemiology of trauma, PTSD, and other post trauma disorders. *Trauma, Violence, & Abuse, 10*: 198–210.

Briere, J., & Lanktree, C. (2012). *Treating Complex Trauma in Adolescents and Young Adults.* New York: Sage Publications Inc. DOI**:** http://dx.doi.org/10.4135/9781452240497

British Columbia Ministry of Public Safety and Solicitor General (2007). *Sexual assault: Victim service worker handbook*. British Columbia: Justice Institute of British Columbia for the Ministry of Public Safety and Solicitor General, Victim Services and Crime Prevention Division). Retrieved from: http:// www.pssg.gov.bc.ca/victimservices/service-provider/docs/victim-service-worker-sexual-assault.pdf

Broaddus-Shea, E., Kobeissi, L., Ummer, O., & Say, L. (2019). A systematic review of monitoring and evaluation indicators for sexual and reproductive health in humanitarian settings. *Conflict & Health, 13*(43): 1-26.

Brown, S. A., Parker, J. D., & Godding, P. R. (2002). Administrative, clinical and ethical issues surrounding the use of waiting lists in the delivery of mental health services. *Journal of Behavioural Health Services and Research, 29*, 217–228.

Browne, A., & Finkelhor, D. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530–541.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*, 66–77.

Brownlie, E.B.J.A., Jabbar, A., Beitchman, J., Vida, R., & Atkinson, L. (2007). Language impairment and sexual assault of girls and women: findings from a community sample. *J Abnorm Child Psychol*,35(4):618–626.

Buist, K.L., Dekoviæ, M., & Prinzie, P. (2013). Sibling relationship quality and psychopathology of children and adolescents: A meta-analysis. *Clin Psychol Rev,* 33(1):97-106.

Bureau of Justice (2006). *Criminal Victimisation in the US: Statistical Tables*. Washington, DC: US Department of Justice.

Caffo, E., & Belaise, C. (2005). Children and adolescents' psychopathology after trauma: new preventive psychotherapeutic strategies. In K.V. Oxington (Ed.), *Psychology of Stress* (pp. 145–163). Hauppauge: Nova Science.

Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence against Women, 12*(1): 30–45

Campbell, R. (2012, December 3). *The neurobiology of sexual assault* [Webinar]. Retrieved from the National Institute of Justice: https://nij.gov/multimedia/presenter/presenter-campbell/Pages/welcome.aspx

Campbell, R., Greeson, M.R., Bybee, D., Kennedy, A., & Patterson, D. (2011). *Adolescent Sexual Assault Victims: Experiences with SANE/SARTS and the Criminal Justice System*. Michigan: Michigan State University.

Campbell, R., Greeson, M. R., & Fehler-Cabral, G. (2013). With care and compassion: Adolescent sexual assault victims' experiences in sexual assault nurse examiner programs. *Journal of Forensic Nursing, 9*(2): 68–75. https://doi.org/10.1097/JFN.0b013e31828badfa

Cangwa, M.C., & Pather, M.K. 92008). The management of sexual assault victims at Odi District Hospital in the North West Province: how can the quality of hospital care be improved? *S Afr Fam Pract., 50*(6):45. doi:0.1080/20786204.2008.10873783/.

Cascardi, M., & Avery-Leaf, S. (2003). Case study of a School-Based Violence Prevention Program. *Sage Open*: 1-9. Doi: 10.11771215824401455171 6

Cascardi, M. & Avery-Leaf, S. (2003). Violence Against Women: Synthesis of Research for Secondary School Officials. *Juv. Justice*.

Casey, E. A. & Lindhorst, T. P. (2009). Toward a Multi-Level, Ecological Approach to the Primary Prevention of Sexual Assault. *Trauma, Violence, Abuse. 10*, 91.

Castelli, P., & Goodman, G. S. (2014). Children's perceived emotional behaviour at disclosure and prosecutors' evaluations. *Child Abuse and Neglect, 38*(9), 1521–1532. https://doi.org/10.1016/j.chiabu.2014.02.010

Centre on the Developing Child at Harvard University (2007). *A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behaviour and health for vulnerable children.* Retrieved from: http://www.developingchild.harvard.edu/content/downloads/Policy_Framework.pdf

Centres for Disease Control and Prevention. (n.d.) *Sexual violence in youth: Findings from the 2012 National Intimate Partner and Sexual Violence Survey.* Retrieved from https://www.cdc.gov/violenceprevention/pdf/2012FindingsonSVinYouth.pdf

Centres for Disease Control. (2000). *Rape Fact Sheet* [Brochure]. Retrieved from http://www.cdc.gov/ncipc/factsheet/rape.htm

Centres for Disease Control and Prevention (2013). *Sexually Transmitted Disease Surveillance 2013*. Atlanta: U.S. Department of Health and Human Services.

Centres for Disease Control. (2013). *Sexual Violence in Youth: Findings from the 2012 National Intimate Partner and Sexual Violence Survey*. Retrieved from: https://www.cdc.gov/ violenceprevention/pdf/2012FindingsonSVinYouth.pdf.

Centre for Enquiry into Health and Allied Themes (CEHAT). (2012). *Establishing a comprehensive health sector response to sexual assault*. Mumbai, India: Centre for Enquiry into Health and Allied Themes.

Center for School Mental Health Assistance (20023). *Crisis Intervention: A Guide for School-based Clinicians*. Baltimore: Center for School Mental Health Assistance

Center for Mental Health Services. (2008). *Community Mental Health Services for Children and Their Families Program: Request for applications (RFA)*. Rockville, Maryland: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2008). *Sustaining grassroots community-based programs: A toolkit for community- and faith-based service providers.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Chandler, G. (2008). From Traditional Inpatient to Trauma-Informed Treatment: Transferring Control from Staff to Patient. *Journal of the American Psychiatric Nurses Association, 14*(5). Doi: https://doi.org/10.1177/1078390308326625

Chandy, J. M., Blum, R. W., & Resnick, M. D. (1996). History of sexual abuse and parental alcohol misuse: Risk, outcomes and protective factors in adolescents. *Child and Adolescent Social Work Journal, 13*(5), 411–32.

Cheng, T., Savageau, J., Sattler, A., & DeWitt, T. (1993). Confidentiality in health care: A survey of knowledge, perceptions, and attitudes among high school students. *JAMA* 269(11):1404 - 8.

Christopher, F.S. & Cate, R.M. (1988). Premarital Sexual Involvement: A Developmental Investigation of Relational Correlates. *Adolescence* 23: 793-803.

Cieslak, T., & Henretig, F. (2003). Bioterrorism. *Pediatric Annals, 32*: 154–165.

Clarke, S. (2003). Psychoanalytic Sociology and the Interpretation of Emotion. *J. Theory Soc. Behav*. 33, 145–163

Clark, T. C. et al. (2012). *Youth '12 Overview: The Health and Wellbeing of New Zealand Secondary Students in 2012*. Auckland, New Zealand: The University of Auckland.

Clark, T.C., Moselen, E., Dixon, R., The Adolescent Health Research Group, & Lewycka, S. (2015). *Sexual and Reproductive Health & Sexual Violence among New Zealand Secondary School Students: Findings from the Youth'12 national youth health and wellbeing survey.* Auckland, New Zealand: The University of Auckland.

Cocciolone, A., Chapin, C., Breer, L. and Michigan Public Health Institute (nd). *Success Stories: Ten Michigan Rape and Sexual Assault Prevention Education Programs*. Lansing: Michigan Department of Community Health.

Cockbain, E., Brayley, H., & Ashby, M. (2014). *Not just a girl thing: A large-scale comparison of male and female users of child sexual exploitation services in the UK*. Barnardo's, London.

Cohen, J.A., Deblinger, E., Mannarino, A.P., & Steer, R.A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry,* 43(4):393-402.

Cohen, J.A., Mannarino, A.P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse Negl,* 29(2):135-145.

Collings, S. J. (2011). Professional services for child rape survivors: A child-centred perspective on helpful and harmful experiences. *Journal of Child and Adolescent Mental Health, 23*(1), 5–15. https://doi.org/10.2989/17280583.2011.594244

Conte, J. R. (1990). Victims of child sexual abuse. In R. T. Ammerman & M. Hersen (Eds.), *Treatment of family violence: A sourcebook* (pp. 50–76). New York: Wiley

Copeland, W., Shanahan, L., Costello, E., & Angold, A. (2009). Configurations of common childhood psychosocial risk factors. *Journal of Child Psychology and Psychiatry, 50*:451–459.

Cram Danielson, C.K., & Holmes, M.M. (2004). Adolescent sexual assault: An update of the literature. *Current Opinion on Obstetrics and Gynaecology, 16*, 383-388

Cram, F., Pihama, L., and Karehana, M. (1999) *Meeting the Needs of Māori Victims*

of Crime. Report prepared for Te Puni Kōkiri. Auckland: University of Auckland.

Crawford-Jakubiak, J.E., Alderman, E.M., Leventhal, J.M., Committee on Child Abuse and Neglect & Committee on Adolescence. (2017). Care of the adolescent After an Acute Sexual Assault. *Paediatrics, 139* (3) e20164243; DOI: https://doi.org/10.1542/peds.2016-4243

Creswell, J.W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches.* London & Thousand Oaks: Sage Publications.

Croft, C., Beckett, C., Rutter, M., Castle, J., Colvert, E., Groothues, C., … Sonuga-Barke, E. J. S. (2007). Early adolescent outcomes of institutionally-deprived and non-deprived adoptees. II: Language as a protective factor and a vulnerable outcome. *Journal of Child Psychology and Psychiatry, 48*(1), 31–44.

Daigneault, I., Hébert, M., & Tourigny, M. (2007). Personal and interpersonal characteristics related to resilient developmental pathways of sexually abused adolescents. *Child and Adolescent Psychiatric Clinics of North America, 16*(2), 415–34.

Danielson, C. K., de Arellano, M. A., Kilpatrick, D. G., Saunders, B. E., & Resnick, H. S. (2005). Child maltreatment in depressed adolescents: Differences in symptomatology based on history of abuse. *Child Maltreatment, 10,* 37-48. doi:10.1177/1077559504271630

Danielson, C. K., & Holmes, M. M. (2004). Adolescent sexual assault: An update of the literature. *Current Opinion Obstetrics and Gynaecology, 16*: 383-388.

Darves-Bornoz, J.M., Lépine, J.P., Choquet, M., Berger, C., Degiovanni, A., & Gaillard, P. (1998). Predictive factors of chronic post-traumatic stress disorder in rape victims. *Eur Psychiatry,* 13: 281-287

Davies, E., & Seymour, F. (2001). Medical evaluations in cases of suspected child sexual abuse: Referrals and perceptions. *New Zealand Medical Journal, 114*(1136), 334–335.

Davies, E., Seymour, F., & Read, J. (2001). Children's and primary caretakers' perceptions of the sexual abuse investigation process: A New Zealand example. *Journal of Child Sexual Abuse, 9*(2), 41–56. https://doi.org/10.1300/J070v09n02_03

Davis, L. (2009). *People with intellectual disabilities and sexual violence*. Washington, DC: The Arc. Retrieved from: www.thearc.org/what-we-do/resources/fact-sheets/sexual-violence

Davis, G., Dewey, J.M., & Murphy, E.L. (2016). Giving Sex: Deconstructing Intersex and Trans Medicalization Practices. *Gender & Society, 30*(3). Doi: 10.1177/0891243215602102

Deblinger, E., Mannarino, A.P., Cohen, J.A., Runyon, M., & Steer, R. (2011). Trauma focused cognitive behavioural therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*(1): 67-75.

Decker, M.R., Peitzmeier, S., Olumide, A. et al. (2014). Prevalence and health impact of intimate partner violence and non-partner sexual violence among female adolescents aged 15–19 years in vulnerable urban environments: a multi-country study. *J Adolesc Health,*55: S58-S67

Decker, S.E., & Naugle, A.E. (2009). Immediate intervention for sexual assault: A review with recommendations and implications for practitioners. *Journal of Aggression, Maltreatment & Trauma, 18*(4): 419-441.

Delisi, M., Kosloski, A.E., Sween, M., Drury, A. et al. (2010). Murder by numbers: Monetary costs imposed by a sample of homicide offenders. *Journal of Forensic Psychiatry and Psychology 21*(4):501-513. DOI: 10.1080/14789940903564388

Denis, C., Seyller, M., & Chariot, P. (2016). Expectations and perceptions of care among victims of sexual assault who first seek care from emergency, primary care and gynaecological doctors. *Emergency Medicine Journal, 33*(2), 134–138. https://doi.org/10.1136/emermed-2015-204655

Denson, T. F., Marshall, G. N., Schell, T. L., & Jaycox, L. H. (2007). Predictors of posttraumatic distress 1 year after exposure to community violence: the importance of acute symptom severity. *Journal of Consulting and Clinical Psychology*, 75(5), 683–692. doi:10.1037/0022-006x.75.5.683.

Díaz, R.M., Ayala, G., & Bein, E. (2004). Sexual risk as an outcome of social oppression: Data from a probability sample of Latino gay men in three U S. cities. *Cultural Diversity & Ethnic Minority Psychology,*10:255–267

Dieltjens T, Moonens I, Van Praet K, De Buck E, Vandekerckhove P (2014) A Systematic Literature Search on Psychological First Aid: Lack of Evidence to Develop Guidelines. *PLoS ONE 9*(12): e114714. https://doi.org/10.1371/journal.pone.0114714

Deimer, K., Powell, A., & Webster, K. (2018). *Four in ten Australians think women lie about being victims of sexual assault.* Retrieved from: https://theconversation.com/four-in-ten-australians-think-women-lie-about-being-victims-of-sexual-assault-107363

Department of Justice (1997). *Crime in the United States, Uniform Crime Reports, 26.* Washington, DC: U.S. Department of Justice.

Department of Justice (2004). *A national protocol for sexual assault medical forensic examinations: Adults/adolescents.* Washington, DC: Department of Justice.

Domino, M.E., Morrissey, J.P., Chung, S., & Nadlicki, T. (2006). Changes in service use during a trauma-informed intervention for women. *Women & Health, 44*(3): 105-122. Doi: 10.1300/JO13v44n03_06.

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28*, 430–438. doi: 10.1016/J.AMEPRE.2005.01.015

Du Mont, J., Kosa, D., Macdonald, S., Benoit, A., & Forte, T. (2017). A comparison of indigenous and non-indigenous survivors of sexual assault and their receipt of and satisfaction with specialized health care services. *PloS One, 12*(11), e0188253-e0188253. https://doi.org/10.1371/journal.pone.0188253

Du Mont, J., Macdonald, S., Kosa, D., & Smith, T. (2016). Nonoffending guardian assessment of hospital-based sexual abuse/assault services for children. *Journal of Forensic Nursing, 12*(1), 35–38. https://doi.org/10.1097/JFN.0000000000000101

Du Mont, J., Macdonald, S., White, M., Turner, L., White, D., Kaplan, S., … Smith, T. (2014). Client satisfaction with nursing-led sexual assault and domestic violence services in Ontario. *Journal of Forensic Nursing, 10*(3), 122–134. https://doi.org/10.1097/JFN.0000000000000035

Duncan, M. K. W., & Sanger, M. (2004). Coping with the paediatric anogenital exam. *Journal of Child and Adolescent Psychiatric*

Easton, S. D., Saltzman, L. Y., & Willis, D. G. (2014). Would you tell under circumstances like that? Barriers to disclosure of child sexual abuse for men. *Psychology of Men & Masculinity, 15*, 460–469. doi:10.1037/a0034223

Edinburgh, L., Saewyc, E., & Levitt, C. (2008). Caring for young adolescent sexual abuse victims in a hospital-based children's advocacy centre. *Child Abuse Negl., 32*(12):1119–26. doi:10.1016/j. chiabu.2008.05.006.

Edmond, T., Rubin, A., & Wambach, K. (1999). The Effectiveness of EMDR with Adult Female Survivors of Childhood Sexual Abuse, *Social Work Research, 23*(2):103–16.

Edmond., T., & Rubin, A. (2004). Assessing the long-term effects of EMDR: results from an 18-month follow-up study with adult female survivors of CSA. *J Child Sex Abus 13*:69–86

Elliott, A. N., & Carnes, C. N. (2001). Reactions of non-offending parents to the sexual abuse of their child: A review of the literature. *Child Maltreatment*, 6(4), 314–331. doi:10.1177/1077559501006004005.

Ending Violence Association of BC (2016). *Responding to a Sexual Assault Disclosure: Practice Tips for Anti-Violence Workers.* Vancouver, British Columbia: Ending Violence Association of BC.

Ending Violence Association of BC (2016a). *Sexual Assault Support Worker Handbook.* Vancouver, British Columbia: Ending Violence Association of BC.

Eruera, M. (2015). '*Hooked Up' - Te Hononga Whaiaipo*. (Te Whāre Wānanga o Awanuiārangi).

Eruera, M. & Dobbs, T. (2010). *Taitamariki Māori kōrero about intimate partner relationships*. (Amokura Family Violence Prevention Consortium, 2010).

Esaki, N., & Larkin, H. (2018). Prevalence of Adverse Childhood Experiences (ACEs) among Child Service Providers. *Families in Society: The Journal of Contemporary Social Services, 94* (1). Doi: https://doi.org/10.1606/1044-3894.4257

Espelage, D. L., Basile, K. C., De La Rue, L., Hamburger, M. E. (2015). Longitudinal associations among bullying, homophobic teasing, and sexual violence perpetration among middle school students. Journal of Interpersonal Violence, 30, 2541–2561. doi:10.1177/0886260514553113

Everly, G., & Flynn, B. (2006). Principles and Practical Procedures for Acute Psychological First Aid Training for Personnel without Mental Health Experience. *International Journal of Emergency Mental Health 8*(2):93-100

Family and Community Services Team, Ministry of Social Development (2019). *Sexual Violence Post-Crisis Care and Recovery: Consultation Summary*. Wellington: Ministry of Social Development.

Fang, X., Brown, D.S., Curtis, F.S., & Mercy, J. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse Neglec,* 36(2):156-165.

Fassler, I. R., Amodeo, M., Griffin, M. L., Clay, C. M., & Ellis, M. A. (2005). Predicting long-term outcomes for women sexually abused childhood: Contribution of abuse severity versus family environment. *Child Abuse & Neglect, 29(3),* 269-284. doi:10.1016/j.chiabu.2004.12.006

Fergusson, D.M., Boden, J.M., & Horwood, L.J. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect,* 32(6):607-619.

Fernet, M., Hébert, M., Gascon, S., & Lacelle, C. (2012). Agression sexuelle et comportements sexuels à risque à l'adolescence. In: Hébert M, Cyr M, Tourigny M, organizadores. L'agression sexuelle envers les enfants. Tome II. Québec: Presses de l'Université du Québec. p. 131-170.

Finkelhor, D. (with Araji, S., Baron, L., Browne, A., Peters, S.D., & Wyatt, G.E.) (1986). *A sourcebook on child sexual abuse.* Beverly Hills: Sage Publications.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of sexual abuse: An update. *Professional Psychology: Research and Practice, 21*, 325–330.

Finkelhor, D., & Baron, L. (1986). High-risk children. In D. Finkelhor et al. (Eds.), *Sourcebook on child sexual abuse*. (pp. 60-88). Beverly Hills, CA: Sage

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national sample of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse & Neglect, 14,* 19-28.

Finkelhor, D., Turner, H., Shattuck, A., & Hamby, S. (2013). Violence, Crime, and Abuse Exposure in a National Sample of Children and Youth: An Update. *JAMA Paediatrics, 167*(7): 614-621

Finkelhor, D., Shattuck, A., Turner, H. A., Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55*, 329–333. doi: 10.1016/j.jadohealth.2013.12.026

Fisher, B., Cullen, F., & Turner, M. (2000). *The Sexual Victimisation of College Women.* US Department of Justice.

Fisher P. A., & Pfeifer J. H. (2011). Conceptual and methodological issues in neuroimaging studies of the effects of child maltreatment. *Archives of Paediatric Adolescent Medicine, 165*, 1133-1134. doi:10.1001/archpediatrics.2011.1046

Fjermestad, K. W., Mowatt Haugland, B. S., Heiervang, E., & Ost, L. G. (2009). Relationship factors and outcome in child anxiety treatment studies. *Clinical Child Psychology and Psychiatry*, 14(2), 195–214.doi: 10.1177/135910450810088

Fleming, T.M., Watson, P.D., Robinson, E., Ameratunga, S., Dixon, R., Clark, T.C., & Crengle, S. (2007). *Violence and New Zealand Young People: Findings of Youth2000 - A National Secondary School Youth Health and Wellbeing Survey*. Auckland: The University of Auckland.

Flyvbjerg, B. (2011). Case study. In N.K. Denzin & Y.S. Lincoln (Eds.). *The sage handbook of qualitative research (4th edition. pp. 301-316)*. Thousand Oaks, CA: Sage.

Fontes, L., Conceicao, O., & Machado, S. (2017). Childhood and Adolescent Sexual Abuse, Victim Profile and its Impact on Mental Health. *Cienc.saude colet, 22*(9).

Fontes, L.A., & Tishelman, A.C. (2016). Language competence in forensic interviews for suspected child sexual abuse. *Child Abuse & Neglect, 58:* 51-62. Doi: 10.1016/j.chiabu.2016.06.014.

Fontes, L.F.C., Conceicao, O.C., & Machado, S. (2017). Childhood and adolescent sexual abuse, victim profile and its impacts ion mental health. *Ciênc. saúde colet. 22* (9) Doi: https://doi.org/10.1590/1413-81232017229.11042017

Foshee, V.A., Bauman, K.E., Greene, F., Koch, G.G., Linder, G.F. & MacDougall, J.E. (2000). The Safe Dates Program: One year follow up results. *American Journal of Public Health, 90*(10): 1619-1622.

Foshee, V.A, Linder, F., MacDougall, J. E. & Bangdiwala, S. (2001). Gender differences in the longitudinal predictors of adolescent dating violence. *Prev. Med*. (Baltim). 32, 128–141.

Foster, J. M. (2014). Supporting child victims of sexual abuse: Implementation of a trauma narrative family intervention. *The Family Journal*, 22(3), 332–338. https://doi.org/10.1177/1066480714529746

Frank, J.D. & Frank, I. (1991). *Persuasion and healing*. Baltimore: Johns Hopkins Press.

Franklin, A., Ras, P., & Smeaton, E. (2015). *Unprotected, overprotected: Meeting the needs of young people with learning disabilities who experience or are at risk of sexual exploitation.* Essex: Barnardo's.

Frothingham, T.E., Hobbs, C.J., Wynne, J.M., Yee, L., Goyal, A., & Wadsworth, D.J. (2000). Follow up study 8 years after diagnosis of sexual abuse. *Arch Dis Child,* 83(2):132-134

Funston L. (2013). Aboriginal and Torres Strait islander worldviews and cultural safety transforming sexual assault service provision for children and young people. *Int J Environ Res Public Health, 10*(9):3818–33. doi:10.3390/ijerph10093818.

Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., & Bjelajac, P. (2007). Effectiveness of an integrated, trauma-informed approach to treating women with co-occurring disorders and histories of trauma: The Los Angeles site experience. *Journal of Community Psychology, 35*(7): 863-878. Doi: https://doi.org/10.1002/jcop.20186

Gavin B. (2004). *AIMHI - Healthy community schools' project. Milestone Report to the Ministry of Education, Dec 2004*. Auckland: AIMHI - Healthy community schools' project.

Gavril, A.R., Kellogg, N.D., & Nair, P. (2012). Value of follow-up examinations of children and adolescents evaluated for sexual abuse and assault. *Paediatrics*, 129(2):282–289

Gewirtz-Meydan, A., & Finkelhor, D. (2020). Sexual abuse and assault in a large national sample of children and adolescents. *Child maltreatment 25*(2): 203-214.

Gilbert, R., Spatz-Widom, C., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet,* 373(9657):68-81.

Gillham, B. (2007). *Developing a questionnaire* (2nd ed.). London: Continuum.

Girardet, R., Giacobbe, L., Bolton, K., Lahoti, S., & McNeese, M. (2006). Unmet health care needs among children evaluated for sexual assault. *Archives of Paediatrics and Adolescent Medicine, 160*(1), 70–73. https://doi.org/10.1001/archpedi.160.1.70

Gohir, S. (2013). *Unheard voices: sexual exploitation of Asian girls and young women*. London: Muslim Women's Network UK.

Games-Schwartz, B., Horowitz, J., & Cardarelli, A. P. (1988). *Child sexual abuse victims and their treatment*. Washington, DC: U. S. Department of Justice.

Goodman, R.M., & Steckler, A.B. (1989). A model for the institutionalization of health promotion programs. *Family and Community Health*, *11*(4): 63-78.

Greaney, H., Ryan, J., & Straddle (1998). Injuries – is current practice safe? *Eur J Emerg Med.* 5(4):421–4.

Grefe, C. (2011). *Treating Adolescent Victims of Physical and Sexual Abuse: A Multiple Baseline Design*. St. John's University: Unpublished Doctoral Dissertation.

Greene, J.C., Benjamin, L., & Goodyear, L. (2001). The merits of mixing methods in evaluation. *Evaluation, 7* (1): 25-44.

Greene, J.C., & Caracelli, V.J. (Eds.) (1997a). *Advances in mixed-method evaluation: The challenges and benefits of integrating diverse paradigms.* New Directions for Evaluation, No 74). San Francisco: Jossey-Bass.

Greene, J.C., & Caracelli, V.J. (1997b). Defining and describing the paradigm issues in mixed-method evaluation. In J.C. Greene & V.J. Caracelli (Eds.), *Advances in mixed-method evaluation: The challenges and benefits of integrating diverse paradigms.* New Directions for Evaluation, No 74, pp. 5-17). San Francisco: Jossey-Bass.

Greene, J.C., Caracelli, V.J., & Graham, W.F. (1989). Towards a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis, 11*: 255-274.

Greenwald, R., Siradas, L., Thomas, M.S., Schitt, A., Reslan, S., & Fierle, J. (2012). Implementing Trauma-Informed Treatment for Youth in a Residential Facility: First-Year Outcomes. *Residential Treatment for Children and Youth, 29*(2): 141-153. Doi: https://doi.org/10.1080/0886571X.2012.676525

Guralnick, M.J. (1997). Effectiveness of early intervention for vulnerable children: A developmental perspective. *Am J Ment Retard, 102:319-45.*

Habigzang, L.F., Stroeher, F.H., Hatzenberger, R., Cunha, R.C.D., Ramos, M.D.S., & Koller, S. H. (2009). Grupoterapia cognitivo-comportamental para crianças e adolescentes vítimas de abuso sexual. *Rev Saude Publica,* 43(1):70-78.

Hales, T.., Green, S.A., Bissonettes et al., (2019). Trauma-Informed Outcome Study. *Res Social Work Practice 29:*529-539. https://doi.org/10.1177/1049731518766618

Hambrick, E., Rubens, S., Vernberg, E., Jacobs, A., & Kanine, R. (2013). Towards Successful Dissemination of Psychological First Aid: A Study of Provider Training Preferences. *THE Journal of Behavioural Health Sciences & Research, 41*(2). DOI: 10.1007/s11414-013-9362-y

Harrell, E. (2012). *Crime Against Persons with Disabilities, 2009-2011 - Statistical Tables*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved from: www.bjs.gov/index.cfm?ty=pbdetail&iid=4574.

Harvard Medical School, Harvard Health Publishing. (2016). *Understanding the stress response: Chronic activation of this survival mechanism impairs health*. Retrieved from http://www.health.harvard.edu/staying-healthy/understanding-the-stress-response

Haugaard, J. J., & Reppucci, N.D. (1988). *The sexual abuse of children*. San Francisco: Jessey-Bass.

Head, B.W. (2008). Three lenses of evidence-based policy*. The Australian Journal of Public Administration, 67*(1): 1-11.

Heady, L., Kail, A., & Yeowart, C. (2011). *Understanding the stability and sustainability of the violence against women voluntary sector.* London: Government Equities Office.

Hébert, M., Lavoie, B., Piche, C., & Poitras, M. (2001). Proximate effects of a child sexual abuse prevention program in elementary school children. *Child Abuse & Neglect, 25,* 505-522.

Hébert, M., Lavoie, F., & Parent, N. (2002). An assessment of outcomes following parents' participation in a child abuse prevention program. *Violence Vict,* 17(3):355-372.

Hébert, M., Paradis, A., & Brabant, M-E. (2013). *Symptom clusters in sexually abused teenage girls*. No prelo.

Hecht, D., & Hansen, D. (1999). Adolescent Victims and Intergenerational Issues in Sexual Assault. In Van Hasselt, V.B. & Hersen, M. (eds.) *Handbook of Psychological Approaches with Violent Offenders: Contemporary Strategies and Issues.* New York: Kluwer Academic/Plenum Publishers

Hellman, C.M., & House, D. (2010). Volunteers serving victims of sexual violence. *The Journal of Social Psychology, 146*(1): 117-123.

Henderson, S. (2012). *The pros and cons of providing dedicated sexual violence services: A literature review.* Scotland: Rape Crisis Scotland.

Henderson, C. E., Taxman, F. S., & Young, D. W. (2008). A Rasch model analysis of evidence-based treatment practices used in the criminal justice system. *Drug and Alcohol Dependence, 93*(1-2), 163-175.

Henderson, C. E., Young, D. W., Jainchil, N., Hawke, J., Farkas, S., & Davis, R. M. (2007). Program use of effective drug abuse treatment practices for juvenile offenders. *Journal of Substance Abuse Treatment, 32*, 279-290.

Henderson, S. (2012). *The pros and cons of providing dedicated sexual violence services: A literature review.* Scotland: Rape Crisis Scotland.

Henry, G.T., & Mark, M.M. (2003). Beyond use: Understanding evaluation's influence on attitudes and actions. *American Journal of Evaluation, 24*(3): 293-314.

Herbert, M., Lagevin, R., & Oussaid, E. (2018). Cumulative childhood trauma, emotion regulation, dissociation, and behaviour problems in school-based sexual abuse victims. *Journal Affect Disorder, 1(225):* 306-312. doi: 10.1016/j.jad.2017.08.044

Hershkowitz, I. (2009). Socioemotional factors in child sexual abuse investigations. *Child Maltreatment, 14*(2), 172–181. https://doi.org/10.1177/1077559508326224

Hershkowitz, I., Orbach, Y., Lamb, M. E., Sternberg, K. J., & Horowitz, D. (2006). Dynamics of forensic interviews with suspected abuse victims who do not disclose abuse. *Child Abuse and Neglect, 30*(7), 753–769. https://doi.org/10.1016/j.chiabu.2005.10.016

Hicks, C. & Hickman, G. (1994). The impact of waiting times on client attendance for relationship counselling. *British Journal of Guidance & Counselling, 22*: 175–182.

Hindle, S. & Morgan, M. (2006). On being a refuge worker: Psycho-social impacts of advocacy. *Women's Studies Journal, 20*, 32–47.

Holmes, K., & Sher, L. (2013). Dating violence and suicidal behaviour in adolescents. *Int J Adolescent Med Health,* 25**:** 257–61.

Huriwai, T & Baker, M (2016). *Manaaki: Mana enhancing and Mana protecting practice*.

Hutson, L. (2002). Development of sexual assault nurse examiner programs. *Nurse Clin North Am, 37*(1):79-88, vii. doi: 10.1016/s0029-6465(03)00084-7.

Institute, R. (1994). *Violence and People with Disabilities: A Review of Literature*. Ottawa, Ontario: National Clearinghouse on Family Violence.

Jackson, S. (2002). Abuse in dating relationships: Young people's accounts of disclosure, ... *NZ. J. Psychol*. 31, 79–86.

Jejeebhoy, S.J., & Bott, S. (2003). *Non-consensual sexual experiences of young people: a review of the evidence from developing countries.* Population Council South and East Asia Regional Working Papers No. 16. New Delhi: Population Council. Retrieved from: http://www.popline. org/node/250871.

Jensen, F. E., & Nutt, A. E. (2015). *The teenage brain: A neuroscientist's survival guide to raising adolescents and young adults*. New York, NY: Harpers Collins.

Ji, K., Finkelhor, D., & Dunne, M. (2013). Child sexual abuse in China: a meta-analysis of 27 studies. *Child Abuse & Neglect,* 37(9):613-622.

Johnson, K., Hays, C., Center, H., & Daley, C. (2004). Building capacity and sustainable prevention innovations: A sustainability planning model. *Evaluation and Program Planning*, *27*: 135-149.

Jones, L. M., Atoro, K. E., Walsh, W. A., Cross, T. P., Shadoin, A. L., & Magnuson, S. (2010). Nonoffending caregiver and youth experiences with child sexual abuse investigations. *Journal of Interpersonal Violence, 25*(2), 291–314. https://doi.org/10.1177/0886260509334394

Jones, L. M., Cross, T. P., Walsh, W. A., & Simone, M. (2007). Do Children's Advocacy Centres Improve Families' Experiences of Child Sexual Abuse Investigations? *Child Abuse and Neglect, 31*(10), 1069–1085. https://doi.org/10.1016/j.chiabu.2007.07.003

Kanin, E.J., & Parcell, S.R. (1977). Sexual Aggression: A second look at the offended female. *Arch Sex Behav, 6*(1): 67-76. Doi: 10.1007/BF01579249.

Kar, N. (2009). Psychological impact of disasters on children: Review of assessment and interventions. *World Journal of Paediatrics,* 5(1):5-11. doi: 10.1007/s12519-009-0001-x.

Kar, N. (2011). Cognitive behavioural therapy for the treatment of post-traumatic stress disorder: A review. *Neuropsychiatric Disorders and Treatment, 7*, 167-181. doi:10.2147/ NDT.S10389

Kassam-Adams, N., & Winston, F. (2004). Predicting child PTSD: the relationship between acute stress disorder and PTSD in injured children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(4), 403–411.

Katz, C. (2015). 'Stand by me': The effect of emotional support on children's testimonies. *British Journal of Social Work, 45*(1), 349–362. https://doi.org/10.1093/ bjsw/bct137

Kaufman, M., & the Committee on Adolescence (2008). Care of Adolescent Sexual Assault Victim. *Paediatrics, 122:*462-470.

Kaura, S. A., & Lohman, B. J. (2007). Dating violence victimization, relationship satisfaction, mental health problems, and acceptability of violence: A comparison of men and women. *Journal of Family Violence, 22:* 367–381.

Kelly, L., & Dubois, L. (2008). *Combating violence against women: Minimum standards for support services*. Strasbourg, Council of Europe: Directorate General of Human Rights and Legal Affairs. Retrieved from: http://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/EG-VAWCONF(2007)Study%20rev.en.pdf

Kendall-Tackett, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: a review and synthesis of recent empirical studies. *Psychol Bull,* 113(1):164-180.

Kendler, K.S., Bulik, C.M., Silberg, J., Hettema, J.M., Myers, J., & Prescott, C.A. (2000). Childhood sexual abuse and adult psychiatric and substance abuse disorders in women. *Arch Gen Psychiatry,* 57(10):953-959.

Kennedy, A., & Prock, K. (218). 'I still feel like I am not normal': A review of the role of stigma and stigmatisation among female survivors of child sexual abuse, sexual assault and intimate partner violence. *Trauma, Violence, Abuse.* Doi: 10.1177/1524838016673601.

Kenny, M.C. (2009). Child sexual abuse prevention: psychoeducational groups for pre-schoolers and their parents. *J Spec Group Work,* 34(1):24-42.

Khadr, S.N., Viner, R.M., & Goddard, A. (2011). Safeguarding in adolescence: under-recognised and poorly addressed. *Arch Dis Child,* 96**:** 991–94.

Khadr, S., Clarke, V., Wellings, K., Villalta, L., Goddard, A., & Welch, J. (2018). Mental and sexual health outcomes following sexual assault in adolescents: A perspective cohort study. *The Lancet Child and Adolescent Health, 2*(9): 654-665.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology, 71*, 692-700. doi:10.1037/0022-006X.71.4.692

Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology, 68*, 19-30. doi:10.1037/0022-006X.68.1.19

Klein J. Adolescents, health services, and access to care. *Journal of Adolescent Health,27*(5):293 - 4.

Kloppen, K., Haugland, S., Svedin, C. G., Mæhle, M., Breivik, K. (2016). Prevalence of child sexual abuse in the Nordic countries: A literature review. *Journal of Child Sexual Abuse, 25*, 37–55. doi:10.1080/10538712.2015.1108944

Klugman, J., Hanmer, L., Twigg, S., Hasan, T., McCleary-Sills, J., & Santamaria, J. (2014). *Voice and Agency: Empowering Women and Girls for Shared Prosperity*. Washington, DC: World Bank. doi:10.1596/978-1-4648-0359-8.

Knight, C. 92015). Trauma-Informed Social Work Practice: Practice Considerations and Challenges. *Clinical Social Work Journal 43*(1) DOI: 10.1007/s10615-014-0481-6

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., … Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*(4), 396.

Koloto, A. (2003) *The Needs of Pacific Peoples When They Are Victims of Crime.* Wellington: Ministry of Justice.

Koss, M.P., & Oros, C.J. (1982). `Sexual Experiences Survey: A Research Instrument Investigating Sexual Aggression and Victimization. *Journal of Consulting and Clinical Psychology* 50: 455-457.

Koss, M.P., Gidycz, C.A. & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology 55*, 162-170.

Koss, M.P., & Dinero, T. (1988). Predictors of Sexual Aggression among a National Sample of Male College Students. *Annals of the New York Academy pf Science, 529,133-147*

Koss, M.P., Goodman, L.A., Browne, A., Fitzgerald, L.F., Keita, G.P., and Russo, N.F. (1994). *No safe haven*. Washington, DC: American Psychological Association.

Kramer, D. N., & Landolt, M. A. (2011). Characteristics and efficacy of early psychological interventions in children and adolescents after single trauma: A meta-analysis. *European Journal of Psycho-traumatology*, 2: 1–24.

Krause-Parello, C. A., & Friedmann, E. (2014). The effects of an animal- assisted intervention on salivary alpha-amylase, salivary immunoglobulin a, and heart rate during forensic interviews in child sexual abuse cases. *Anthrozoos, 27*(4), 581–590. https://doi.org/10.2752/089279314X14072268688005

Krebs, C., Lindquest, C., Berzofsky, M., Shook-Sa, B., & Peterson, K. (2016). *Campus Climate Survey Validation Study: Final Technical Report.* Washington: Bureau of Justice Statistics. Research and Development Series.

Krug, E.G. et al (eds). (2002). *World Report on Violence and Health (First Edition).* Geneva: World Health Organization. Retrieved from: http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf.

Lane, K., Judy, A., & Sweet, M. (2011). *A Practical Guide for Creating Trauma-Informed Disability Domestic Violence and Sexual Assault Organisations.* Wisconsin: Disability Rights Wisconsin, Wisconsin Coalition Against Domestic Violence & Wisconsin Coalition Against Sexual Assault.

Lang, D. L., Sales, J. M., Salazar, L. F., Hardin, J. W., DiClemente, R. J., Wingood, G. M., & Rose, E. (2011). Rape victimization and high-risk sexual behaviours: Longitudinal study of African-American adolescent females. *Western Journal of Emergency Medicine, 12*, 333-342. Retrieved from the U.S. National Library of Medicine, National Center for Biotechnology Information: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117610/pdf/wjem12_3p0333.pdf

Lanktree, C., & Briere, J. (2013). *Integrative treatment of complex trauma.* In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models* (p. 143–161). The Guilford Press.

Ledray, L. (1999). *Sexual assault nurse examiner (SANE) development & operation guide*. Washington, DC: Office for Victims of Crime, U.S. Department of Justice.

Lemaigre, C., Taylor, E. P., & Gittoes, C. (2017). Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. *Child Abuse and Neglect*, 70(February), 39– 52. https://doi.org/10.1016/j.chiabu.2017.05.009

Liang, B., Spencer, R., Brogan, D., Corral, M. (2008). Mentoring relationships from early adolescence through emerging adulthood: A qualitative analysis. *Journal of Vocational Behaviour, 72*, 168-182.

Lindley, L.L., Walsemann, K.M., & Carter, J.W. (2013). Invisible and at risk: STDs among young adult sexual minority women in the United States. *Perspect Sex Reprod Health, 45*:66-73.

Lindley, L. L., & Walsemann, K. M. (2015). Sexual orientation and risk of pregnancy among New York City high school students. *American Journal of Public Health, 105,* 1379-1386. doi:10.2105/AJPH.2015.302553

Littel, K. (2001). Sexual assault nurse examiner programs: Improving the community response to sexual assault victims. *Office for Victims of Crime Bulletin, 4*, 1-19.

London, K., Bruck, M., Ceci, S.J., & Shuman, D.W. (2005). Disclosure of child sexual abuse: what does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law,* 11(1):194-226.

Lovett, B.B. (2004). Child sexual abuse disclosure: Maternal response and other variables impacting the victim. *Child and Adolescent Social Work Journal,* 21(4):355-371.

Lundquist, L. M., & Hansen, D. J. (1998). Enhancing treatment adherence, social validity, and generalization of parent-training interventions with physically abusive and neglectful families. In J. R. Lutzker (Ed.), *Handbook of child abuse research and treatment* (pp. 449–471). New York: Pergamon.

Macdonald, G., Higgins, J.P., Ramchandani, P., Valentine, J.C., Bronger, L.P., Klein, P., O'Daniel, R., Pickering, M., Rademaker, B., Richardson, G., & Taylor, M. (2012). Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database Syst Rev,* (5):CD001930.

Macdowall, W., Gibson, L.J., Tanton, C., et al. (2013). Lifetime prevalence, associated factors, and circumstances of non-volitional sex in women and men in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet,* 382**:** 1845–55.

MacFarlane, M., Harris, M., Michael, S. & Jakob, L. (2009). *Evaluation of Youth One Stop Shops: Final Report.* Wellington: Ministry of Health and Communico.

MacKillop, W. J., Bates J. H. T., O'Sullivan, B., & Withers, H. R. (1996). The effect of delay in treatment on local control by radiotherapy. *International Journal of Radiation Oncology Biology Physics, 34:* 243–250.

MacMillan, H., Wathen, C.N., Barlow, J., Fergusson, D.M., Lenethal, J.M., & Taussig, H.N. (2009). Interventions to prevent child maltreatment and associated impairment. *Lancet,* 373(9659):250-266.

Macmillan, R., & Hagan, J. (2004). Violence in the transition to adulthood: Adolescent victimization, education, and socioeconomic attainment in later life. *Journal of Research on Adolescence, 14*, 127-158. doi:10.1111/j.1532-7795.2004.01402001.x

Macy, R., Giattina, M., Sangster, T.H., Crosby, C., & Montijo, N.J. (2009). Domestic violence and sexual assault services: Inside the black box. *Aggression and Violence Behaviour, 14*: 359-373.

Mancini, J.A., & Marek, L.I. (2004). Sustaining community-based program for families: Conceptualization and measurement. *Family Relations*, *53*(4): 339-347.

Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review, 29*(7), 647–657.

Marks, S., Lamb, R., & Tzioumi, D. (2009). Do no more harm: The psychological stress of the medical examination for alleged child sexual abuse. *Journal of Paediatrics and Child Health, 45*(3), 125–132. https://doi.org/10.1111/j.1440-1754.2008.01443.x

Marshall, A. D. (2016). Developmental timing of trauma exposure relative to puberty and the nature of psychopathology among adolescent girls. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*, 25-32.e1.doi:10.1016/j.jaac.2015.10.004 17

Martin, G., Bergen, H., Richardson, A.S., Roeger, L., & Allison, S. (2004). Sexual abuse and suicidality: Gender differences in a large community sample of adolescents. *Child Abuse & Neglect*, 28(5):491-503.

Martz, D.M., Jameson, J.P., & Page, A.D. (2016). Psychological health and academic success in rural Appalachian adolescents exposed to physical and sexual interpersonal violence. *Am J Orthopsychiatry,* 86: 594-601

Mayer, R. C., Davis, J. H., Schoorman, F. D. (1995). An integrative model of organizational trust. *Academy of Management Review, 20*, 709-734.

Mayhew, P. and Reilly, J., (2007). *The New Zealand Crime and Safety Survey 2006*. Wellington: Ministry of Justice.

McCubbin, M. A., & McCubbin, H. I. (1987). Family Stress Theory and Assessment. In H. I. McCubbin, & A. I. Thompson (Eds.), *Family Assessment Inventories for Research and Practice* (pp. 3-22). Madison, WI: University of Wisconsin- Madison.

McDermott, B. M., & Palmer, L. J. (1999). Post-disaster service provision following proactive identification of children with emotional distress and depression. *Australian and New Zealand Journal of Psychiatry, 33*: 855–863.

McKenzie, Kathryn and Botts, Theresa (2018). Evaluating Shame; A Comparative Look at Sexual and Physical Abuse. *Kentucky Journal of Undergraduate Scholarship*, 2(1), Article 9. Available at: https://encompass.eku.edu/kjus/vol2/iss1/9

McNaughton Nicholls, C., Harvey, S., & Paskell, C. (2014). *Gendered perceptions: What professionals know about the sexual exploitation of boys and young men in the UK*. Barnardo's, London.

McPhillips, K., Sullivan, H., Watts, V.M., Peipi Te Pou, S., Black, A., Berman, S., et al., (2009). *Tauiwi responses to sexual violence: Mainstream crisis support and recovery support services and Pacific services.* Wellington: Ministry of Social Development.

Meltzer, A., Muir, K., & Craig, L. (2016). The Role of Trusted Adults in Young Peoples Social and Economic Lives. *Youth and Society,* 50(5). Doi 10.1177/0044118X16637610

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (2nd ed.). San Francisco, CA: Jossey-Bass.

Messina, N., Calhoun, S., & Braithwaite, J. (2014). Trauma-Informed Treatment Decreases PTSD among Women Offenders. *J Trauma Dissociation. 2014; 15*(1). doi: 10.1080/15299732.2013.818609

Mila-Schaaf, K., Robinson, E., Schaaf, D., Denny, S., & Watson, P. (2008). *A health profile of Pacific youth: Findings of Youth2000.* A national secondary school youth health survey. Auckland, New Zealand: The University of Auckland.

Miller, E., Culyba, A., Paglisotti, T., Espelage, D., Abebe, K., & Jones, K. (2019). Male Adolescents' Gender Attitudes and Violence: Implications for Youth Violence Programmes. *American Journal of Preventative Medicine, 58*(3): 396-406. Doi: 10.1016/j.amepre.2019.10.009.

Miller, T.R., Cohen, M.A., & Wiersema, B. (1996). *Victim costs and consequences: A new look*. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Ministry of Health and Communio (2009). *Evaluation of Youth One Stop Shops*. Wellington: Ministry of Health.

Ministry of Justice (2009). *Te Toiora mata Tauherenga – Report of the Taskforce for Action on Sexual Violence*. Wellington: Ministry of Justice.

Ministry of Social Development (2017:13). *Sexual Violence Crisis Support Services: Service Development Consultation Document.* Wellington: Ministry of Social Development

Ministry of Social Development (2021). *Sexual Harm Crisis Support Service Guidelines, F21.* Wellington: Ministry of Social Development.

Ministry of Youth Development (2009). *An Introduction and Context for the Development of Youth Policy.* Wellington: Ministry of Youth Development.

Morrison, S. E., Bruce, C. and Wilson, S. (2018). Children's disclosure of sexual abuse: a systematic review of qualitative research exploring barriers and facilitators. *Journal of Child Sexual Abuse, 27*(2), pp. 176-194. doi:10.1080/10538712.2018.1425943.

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56,* 1213–1222.

Muehlenhard, C. L., & Linton, M. A. (1987). Date rape and sexual aggression in dating situations: Incidence and risk factors. *Journal of Counselling Psychology, 34*(2), 186–196. https://doi.org/10.1037/0022-0167.34.2.186

Mueller-Johnson, K., Eisner, M. P., & Obsuth, I. (2014). Sexual victimization of youth with a physical disability: An examination of prevalence rates, and risk and protective factors. *Journal of Interpersonal Violence, 29*, 3180-3206. doi:10.1177/0886260514534529

Munson, M. R., Smalling, S. E., Spencer, R., Scott, L. D., Tracy, E. M. (2010). A steady presence in the midst of change: Non-kin natural mentors in the lives of older youth exiting foster care. *Children and Youth Services Review, 32*, 527-535.

Najman, J.M., Dunne, M.P., Purdie, D.M., Boyle, F.M. & Coxter, P.D. (2005). Sexual abuse, childhood and sexual dysfunction in adulthood: An Australian population-based study. *Arch Sex Behaviour, 34*(5): 517-26. Doi: 10.1007/s10508-005-6277-6.PMID: 16211473.

NASASV (National Association of Services Against Sexual Violence) (2015). *Standards of Practice for Services Against Sexual Violence.* Australia: NASASV

National Child Traumatic Stress Network (2008). *Child Trauma Toolkit for Education.* Rockville: NCTSN.

National Child Traumatic Stress Network (2011). *Why don't they tell? Teens and Sexual Assault Disclosure.* In Working with Teen Survivors of Sexual Violence: Resource Sharing Project. UK: NSPCC. Retrieved from: www.nspcc.org.uk/inform

National Institute of Mental Health. (2017). *Suicide*. Retrieved from https://www.nimh.nih.gov/health/statistics/suicide.shtml

National Sexual Violence Resource Centre (2014). *Listening to Our Communities: Assessment Toolkit.*

National Sexual Violence Resource Centre (2015). *Statistics about Sexual Violence.* Retrieved from*:* 2015MediaPacketInsertsFINAL508.pdf (nsvrc.org)

National Sexual Violence Resource Centre (2018). *Teenagers and Sexual Violence.* Retrieved from: https://www.nsvrc.org/sites/default/files/publications/2019-02/Teenagers_508.pdf

Nelis, S.M., & Rae, G. (2009). Peer attachment in adolescents. *J Adolesc,* 32(2):443-447.

Netsafe (2017). *Teens and 'sexting' in New Zealand: Prevalence and Attitudes.* Wellington: Netsafe. Doi: https//doi.org/10.2139/ssrn.3128598

Netsafe (2018). *Harmful digital communications in New Zealand: Annual population survey 2017.* Wellington: Netsafe. https//doi.org/10.2139/ssrn.3128121

Newberger, C. M., & DeVos, E. (1988). Abuse and victimization: A life-span developmental perspective. *American Journal of Orthopsychiatry, 58*, 505–511.

New Philanthropy Capital (2011). *Understanding the stability and sustainability of the violence against women voluntary sector.* Report prepared for the Government Equalities Office. London: New Philanthropy Capital.

Nickel, M.K., Tritt, K., Mitterlehner, F.O., Leiberich, N.C., Lahmann, C., Forthuber, P., Rother, W.K., & Loew, T.H. (2004). Sexual abuse in childhood and youth as psychopathologically relevant life occurrence: Cross-sectional survey. *Croat Med J,* 45(4):483-489.

Noll, J. G., Shenk, C. E., & Putnman, K. T. (2009). Childhood sexual abuse and adolescent pregnancy: A meta-analytic update. *Journal of Paediatric Psychology, 34*, 336-378. doi:10.1093/jpepsy/jsn098

Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003). Revictimization and self-harm in females who experienced childhood sexual abuse: Results from a prospective study. *Journal of Interpersonal Violence, 18*, 1452-1471. doi:10.1177/0886260503258035

Nooner, K.B., Linares, L.O., Batinjane, J., Kramer, R.A., Silva, R., & Cloitre, M. (2012). Factors related to posttraumatic stress disorder in adolescence. *Trauma, Violence, & Abuse*, 13(3):153-166.

Norris, F. H., Friedman, M. J., & Watson, P. J. (2002). 60,000 disaster victims speak: Part II. Summary and implications of disaster mental health research. *Psychiatry, 65*, 240–260.

O'Donovan, A., Epel, E., Lin, J., Wolkowitz, O., Cohen, B., Maguen, S., Metzler, T., Lenoci, M., Blackburn, E., & Neylan, T.C. (2011). Childhood trauma associated with short leukocyte telomere length in posttraumatic stress disorder. *Biological Psychiat.,*705:465–471.

Olavarria, M. et al. (2009). Organizational Cultural Competence in Community Health and Social Service Organisations: How to Conduct a Self-Assessment. *Journal of Cultural Diversity.* Winter, 16(4).

O'Leary, P. J., Barber, J. (2008). Gender differences in silencing following childhood sexual abuse. *Journal of Child Sexual Abuse, 17:* 133-143. doi:10.1080/10538710801916416

Omoto, A.M., & Synder, M. (1995). Sustained help without obligations: Motivation, longevity of service and perceived attitude change among AIDS volunteers. *Journal of Personality and Applied Psychology, 68*: 671-686.

Omoto, A.M., & Synder, M. (2002). Considerations of community: The context and process of volunteerism. *American Behaviour Science, 45*: 846-866.

Owen, J.M. (2001). *Using proactive evaluation to develop evidence-based policy.* Third International, Inter-disciplinary Evidence-Based Policies and Indicator Systems Conference, July 2001. CEM Centre: University of Durham. Retrieved from: http://cem.dur.ac.uk

Owens, E.W., Behun, R.J., Manning, J. C. & Reid, R.C. (2012). The Impact of Internet Pornography on Adolescents: A Review of the Research. *Sexual Addiction & Compulsivity, 19*(1): 99-122. Doi: 10.1080/10720162.2012.660431.

Padgett, S.M., Bekemeier, B., & Berkowitz, B. (2005). Building sustainable public health systems change at the state level. *Journal of Public Health Management Practice, 11*(2): 109-115.

Palusci, V. J., Cox, E. O., Shatz, E. M., & Schultze, J. M. (2006). Urgent medical assessment after child sexual abuse. *Child Abuse and Neglect, 30*(4), 367–380. https:// doi.org/10.1016/j.chiabu.2005.11.002

Patton, M. Q. (2008). *Utilization-focused evaluation* (4th ed). Thousand Oaks, CA: Sage.

Patton, M. Q. (2012). *Essentials of utilization-focused evaluation*. Thousand Oaks, CA: Sage.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.

Pawson, R., Boaz, A., Grayson, L., Long, A., & Barnes, C. (2003). *Types and quality of knowledge in social care.* Knowledge Review No 3, Social Care Institute for Excellence. Bristol: Policy Press.

Penner, L.A. (2002). Dispositional and organisational influences on sustained volunteerism: An interactionist perspective. *Journal of Social Issues, 58*: 447-467.

Pennsylvania Coalition Against Rape. (n.d.). *Oppression & sexual violence*. Retrieved from http://www.pcar.org/about-sexual-violence/oppression-sexual-violence

Perkins, D. F., & Jones, K. R. (2004). Risk behaviours and resiliency within physically abused adolescents. *Child Abuse & Neglect, 28*(5), 547–63.

Pihama, L. (2001). *Tīhei mauri ora: Honouring our voices: Mana wahine as kaupapa Māori theoretical framework* (Unpublished doctoral thesis). The University of Auckland, Auckland, New Zealand.

Pihama, L., Te Nana, R., Cameron, N., Smith, C., Reid, J., & Southey, K. (2016). Maori cultural definitions of sexual violence. *Sexual Abuse in Australia and New Zealand, 7*(1), 43-50.

Piripi, T. & Body, V. (2010). Tihei-wa Mauri Ora! *The New Zealand Journal of Counselling. 30* (1). Retrieved from: https://www.nzac.org.nz/assets/Uploads/Journals/Vol-30-No.-1-Piripi-Body.pdf

Pirog-Good, M.A., & Stets, J.E. (1989). The help-seeking behaviours of physically and sexually abused college students. In Pirog-Good, M.A., & Stets, J.E. (Eds.) *Violence in Dating Relationships: Emerging Social Issues.* (pp. 108-125). New York: Praeger.

Plummer, S., & Findley, P. (2012). Women with Disabilities' Experience with Physical and Sexual Abuse: A review of the literature and Implications for the Field. *Trauma, Violence & Abuse, 13*(1): 15-29.

Pluye, P., Potvin, L., & Denis, J.L. (2004a). Making public health programs last: Conceptualizing sustainability. *Evaluation and Program Planning*, *27*: 121-133.

Pōhatu, T. (2005). *Āta: Growing respectful relationships*. Retrieved from www.kaupapamaori.com.

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *BMJ, 320(*7227): 114-116. Doi: 10.1136/bmj.320.7227.114.

Priebe, G., & Svedin, C.G. (2008). Child sexual abuse is largely hidden from the adult society - An epidemiological study of adolescents' disclosures. *Child Abuse & Neglect,* 32(12):1095-1108.

Purnell, L, et al. (2011). A Guide to Developing a Culturally Competent Organisation. *Journal of Trans-cultural Nursing* 22 (1): 7-14.

Pynoos, R. S., & Nader, K. (1988). Psychological First Aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*: 445–473.

Quixley, S. (2010). *The right to choose: Enhancing best practice in responding to sexual assault in Queensland.* Queensland Sexual Assault Services. Retrieved from: http://apo.org.au/node/22924 .

Radford, L. et al., (2011). *Child abuse and neglect in the UK today*. London: NSPCC. Retrieved from: https://www.gov.uk/govrnment/statistics/police-recorded-crime-open-data-tables>

Radford, L., Corral, S., Bradley, C., Fisher, H. L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults. *Child Abuse and Neglect*, 37, 801–813. doi:10.1016/j.chiabu.2013.02.004.

Raj, A., Clarke, J.G., Silverman, J.G., Rose, J., Rosengard, C., Hebert, M.R., et al. (2006). Gender-based violence against women associated with arrest for sex trade but not drug charges. *International Journal of Law and Psychiatry, 29*, 204-211.

Rajan, R., & Waru, N. (2020). *Understanding Māori perspectives: tamariki and rangatahi who are victims of sexual violence or display harmful sexual behaviour*. Wellington: Oranga Tamariki.

Ramirez, R., & Brodhead, D. (2013). *Utilisation-focused evaluation: A primer for evaluators.* Penang, Malaysia: Southbound.

Rapaport, K., & Burkhart, B. R. (1984). Personality and attitudinal characteristics of sexually coercive college males. *Journal of Abnormal Psychology, 93*(2), 216–221. https://doi.org/10.1037/0021-843X.93.2.216

Raphael, B. (1986). *When disaster strikes*. New York: Basic Books.

Ratliff, E., Morris, A., & Hays-Grudo, J. (2020). *Paces for Children: Overcoming Adversity and Building Resilience.* Oklahoma: Oklahoma State University.

Rennison, C.M. (2001). *Criminal Victimization 2000: Changes 1999-2000 with trends 1993-2000.* National Crime Victimization Survey *(NCJ 187007).* Washington, D.C. Bureau of Justice Statistics, U.S. Department of Justice.

Rispens, J., Aleman, A., & Goudena, P.P. (1997). Prevention of child sexual abuse victimization: a meta-analysis of school programs. *Child Abuse Negl,* 21(10):975-987.

Ro¨hrs, S. (2011). *"I feel for rape survivors, but I don't have the time. I'm always running." Barriers to accessing post-rape health care in South Africa*. Cape Town, South Africa: University of Cape Town, The Gender, Health & Justice Research Unit.

Rosenthal, S., Feiring, C., & Taska, L. (2003). Emotional support and adjustment over a year's time following sexual abuse discovery. *Child Abuse and Neglect, 27*(6), 641–661. https://doi.org/10.1016/S0145-2134(03)00104-2

Runyon, M. K., Spandorfer, E. D., & Schroeder, C. M. (2014). Cognitions and distress in caregivers after their child's sexual abuse disclosure. *Journal of Child Sexual Abuse, 23*(2), 146–159. https://doi.org/10.1080/10538712.2014.869291

Ruzek, J., Brymer, M., Jacobs, A., Layne, C., Vernberg, E., & Watson, P. (2007). Psychological First Aid. *Journal of Mental Health Counselling, 29*(1): 17-49. DOI: 10.17744/mehc.29.1.5racgxjueafabgwp

Saied-Tessier, A. (2014). *Estimating the costs of child sexual abuse in the UK* London: NSPCC.

SAMHSA (Substance Abuse and Mental Health Services Administration) (2014). *Trauma-Informed Care in Behavioural Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sandoval, J. (1985). Crisis counselling: Conceptualizations and general principles. *School Psychology Review, 14*, 257-265.

Sandoval., J. (Ed.). (2002). *Handbook of crisis counselling, intervention, and prevention in the schools* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.

Sarantakos, S. (2005). *Social research* (3rd ed.). New York: Palgrave Macmillan.

Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment*. Charleston, SC: National Crime Victims Research and Treatment Centre.

Sayfan, L., Mitchell, E. B., Goodman, G. S., Eisen, M. L., & Qin, J. (2008). Children's expressed emotions when disclosing maltreatment. *Child Abuse and Neglect, 32* (11), 1026–1036. https://doi.org/10.1016/j.chiabu.2008.03.004

Saywitz, K.J., Mannarino, A.P., Berliner, L., & Cohen, J.A. (2000). Treatment for sexually abused children and adolescents. *Am Psychol*., 55(9):1040–1049

Scheirer, M.A. (2005). Is sustainability possible? A review and commentary on empirical studies of program sustainability. *American Journal of Evaluation*, *26*(3), 320-347.

Schonfeld, D. J. (2002). Almost one year later: Looking back and looking ahead. *Developmental and Behavioural Paediatrics, 23*: 292–294.

Schraeder, K.E., & Graham, J.R. (2015). Why wait? The effect of wait-times on subsequent help-seeking among families looking for children's mental health services. *Journal of Abnormal Child Psychology, 43(3):553-565.*

Self-Brown., S., Rheingold, A.A., Campbell, C., & Arellano, M.A. (2008). A media campaign prevention program for child sexual abuse: community members' perspectives. *J Interpers Violence,* 23(6):728-743.

Selim, M., Abdel-Tawab, N., Elsayed, K., El Badawy, A., & El Kalaawy, H. (2013). *The Ishraq Program for Out-of-School Girls: From Pilot to Scale-up*. Cairo: Population Council. Retrieved from: https://www.popcouncil.org/uploads/pdfs/2013PGY_IshraqFinalReport.pdf. 37.

Shama (2019). *Addressing Sexual Violence for Ethnic Communities.* Documents 1-4*.* Hamilton: Shama Hamilton Ethnic Women's Centre Trust. Retrieved from: info@shama.org.nz

Shaw, J. A. (2000). Children, adolescents and trauma. *Psychiatric Quarterly, 71,* 227-243.

Shediac-Rizkallah, M.C., & Bone, L.R. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research*, *13*(1): 87-108.

Sieber, J. E. (1997). Planning ethically responsible research. In L. Bickman & D. Rog (Eds.), *Handbook of applied research methods* (pp. 127-156). Newbury Park: Sage.

Denzin, N.K (1978). *The research art: A theoretical introduction to sociological methods.* New York: McGraw-Hill.

Siegel, R. M., Hill, T. D., Henderson, V. A., & Daniels, K. (1999). Comparison of an intraoral camera with colposcopy in sexually abused children. *Clinical Paediatrics, 38* (6), 375.

Silverman, W. K., & La Greca, A. M. (2002). Children experiencing disasters: Definitions, reactions, and predictors of outcomes. In A. M. La Greca, W. K. Silverman, E. M. Vernberg, & M. C. Roberts (Eds.), *Helping children cope with disasters and terrorism* (pp. 11–33). Washington, D.C.: American Psychological Association

Silverman, J.G., Raj, A., Mucci, L.A., & Hathaway, J.E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behaviour, pregnancy and suicidality. *JAMA,* 286: 572-579

Sivagurunathan, M., Orchard, T., Macdermid, J. & Evans, M. (2018). Barriers and facilitators affecting self-disclosure among male survivors of child sexual abuse: The service providers' perspective. *Child Abuse and Neglect, 88.* DOI: 10.1016/j.chiabu.2018.08.015

Smith, C.A., Thornberry, T.P., & Fielord, T.O. (204). Adolescent Maltreatment and It's Impact: Timing Matters. *The Prevention Researcher 11*(1): 7-11.

Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., … Jain, A. (2017). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 state report.* Retrieved from the Centres for Disease Control and Prevention, National Center for Injury Prevention and Control: https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf

Smothers, M.K., & Smothers, B. (2011). A Sexual Assault Primary Prevention Model with Diverse Urban *Youth. Journal of Child Sexual Abuse 20*(6):708-27. DOI: 10.1080/10538712.2011.622355

Social Services Select Committee (2014). *Inquiry into the funding of specialist sexual violence social services.* Wellington: House of Representatives.

Socolar, R. R. S. (1996). Physician knowledge of child sexual abuse. *Child Abuse and Neglect, 20*(8), 783–790. https://doi.org/10.1016/0145-2134(96)00065-8

Socolar, R. R. S., Raines, B., Chen-Mok, M., Runyan, D. K., Green, C., & Paterno, S. (1998). Intervention to improve physician documentation and knowledge of child sexual abuse: A randomized, controlled trial. *Paediatrics, 101*(5), 817–824. https://doi.org/10.1542/peds.101.5.817

Sowmya, B. T. S., Seshadri, S. P., Srinath, S., Girimaji, S., & Sagar, J. V. (2016). Clinical characteristics of children presenting with history of sexual abuse to a tertiary care centre in India. *Asian Journal of Psychiatry, 19*, 44–49. https://doi.org/10.1016/j.ajp.2015.12.007

Stake, R. E. (2006). *Multiple case study analysis*. New York, NY: Guilford.

Stake, R.E. (1995). *The art of case study research.* London: Sage Publications Ltd.

Stephen, J. (2018). Why Carl Rogers' Person-Cantered Approach Is Still Relevant." *Psychology Today Blog* (2018, Apr. 15). Retrieved from: https://www.psychologytoday.com/us/blog/what-doesnt-kill-us/201804/why-carl-rogers-person-centered-approach-is-still-relevant

Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment*, *16* (79), 79-101.doi: 10.1177/1077559511403920.

Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Behaviour, 14*:170–179.

Stotzer, R. L., Silverschanz, P., & Wilson, A. (2013). Gender identity and social services: Barriers to care. *Journal of Social Service Research, 39*: 63–77.

Suarez-Balcazar, Y., Balcazar, F., Taylor-Ritzler, T., Portillo, N., Rodakowsk, J., Garcia-Ramirez, M., & Willis, C. (2011). Development and Validation of the Cultural Competence Assessment Instrument: A Factorial Analysis. *Journal of Rehabilitation*, 77(4): 4-13.

Substance Abuse and Mental Health Services Administration (2014). *Trauma-Informed Care in Behavioural Health Services, Treatment Improvement Protocol (TIP) Series 57, HHS Publication No. (SMA) 13-4801*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sullivan, P.M., & Knutson, J.F. (2000*). Maltreatment and Disabilities: A Population-Based Epidemiological Study. Child Abuse & Neglect, 24*(10): 1257-73. DOI: 10.1016/S0145-2134(00)00190-3

Sutton, C. S., & Dixon, D. (1986). Resistance in parent training: A study of social influence. *Journal of Social and Clinical Psychology,* 4, 133–144.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal, 21*(3): 174-192. DOI 10.1108/MHRJ-01-2015-0006

Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health (Abingdon, England)*, *27*(5), 383–387. https://doi.org/10.1080/09638237.2018.1520973

Taal, M., & Edelaar, M. (1997). Positive and negative effects of a child sexual abuse prevention program. *Child Abuse Negl,* 21(4):399-410.

Tamatea, A. J., Tolliday, D., & Greer, P. (2016). Culture, indigenous peoples and sexual harm: Practice and research issues. *Sexual Abuse in Australia and New Zealand, 7*(1), 1-3.

Together for Girls. (2017). *Together for Girls fact sheet*. Retrieved from: http://www.togetherforgirls.org/wp-content/uploads/201703_T4G_FactSheet_web.pdf. 38.

Treisman, K. (2017). *A Treasure Box for Creating Trauma-Informed Organisations.* London: Jessica Kingsley Publications

Tschannen-Moran, M., Hoy, W. K. (2000). A multidisciplinary analysis of the nature, meaning, and measurement of trust. *Review of Educational Research, 70*, 547-593.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). The effects of adolescent victimization on self-concept and depressive symptoms. *Child Maltreatment, 15*, 76-90. doi:10.1177/1077559509349444

Tyler, K. A. (2002). Social and emotional outcomes of childhood sexual abuse: a review of recent research. *Aggression and Violent Behavior*,7(6), 567–589.

Ullman, S. E., & Townsend, S. M. (2007). Barriers to working with sexual assault survivors: A qualitative study of rape crisis centre workers. *Violence Against Women, 13*(4): 412-443. https://doi.org/10.1177/1077801207299191

United Nations Children's Fund. (2014). *A Statistical Snapshot of Violence Against Girls*. New York, NY: UNICEF. Retrieved from: https://www.unicef.org/publications/files/A_Statistical_snapshot_of_Violence_Against_Adolescent_Girls.pdf.

Vagi, K. J. et al. (2013). Beyond Correlates: A Review of Risk and Protective Factors for Adolescent Dating Violence Perpetration. *J. Youth Adolesc*. 42, 633–649.

Veenema, T., Thornton, C., & Corley, A. (2015). The public health crisis of child sexual abuse in low- and middle-income countries: An integrative review of the literature. *International Journal of Nursing Studies,* 52(4): 864-881.

Vésina, J. & Hébert, M. (2007). Risk factors for victimization in romantic relationships of young women: a review of empirical studies and implications for prevention. *Trauma Violence Abuse.* 2007; 8: 33-66

Vicary, J. R., Klingaman, L. R., & Harkness, W. L. (1995). Risk factors associated with date rape and sexual assault of adolescent girls. *Journal of Adolescence, 18,* 289-306.

Wacker, J., Macy, R., Barger, E., & Parish, S. (2009). Sexual assault prevention for women with intellectual disabilities: a critical review of the evidence. *Intellect Dev Disabil,* 47(4):249–262.

Walsh, K., Zwi, K., Woolfenden, S., & Shlonsky, A. (2015). School-based education programmes for the prevention of child sexual abuse. *Cochrane Database Syst Rev,* (4):CD004380.

Wangamati, C. K., Combs Thorsen, V., Gele, A. A., & Sundby, J. (2016). Postrape care services to minors in Kenya: Are the services healing or hurting survivors? *Int J Womens Health, 8*: 249–259. https://doi.org/10.2147/ijwh.s108316

Wasco. S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly, 26*(2), 120–30.

Wasco, S. M., Campbell, R., & Clark, M. (2002). A multiple case study of rape victim advocates' self-care routines: The influence of organizational context. *American Journal of Community Psychology, 30*(5): 731–60.

Watkeys, J. M., Price, L. D., Upton, P. M., & Maddocks, A. (2008). The timing of medical examination following an allegation of sexual abuse: Is this an emergency? *Archives of Disease in Childhood, 93*(10), 851–856. https://doi.org/10.1136/adc.2007.123604

Weeks, W. (2001). *Access and equity in services against sexual violence*. Paper presented at Seeking Solutions Conference, Gold Coast, Australia, 5–7 September. Retrieved from http://www.austdvclearinghouse.unsw.edu.au/Conference%20papers/Seeksoln/Weeks,Wendy.pdf

Weiner, D.A., Schneider, A., & Lyons, J.S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review.* 31:1199–1205

Weiss C. (1995) Nothing as practical as good theory: exploring theory-based evaluation for comprehensive community initiatives for children and families. In Connell AC, Kubisch L, Schorr B, Weiss CH. (Eds), *New approaches to evaluating community initiatives: volume 1, concepts, methods and contexts*. Washington DC: Aspen Institute.

Weiss C. (1997) How can theory-based evaluation make greater headway? *Evaluation Review* 21: 501–24.

Weiss, H., Coffman, J., & Bohan-Baker, M. (2002). *Evaluation's role in supporting initiative sustainability.* Cambridge, MA: Harvard Family Research Project, Harvard University Graduate School of Education

Weissbecker, I., & Clark, C. (2007). The impact of violence and abuse on women's physical: Can trauma-informed treatment make a difference? *Journal of Community Psychology, 35*(7), 909–923. doi:10.1002/jcop.20189

Wenger, E. (1998). *Communities of practice: Learning, meaning and identity.* Cambridge: Cambridge University.

Wharewera-Mika, J.M. & McPhillips, K.M. (2016). *Good Practice Responding to Sexual Violence: Guidelines for 'Mainstream' Crisis Support Services for Survivors*. Round Two. Auckland: TOAH-NNEST.

Whitman, J. L. (2007). *Teen Action Toolkit: Building a Youth-led Response to Teen Victimization*. National Center for Victims of Crime.

Wilcox, P., Jordan, C., & Pritchard, A. (2006). Fear of acquaintance versus stranger rape as a "master status": towards refinement of the "shadow of sexual assault" *Violence Vict, 21*(3): 355-70. Doi: 10.1891/vivi.21.3.355

Williams, J., & Nelson–Gardell, D. (2012). Predicting resilience in sexually abused adolescents. *Child Abuse & Neglect, 36*(1), 53–63.

Winnard, D., Denny, S., and Fleming, T. (2005). *Successful school health services for adolescents: Best practice review*. Manukau, New Zealand: Kidz First Community Health.

Wisconsin Coalition Against Sexual Assault (2011). *A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organisations*. Wisconsin: Wisconsin Violence Against Women with Disability and Deaf Women Project.

Women's Refuge. (2016). *Annual Report 2016.* Wellington: Women's Refuge.

Women's Refuge (2019). *Women's Refuge Annual Report 2018-2019.* Wellington: Women's Refuge.

Woodley, A., Davis, R. & Metzger, N. (2013). *Breaking the Silence but Keeping Secrets: What Young People Want to Address Sexual Violence*. Auckland: Tu Wahine Trust and HELP Auckland Sexual Abuse HELP Foundation.

Woody, J. D., & Beldin, K. L. (2012). The mental health focus in rape crisis services: Tensions and recommendations. *Violence and Victims, 27*(1), 95–108. https://doi.org/10.1891/0886-6708.27.1.95

World Health Organization. (2002). *Defining sexual health. Report of a technical consultation on sexual health 28-31.* Geneva: World Health Organization.

World Health Organisation. (2002). *World report on violence and health.* Geneva: World Health Organisation.

World Health Organization. (2010). *Violence Prevention: The Evidence*. Geneva: World Health Organization. Retrieved from: http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/evidence_briefings_all.pdf.

World Health Organisation. (2010). *Developing sexual health programmes: A framework for action*. Geneva: World Health Organisation.

World Health Organization. (2017). *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

Wright, V., Akers, S., & Rita, S. (2000). THE Community Awareness Rape Education (CARE) Program for high school students. *Journal of emergency Nursing, 26*(2): 182-185.

Yauch, C. A., & Steudel, H. J. (2002). Cellular manufacturing for small businesses: Key cultural factors that impact the conversion process. *Journal of Operations Management, 20*, 593-617

Ybarra, M. L., Mitchell, K. J. (2013). Prevalence rates of male and female sexual violence perpetrators in a national sample of adolescents. *JAMA Pediatrics, 167*, 1125–1134. doi:10.1001/jamapediatrics.2013.2629
Yin, R. K. (2014). *Case Study Research: Design and methods*. Los Angeles, CA: Sage.

Youthline (2016). *Annual Report 2016*. Wellington: Youthline.

Zwi, K.J., Woolfenden, S.R., Wheeler, D.M., O'brien, T.A., Tait, P., & Williams, K.W. (2007). School-based education programmes for the prevention of child sexual abuse. *Cochrane Database Syst Rev,* (3):CD004380.

Appendix

PARTICIPANT INFORMATION SHEET

1) What is the research project about?

While there are currently best practice crisis response models available to support adults, who have experienced a sexual assault, there appears to be a gap in best practice crisis response services for youth aged 13-25 years. More often than not the crisis response for youth, at present, involves applying adult best practice models – models that do not take into account the developmental milestones and needs of youth.

This research project has been commissioned by Aviva to assemble an empirical and experiential evidence base that will support the co-design of a youth crisis response service for young people who have experienced sexual harm.

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 includes two parts. First, it involves exploring what is known in the existing literature about sexual assault support services for youth that are effective. Second, to engage a range of key stakeholders and agencies to ascertain their views about the current gaps in services and future design of support for youth who have experienced sexual assault that is effective and sustainable.

For participants, the research study involves participating in an interview. Each interview will explore your experiences of, and opinions about, 'best practice' sexual assault support services for youth. 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 up until the research report is written. 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. All written material will be kept for one year after completion of the research and then destroyed.

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 youth 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 youth who have been sexually assaulted, their families/whānau, 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 Sofia Ayushi, SASSC Clinician on 027 722 7286 or sofiaA@avivafamilies.org.nz

9) What if I require further information or have any concerns?

If you require further information, or have concerns about, the research please contact Sofia Ayushi, SASSC Clinician on 027 722 7286 or sofiaA@avivafamilies.org.nz

We appreciate your time and consideration in participating in this research.

This information sheet is for you to keep

Aviva
PO Box 24161
Christchurch 8141
Free phone: 0800 28482 669
Email: enquiries@avivafamilies.org.nz

Interview Consent Form

Research for Sexual Harm Crisis Support Service for Canterbury Youth Project

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 up until the research report is written without affecting my relationship with the researcher, the service or Aviva now or in the future
- My name or identity will not be revealed in any part of 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 co-designing and implementing a sexual assault support service in Canterbury for youth
- The interviews will be audio-taped so that the researcher can accurately record my comments
- I give consent for my comments to be included in the research
- A transcript of my interview will be available from the researcher on request

I understand this consent form and am happy to take part in this research

Name: _____

Signed: _____

Date: _____

Interview Questionnaire

Demographics

Name of participant: Designation:

Interview Date & Time: Interview duration:

Section 1: Respondents and their Agency's Role in the Sexual Violence Response for youth

1. Can you describe your role within your agency?
2. Can you describe your agency's role within the context of responses for youth aged between 13 and 25 years who have experienced sexual harm?

Section 2: Current Situation

I'm wanting to map the services that are currently available for youth who have experienced sexual harm and to identify what currently working well and where are the gaps …

3. What services are currently available for youth aged between 13-25 years who experience sexual harm?
    - Across NZ?
    - Within Christchurch?
4. What is working well for these services for youth aged between 13-25 years?
5. What is not working so well for these services for youth?
6. Where do you see the gaps in services for youth?

Section 3: Design of Service Elements

Anticipated Demand for Service and Presenting Needs

I am interested in estimating the size of the potential target client population for a service for youth who have experienced sexual harm and the demographic and social history characteristics that might need to be considered when the service is designed ...

7. In your experience what is the prevalence of sexual harm of youth in NZ? Canterbury? in any 12-month period? What percentage of this group report such harm? Of those who report, what percentage might access a sexual harm support service?

8. If we think about youth who have experienced sexual harm and their families/whānau and others who support them, can you identify the sorts of presenting needs that a youth sexual harm support service might assist with?

Accessibility

9. What are some of the barriers to accessing a sexual harm support service for youth and how can these barriers be overcome?

10. If we are thinking about maximising the accessibility of a service for youth who have experienced sexual harm, what advice would you give about ways to do that?

11. The literature suggests that access to supports for indigenous peoples, people with disabilities and members of the Rainbow community is poor. How can access be improved for these groups?

Principles

12. In your view what principles/values might underpin a sexual harm support service for youth?

Structure

13. There are a number of different possible locations to deliver a support service for youth who have experienced sexual harm. I will read out a list of such locations and I would like you to think about the benefits and difficulties associated with each?

    - Part of a hub of agencies
    - At home
    - At school
    - At a General Practice
    - A house in a neighbourhood
    - In an office
    - Online
    - any other options?

Service Elements

14. In your view what range of services and supports should a sexual harm support service deliver?

15. From your experience, what practices and approaches are effective in providing a sexual harm support service for youth?

Workforce

16. If we think about the workforce required to deliver a sexual harm support service for youth, do you have any advice about the competencies and/or background required to competently carry out the role?

Infrastructure

17. What organisational infrastructure factors do you think need to be considered to maximise the success of a sexual harm support service for youth?

Legal/Regulatory Frameworks

18. Are there any legal, regulatory or policy frameworks that need to be taken into account when designing a sexual harm support service for youth? In your experience, what is the best way to operationalise these frameworks within this context?

Outcomes

19. In your view, what outcomes might a sexual harm support service for youth seek to achieve or contribute to? Short-term? Longer term?

Section 3: Sustainability

20. Do you have any advice about ways in which to ensure the sexual harm support service for youth is sustainable over the longer term?

Section 4: Summary and Conclusion

21. Do you have any other advice about the design of sexual harm support service for youth that we haven't discussed that you would like to comment on?

22. Can you suggest any papers or information about designing a sexual harm support service for youth that might inform the design and implementation of this service in Canterbury?

Thank you for your participation

Acronyms

ACC	Accident Compensation Corporation
EVABC	Ending Violence Association British Columbia
GP	General Practice
ISSC	Integrated Services for Sensitive Claims
NASASV	National Association of Services Against Sexual Violence, Mildura, Victoria Australia
NatSCEV	National Survey of Children's Exposure to Violence (United States of America)
NSPCC	National Society for the Protection of Cruelty to Children
PFA	Psychological First Aid
RTLB	Resource Teacher: Learning and Behaviour
SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
SASH	Sexual Abuse Support and Healing
SASSC	Sexual Assault Support Service Canterbury
Shama	Shama Ethnic Women's Trust
SHCSS	Sexual Harm Crisis Support Service
WHO	World Health Organisation
WINZ	Work and Income New Zealand